

STATE OF HAWAII

**DEPARTMENT OF HUMAN SERVICES
MED-QUEST DIVISION
KAPOLEI, HAWAII**

**Legal Ad Date: October 10, 2007
REQUEST FOR PROPOSALS**

No. RFP-MQD-2008-006

Competitive Sealed Proposals:

**QUEST Expanded Access (QExA) Managed Care Plans to Cover
Eligible Individuals Who Are Aged, Blind, or Disabled**

**will be received up to 4:30 p.m. Hawaii Standard Time (H.S.T.)
on December 7, 2007
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.

SECTION 10	ADMINISTRATIVE OVERVIEW.....	1
10.100	PURPOSE OF THE REQUEST FOR PROPOSALS	1
10.200	AUTHORITY FOR ISSUANCE OF RFP	1
10.300	ISSUING OFFICER	2
10.400	USE OF SUBCONTRACTORS	2
10.500	ORGANIZATION OF THE RFP	3
SECTION 20	RFP SCHEDULE AND REQUIREMENTS.....	5
20.100	RFP TIMELINE	5
20.200	ORIENTATION.....	5
20.300	SUBMISSION OF WRITTEN QUESTIONS	6
20.400	NOTICE OF INTENT TO PROPOSE	7
20.500	TAX CLEARANCE.....	7
20.600	CERTIFICATE OF GOOD STANDING	8
20.700	DOCUMENTATION.....	9
20.800	ORAL PRESENTATIONS	10
20.900	RULES OF PROCUREMENT	10
20.910	<i>No Contingent Fees.....</i>	<i>10</i>
20.920	<i>Discussions with Applicants</i>	<i>11</i>
20.930	RFP AMENDMENTS	11
20.940	COSTS OF PREPARING PROPOSAL	11
20.950	PROVIDER PARTICIPATION IN PLANNING.....	11
20.960	DISPOSITION OF PROPOSALS	11
20.970	RULES FOR WITHDRAWAL OR REVISION OF PROPOSALS.....	12
20.980	INDEPENDENT PRICE DETERMINATION	12
21.100	CONFIDENTIALITY OF INFORMATION.....	13
21.200	ACCEPTANCE OF PROPOSALS.....	13
21.300	SUBMISSION OF PROPOSALS	14
21.400	DISQUALIFICATION OF APPLICANTS	16
21.500	IRREGULAR PROPOSALS	16
21.600	REJECTION OF PROPOSALS	17
21.700	CANCELLATION OF RFP	18
21.800	OPENING OF PROPOSALS.....	18
21.900	ADDITIONAL MATERIALS AND DOCUMENTATION.....	18
22.100	CONTRACT AWARD NOTICE	18
22.200	PROTESTS	19
SECTION 30	BACKGROUND AND DEPARTMENT OF HUMAN SERVICES RESPONSIBILITIES	21
30.100	SCOPE OF SERVICE AND BACKGROUND	21
30.110	<i>Scope of Service.....</i>	<i>21</i>
30.120	<i>Background.....</i>	<i>21</i>
30.200	DEFINITIONS/ACRONYMS	22
30.300	PROGRAM POPULATION DESCRIPTIONS	44
30.400	OVERVIEW OF THE DEPARTMENT OF HUMAN SERVICES (DHS) RESPONSIBILITIES	47

30.500	ELIGIBILITY AND ENROLLMENT RESPONSIBILITIES.....	48
30.510	<i>Eligibility Determinations</i>	49
30.520	<i>Enrollment Overview</i>	49
30.530	<i>Transition Period Enrollment</i>	52
30.540	<i>Newborn Enrollment</i>	52
30.550	<i>90-Day Grace Period</i>	53
30.560	<i>Annual Health Plan Change Period</i>	54
30.570	<i>Member Enrollment Caps</i>	55
30.580	<i>Member Education Regarding Status Changes</i>	56
30.600	DISENROLLMENT RESPONSIBILITIES.....	57
30.700	COVERED BENEFITS AND SERVICES PROVIDED BY THE DHS.....	59
30.710	<i>State of Hawaii Organ and Transplant (SHOTT) Program</i>	59
30.720	<i>PACE and Pre-PACE Programs</i>	59
30.730	<i>Dental Services</i>	59
30.740	<i>Behavioral Health Services for Adults with Serious Mental Illness (SMI)</i>	60
30.800	COVERED BENEFITS AND SERVICES PROVIDED BY OTHER STATE AGENCIES.....	60
30.810	<i>School Health Services</i>	60
30.820	<i>Department of Health (DOH) Programs</i>	61
30.820.1	<i>Vaccines for Children (VFC) Program</i>	61
30.820.2	<i>Zero-To-Three Program</i>	61
30.820.3	<i>Behavioral Health Services for Adults with Serious Mental Illness/Serious Persistent Mental Illness (SMI/SPMI)</i>	62
30.820.4	<i>Behavioral Health Services for Children/Support for Emotional and Behavioral Development (SEBD) Program</i>	62
30.820.5	<i>Specific Services for Individuals with Developmental Disabilities/Mental Retardation (DD/MR)</i>	62
30.900	MONITORING AND EVALUATION.....	62
30.910	<i>General Overview</i>	62
30.920	<i>Quality Assessment and Performance Improvement (QAPI) Program Monitoring</i>	63
30.930	<i>External Quality Review/Monitoring</i>	65
30.940	<i>Case Study Interviews</i>	67
30.950	<i>QExA Policy Memoranda</i>	67
30.960	<i>Readiness Review</i>	67
31.100	INFORMATION TECHNOLOGY (IT).....	68
SECTION 40	PROVISION OF SERVICES – HEALTH PLAN RESPONSIBILITIES.....	71
40.100	HEALTH PLAN’S ROLE IN MANAGED CARE & QUALIFIED HEALTH PLANS.....	71
40.200	PROVIDER NETWORK.....	71
40.210	<i>General Provisions</i>	71
40.220	<i>Specific Minimum Requirements</i>	76
40.230	<i>Availability of Providers</i>	79
40.240	<i>Geographic Access of Providers</i>	80
40.250	<i>Expanding Personal Assistance Services Level I and HCBS</i>	81
40.260	<i>Primary Care Providers (PCPs)</i>	81
40.270	<i>Direct Access to Women’s Health Specialists</i>	84
40.280	<i>Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)</i>	84

40.290	<i>Certified Nurse Midwives, Pediatric Nurse Practitioners, Family Nurse Practitioners and Behavioral Health Nurse Practitioners</i>	85
40.295	<i>Rural Exceptions</i>	85
40.300	PROVIDER “GAG RULE” PROHIBITION.....	86
40.400	PROVIDER CREDENTIALING, RECREDENTIALING AND OTHER CERTIFICATION	88
40.500	PROVIDER CONTRACTS.....	89
40.600	PROVIDER SERVICES.....	95
40.610	<i>Provider Education</i>	95
40.620	<i>Provider Grievance, Complaints and Appeals Process</i>	97
40.630	<i>Provider Manual</i>	97
40.640	<i>Provider Call-Center/PA Line</i>	102
40.650	<i>Web-site for Providers</i>	103
40.700	COVERED BENEFITS AND SERVICES.....	103
40.710	<i>General Overview</i>	103
40.720	<i>Primary and Acute Services - Physical Health</i>	105
40.730	<i>Primary and Acute Services – Behavioral Health</i>	106
40.740	<i>Long-Term Care Services</i>	106
40.750	<i>Coverage Provisions</i>	107
40.750.1	<i>Primary and Acute Care Services – Physical Health</i>	107
40.750.2	<i>Primary and Acute Care Services - Behavioral Health</i>	127
40.750.3	<i>Long-Term Care Services</i>	132
40.750.4	<i>Expanded Personal Assistance Services Level I Capacity</i>	143
40.750.5	<i>Expanded HCBS Capacity</i>	145
40.760	<i>Services to Persons with Neurotrauma</i>	147
40.770	<i>Self-Direction</i>	147
40.780	<i>Sub-Acute Level of Care</i>	154
40.800	SERVICE COORDINATION, ASSESSMENTS & CARE PLANS.....	154
40.810	<i>Service Coordination System</i>	154
40.820	<i>Assessments</i>	159
40.830	<i>Care Plan</i>	161
40.900	OTHER SERVICES TO BE PROVIDED.....	164
40.910	<i>Cultural Competency Plan</i>	164
40.920	<i>Disease Management</i>	165
40.930	<i>Children with a Disability who are Receiving Foster Care/Child Protective Services (CPS)</i>	166
40.940	<i>Vaccines for Children (VFC) Program</i>	167
40.950	<i>Children’s Medical and Behavioral Health Services (EPSDT Services)</i>	168
41.100	SECOND OPINIONS	172
41.200	ADVANCE DIRECTIVES	173
41.300	OUT-OF-STATE AND OFF-ISLAND COVERAGE	174
41.400	OTHER COORDINATION ACTIVITIES	175
41.410	<i>Collaboration with the Alcohol and Drug Abuse Division (ADAD)</i>	175
41.420	<i>Supplemental Nutrition Program for Women, Infants, and Children (WIC) Coordination</i>	176
41.500	TRANSITION OF CARE TO AND FROM THE HEALTH PLAN.....	177
41.510	<i>Transition to the Health Plan</i>	177

41.520	Transition from the Health Plan	177
41.530	Transition of Care Policies and Procedures.....	178
SECTION 50	HEALTH PLAN ADMINISTRATIVE REQUIREMENTS.....	179
50.100	HEALTH PLAN ENROLLMENT RESPONSIBILITIES.....	179
50.110	General Overview	179
50.120	Hospitalizations and Short Stays (Less than 30 Days) in Long-Term Care Residential Facilities During Enrollment Changes.....	180
50.130	PCP Selection.....	181
50.140	Member Status Change.....	181
50.150	Newborn Enrollment.....	182
50.160	Enforcement of Documentation Requirements.....	182
50.170	Informational Brochure.....	182
50.180	Collection of Spend-Down Amounts.....	182
50.200	DISENROLLMENT.....	183
50.210	Acceptable Reasons for Health Plan Disenrollment Requests	183
50.220	State of Hawaii Organ and Tissue Transplant Program (SHOTT)	183
50.230	Unacceptable Reasons for Health Plan Initiated Disenrollment Requests.....	184
50.300	MEMBER SERVICES	184
50.310	General Requirements.....	184
50.320	Member Education.....	185
50.330	Requirements for Written Materials.....	187
50.340	Member Handbook Requirements.....	188
50.350	Member Rights	193
50.360	Provider Directory	195
50.370	Member Identification (ID) Card.....	196
50.380	Member Toll-Free Call Center.....	196
50.390	Internet Presence/Web-Site	198
50.395	Translation Services.....	198
50.400	MARKETING AND ADVERTISING	199
50.410	Prohibited Activities.....	199
50.420	Allowable Activities	200
50.430	State Approval of Materials.....	200
50.500	QUALITY MANAGEMENT	201
50.510	Accreditation.....	201
50.520	General Provisions.....	201
50.530	Quality Assessment and Performance Improvement (QAPI) Program.....	204
50.540	Performance Improvement Projects (PIPs).....	205
50.550	Performance Measures.....	207
50.550.1	Clinical Measures.....	207
50.550.2	EPSDT Participation.....	209
50.555	Performance Standards.....	210
50.560	Data Collection Procedures.....	211
50.570	Practice Guidelines.....	211
50.580	Medical Records Standards	213
50.590	External Quality Review Organization (EQRO).....	216

50.595	<i>Performance Incentives</i>	216
50.600	UTILIZATION MANAGEMENT PROGRAM (UMP)	217
50.700	AUTHORIZATION OF SERVICES	219
50.800	MEMBER GRIEVANCE SYSTEM	221
50.805	<i>General Requirements</i>	221
50.810	<i>Recordkeeping</i>	222
50.815	<i>Inquiry Process</i>	223
50.820	<i>Grievance Process</i>	223
50.825	<i>State Grievance Review</i>	224
50.830	<i>Appeals Process</i>	225
50.835	<i>Expedited Appeal Process</i>	226
50.840	<i>State Administrative Hearing for Regular Appeals</i>	228
50.845	<i>Expedited State Administrative Hearings</i>	229
50.850	<i>Continuation of Benefits During an Appeal or State Administrative Hearing</i>	230
50.855	<i>External Review Procedures</i>	231
50.860	<i>Notice of Action</i>	231
50.900	INFORMATION TECHNOLOGY	234
50.910	<i>General Requirements</i>	234
50.920	<i>Expected Functionality</i>	234
50.930	<i>Method of Data Exchange with MQD</i>	235
50.940	<i>Compliance with the Health Insurance Portability and Accountability Act (HIPAA)</i>	235
50.950	<i>Possible Audits of Health Plan Information Technology</i>	235
50.960	<i>Health Plan Information Technology Changes</i>	235
50.970	<i>Disaster Planning and Recovery Operations</i>	235
51.100	FRAUD & ABUSE	237
51.110	<i>General Requirements</i>	237
51.120	<i>Reporting and Investigating Suspected Fraud and Abuse</i>	237
51.130	<i>Compliance Plan</i>	238
51.140	<i>Employee Education About False Claims Recovery</i>	240
51.150	<i>Child and Adult Abuse Reporting Requirements</i>	240
51.200	HEALTH PLAN PERSONNEL	240
51.210	<i>General Requirements</i>	240
51.220	<i>Specific Descriptions</i>	243
51.300	REPORTING REQUIREMENTS	247
51.310	<i>General Requirements</i>	247
51.320	<i>Provider Network Reports</i>	251
51.320.2	<i>GeoAccess (Or Similar Program) Reports</i>	251
51.320.3	<i>PCP Report</i>	252
51.320.4	<i>Timely Access Report</i>	252
51.320.5	<i>Annual Report of Services Rendered to Members by an FQHC or RHC</i>	253
51.320.6	<i>Provider Suspensions and Termination Report</i>	253
51.330	<i>Provider Services Reports</i>	254
51.330.1	<i>Provider Complaints Report</i>	254
51.340	<i>Covered Benefits and Services Reports</i>	255
51.340.1	<i>Long-Term Care Services Report</i>	255

51.340.2	<i>Personal Assistance Services Level I Report</i>	256
51.340.3	<i>HCBS Report</i>	256
51.340.4	<i>Service Coordinator Report</i>	256
51.340.5	<i>CMS 416 Report – EPSDT</i>	257
51.350	<i>Member Services Reports</i>	257
51.350.1	<i>Call Center Report</i>	257
51.350.2	<i>Translation/Interpretation Services Report</i>	258
51.350.3	<i>Requests for Documents in Alternate Languages Report</i>	258
51.350.4	<i>Member Grievance and Appeals Report</i>	258
51.360	<i>Quality Assessment and Performance Improvement (QAPI) Program Reports</i>	259
51.360.2	<i>QAPI Program Description</i>	259
51.360.3	<i>QAPI Program Evaluation</i>	260
51.360.4	<i>Proposed Performance Improvement Projects (PIPs)</i>	260
51.360.5	<i>PIP Evaluation</i>	260
51.360.6	<i>Proposed Performance Measures</i>	261
51.360.7	<i>Performance Measures</i>	261
51.360.8	<i>Performance Measures Evaluation</i>	261
51.360.9	<i>Health Plan Employer Data and Information Set (HEDIS) Report</i>	261
51.370.1	<i>Prior Authorization Requests Denied/Deferred</i>	261
51.370.2	<i>Report of Over- and Under-Utilization of Drugs</i>	262
51.370.3	<i>Report of Over- and Under-Utilization of Services</i>	263
51.380	<i>Administration and Financial Reports</i>	264
51.380.1	<i>Fraud and Abuse Summary Reports</i>	264
51.380.2	<i>QExA Financial Reporting Guide</i>	265
51.380.3	<i>Third Party Liability (TPL) Cost Avoidance Report</i>	265
51.380.4	<i>Disclosure of Information on Annual Business Transaction Report</i>	266
51.380.5	<i>Encounter Data/Financial Summary Reconciliation Report</i>	267
51.390	<i>Incentive Reports</i>	267
51.390.1	<i>Personal Assistance Services Level I Report Incentive Report</i>	267
51.390.2	<i>HCBS Incentive Report</i>	268
51.390.3	<i>Additional Incentive Reports</i>	268
51.395	<i>Encounter Data Reporting</i>	268
51.395.1	<i>Accuracy, Completeness and Timeliness of Encounter Data Submissions</i>	268
51.400	HEALTH PLAN CERTIFICATION	270
51.500	FOLLOW-UP BY HEALTH PLANS/CORRECTIVE ACTION PLANS/POLICIES AND PROCEDURES	271
51.600	READINESS REVIEW	272
51.610	<i>Required Review Documents</i>	272
51.620	<i>Implementation Plans</i>	276
51.630	<i>Updated GeoAccess Reports</i>	276
SECTION 60	FINANCIAL RESPONSIBILITIES	278
60.100	THE DHS RESPONSIBILITIES	278
60.110	<i>Daily Rosters/Health Plan Reimbursement</i>	278
60.120	<i>Incentives for Health Plan Performance</i>	279
60.120.1	<i>Diabetes Mellitus</i>	280
60.120.5	<i>Incentives for SFY 2011</i>	282

60.130	<i>Third-Party Liability (TPL)</i>	283
60.140	<i>Catastrophic Care</i>	283
60.150	<i>Risk Share Program</i>	283
60.200	HEALTH PLAN RESPONSIBILITIES.....	284
60.210	<i>Daily Rosters/Health Plan Reimbursement</i>	284
60.220	<i>Provider and Subcontractor Reimbursement</i>	284
60.230	<i>Physician Incentives</i>	287
60.240	<i>Billing Members and Non-Payment to Providers</i>	288
60.250	<i>Collection of Spend-Down Amounts</i>	289
60.260	<i>Third-Party Liability (TPL)</i>	289
60.270	<i>Catastrophic Care</i>	291
SECTION 70	TERMS AND CONDITIONS	293
70.100	GENERAL.....	293
70.110	<i>Compliance with other Federal Laws</i>	295
70.200	TERM OF THE CONTRACT.....	295
70.210	<i>Availability of Funds</i>	297
70.300	CONTRACT CHANGES.....	297
70.400	HEALTH PLAN PROGRESS.....	298
70.410	<i>Readiness Review</i>	298
70.420	<i>Ongoing Inspection of Work Performed</i>	298
70.500	SUBCONTRACTOR AGREEMENTS.....	298
70.600	REINSURANCE.....	301
70.700	APPLICABILITY OF HAWAII REVISED STATUTES.....	301
70.710	<i>Licensed as a Health Plan</i>	301
70.720	<i>Wages, Hours and Working Conditions of Employees Providing Services</i>	302
70.730	<i>Standards of Conduct</i>	302
70.740	<i>Campaign Contributions by State and County Contractors</i>	302
70.800	DISPUTES.....	302
70.900	AUDIT REQUIREMENTS.....	303
70.910	<i>Accounting Records Requirements</i>	303
70.920	<i>Inclusion of Audit Requirements in Subcontracts</i>	304
71.100	RETENTION OF MEDICAL RECORDS.....	304
71.200	CONFIDENTIALITY OF INFORMATION.....	304
71.300	LIQUIDATED DAMAGES, SANCTIONS AND FINANCIAL PENALTIES.....	306
71.310	<i>Liquidated Damages</i>	306
71.320	<i>Sanctions</i>	307
71.330	<i>Special Rules for Temporary Management</i>	310
71.400	USE OF FUNDS.....	310
71.500	PERFORMANCE BOND.....	311
71.600	ACCEPTANCE.....	312
71.700	EMPLOYMENT OF DEPARTMENT PERSONNEL.....	312
71.800	WARRANTY OF FISCAL INTEGRITY.....	312
71.900	FULL DISCLOSURE.....	313
71.910	<i>Litigation</i>	314
72.100	TERMINATION OF THE CONTRACT.....	314

72.110	Termination for Default.....	314
72.120	Termination for Expiration or Modification of the Programs by CMS.....	315
72.130	Termination for Bankruptcy or Insolvency.....	315
72.140	Procedure for Termination.....	316
72.150	Termination Claims.....	318
72.200	CONFORMANCE WITH FEDERAL REGULATIONS.....	319
72.300	FORCE MAJEURE.....	319
72.400	CONFLICT OF INTEREST.....	320
72.500	PROHIBITION OF GRATUITIES.....	321
72.600	PUBLICITY.....	321
72.700	NOTICES.....	322
72.800	ATTORNEY’S FEES.....	322
72.900	AUTHORITY.....	322
SECTION 80	MANDATORY AND TECHNICAL PROPOSAL.....	324
80.100	INTRODUCTION.....	324
80.200	MANDATORY REQUIREMENTS.....	324
80.210	Attachment: Transmittal Letter.....	324
80.220	Company Background Narrative.....	326
80.230	Attachment: Other Documentation.....	326
80.240	Attachment: Financial Statements.....	328
80.300	TECHNICAL PROPOSAL.....	329
80.310	EXPERIENCE AND REFERENCES (10 PAGES MAXIMUM NOT INCLUDING ATTACHMENTS).....	329
80.315	PROVIDER NETWORK (7 PAGES MAXIMUM NOT INCLUDING ATTACHMENTS).....	330
80.315.1	Provider Network Narrative.....	330
80.315.2	Provider Network Attachment: Letters of Intent (LOIs).....	331
80.320	Provider Services (8 pages maximum not including attachments).....	334
80.320.1	Provider Services Narrative - Provider Credentialing and Recredentialing.....	334
80.320.2	Provider Services Narrative – General Requirements.....	334
80.325	COVERED BENEFITS AND SERVICES (18 PAGES MAXIMUM).....	335
80.325.1	Covered Benefits and Services Narrative.....	335
80.330	SERVICE COORDINATION, ASSESSMENTS AND CARE PLANS (18 PAGES MAXIMUM).....	336
80.330.2	Service Coordination, Assessments and Care Plans Narrative - Assessments.....	337
80.340	TRANSITION OF CARE NARRATIVE (5 PAGES MAXIMUM).....	338
80.345	MEMBER SERVICES (8 PAGES MAXIMUM).....	338
80.345.1	Member Services Narrative - General Member Services.....	338
80.345.2	Member Services Narrative - Toll-free Call Center and Twenty-Four Hour Nurse Line.....	339
80.350	QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) (20 PAGES MAXIMUM).....	339
80.350.1	QAPI Narrative – General Provisions.....	339
80.350.2	QAPI Narrative – QAPI Program.....	340
80.350.3	QAPI Narrative - Performance Measures.....	340
80.350.4	QAPI Narrative - Medical Records Standards.....	341
80.350.5	QAPI Narrative - Performance Improvement Projects (PIPs).....	341
80.355	UTILIZATION MANAGEMENT PROGRAM (UMP) AND AUTHORIZATION OF SERVICES (6 PAGES MAXIMUM).....	342

80.360	INFORMATION TECHNOLOGY NARRATIVE (15 PAGES MAXIMUM)	343
80.365	GENERAL ADMINISTRATIVE REQUIREMENTS (12 PAGES MAXIMUM NOT INCLUDING ATTACHMENTS)....	344
80.365.2	<i>General Administrative Requirements Narrative - Organization Charts and Narrative on Organization Charts.....</i>	<i>344</i>
80.365.3	<i>General Administrative Requirements Narrative - Organization and Staffing Table.....</i>	<i>344</i>
80.365.5	GENERAL ADMINISTRATIVE REQUIREMENTS NARRATIVE - REPORTING REQUIREMENTS	345
80.370	FINANCIAL RESPONSIBILITIES (6 PAGES MAXIMUM NOT INCLUDING ATTACHMENTS)	345
SECTION 90	BUSINESS PROPOSAL/BID RATE SUBMISSIONS	349
90.100	INTRODUCTION.....	349
90.200	OVERVIEW OF THE RATE STRUCTURE	349
90.300	BIDDING RULES AND REQUIREMENTS.....	350
90.400	BID RATE ADJUSTMENTS.....	351
90.500	FUTURE RATE SETTING.....	352
90.600	ACTUARIAL CERTIFICATION SPECIFICATIONS	352
SECTION 100	EVALUATION AND SELECTION.....	354
100.100	INTRODUCTION.....	354
100.200	EVALUATION COMMITTEE(S)	355
100.300	MANDATORY PROPOSAL EVALUATION.....	355
100.400	TECHNICAL PROPOSAL EVALUATION	356
100.500	BUSINESS PROPOSAL EVALUATION	357
100.700	CONTRACT AWARD.....	358

Appendices

- Appendix A Written Questions Forma
- Appendix B Risk Share Program
- Appendix C Population Descriptions
- Appendix D Behavioral Health Definitions and Information
- Appendix E Covered Preventive Services for Adults and Children
- Appendix F Dental Procedures Which are the Responsibility of the Health Plan
- Appendix G QExA Service Coordinator Responsibilities and Ratios
- Appendix H LOC Instructions and Forms
- Appendix I EPSDT Screening Form
- Appendix J CMS-416 Form
- Appendix K General Conditions for Health & Human Services Contracts
- Appendix L Proposal Forms
- Appendix M Sample Letters of Intent

SECTION 10 ADMINISTRATIVE OVERVIEW

10.100 Purpose of the Request for Proposals

This Request for Proposals (RFP) solicits participation by qualified and properly licensed health plans to provide required service coordination, outreach, improved access, and enhanced quality healthcare services through a managed care system for the State's Medicaid aged, blind or disabled (ABD) members who are currently not covered through a managed care system across the continuum of care. 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 eligibility groups and to negotiate different or new rates to include coverage of these new groups. Services to health plan members under the contracts awarded shall commence on the date identified in Section 20.100.

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

The DHS reserves the right to modify, amend, change, add or delete any requirements in this RFP and the documentation library to serve the best interest of the State. If significant amendments are made to the RFP, the applicants 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 applicants are charged with presumptive knowledge of all

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

10.300 Issuing Officer

This RFP is issued by the State of Hawaii, 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 applicant. The Issuing Officer is:

Ms. Lois Lee
Acting Med-QUEST Division Administrator
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 applicant and shall have responsibility for not less than forty percent (40%) of the work to be performed. The project leader shall be an employee of the prime applicant 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 applicant shall be wholly responsible for the entire performance whether or not subcontractors are used. The prime applicant 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 QExA program, provides definitions, and describes the role of the DHS.
- Section 40 – Provisions of Services – Health Plan Responsibilities – Provides information on the medical, behavioral health, service coordination and long-term care 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/Bid Rate Submissions – 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	October 10, 2007
Orientation	October 18, 2007
Submission of Written Questions	October 26, 2007
Notice of Intent to Propose	October 29, 2007
Written Responses to Questions	November 16, 2007
Proposal Due Date	December 7, 2007 at 4:30 p.m. (H.S.T.)
Oral Presentations	January 1 – 31, 2008 (specific dates to be determined)
Contract Award	February 1, 2008
Contract Effective Date	February 15, 2008
Commencement of Services to Members	November 1, 2008

20.200 Orientation

The Orientation for applicants in reference to this RFP will be held on the date identified in Section 20.100 at 9:30 a.m (H.S.T.) in Room 167 in the Kakuhihewa Building, 601 Kamokila Boulevard, Kapolei, Hawaii. Teleconference services will be available. Applicants interested in participating via teleconference shall send an e-mail requesting that the call-in number be e-mailed to them. The applicant shall send this e-mail to gexarfp@medicaid.dhs.state.hi.us no later than 12:00 noon (H.S.T.) on the day 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 deadline for Submission of Written Questions indicated in Section 20.100.

20.300 Submission of Written Questions

Applicants shall submit questions in writing via e-mail or on diskette in Word 2003 format or lower to the following mailing address or e-mail address:

Ms. Lois Lee
C/O Ms. Dona Jean Watanabe
Med-QUEST Division (MQD) - Finance Office
1001 Kamokila Boulevard, Suite 317
Kapolei, Hawaii 96707-2005
Email Address: qexarfp@medicaid.dhs.state.hi.us

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

20.400 Notice of Intent to Propose

Applicants shall submit a Notice of Intent to Propose to the Issuing Officer no later than 4:30 p.m. (H.S.T.) on the date identified in Section 20.100. Submission of a Notice of Intent to Propose is not a prerequisite for the submission of a proposal, but it is necessary that the Issuing Officer receive the letter by this deadline to assure proper distribution of amendments, questions and answers and other communication regarding this RFP.

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

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

20.500 Tax Clearance

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

Tax clearance certificates are valid for a six (6)-month period (not one hundred eighty (180) days) 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. 2006) which is available at the DOTAX and IRS office in the State of Hawaii or the DOTAX website, and by mail or fax:

DOTAX Website (Forms & Information): <http://www.state.hi.us/tax/tax.html>
DOTAX forms by mail: (808) 587-7572 or 1-800-222-7572
DOTAX forms by fax: (on Oahu) (808) 587-7272
(outside Oahu) (808) 678-0522

The applicant is also required to submit an original current tax clearance certificate for final payment on the contract.

20.600 Certificate of Good Standing

The health plan shall be required to obtain a Certificate of Good Standing from the Department of Commerce and Consumer Affairs (DCCA) Business Registration Division (BREG). Any health plan awarded a contract shall submit the Certificate of Good Standing to the DHS with its signed contract.

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. The health plan shall submit a “Certificate of Good Standing” which 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 p.m. (H.S.T.)). The “Certificate of Good Standing” is valid for six (6) months from date of issue and must be valid on the date it is received by the purchasing agency. There are costs associated with registering and obtaining a “Certificate of Good Standing” from the DCCA; these costs are the responsibility of the health plan.

20.700 Documentation

Applicants may review information describing Hawaii's Medicaid programs by contacting the Med-QUEST Division, Health Coverage Management Branch secretary by telephone at (808) 692-8085 between 9:00 a.m. (H.S.T.) and 3:00 p.m. (H.S.T.) 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.

- QExA RFP Summary
- Organization charts and functional statements
- QUEST Policy Memorandum Manual
- Standards of Internal Quality Assurance
- HEDIS
- QUEST Financial Reporting Guide
- Current QUEST Formulary
- Information on the development of the QExA capitated rate ranges
- Memoranda of Agreements between DHS and DOH
- Medicaid Provider Manual
- QUEST Financial Reporting Guide
- 2005-2006 Performance Improvement Projects (PIPs) Policy
- QUEST Encounter Data/Financial Summary Reconciliation Form
- QUEST EPSDT periodicity schedule
- Current FFS fee schedule
- Current FFS provider network
- Other pertinent data

Applicants 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 applicants.

All reasonable 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 documentation library is complete or correct and reserves the right to amend, delete and modify the information at any time without notice to the applicants.

20.800 Oral Presentations

Applicants who submit a proposal in response to this RFP will be required to make an oral presentation of their proposal. Additional information about the oral presentations is in Section 80.375.

20.900 Rules of Procurement

To facilitate the procurement process, various rules have been established as described in the following subsections. This procurement is subject to HRS chapter 103F and Hawaii Administrative Rules (HAR), Title 3, Subtitle 11 (chapters 3-140, et seq.) (hereinafter “the procurement rules”). If the terms of this RFP conflict with the procurement rules, then the procurement rules then in effect will apply.

20.910 No Contingent Fees

No applicant shall employ any company or person, other than a bona fide employee working solely for the applicant or company regularly employed as its marketing agent, to solicit or secure this contract, nor shall it pay or agree to pay any company or person, other than a bona fide employee working solely for the applicant or a company regularly employed by the applicant as its marketing agent, any fee commission, percentage, brokerage fee, gift, or other consideration contingent upon or resulting from the award of a contract to perform the specifications of this RFP.

20.920 Discussions with Applicants

The DHS may engage in discussions with applicants only to the extent allowed and under conditions established by the procurement rules at chapter 3-143, subchapter 4, Allowable Communications.

20.930 RFP Amendments

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

20.940 Costs of Preparing Proposal

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

20.950 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 HAR § 3-142-202 and 3-142-203.

20.960 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.

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

20.970 Rules for Withdrawal or Revision of Proposals

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

After the Proposal Due Date as defined in Section 20.100, all proposals timely received shall be deemed to be firm offers that are binding on the applicants for ninety (90) days. During this period, applicants may neither modify nor withdraw their proposals without written authorization or invitation from the DHS.

20.980 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 applicant or with any competitor.

The applicant 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 applicant shall assume all costs of this project until such time that a new applicant is selected.

21.100 Confidentiality of Information

The DHS will maintain the confidentiality of proposals only to the extent allowed or required by law, including but not limited to HRS § 92F-13, and HAR §§ 3-143-604 and 3-143-616. If the applicant 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. **Note that price is not considered confidential and will not be withheld.** Blanket labeling of the entire document as “proprietary” or “confidential” will result in none of the document being considered proprietary or confidential.

21.200 Acceptance of Proposals

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

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

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

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

21.300 Submission of Proposals

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

The business proposal shall be submitted in a separate envelope or box from the technical proposal. The applicant shall supply six (6) bound copies of the technical proposal, one (1) unbound copy of the technical proposal, and a complete electronic version, in MS Word 2003 or lower or PDF, of the technical proposal on a CD. In a separate envelope or box, the applicant shall supply four (4) bound copies of the business proposal, one (1) unbound copy of the business proposal, and a complete electronic version, in MS Word or Excel (version 2003 or lower) of the business proposal on a CD. Both the technical and business proposals shall be received by the Issuing Officer no later than the Proposal Due Date identified in Section 20.100, or postmarked by the USPS no later than the date identified in Section 20.100. All mail-ins postmarked by USPS after the Proposal Due Date will be rejected. Hand deliveries will not be accepted after 4:30 p.m. (H.S.T.) on the Proposal Due Date. 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.) on the Proposal Due Date. Proposals shall be mailed or delivered to:

Attn: Ms. Lois Lee
C/O Ms. 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-2008-006
QUEST Expanded Access (QExA) Managed Care to Cover Medicaid
Individuals Who Are Aged, Blind or Disabled
Technical Proposal
(Name of Applicant)

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

Hawaii DHS/RFP-MQD-2008-006
QUEST Expanded Access (QExA) Managed Care to Cover Medicaid
Individuals Who Are Aged, Blind or Disabled
Business Proposal
(Name of Applicant)

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

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

21.400 Disqualification of Applicants

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

- Proof of collusion among applicants, 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 applicant;
- An applicant's lack of responsibility and cooperation as shown by past work or services;
- An applicant's being in arrears on existing contracts with the State or having defaulted on previous contracts;
- An applicant shows any noncompliance with applicable laws;
- An applicant's delivery of proposal after the proposal due date;
- An applicant's failure to pay, or satisfactorily settle, all bills overdue for labor and material on former contracts with the State at the time of issuance of this RFP;
- An applicant's lack of financial stability and viability;
- An applicant's consistently substandard performance related to meeting the MQD requirements from previous contracts; or
- Failure to show proof of accreditation by National Committee for Quality Assurance (NCQA), American Accreditation HealthCare Commission/URAC or Joint Commission on Accreditation of HealthCare Organizations (JCAHO) in any state in which the applicant is currently operating.

21.500 Irregular Proposals

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

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

21.600 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:

1. Rejection for failure to cooperate or deal in good faith (§ 3-141-201, HAR);
2. Rejection for inadequate accounting system (§ 3-141-202, HAR);
3. Late Proposals (§ 3-143-603, HAR);
4. Unauthorized Multiple/Alternate Proposals (§ 3-143-605, HAR);
5. Inadequate response to RFPs (§ 3-143-609, HAR);
6. Proposal not responsive (§ 3-143-610 (1), HAR); or
7. Applicant not responsible (§ 3-143-610(2), HAR).

21.700 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 interest of the State.

21.800 Opening of Proposals

Proposals, modifications to proposals, and withdrawals of proposals shall be date-stamped and, when possible, time-stamped upon receipt by the DHS. All documents so received shall be held in a secure place by the state-purchasing agency (DHS, MQD) and not examined for evaluation purposes until the Proposal Due Date.

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

21.900 Additional Materials and Documentation

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

22.100 Contract Award Notice

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

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

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

22.200 Protests

Applicants may file a Notice of Protest against the awarding of the contract. The Notice of Protest form, SPO-H-801, is available on the State Procurement Office (SPO) website 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.

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

Head of State Purchasing Agency	Chief Procurement Officer for the DHS
<p>Lillian B. Koller, Esq. Director, Department of Human Services, State of Hawaii</p> <p><u>Mailing Address:</u> P.O. Box 339 Honolulu, Hawaii 96809-0339</p> <p><u>Business Address:</u> 1390 Miller St. Honolulu, Hawaii 96813</p>	<p>Lois Lee Acting Administrator, Med-QUEST Division, Department of Human Services, State of Hawaii</p> <p><u>Mailing Address:</u> P.O Box 700190 Kapolei, Hawaii 96709-0190</p> <p><u>Business Address:</u> 1001 Kamokila Boulevard, Suite 317 Kapolei, Hawaii 96707</p>

SECTION 30 BACKGROUND AND DEPARTMENT OF HUMAN SERVICES RESPONSIBILITIES

30.100 Scope of Service and Background

30.110 Scope of Service

The State of Hawaii seeks to contract with health plans to provide service coordination, outreach, improved access, and enhanced quality healthcare services to QUEST Expanded Access (QExA) Medicaid enrollees in a mandatory managed care system.

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 Expanded Access (QExA) program are to:

- Improve the health 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, the health plan and healthcare providers;
- Expand and strengthen a sense of member responsibility and promote independence and choice among members;
- Assure access to high quality, cost-effective care that is provided, whenever possible, in a member’s home and/or community;
- Coordinate care for the members across the benefit continuum, including primary, acute and long-term care benefits;
- Provide home and community based services (HCBS) to persons with neurotrauma;
- Develop a program that is fiscally predictable, stable and sustainable over time; and

- Develop a program that places maximum emphasis on the efficacy of services and offers health plans both incentives for quality and sanctions for failure to meet measurable performance goals.

30.200 Definitions/Acronyms

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

Activities of Daily Living (ADLs) – Activities a person performs on a daily basis, for self care, such as feeding, grooming, bathing, walking, dressing and toileting.

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

- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or part, of payment for a service;
- The failure to provide services in a timely manner, as defined in the contract;
- The failure of the health plan to act within prescribed time frames;
- For a rural area member or for islands with only one health plan or limited providers, the denial of a member's request to obtain services outside the network:
 - From any other provider (in terms of training, experience, and specialization) not available within the network;
 - From a provider not part of a network that is the main source of a service to the member, provided that the provider is given the same opportunity to become a participating provider as other similar providers;

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

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

Adult Day Care Center – A facility, as defined in HAR §17-1417-3, that is licensed by the Department of Human Services and maintained and operated by an individual, organization, or agency for the purpose of providing regular care which includes supportive care to four (4) or more disabled adults.

Adult Day Health Center – A facility, as defined in HAR §11-96-2, that is licensed by the Department of Health to provide organized day programs of therapeutic, social, and health services provided to adults with physical or mental impairments, or both, which require nursing oversight or care, for the purpose of restoring or maintaining, to the fullest extent possible, their capacity for remaining in the community.

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

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 healthcare 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 healthcare plans.

Appeal - A request for review of an action.

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

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

Assisted Living Facility – A facility, as defined in HRS 321-15.1, that is licensed by the Department of Health. This facility shall consist of a building complex offering dwelling units to individuals and services to allow residents to maintain an independent assisted living lifestyle. The facility shall be designed to maximize the independence and self-esteem of limited-mobility persons who feel that they are no longer able to live on their own.

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

Balanced Budget Act of 1997 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.

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

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

Benefit Year - The 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 QExA program and which the health plan arranges to provide to its members.

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

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

Care Plan – As defined in HAR §17-1440-2, a written plan based on an assessment that includes, but is not limited to, the following:

- Goals, objectives or desired outcomes; and
- A list of all services required (Medicaid and non-Medicaid) and their frequency.

The care plan is regularly reviewed and updated and agreed upon by the member and their care coordinator.

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.

The Centers for Medicare & Medicaid Services (CMS) – The organization within the federal Department of Health and Human Services that administers the Medicaid and Medicare programs.

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

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

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.

Community Care Management Agency - An agency licensed by the DHS or its designee under HAR chapter 17-1454, subchapters 1 and 2, to engage in locating, coordinating and monitoring comprehensive services to residents in community care foster family homes or members in E-ARCHS and assisted living facilities. A health plan may be a community care management agency.

Community Care Foster Family Home - A home issued a certificate of approval by the DHS to provide, for a fee, twenty-four (24) hour living accommodations, including personal care and homemaker services. The home must meet all applicable requirements of HAR §17-1454-37 through HAR §17-1454-56.

Contract - Written agreement between the DHS and the contractor, which will include the State's Agreement (form AG3-Comp (4/99)), general conditions (AG Form 103F (09/06), see Appendix K), any special conditions and/or appendices, this RFP, including all attachments and addenda, and the health plan's proposal.

Contract Services - The services to be delivered by the contractor that is designated by the DHS.

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

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

Cost-neutral – When the aggregate cost of serving people in the community is less than the aggregate cost of serving the same (or comparable) population in an institutional setting.

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

Cultural Competency – A set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance, and respect for cultural

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

Days - Unless otherwise specified, 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 – A member's legal spouse or dependent child who meets all eligibility requirements.

Dependent Child - A child under nineteen (19) for whom an enrollee or member 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.

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 healthcare treatment and other measures to correct or ameliorate any conditions identified during the screening process.

Effective Date Of Enrollment - The date from which the health plan is required to provide benefits to a member. This date is the date when eligibility is determined by the DHS and may precede the date upon which the health plan receives notification of enrollment.

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

Encounter Data - A compilation of encounters.

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

Enrollee (Potential) – An individual eligible for the QExA program who is subject to mandatory enrollment or may voluntarily elect to enroll in a MCO, who must make a choice on which plan to enroll into within a specified time designated by the DHS. See also Potential Member.

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

Enrollment Counseling – Functions performed by the State or its designee that relate to outreach and education regarding the QExA program and the potential member’s health plan selection.

Enrollment Counselor – DHS designee who provides one-on-one information and assistance to Medicaid enrollees and potential QExA members in the areas of selecting a QExA health plan and educating them about the QExA program.

Expanded Adult Residential Care Home (E-ARCH) – A facility, as defined in HAR §11-100.1.2 and licensed by the Department of Health, that provides twenty-four (24) hour living accommodations, for a fee, to adults unrelated to the family, who require at least minimal assistance in the activities of daily living, personal care services, protection, and healthcare services, and who may need the professional health services provided in an intermediate care facility or skilled nursing facility. There are two types of expanded care ARCHs in accordance with HRS § 321-1562:

- Type I – home consisting of six (6) or fewer residents with no more than two nursing facility level residents; and
- Type II – home consisting of seven (7) or more residents with no more than twenty percent (20%) of the home’s licenses capacity as nursing level residents.

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 both the health plan's and the State's 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 – 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 enrollee.

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

Fraud - The intentional deception or misrepresentation made by 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 for members 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 enrollees.

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

Health Maintenance Organization (HMO) – See Managed Care Organization.

Health Plan - Any healthcare organization, insurance company or health maintenance organization, which provides covered services on a risk basis to members in exchange for capitation 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.

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

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

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

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

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

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

Incentive Arrangement – Any payment mechanism under which a health plan may receive additional funds over and above the capitation payments 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, 2008 and discharged on July 5, 2008 would be associated with the 2008 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.

Independent Activities of Daily Living (IADLs) – Activities related to independent living, including preparing meals, managing money, shopping for groceries or personal items, and performing light or heavy housework.

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 disenrollment 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.

Long-Term Care – A continuum of care and assistance ranging from in-home and community-based services for elderly people and people with disabilities who need help in maintaining their independence, to institutional care for those who require that level of support.

Long-Term Care Residential Facility - A facility which cares for members who are NF LOC. These facilities are: assisted living facilities, expanded ARCHs, CCFFHs, nursing facilities, and sub-acute units.

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

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 enrollees within the area served by the entity and (b) meets the solvency standards of 42 CFR Section 438.116 and HRS § 432-D-8.

Marketing – Any communication from a health plan to a member or potential member who is not yet enrolled in the health plan, that can reasonably be interpreted as intended to influence the member or potential member 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 federal financial participation (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 – As defined in Hawaii Revised Statutes (HRS) 432E-1.4 or health interventions that the health plans are required to cover within the

specified categories that meet the criteria identified below, whichever is the least restrictive:

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

Medical Condition: 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: outcomes of medical conditions that directly affect the length or quality of a person's life;

Sufficient Evidence: 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: 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 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.

Medically Fragile Child – A child with a condition or conditions that require complex medical and/or ancillary services who is sustained in the community. The child has a need for twenty-four (24) hour oversight of his/her health status and requires an extended amount of multidisciplinary care in a supportive environment to prevent hospitalization or institutionalization.

Medicare - A federal program authorized by Title XVIII of the Social Security Act, as amended, which provides health insurance for persons aged sixty-five (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 C of the program is the Medicare Advantage (managed care) program and is voluntary; Part D of the program covers prescription drugs.

Medicare Special Savings Program Recipients – Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMB's), Qualifying Individuals (QIs) and Qualified Disabled Working Individuals (QDWI).

Member – A Medicaid/QEXA program enrollee who is currently enrolled in a QExA health plan.

Med-QUEST Division (MQD) – The division within the State Department of Human Services that has the responsibility for administering the Medicaid programs, including QExA.

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

Nurse Delegation – In accordance with HAR 16-89-106, the ability of a registered nurse to delegate the special task for nursing care to an unlicensed assistive person.

Nursing Facility (NF) – A facility, as defined in HAR§11-94-2, which provides appropriate care to persons referred by a physician. Such persons are those who:

- Need twenty-four (24) hour a day assistance with the normal activities of daily living;
- Need care provided by licensed nursing personnel and paramedical personnel on a regular, long-term basis, and;
- May have a primary need for twenty-four (24) hours of skilled nursing care on an extended basis and regular rehabilitation services.

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

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

Personal Assistance – Care provided when a member, member’s parent, guardian or legal representative employs and supervises a personal assistant who is certified by the health plan as able to provide the designated services whose decision is based on direct observation of the member and the personal assistant during the actual provision of care. Documentation of this certification will be maintained in the member’s individual plan of care.

Physician - A licensed doctor of medicine or doctor of osteopathy.

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

Potential Member – An enrollee who is subject to mandatory enrollment and must choose a health plan in which to enroll within a specified time frame determined by DHS.

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

Primary Care – All healthcare 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 geriatrician; or 2) an advanced practice registered nurse with prescriptive authority. PCPs have the responsibility for supervising, coordinating and providing initial and primary care to the member and for initiating referrals and maintaining the continuity of member care.

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

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

Program – As used in this RFP, refers to the QExA program, unless otherwise expressly stated.

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

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

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

Provider Complaint – An expression of dissatisfaction made by a provider in the following areas:

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

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

- Issues related to availability of health services from the health plan to a member, for example delays in obtaining or inability to obtain emergent/urgent services; medications; specialty care; ancillary services such as transportation; medical supplies, etc.;

- Issues related to the delivery of health services, for example, the PCP did not make 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.

Psychotropic Medication – Those agents approved by the United States Food and Drug Administration for the treatment of mental or emotional disorders.

QUEST – The capitated managed care program that provides Medicaid State Plan benefits to families and children with income up to the specified federal poverty level (FPL).

QUEST Expanded Access (QExA) – The capitated managed care program that provides all acute and long-term care services to individuals eligible as aged, blind or disabled (ABD) under the Medicaid State Plan, including those individuals enrolled in the State of Hawaii's 1915(c) waiver programs as of date of Commencement of Services to Members identified in Section 20.100.

Representative – A person who can make care-related decisions for a member who is not able to make such decisions alone. A representative may, in the following order of priority, be a person who is:

- A court-appointed guardian of the person;
- A spouse or other family member (parent) as designated by the member or the State according to HRS 327 E-5; or

- Any other person who is not court-appointed, not a spouse or other family member who is designated as the member's healthcare representative according to HRS 327 E-5.

Request For Proposals (RFP) – This Request for Proposals number RFP-MQD-2008-006, issued on October 10, 2007.

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.

Rural Health Center (RHC) - An entity that provides outpatient health programs pursuant to Section 1905 (1) (1) (B) of the Social Security Act.

Risk Share – Those risks associated with the costs of healthcare 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 B).

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

Service Coordination – The process which assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet a member's healthcare needs using communication and all available resources to promote quality outcomes. Proper care coordination occurs across a continuum of care, addressing the ongoing individual needs of a member rather than being restricted to a single practice setting.

Service Coordinator – An individual who coordinates, monitors and ensures that appropriate and timely care is provided to the member.

Special Treatment Facility – A facility, as defined in HAR§11-98-02, that provides a therapeutic residential program for care, diagnoses, treatment or rehabilitation services for socially or emotionally distressed persons, mentally ill

persons, persons suffering from substance abuse, and developmentally disabled persons.

State - The State of Hawaii.

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

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

Sub-Acute Care – As defined in HAR §17-1737-116, a level of care that is needed by a patient not requiring acute care, but who needs more intensive skilled nursing care than is provided to the majority of patients in a skilled nursing facility.

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

Subcontractor – A party with whom the health plan contracts to provide services and/or conduct activities related to fulfilling the requirements of this RFP and contract.

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

Surrogate – An individual, other than a member's agent or guardian, authorized to make a healthcare decision for the member.

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 an enrollee in QExA.

Transition Period Enrollment – A two-month period of time preceding the Commencement of Services to Members date identified in Section 20.100 when individuals eligible for QExA select a health plan. The actual transition period enrollment dates will be identified via memorandum following the Contract Effective Date.

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 twenty-four (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.

Workforce Development – All activities that increase the number of individuals participating in the long-term healthcare workforce. It includes actions related to the active recruitment and pre-employment training of new caregivers and opportunities for the continued training of caregivers. It also includes efforts to review compensation and benefit incentives, while providing a plan for the expansion of the paraprofessional network at all levels of member care.

30.300 Program Population Descriptions

QExA is a mandatory managed care program that provides for a comprehensive package of medical, dental, long-term care, and behavioral health benefits to the following individuals if they meet the Medicaid financial and non-financial eligibility requirements:

- **ABD individuals living in the community** including:
 - SSI recipients;

- ABD individuals whose countable household income is less than or equal to 100 percent of FPL ; and
- ABD individuals receiving state supplemental payments (SSP).
- **ABD individuals residing in long-term care institutions** (e.g., nursing facilities or long-term care hospitals), including those who are subject to post-eligibility treatment of income (or patient share-of-cost or “payability” provisions). This category of ABD individuals includes the Medically Needy with Spenddown eligibility group in long-term care institutions (i.e., those who have countable incomes greater than 100 percent of FPL but who incur substantial long-term care and other medical expenses).
- **ABD individuals enrolled in one of the following existing Home and Community Based Services (HCBS) 1915 (c) waiver programs:**
 - Nursing Homes Without Walls (NHWW) for aged and disabled individuals of all ages who meet a NF LOC ;
 - Residential Alternatives Community Care Program (RACCP) for aged and disabled individuals eighteen (18) years and older who are ABD and meet a NF LOC;
 - Medically Fragile Community Care Program (MFCCP) for medically fragile children under age twenty-one (21) who are ABD and are in foster care or have an adoption subsidy agreement and meet a sub-acute or NF LOC;
 - HIV Community Care Program (HCCP) for ABD individuals of all ages who meet a NF LOC and have a diagnosis of AIDS, a condition associated with HIV; and
 - Developmental Disabilities and/or Mental Retardation (DD/MR) for ABD individuals of all ages who meet an ICF/MR LOC. The DHS will provide case management services and oversee 1915(c) HCBS and ICF/MR services for individuals with DD/MR.
- **Other relatively small, specialized ABD populations** who previously received SSI cash payments, including:

- Enrollees deemed to be receiving SSI for purposes of Medicaid but who may not receive actual SSI cash benefits because of earnings (including those eligible under § 1619(a) and (b), the PASS program, etc.);
- “Pickle” enrollees who lost SSI cash benefits because of the cost-of-living adjustment (COLA) increase in their OASDI benefits;
- Disabled adult children (DACs) who lost SSI cash benefits because they became eligible for OASDI payments or an increase in benefits; and
- Disabled widow/widower beneficiaries (DWBs) who lost SSI cash benefits because they became eligible for OASDI payments.
- **Other populations who meet QExA eligibility criteria, including:**
 - Children age eighteen (18) or younger who are wards of the State (including but not limited to those whom the State has placed in foster care) and meet QExA eligibility criteria;
 - Children age twenty-one (21) or younger who have a subsidized adoption agreement and meet QExA eligibility criteria;
 - Women eligible for Medicaid only by virtue of their need for treatment of breast and cervical cancer;
 - Terminally ill individuals of any age eligible for Medicaid by virtue of their need for hospice services (and who would be eligible for Medicaid if in a medical institution);
 - Individuals not in receipt of Retirement, Survivors and Disability Insurance (RSDI) and Social Security Insurance (SSI) disability benefits who have been determined disabled by the State’s Aid to Disabled Review Committee (ADRC);
 - Disabled children under age twenty-one (21) who meet the criteria in this section; and
 - Disabled and aged parents (and caretakers) of minor children who meet the criteria in this section.

Appendix C provides additional information about the numbers of QExA eligible individuals.

30.400 Overview of 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 and long-term care benefits to be provided by the health plan;
- Develop the rules, policies, regulations, and procedures governing the QExA program;
- Negotiate and contract with the health plan;
- Determine initial and continued eligibility of QExA enrollees;
- Enroll and disenroll members;
- Make determinations as to whether an adult, who has first been determined not eligible for services by the AMHD, meets the criteria for serious mental illness (SMI);
- Provide benefits and services as described in Section 30.700;
- 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;
- Monitor the financial status of the programs;
- Analyze the QExA program to ensure that it is 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;

- Oversee the activities of the enrollment counselor or other entity to whom the State delegates the responsibilities of assisting people in selecting a health plan and educating new members;
- Oversee the activities of the ombudsman program which will be available to all members to assure access to care, to promote quality of care and to strive to achieve member satisfaction with QExA;
- Oversee the activities of other State contracts, including but not limited to the SHOTT program contractor, the Behavioral Health Managed Care contractor, and the Catastrophic Claims Manager;
- Review and approve the health plan's marketing materials;
- Establish health plan incentives when deemed appropriate;
- Conduct the readiness review as described in Sections 30.960 and 51.600;
- Impose civil or administrative monetary penalties and/or financial sanctions for violations or health plan non-compliance with contract provisions;
- Report criminal conviction information disclosed by providers and report provider application denials pursuant to 42 CFR Part 455.106(b);
- Verify out-of-state provider licenses during provider enrollment and review and monitor provider licenses on an ongoing 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.

30.500 Eligibility and Enrollment Responsibilities

30.510 Eligibility Determinations

The DHS is the sole authority and is solely responsible for determining eligibility for the programs. Provided the individual meets all eligibility requirements, he or she will become eligible for Medicaid and QExA (due to prior period coverage) on:

- The date of the application; or
- Any date specified by the individual 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
- On the first day of the subsequent month in which all eligibility requirements are met if the individual cannot meet eligibility requirements at the time of the application.

30.520 Enrollment Overview

After an individual is determined eligible for the QExA program, the DHS or its designee will initiate the enrollment process. Within ten (10) days of the individual being determined eligible, the DHS or its designee 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 and those excluded from enrolling; the health plans available on the island on which the individual lives; and the health plans' provider networks.

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

- Transition period enrollment for existing members shall be as described in Section 30.530;

- Newborn enrollment shall be as described in Section 30.540
- Changes made during the annual plan change period shall be as described in Section 30.560; and
- Enrollment during hospitalizations and short stays (less than 30 days) in long-term care residential facilities as described in Section 50.120.

The DHS or its designee 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 and birth, sex, and other data that the DHS deems pertinent and appropriate.

Except as provided for in Sections 30.530, 30.540 and 30.560, the DHS or its designee will auto-assign any individual who does not select a health plan within fifteen (15) days. The DHS will make the auto-assignment according to the following algorithm.

For enrollees in a long-term care residential facility:

- If the facility is in only one (1) health plan, the enrollee shall be assigned to that health plan provided that health plan has not exceeded the enrollment cap as described in Section 30.570;
- If the facility is in more than one (1) health plan, and the enrollee has a relationship with a PCP that is in only one (1) health plan, the enrollee shall be assigned to that health plan provided that

health plan has not exceeded the enrollment cap as described in Section 30.570;

- If the facility is in more than one (1) health plan and the enrollee has a relationship with a PCP that is in more than one (1) health plan, the DHS shall make an auto-assignment to the health plan that did not receive the most recent auto-assigned individual, provided that health plan has not exceeded the enrollment cap as described in Section 30.570;
- If the facility is in more than one (1) health plan and the enrollee does not have a relationship with any PCP, the DHS shall make an auto-assignment to the health plan that did not receive the most recent auto-assigned individual, provided that health plan has not exceeded the enrollment cap as described in Section 30.570.

For enrollees not in a long-term care residential facility:

- If the enrollee has a relationship with a PCP that is in only one (1) health plan, the enrollee shall be assigned to that health plan provided that health plan has not exceeded the enrollment cap as described in Section 30.570;
- If the enrollee has a relationship with a PCP that is in more than one (1) health plan, the DHS shall make an auto-assignment to the health plan that did not receive the most recent auto-assigned individual, provided that health plan has not exceeded the enrollment cap as described in Section 30.570;
- If the enrollee does not have a relationship with a PCP, the DHS shall make an auto-assignment to the health plan that did not receive the most recent auto-assigned individual, provided that health plan has not exceeded the enrollment cap as described in Section 30.570.

If no members of a household have selected a health plan, the entire household shall be auto-assigned to the same health plan.

30.530 Transition Period Enrollment

Prior to the Commencement of Services to Members date identified in Section 20.100 all individuals in the populations identified in Section 30.300 who are enrolled in Medicaid will be required to select a health plan. This sixty (60) day period is hereby referred to as the transition period enrollment. In the event an individual 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 Section 30.520. All enrollments for these individuals will be effective on the date of Commencement of Services identified in Section 20.100.

30.540 Newborn Enrollment

Throughout the term of the contract, newborns born to QExA enrolled mothers will be enrolled into the health plan of the mother retroactive to the date of birth. The newborn auto-assignment will be effective for the first thirty (30) calendar days following the birth or until the DHS notifies the mother's health plan of a change in the health plan enrollment of the newborn, whichever is later. Immediately following receipt of notification from the health plan of the birth, the DHS will notify the mother that she has fifteen (15) days to select a health plan for her newborn. The DHS will inform the mother of the health plan choices, depending upon the eligibility category of the newborn.

If the newborn is eligible for QUEST, and the QExA enrolled mother does not make a selection of a health plan in the allotted time, the DHS will auto-assign the newborn into a health plan according to the auto-assignment algorithm used in the QUEST program. If the mother's QExA health plan is also a QUEST health plan, the newborn shall be auto-assigned to that health plan.

If the newborn is eligible for QExA, and the QExA enrolled mother does not make a selection of a health plan in the allotted time, the DHS will auto-assign the newborn to the mother's QExA health plan.

The DHS reserves the right to disenroll the newborn if the newborn is later determined to be ineligible for QExA 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.

30.550 90-Day Grace Period

Provided the health plan into which the member wants to enroll is not capped, the DHS will allow members who have enrolled during the transition period to change health plans without cause for the first ninety (90) days from the date of Commencement of Services to Members identified in Section 20.100 regardless of whether enrollment is a result of selection or auto-assignment. Thereafter, the DHS will allow members who become eligible for QExA and have been auto-assigned to a health plan to change health plans without cause for the first ninety (90) days from the effective date of enrollment in that health plan. Members who become eligible for QExA and selected a health plan will not be permitted to change health plans without cause but shall apply to the DHS for a health plan change for cause as defined in Section 30.600.

After the initial ninety (90) day grace period (for those eligible for it), members will only be allowed to change health plans during the annual plan change period, as described in Section 30.560, or as outlined in Section 30.600.

The DHS will educate PCPs about how to assist members in changing health plans during the 90-day grace period.

The DHS will process the health plan change request and enrollment in the new health plan will begin the first day of the month following the month in which the health plan change was requested.

The DHS will enroll members in the same health plan (even if the health plan is capped) and not allow the ninety (90) day grace period in the following situations:

- A member is changing eligibility categories within the QExA program; 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.

30.560 Annual Health 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 health plan change period will be in May, 2009. Thereafter, unless circumstances prevent the DHS from administering the annual health 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) days prior to the end of the health plan year, the DHS will mail an information packet to all households with individuals who are eligible to participate in the annual health plan change period. This information packet describes the annual health 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, no health plan selection is made and the member is enrolled in a returning health 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 detailed in Section 30.520.

30.570 Member Enrollment Caps

The DHS will implement enrollment caps as follows:

Island	Enrollment Cap
Oahu	60% of island enrollment (for the health plan receiving the most points for its technical and business proposals)
Hawaii, Maui, Kauai	50% of island enrollment

The DHS will implement enrollment caps during the transition period enrollment described in Section 30.530.

On the fifteenth (15th) of each month (or on the business day immediately following the fifteenth (15th) in the event the day falls on a weekend or holiday), the DHS will review the enrollments of the health plans. Effective the following business day, the DHS will implement an enrollment cap on any health plan that has an enrollment equal to or exceeding its enrollment cap for the island. The enrollment cap will

remain in effect until the fifteenth (15th) of the following month when the DHS will again review enrollment and either lift the cap or keep it in place for the following month.

If a plan is capped, it will not be available for selection or auto-assignment until the next month. There are two (2) exceptions to this policy:

1. Newborns who are eligible for QExA and born to QExA mothers enrolled in the capped plan will be enrolled with the mother; or
2. Members who have lost eligibility for a period of less than sixty (60) days may return to the capped plan.

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

30.580 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;
- Change in health status;
- Change of residence and/or mailing address;
- Entrance into the Hawaii State 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 DRA Section 6037 and in other federal law; 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 QExA program. 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 program;
- Death of a member;
- Incarceration of the member;
- Member enters the Hawaii State Hospital;
- Member becomes a PACE or Pre-Pace participant;
- Member enters the State of Hawaii Organ and Transplant (SHOTT) program;
- 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 provides false information with the intent of enrolling in the programs under false pretenses;
- Member chooses another health plan during the annual plan change period and that health plan is not capped;
- Member's long-term care residential facility is not in the health plan's provider network and is in the provider network of a different health plan (so long as that health plan is not capped);
- Member's PCP is not in the health plan's provider network and is in the provider network of a different health plan (so long as that health plan is not capped); or
- Member requests disenrollment for cause, at any time, due to:

- An administrative appeal decision;
- Provisions in administrative rules or statutes;
- A legal decision;
- Relocation of the member to a service area where the health plan does not provide service;
- An administrative decision for foster children which is the result of an agreement between the DHS, the child welfare service worker and the health plan involved;
- The health plan's refusal, because of moral or religious objections, to cover the service the member seeks as allowed for in Section 40.300;
- The member's need for related services (for example a cesarean section and a tubal ligation) to be performed at the same time and not all related services are available within the network and the member's PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk;
- Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's healthcare 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 healthcare specialists for breast cancer screenings, pap smears and pelvic exams.

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.

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

30.700 Covered Benefits and Services Provided by the DHS

30.710 State of Hawaii Organ and Transplant (SHOTT) Program

The DHS will provide transplants through the SHOTT program which are not experimental or investigational and not covered by the health plan. The SHOTT program covers adults and children (defined as those from birth through the month of their twenty-first (21st) birthday) for liver, heart, heart-lung, lung and allogenic and autologous 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 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

The DHS will provide all covered services to Medicaid enrollees who are determined eligible for or elect to participate in the PACE or Pre-PACE programs.

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 40.710.

30.740 Behavioral Health Services for Adults with Serious Mental Illness (SMI)

The DHS shall oversee all activities related to the behavioral health managed care (BHMC) plan. Adult members, as determined by the DHS to be SMI will be enrolled in the BHMC for receipt of their behavioral health services only.

Persons who are SMI for the purposes of the BHMC plan 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 for the purposes of the BHMC plan can be found in Appendices D.1 and D.2.

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 for the purposes of the BHMC plan and who require alcohol and/or drug abuse treatment and/or rehabilitative services may receive these services from the BHMC plan.

30.800 Covered Benefits and Services Provided by Other State Agencies

30.810 School Health Services

The Department of Education (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.

30.820 Department of Health (DOH) Programs

DOH, through its various programs, may provide direct services to QExA program members.

30.820.1 *Vaccines for Children (VFC) Program*

The VFC program replaces public and private vaccines for children under age nineteen (19) enrolled in the QExA program. 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 plan. The fee for the administration of the vaccine is included in the capitation rate.

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

30.820.2 *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 (0) to three (3) 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 in the QExA program and EPSDT screens/services including evaluations to confirm the medical necessity of the service.

30.820.3 *Behavioral Health Services for Adults with Serious Mental Illness/Serious Persistent Mental Illness (SMI/SPMI)*

The DOH, through its Adult Mental Health Division (AMHD), will provide services to adults meeting the criteria outlined in Appendix D.

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

The DOH, through its Child and Adolescent Mental Health Division (CAMHD), will provide acute inpatient psychiatric and outpatient behavioral health services to children and adolescents age three (3) through age twenty (20) who the DOH determines are in need of intensive mental health services and are determined eligible for the SEBD Program. Additional information on the SEBD program is available in Appendix D.

30.820.5 *Specific Services for Individuals with Developmental Disabilities/Mental Retardation (DD/MR)*

The DOH Developmental Disability Division shall provide case management services and oversee 1915(c) HCBS and ICF/MR services for individuals with DD/MR.

30.900 Monitoring and Evaluation

30.910 General Overview

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.

As part of these monitoring responsibilities, the DHS will, at a minimum:

- Assess the quality and appropriateness of care and services furnished to all members;
- Regularly monitor and evaluate the health plan's compliance with the standards established by the State in accordance with federal law and regulations;
- Arrange for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered under each health plan;
- Monitor the number/percentage of members who transfer from non-nursing facilities to NF LOC;
- Monitor the number/days of acute care hospital admissions for NF LOC members;
- Monitor all activities related to the Incentives for Health Plan Performance Program as described in Section 60.120;
- Monitor the number and percentage of members receiving HCBS;
- Monitor the number and percentage of members placed in an institutional setting; and
- Review reports submitted by the health plan.

The DHS may add additional monitoring activities at any point.

30.920 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:
 - Member rights and protections;
 - 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;
 - Member information;
 - Confidentiality;
 - Enrollment and disenrollment;
 - Grievance systems;
 - Subcontractual relationships and delegation;
 - Measurement and improvement standards;
 - Practice guidelines;
 - QAPI Program;
 - Health information systems;

- Conducting on-site reviews to interview health plan staff for clarification, 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.

30.930 External Quality Review/Monitoring

The DHS through its designee 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) that meets the competence and independence requirements set forth in CFR 438.354. The EQRO will monitor the health plan's compliance with all applicable provisions of 42 CFR Part 438, Subpart D.

Specifically, as specified in CFR 438.358, the EQRO will provide the following mandatory activities:

- Validation of Performance Improvement Projects (PIPs), 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 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 its health plan-specific raw data by island;
- Administration and reporting of the results of the provider satisfaction survey. This survey will be conducted annually 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. The DHS will provide the health plan with a diskette with its plan-specific raw data per island. If the health plan scores low in certain areas, the DHS will require that the health plan initiate corrective action plans to resolve these areas of concern. The results of the provider survey will also be made available to providers; and
- Providing technical assistance to the health plan to assist 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.

30.940 Case Study Interviews

The DHS or its designee may conduct case study interviews. These could require that key individuals involved with the program (including representatives of the health plan, 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.

30.950 QExA Policy Memoranda

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 sign and return to the DHS each QExA memorandum when distributed by the DHS during the period of the contract. For reference, QUEST memorandums are available in the documentation library.

30.960 Readiness Review

Prior to the date of Commencement of Services to Members identified in Section 20.100, the DHS or its designee will conduct a comprehensive readiness review of the health plan in order to ensure 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 will include, but not be limited to, an on-site review of the health plan's operations, information system demonstrations and systems testing, and interviews with health plan staff.

The review will also include desk reviews of documentation that includes but is not limited to:

- Provider network composition and access documentation;
- QAPI program standards;
- Utilization management program (UMP) strategies;
- Member handbooks and other information to be distributed to members; and
- Any and all required policies and procedures.

In addition, the DHS will require periodic and ongoing reporting in key areas including but not limited to network development, transition of care activities, call center operations and enrollment activities.

Based on the results of the review activities, 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.

31.100 Information Technology (IT)

To effectively and efficiently administer the QExA program, 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 and from the health plan based on established enrollment/disenrollment rules;
- Processing member health plan choices;

- Producing daily enrollment/disenrollment rosters; monthly enrollment rosters; and TPL rosters;
- Processing monthly encounter submissions from the health plan and generating encounter error reports for health plan correction.
- Accepting and processing monthly health plan provider network submissions to assign QExA 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 plan and the activities or movement of the members within and between the health plans;
- Monitoring the activities of the health plan through information and data received from the health plans and generating management reports;
- Determining the amount due to the health plan for the monthly capitated rate for enrolled members;
- Producing a monthly provider master registry file for the health plans to use for assigning QExA 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 plan and HPMMIS is done via the MQD FTP file server. The MQD requires that the health plan 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 plan 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.

The HPMMIS processes and reports on dental services for the QExA 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

QExA is a managed care program and, as such, all acute, pharmacy and long-term care services to members shall be provided in a managed care system. The health plan, through an integrated service coordination system, shall provide for the direction, coordination, monitoring and tracking of all medical, behavioral health, and long-term care services needed by the members.

The health plan shall also provide each member with a PCP who assesses the member’s healthcare needs and provides/directs the services to meet the member’s needs. The health plan shall also assign each member to a service coordinator who will be responsible for coordinating services and ensuring needed services are provided in the most appropriate and least restrictive manner and setting.

The health plan shall develop and maintain a provider network capable of providing the required individualized health services needed by the members.

The health plan shall be properly licensed as a health plan in the State of Hawaii (See Chapters 431, and 432, and 432D, HRS). The 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 General Provisions

The health plan shall develop and maintain a provider network that is sufficient to ensure that all medically necessary covered services are

accessible and available. At a minimum, this means that the health plan shall have sufficient providers to ensure all access and appointment wait times defined in Sections 40.230 and 40.240 will be met. This network of providers shall provide the benefits defined in Sections 40.700.

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.

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. The health plan shall not discriminate against providers serving high-risk populations or those that specialize in conditions requiring costly treatments. This is not to be construed as (1) requiring that the health plan contract with providers beyond the number necessary to meet the needs of its members, (2) precluding the health plan from using different reimbursement amounts for different specialties or for different practitioners in the same specialty, or (3) precluding the health plan from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members. 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.

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

The health plan shall not include in its network any providers or providers whose owners or managing employees have been excluded from participation by the 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 with the MQD for those providers excluded from the program and shall immediately terminate any provider(s) or affiliated provider(s) whose owners or managing employees are found to be excluded. As they occur, the health plan shall report provider application denials or termination to the DHS attributable to those providers appearing on the MQD exclusions list. The health plan shall utilize the format provided by the DHS.

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

Annually, on the date identified in Section 51.310, the health plan shall provide to the DHS a Provider Network Development and Management Plan. In this plan, the health plan shall:

- Identify the current status of the network at all levels (acute, institutional, HCBS, non-emergency transportation, etc.);
- Project future needs based upon, at a minimum, the anticipated enrollment, including expected growth;
- Project the expected utilization of services, taking into consideration the characteristics and health needs of specific populations in the health plan;
- Project the number and types (in terms of training, experience and specialization) of providers required to furnish the contracted services;
- Take into account the numbers of network providers who are not accepting new patients;
- Consider the geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities;
- Include a component regarding paraprofessional workforce development (as defined in Section 30.200) in nursing facilities, alternative residential facilities and in-home settings (attendant care, personal care and homemaker);
- Specifically, include the following:
 - Evaluation of prior year's plan;
 - Current status of the network, including (1) how members access the system, and (2) relationships between the various levels;
 - Current network gaps and the methodology used to identify them;
 - Immediate short-term interventions when a gap occurs including expedited or temporary credentialing;
 - Interventions to fill network gaps and barriers to those interventions;
 - Outcome measures/evaluation of interventions;

- Ongoing activities for network development, including (1) current unmet needs, and (2) future needs relating to membership growth;
- Coordination between the health plan departments and outside organizations;
- A description of the network for special populations including but not limited to behavioral health and young adults and children including (1) current unmet needs, and (2) future needs relating to membership growth;
- A description of the adequacy of the geographic access to tertiary hospital services;
- The methodology(ies) the health plan uses to collect and analyze provider feedback about the network designs and implementation and when specific provider issues are identified, the protocols for handling them; and
- The strategies the health plan has for workforce development.
- Include the answers to the following questions:
 - Does the health plan utilize any of the following strategies to reduce unnecessary emergency department utilization by its membership? If so, how are members educated about these options: (1) physical coverage/call availability after-hours and on weekends, (2) same day PCP appointments, (3) nurse call-in centers/information lines, (4) urgent care facilities;
 - What are the most significant barriers to efficient network development within the health plan's service area? How can the DHS best support the health plan's efforts to improve its network and the quality of care delivered to its membership?
 - What types of members are assigned to specialists for their PCPs?

The health plan shall provide the Provider Network Development and Management Plan to the DHS for review and approval as required in Section 51.600, Readiness Review.

In addition to the Provider Network Development and Management Plan described above, the health plan shall report on its network as described in Section 51.320.

40.220 Specific Minimum Requirements

The health plan is solely responsible for ensuring it (1) has the network capacity to serve the expected enrollment in the service area, (2) offers an appropriate range of services and access to preventive, primary and long-term care services, and (3) maintains a sufficient number, mix, and geographic distribution of providers of services. The following is a listing of the minimum required components of the provider network. This is not meant to be an all-inclusive listing of the components of the network, rather the health plan may add provider types, or the DHS may require that the health plan add providers as required based on the needs of the members or due to changes in federal or state statutes. At a minimum, the network shall include the following medical care providers:

- Hospitals (a minimum of 5 for Oahu; 1 for Maui; 1 for Kauai; 2 for Hawaii: 1 in East Hawaii (i.e. Hilo) and 1 in West Hawaii (i.e. Waimea-Kona));
- Emergency transportation providers (both ground and air);
- Laboratories which have either a CLIA certificate or a waiver of a certificate of registration;
- Non-emergency transportation providers (both ground and air);
- Optometrists;
- Pharmacies;
- Physical and occupational therapists, audiologists, and speech-language pathologists;
- Physician Assistants;
- Physician specialists, including but not limited to: cardiologists, endocrinologists, general surgeons, geriatricians, hematologists, infectious disease specialists, nephrologists, neurologists,

obstetricians/gynecologists, oncologists, ophthalmologists, orthopedists, otolaryngology, plastic and reconstructive surgeons, psychiatrists, pulmonologists, radiologists and urologists;

- Primary Care Providers (PCPs) (at least 1 per 600 members) as described in Section 40.260; and
- Sign language and foreign language translators.

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

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

The health plan shall require that a provider (either PCP or medical specialist) with an ambulatory practice who does not have admission and treatment privileges 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. For the island of Hawaii, the requirement means that a provider in East Hawaii who does not have admission and treatment privileges shall have a written arrangement with another provider with admitting and treatment privileges in East Hawaii and that a provider in West Hawaii who does not have admission and treatment privileges shall have a written arrangement with another provider with admitting and treatment privileges in West Hawaii.

At a minimum, the network shall include the following behavioral health providers: licensed therapists, counselors and substance abuse counselors; and State licensed Special Treatment Facilities for the provision of adolescent substance abuse therapy/treatment.

At a minimum, the network shall include the following long-term care providers:

- Adult day care facilities;
- Adult day health facilities;
- Assisted living facilities;
- Chore or homemaker service providers;
- Community care foster family homes;
- Community care management agencies;
- Environmental adaptation providers;
- Expanded adult residential care homes (ARCHs);
- Home delivered meals providers;
- Home health agencies;
- Home maintenance providers;
- Home modification providers;
- Hospice care agencies;
- Non-medical transportation providers;
- Nursing facilities;
- Nutritional counseling providers;
- Personal care assistance providers;
- Personal emergency response systems providers;
- Private duty nursing providers;
- Providers of lodging and meals associated with obtaining necessary medical care;
- Respiratory therapy providers;
- Respite service providers; and
- Specialized medical equipment and supply providers.

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 PCP visits (routine visits for adults and children); and
- Appointments within four (4) weeks for visits with a specialist or for non-emergency hospital stays.

The health plan shall ensure that:

- All network providers accept members for treatment unless the provider has requested a waiver from this provision and the health plan has received a waiver from the DHS;
- Network providers do not intentionally segregate members in any way from other persons receiving services;
- Members are provided services without regard to race, color, creed, sex, religion, health status, income status, or physical or mental disability;
- 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 has no commercial members.

The health plan shall establish policies and procedures to ensure that network providers comply with these acceptable wait times; monitor providers regularly to determine compliance; and take corrective action if there is a failure to comply. The health plan shall submit these availability of providers policies and procedures as required in Section 51.600, Readiness Review.

40.240 Geographic Access of Providers

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

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

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

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

The health plan may submit to the DHS a formal written request for a waiver of these requirements for areas where there are no providers within the required driving time. In such situations the DHS may waive the requirement entirely or expand the driving time. The health plan may also submit to the DHS a formal written request for a waiver of these

requirements if it is unable to enter into an agreement with a specialty or ancillary service provider within the required driving time. In such situations the DHS may waive the requirement entirely or expand the driving time.

40.250 Expanding Personal Assistance Services Level I and HCBS

The health plan is responsible for increasing personal assistance services Level 1 and HCBS capacity as described in Sections 40.750.4 and 40.750.5. The health plan may also be eligible for financial incentives, as described in Section 60.120.

40.260 Primary Care Providers (PCPs)

The health plan shall ensure that each member has selected or is assigned to one (1) PCP who shall be an ongoing source of primary care appropriate to his or her needs. This PCP shall be formally designated as primarily responsible for coordinating the healthcare services furnished to the member. The health plan shall notify all members, in writing and within ten (10) days of selection, assignment, or processed PCP change, of who their PCP is.

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, obstetrician/gynecologist or geriatrician; or
2. An advanced practice registered nurse with prescriptive authority (APRN-Rx) who:
 - a. Is a registered professional nurse who is authorized by the State to practice as a nurse practitioner in accordance with State law;

- b. Is certified as a nurse practitioner by a recognized national certifying body that has established standards for a nurse practitioner; and
- c. Possesses a master's degree in nursing.

The health plan shall allow specialists or other healthcare practitioners to serve as PCPs for members with chronic conditions, provided:

- The member has selected a specialist with whom he or she has a historical relationship as his or her PCP; and
- The specialist agrees, in writing, to assume the responsibilities of the PCP.

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 and so long as the clinic agrees, in writing, to assume the responsibilities of the PCP.

The PCP is responsible for supervising, coordinating, and providing all primary care to each assigned member. In addition, the PCP is responsible for coordinating and initiating referrals for specialty care (both in and out-of-network), maintaining continuity of each member's healthcare and maintaining the member's medical record, 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. For the island of Hawaii, this means one (1) general acute care hospital in East Hawaii and one (1) in West Hawaii. 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 (1) other provider with admitting and treatment privileges with an acute care

hospital within the health plan's network. The health plan shall validate the provider's arrangement and take appropriate steps to ensure arrangements are satisfactory prior to PCP patient assignment.

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

- Not establish any limits on how frequently and for what reasons a member may choose a new PCP;
- Allow each member, to the extent possible and appropriate, to have freedom of choice in choosing his or her PCP;
- Describe the steps taken to assist and encourage members to select a PCP;
- Describe the process for informing members about available PCPs;
- Describe the process for selecting a PCP;
- Describe the process for auto-assigning a member to a PCP if one is not selected;
- Describe the process for changing PCPs; and
- Describe the process for monitoring PCPs, including specialists acting as PCPs, to ensure PCPs are fulfilling all required responsibilities described above.

The health plan shall submit the PCP policies and procedures to the DHS for review and approval by the date identified in Section 51.600, Readiness Review. If the health plan revises its PCP policies and procedures during the term of the contract, the DHS must be advised and copies of the revised policies and procedures must be submitted to the DHS for review and approval prior to implementation of the revised policies and procedures.

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

describe, in the Member Handbook, how PCPs are auto-assigned if necessary.

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

40.270 Direct Access to Women's Health Specialists

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

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

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

40.290

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

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

40.295

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, 30.560 and 30.600 of this RFP. In this case the member must have the freedom to:

- Choose from at least two (2) PCPs or service coordinators;
- Obtain services from any other provider under any of the following circumstances:
 - The service or type of provider (in terms of training, experience, and specialization) is not available within the health plan;
 - The provider is not part of the network but is the main source of a service to the member, is given the opportunity to become a participating provider under the same requirements for participation in the health plan, and chooses to join the network. If this provider chooses not to join the network, or does not meet the necessary qualifications to join, the health plan shall transition the member to an in-network provider within sixty (60) days. If the provider is not appropriately licensed or is sanctioned, the health plan shall transition the member to another provider immediately;
 - Select an out-of-network provider because the only provider in-network and available to the member does not, because of moral or religious objections provide the services the member seeks or all related services are not available;
 - The member's PCP determines that the member needs related services that would subject the member to unnecessary risk if received separately and not all of the related services are available within the network; and
 - The State determines that other circumstances warrant out-of-network treatment.

40.300 Provider "Gag Rule" Prohibition

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

- The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
- Any information the member needs in order to decide among all relevant treatment options;
- The risks, benefits and consequences of treatment or non-treatment; and
- The member's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions.

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

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

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

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

40.400 Provider Credentialing, Recredentialing and Other Certification

The health plan shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for credentialing and recredentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.

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

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

The health plan shall ensure that all providers including, but not limited to, HCBS providers, meet State licensure and/or certification requirements.

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

The health plan shall submit its credentialing, recredentialing and other certification policies and procedures to MQD for review and approval by the due date identified in Section 51.600, Readiness Review.

40.500 Provider Contracts

All contracts between providers and the health plan shall be in writing.

All of the health plan's written provider contracts shall:

1. Specify covered populations and specifically cite the QExA program;
2. Specify covered services;
3. Specify rates of payment;
4. Prohibit the provider from seeking payment from the member for any covered services provided to the member within the terms of the contract and require the provider to look solely to the health plan for compensation for services rendered, with the exception of cost sharing pursuant to the Hawaii Medicaid State Plan;
5. Specify that in the case of newborns, the provider shall not look to any individual or entity other than the health plan for any payment owed to providers related to the newborn;
6. Require the provider to cooperate with the health plan's quality improvement activities;
7. Require that providers meet all applicable State and federal regulations, including but not limited to all applicable HAR sections, and Medicaid requirements for licensing, certification and recertification;
8. Require the provider to cooperate with the health plan's utilization review and management activities;
9. 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;

10. 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;
11. Not prohibit, or otherwise restrict, a provider from advocating on behalf of the member to obtain necessary healthcare services in any grievance system or utilization review process, or individual authorization process;
12. Require providers to meet appointment waiting time standards pursuant to the terms of this contract and as described in Section 40.230;
13. Provide for continuity of treatment in the event a provider's participation terminates during the course of a member's treatment by that provider except in the case of adverse reasons on the part of the provider;
14. Require that providers comply maintain the confidentiality of member's information and records as required by law, including but not limited to privacy and security regulations adopted under HIPAA;
15. Keep any records necessary to disclose the extent of services the provider furnishes the members;
16. Specify that CMS, the State Medicaid Fraud Control Unit 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;
17. 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;

18. Require provider to certify claim/encounter submissions to the plan as accurate and complete;
19. Require the provider to provide medical records or access to medical records to the health plan and the DHS or its designee, within sixty (60) days of a request. Refusal to provide medical records, access to medical records or inability to produce the medical records to support the claim/encounter shall result in recovery of payment;
20. Include the definition and standards for medical necessity, pursuant to the definition in Section 30.200 of this RFP;
21. Specify acceptable billing and coding requirements;
22. Require that providers comply with the health plan's cultural competency plan;
23. Require that the provider submit to the health plan any marketing materials developed and distributed by providers relating to the programs;
24. Require that the provider maintain the confidentiality of members' information and records as required by the RFP and in federal and state law, including but not limited to:
 - a. The AS provisions of HIPAA, Public Law 104-191 and the regulations promulgated thereunder, including but not limited to 45 CFR Parts 160, 162, 164, if the provider is a covered entity under HIPAA;
 - b. 42 CFR Part 431 Subpart F;
 - c. HAR § 17-1702;
 - d. HRS § 346-10;
 - e. 42 CFR Part 2;
 - f. HRS § 334-5;
 - g. HRS Chapter 577A.
25. Require that providers comply with 42 CFR 434 and 42 CFR 438.6, if applicable;
26. Require that providers not employ or subcontract with individuals or entities whose owner or managing employees are on the state or federal exclusions list;

27. Prohibit providers from making referrals for designated health services to healthcare entities with which the provider or a member of the provider's family has a financial relationship as defined in Section 30. 200;
28. Require providers of transitioning members to cooperate in all respects with providers of other health plans to assure maximum health outcomes for members;
29. Require the provider to comply with corrective action plans initiated by the health plan;
30. Specify the provider's responsibilities regarding third party liability;
31. Require the provider to comply with the health plan's compliance plan including all fraud and abuse requirements and activities;
32. Require that providers accept members for treatment, unless the provider applies to the health plan for a waiver of this requirement;
33. Require that the provider provide services without regard to race, color, creed, sex, religion, health status, income status, or physical or mental disability;
34. Require that providers offer hours of operation that are no less than the hours of operation offered to commercial members or, if the provider has no commercial members, that the hours of operation are comparable to Medicaid FFS;
35. Include a statement that the State and the health plan members shall bear no liability for the health plan's failure or refusal to pay valid claims of subcontractors or providers for covered services;
36. Include a statement that the State and the health plan members shall bear no liability for services provided to a member for which the State does not pay the health plan;
37. Include a statement that the State and the health plan members shall bear no liability for services provided to a member for which the plan or State does not pay the individual or healthcare provider that furnishes the services under a contractual, referral, or other arrangement to the extent that the payments are in excess of the amount that the member would owe if the health plan provided the services directly;

38. Require the provider to secure all necessary liability and malpractice coverage as is necessary to protect the health plan's members and the health plan;
39. Require that the provider use the definition for emergency medical condition included in the provider manual;
40. Require that the provider complies with all EPSDT requirements.
41. Require that the provider provides copies of medical records to requesting members and allows them to be amended as specified in 45 CFR Part 164;
42. Require that the provider provide record access to any authorized DHS personnel or personnel contracted by the DHS without member authorization so long as the access to the records is required to perform the duties of the contract with the State and to administer the QExA program;
43. Require that the provider complies with health plan standards that provide the DHS or its designee(s) prompt access to members' medical records whether electronic or paper;
44. Require that the provider coordinate with the health plan in transferring medical records (or copies) when a member changes PCPs;
45. Require that the provider comply with the advance directives requirements for hospitals , nursing facilities, providers of home and health care and personal care services, hospices, and HMOs specified in 42 CFR Part 49, subpart I, and 42 CFR §417.436(d);
46. Require that medical records be retained in accordance with §§ 622-51 and 622-58, HRS for a minimum of seven (7) years after the last date of entry in the records. For minors, records must be preserved and maintained during the period of minority plus a minimum of seven (7) years after the age of majority;
47. Require that the provider complies with all credentialing and re-credentialing activities;
48. Require that the provider refund any payment received from a resident or family member (in excess of share of cost) for the prior coverage period;

49. Require that the provider submit annual cost reports to the MQD;
50. Require that the provider comply with all requirements regarding when they may bill a member or assess charges as described in the provider manual;
51. Require that the provider is licensed or certified and in good standing, in the State of Hawaii; and
52. Require that providers (if they will be providing vaccines to children) enroll and complete appropriate forms for the VFC program.

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

1. A requirement that the provider be responsible for supervising, coordinating, and providing all primary care to each assigned member;
2. A requirement that the provider coordinates and initiates referrals for specialty care;
3. A requirement that the provider maintains continuity of each member's healthcare and maintains the member's health record;
4. A requirement that the provider has admission and treatment privileges in a minimum of one general acute care hospital which is in the health plan's network and on the island of service. For the island of Hawaii this means that the provider shall have admission and treatment privileges in one general acute care hospital in either East Hawaii or West Hawaii depending on which is closer; and
5. A requirement that if the provider (both PCP and specialist acting as a PCP) has a written arrangement with at least one other provider with admitting and treatment privileges with an acute care hospital in the event he/she does not have one.

The health plan may utilize a QExA addendum to an already executed provider contract provided that the QExA addendum and the provider

agreement together include all requirements to the QExA provider contract. In addition, it must be clearly stated that if language in the addendum and the provider agreement conflict, the language in the QExA addendum shall apply.

The health plan shall submit to the DHS for review and approval a model for each type of provider contract by the due date identified in Section 51.600, Readiness Review, and at the DHS's request at any point during the contract period.

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

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

Requirements for contracts with subcontractors (non-providers) are addressed in Section 70.500.

40.600 Provider Services

40.610 Provider Education

The health plan shall be responsible for educating the providers about managed care and all program requirements. The health plan shall conduct initial education, either one-on-one or in a group setting, for all providers with whom it has contracts during the two (2) month period prior to the Date of Commencement of Services to Members identified in Section 20.100. Thereafter, the health plan shall conduct ongoing education sessions at least every six (6) months. In addition, the health

plan shall provide one-on-one education to providers who are not fulfilling program requirements as outlined in the provider agreements and/or provider manual.

Specifically, the health plan shall educate providers on:

- The health plan's referral process and prior authorization process,;
- The role of the PCP;
- Service coordination activities, the role of the service coordinators and how to access information on a member's assigned service coordinator;
- Members' rights and responsibilities, including the right to file a grievance or appeal and how a provider can assist members;
- Reporting requirements;
- Encounter data submission requirements;
- Circumstances and situations under which the provider may bill a member for services or assess charges or fees;
- Provider responsibilities for compliance with the Americans with Disabilities Act (ADA) and how to access health plan interpretation and sign language services;
- The health plan's medical records documentation requirements including the requirement that this documentation must be tied to encounter data;
- Methods the health plan will use to update providers on program and health plan changes (e.g. monthly newsletters, etc.); and
- The provider grievance, complaints and appeals process.

The health plan shall develop provider education curricula and schedules which shall be submitted to the DHS for review and approval by the due date identified in Section 51.600, Readiness Review.

40.620 Provider Grievance, Complaints and Appeals Process

The health plan shall have a provider complaint, grievance and appeals process that provides for the timely and effective resolution of any disputes between the health plan and provider(s). The process shall include provider complaints, provider grievances, and provider appeals as defined in Section 30.200. Providers may utilize the provider grievance system to resolve issues and problems with the health plan (this includes a problem regarding a member). 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. The health plan shall give providers thirty (30) days from the decision of the grievance to file an appeal.

The health plan shall have provider grievance, complaints and appeals system policies and procedures. These policies and procedures shall be submitted to the DHS for review and approval by the due date identified in Section 51.600, Readiness Review.

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.

40.630 Provider Manual

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

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

The health plan may utilize a developed provider manual, provided that (1) all QExA provider manual requirements are included, (2) it is clear which requirements apply to the QExA program, and (3) the requirements are clear and easy to understand.

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

- A table of contents;
- An introduction that explains the health plan's organization and administrative structure, including an overview of the health plan's provider services department, function, and how they may be reached;
- Provider responsibilities and the health plan's expectations of the provider;
- A listing and description of covered and non-covered services, requirements and limitations;
- Information about appropriate and inappropriate utilization of emergency room services as well as the definitions of emergency medical condition and emergency medical services as provided in Section 30.200;
- Health plan fraud and abuse activities, including how to report suspected fraud and/or abuse;
- QExA appointment and waiting time standards as described in Section 40.230;

- Formulary information which shall be updated in advance of the change and sent to the providers;
- The description of the referral process which explains the services requiring referrals and how to obtain referrals;
- A description of the prior authorization (PA) process, including the services requiring PA and how to obtain PAs;
- A description of who may serve as a PCP as described in Section 40.260;
- Applicable criteria for specialists or other healthcare practitioners to serve as PCPs for members with chronic conditions as described in Section 40.260;
- The description of the roles and responsibilities of the PCP, including:
 - Serving as an ongoing source of primary care for the member, including supervising, coordinating, and providing all primary care to the member;
 - Being primarily responsible for coordinating other healthcare services furnished to the member, including:
 - Coordinating and initiating referrals to specialty care (both in and out-of-network);
 - Maintaining continuity of care; and
 - Maintaining the member's medical record (this includes documentation of services provided by the PCP as well as any specialty services);
- Information on the health plan's P&P for changing PCPs, including:
 - The process for changing PCPs, including, e.g., whether the member may make the request by phone; and
 - When PCP changes are effective;
- Information on the availability of service coordination and how to access these services;
- The description of the role of service coordinators;

- The description of members' rights and responsibilities as identified in Section 50.350;
- A description of cost sharing responsibilities;
- A description of reporting requirements including encounter data requirements;
- Reimbursement information, including reimbursement for members eligible for both Medicare and Medicaid (dual eligibles), or members with other insurance;
- Explanation of remittance advices;
- A statement that if a provider fails to follow plan procedures which results in nonpayment, the provider may not bill the member;
- The description of when a provider may bill a member or assess charges or fees which shall include language stating that the provider may not bill a member or assesses charges or fees except:
 - If a member self-refers to a specialist or other provider within the network without following health plan procedures (e.g. without obtaining prior authorization) and the health plan denies payment to the provider, the provider may bill the member; and
 - If a provider bills the member for non-covered services or for self-referrals, 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;
- A description of the health plan's grievance system process and procedures for members which shall include, at a minimum:
 - The member's right to file grievances and appeals and their requirements, and time frames for filing;
 - The member's right to a State administrative hearing, how to obtain a hearing and rules on representation at a hearing;

- The availability of assistance in filing a grievance or an appeal;
- The member's right to have a provider or authorized representative file a grievance and/or an appeal on his or her behalf, provided he or she has provided consent to do so;
- The toll-free numbers to file a grievance or an appeal; and
- When an appeal or hearing has been requested by the member, the right of a member to receive benefits while the appeal or hearing is pending and that the member may be held liable for the costs of those benefits if the health plan's adverse action is upheld;
- A description of the provider grievance, complaints and appeal process including how to file a grievance, complaint or appeal;
- A description of how the provider can access language interpretation, sign language services, and specialized communication (Braille, large print, etc.);
- A description of the provider's responsibility for continuity of treatment in the event a provider's participation with the health plan terminates during the course of a member's treatment by that provider;
- A description of credentialing and recredentialing requirements and activities;
- A description of the health plan's QAPI and the provider's responsibilities as it relates to the QAPI;
- Medical records standards and the provider's responsibilities regarding medical records;
- A description of confidentiality and HIPAA requirements with which the provider must comply;
- A statement that the health plan shall immediately transfer a member to another PCP, health plan, or provider if the member's health or safety is in jeopardy;
- Claims submission and adjudication procedures;

- Utilization review and management activities; and
- A description of the provider's role in the development of care plans for members, as needed.

The health plan shall submit the provider manual to the DHS for review and approval by the due date identified in Section 51.600, Readiness Review.

40.640 Provider Call-Center/PA Line

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

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

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

The health plan shall meet the following call center standards:

- Ninety-nine percent (99%) of calls are answered by the fourth ring;
- The call abandonment rate is five percent (5%) or less;
- The average hold time is two (2) minutes or less; and
- The blocked call rate does not exceed one percent (1%).

The health plan shall have an automated system or answering service available between the hours of 4:30 p.m. (H.S.T.) and 7:45 a.m. (H.S.T.) Monday through Friday and during all hours on weekends and holidays.

This automated system or answering service shall include a voice mailbox or other method for providers to leave messages. The health plan shall ensure that the voice mailbox has adequate capacity to receive all messages. The health plan shall ensure that representatives return all calls by close of business the following business day.

The health plan shall develop provider call center/PA line policies and procedures. The health plan shall submit these policies and procedures to the DHS for review and approval by the due date identified in Section 51.600, Readiness Review.

40.650 Web-site for Providers

The health plan shall have a provider portal on its web-site that is accessible to providers. The portal shall include all pertinent information including, but not limited to, the provider manual, sample provider contracts, update newsletters and notifications and information about how to contact the health plan's provider services department. In addition, the web-site shall have the functionality to allow providers to make inquiries and receive responses from the health plan.

The health plan shall have policies and procedures in place to ensure the web-site is updated regularly and contains accurate information. The health plan shall submit these policies and procedures to the DHS for review and approval by the due date identified in Section 51.600, Readiness Review.

The health plan shall submit screenshots of its provider web-site to the DHS for review and approval by the due date identified in Section 51.600, Readiness Review.

40.700 Covered Benefits and Services

40.710 General Overview

The health plan shall be responsible for providing all medically necessary primary, acute and long-term care services to all eligible members as defined in this section (unless otherwise stated).

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 ensure that services are provided in a manner that facilitates maximum community placement. The health plan shall also provide members with the LOC appropriate for their needs.

The health plan shall provide all preventive services as defined in Appendix E and all required EPSDT services defined in Section 40.950.

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 F.

With the exception of covering services specifically excluded by federal Medicaid or State requirements, the health plan may, at its own option, choose to provide additional services, either non-covered services or services in excess of the required covered services or benefit limits. The health plan shall provide a description of any additional services or additional benefit limits that it will provide to the DHS by the due date identified in Section 51.600, Readiness Review. The DHS or its designee

will inform potential enrollees of these additional services during the enrollment and/or open enrollment period.

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

40.720 Primary and Acute Services - Physical Health

The health plan shall provide the following services to all members, including those enrolled in the health plan during prior period coverage (as defined in Section 30.200):

- Acute inpatient hospital services for medical, surgical, psychiatric, and maternity/newborn care;
- Cognitive rehabilitation services;
- Cornea transplants and bone graft services;
- Durable medical equipment and medical supplies ;
- Emergency and Post Stabilization services;
- Family planning services;
- Home health services;
- Hospice services;
- Maternity services;
- Medical services related to dental needs;
- Other practitioner services;
- Outpatient hospital services;
- Personal assistance services - Level I;
- Physician services;
- Prescription drugs;

- Preventive services including (See Appendix E for more details on preventive services);
- Radiology/laboratory/other diagnostic services;
- Rehabilitation services;
- Sterilizations and hysterectomies;
- Transportation services;
- Urgent care services; and
- Vision services.

40.730 Primary and Acute Services – Behavioral Health

The health plan shall provide services, in accordance with the parameters of Section 40.750.2, to address the behavioral health needs of members.

40.740 Long-Term Care Services

Members who meet a NF LOC are eligible to receive long-term care services. Long-term care services are divided into two categories: (1) HCBS (services provided in a member’s home or other community residential setting) and (2) services provided in an institutional setting.

- HCBS:
 - Adult day care;
 - Adult day health;
 - Assisted living services;
 - Attendant care;
 - Community Care Management Agency (CCMA) services;
 - Community Care Foster Family Home (CCFFH) services;
 - Counseling and training;
 - Environmental accessibility adaptations;
 - Home delivered meals;
 - Home maintenance;
 - Medically fragile day care;

- Moving assistance;
- Non-medical transportation;
- Personal assistance services - Level II;
- Personal Emergency Response Systems (PERS);
- Private duty nursing;
- Residential care;
- Respite care; and
- Specialized medical equipment and supplies.
- Institutional Services:
- NF services

40.750 Coverage Provisions

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

40.750.1 *Primary and Acute Care Services – Physical Health*

a. *Acute Inpatient Hospital Services for Medical, Surgical, Psychiatric and Maternity/Newborn Care*

This service includes the cost of room and board for inpatient stays. The services also include: nursing care; medical supplies, equipment and drugs; diagnostic services; and physical and occupational therapy, audiology and speech-language pathology services.

b. *Cognitive Rehabilitation Services*

Cognitive Rehabilitation Services are services provided to cognitively impaired persons that assess and treat communication skills, cognitive and behavioral ability, and cognitive skills related to performing ADLS. Reassessments are completed at regular intervals, determined by the

provider and according to the member's assessed needs, treatment goals and objectives. Treatment may last up to one (1) year if the member is making progress.

Five cognitive skills area should be comprehensively assessed and, as appropriate, treated:

- Attention Skills- sustained, selective, alternating, and divided;
- Visual Processing Skills- acuity, oculomotor control, fields, visual attention, scanning, pattern recognition, visual memory, or perception;
- Information Processing Skills- auditory or other sensory processing skills, organizational skills, speed, and capacity of processing;
- Memory Skills- orientation, episodic, prospective, encoding, storage, consolidation, and recall; and
- Executive Function Skills- self-awareness, goal setting, self-initiation, self-inhibition, planning and organization, self-monitoring, self-evaluation, flexible problem solving, and metacognition.

Assessment and treatment should begin at attention skills and move up accordingly. Executive function skills should be worked on at all levels of cognitive skill areas.

There are several approaches and techniques/strategies that can be used to provide cognitive rehabilitation services. The approaches include:

- Education;
- Process training;
- Strategy development and implementation; and
- Functional application.

Selected approaches should match the appropriate level of awareness of cognitive skills.

Some of the approved cognitive rehabilitation techniques/strategies include:

- Speech/language/communication – Process to address the member’s articulation, distortions, and phonological disorders, including: 1) inappropriate pitch, loudness, quality or total loss of speech, and fluency disorder or stuttering and 2) training on the tools needed to effectively communicate wants and needs.
- Neuropsychological assessment - Process to provide an objective and quantitative assessment of a member’s functioning following a neurological illness or injury. The evaluation consists of the administration of a series of objective tests, designed to provide specific information about the member’s current cognitive and emotional functioning.
- Compensatory memory techniques - Strategies to improve functions of attention and concentration that can impact on the member’s ability to regain independence in daily living activities as well as in auditory processing, planning, problem solving, decision making, and memory functions.
- Executive functions strategies – Strategies to teach the member to engage in self-appraisal of strengths and weakness, setting goals, self-monitoring, self-evaluating and problem solving.
- Reading/writing skills retraining – Process to relearn levels of writing and reading structure and content to member’s maximum potential.

c. Cornea Transplants and Bone Graft Services

Cornea (keraplasty) transplants will be provided in accordance with HAR § 17-1737-92. Bone graft is an orthopedic procedure and not part of the transplant program.

d. Durable Medical Equipment and Medical Supplies

Durable medical equipment and medical supplies include, but are not limited to, the following: oxygen tanks and concentrators; ventilators; wheelchairs; crutches and canes; eyeglasses; orthotic devices; prosthetic devices; hearing aids; pacemakers; and medical supplies such as surgical dressings and ostomy supplies.

e. *Emergency and Post Stabilization Services*

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

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 necessary 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.

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

The health plan shall be responsible financially for post-stabilization services that are not prior authorized or pre-certified by an in-network provider or organization representative, regardless of whether the services are provided within or outside the health plan's network of providers.

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

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

The health plan's responsibility for post-stabilization services that it has not approved 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.

f. 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.

g. Home Health Services

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

Medicare home health services that are duplicative of Medicare home health benefits (i.e., physical therapy and home health aides) will not be covered.

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

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

h. Hospice Care

Hospice is a program that provides care to terminally ill patients who have six (6) months or less to live. A participating hospice provider must meet Medicare requirements. Medicaid services provided to members receiving Medicare hospice services that are duplicative of Medicare hospice benefits (i.e., personal care and homemaker services) will not be covered. In these instances, only when the service need is not related to the hospice diagnosis can the service be covered by Medicaid.

i. Maternity Services (Services for Pregnant Women)

The following services are covered under maternity services: prenatal care; prenatal laboratory screening tests and diagnostic tests; treatment of missed, threatened, and incomplete abortions; delivery of infant; postpartum care; and prenatal vitamins.

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.

j. 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 (1) medical services provided to QExA adults and children that are required as part of a dental treatment and (2) certain dental procedures performed by both dentists (oral surgeons) and physicians (primarily plastic surgeons, otolaryngologists and general surgeons), as defined in Appendix F.

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. 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 FFS 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.

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.

The health plan shall work closely and coordinate with the DHS or its designee to assist members in Medicaid's FFS dental program to include finding a dentist, making appointments, and coordinating transportation and translation services.

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

k. Other Practitioner Services

Other practitioner services include, but are not limited to: certified nurse midwife services, licensed advanced practice registered nurse services (including family, pediatric, geriatric, and psychiatric health specialists), and other medically necessary practitioner services provided by a licensed or certified healthcare provider.

l. Outpatient Hospital Services

This service includes: twenty four (24) hours a day, seven (7) days per week, emergency services; ambulatory center services; urgent care

services; medical supplies, equipment and drugs; diagnostic services; and therapeutic services including chemotherapy and radiation therapy.

m. Personal Assistance Services - Level I

Personal assistance services Level I are provided to individuals requiring assistance with IADLs who do not meet an institutional LOC in order to prevent a decline in the health status and maintain individuals safely in their home and communities. Personal assistance services Level I may be self-directed and consist of the following:

1. Companion Services

Companion services, pre-authorized by the service coordinator in the member's care plan, means non-medical care, supervision and socialization provided to a member who is assessed to need these services. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping/ errands, but do not perform these activities as discrete services. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the individual.

2. Homemaker Services

Homemaker services means any of the activities listed below, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for himself/herself or others. Homemaker services, pre-authorized by the service coordinator in the member's care plan, are of a routine nature and shall not require specialized training or professional skills such as those possessed by a nurse or home health aide. The scope of homemaker services specified in this section shall cover only the activities that need to be provided for the member, and not for other members of the household.

- A. Routine housecleaning such as sweeping, mopping, dusting, making beds, cleaning the toilet and shower or bathtub, taking out rubbish;
- B. Care of clothing and linen by washing, drying, ironing, mending;
- C. Marketing and shopping for household supplies and personal essentials (not including cost of supplies);
- D. Light yard work, such as mowing the lawn;
- E. Simple home repairs, such as replacing light bulbs;
- F. Preparing meals;
- G. Running errands, such as paying bills, picking up medication;
- H. Escort to clinics, physician office visits or other trips for the purpose of obtaining treatment or meeting needs established in the service plan, when no other resource is available;
- I. Standby/minimal assistance or supervision of activities of daily living such as bathing, dressing, grooming, eating, ambulation/mobility and transfer;
- J. Reporting and/or documenting observations and services provided, including observation of member self-administered medications and treatments, as appropriate; and
- K. Reporting to the assigned provider, supervisor or designee, observations about changes in the member's behavior, functioning, condition, or self-care/home management abilities that necessitate more or less service.

The health plan shall expand capacity for personal assistance services Level I per requirements specified in Section 40.750.4.

n. Physician Services

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

licensed hospital; a licensed skilled nursing or intermediate care facility; or a licensed or certified residential setting.

o. Prescription Drugs

Prescriptions that are determined 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 are also included in this service.

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. However, in accordance with HRS § 346-59.9, a member shall not be denied access to, or limitations on, any psychotropic medication prescribed by a licensed psychiatrist or by a physician duly licensed in the State.

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

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

Initial and interval histories, comprehensive physical examinations and development services are included as a component of this service. This service also includes: immunizations; family planning; diagnostic and

screening laboratory and x-ray services, including screening for tuberculosis.

q. *Radiology/Laboratory Diagnostic and Therapeutic Services*

Included in this service are the following: diagnostic and therapeutic radiology and imaging; and screening and diagnostic laboratory tests

r. *Rehabilitation Services*

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

s. *Sterilizations, Hysterectomies, and Intentional Termination of Pregnancies (ITOPs)*

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

- The member is at least twenty-one (21) years of age at the time consent is obtained;
- The member is mentally competent;
- The member voluntarily gives informed consent by completing the Informed Consent for Sterilization Form DSSH 1146;
- The provider completes the Sterilization Required Consent Form (DHS 1146 Form);
- 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 (1) purpose for performing the hysterectomy but the primary purpose is to render the member permanently incapable of reproducing; or
- It is performed for the purpose of cancer prophylaxis.

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

The health plan is not responsible for covering any ITOPs. 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.

t. Transportation Services

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

The health plan shall provide transportation to and from medically necessary 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 providers. The health plan is responsible for the arrangement and payment of the travel costs for the member and the attendant 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, specialty physicians, and APRNs), the health plan shall make arrangements to transport providers.

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

u. Urgent Care Services

The health plan shall provide urgent care services as necessary. Such services shall not be subject to prior authorization or pre-certification.

v. Vision Services

The health plan shall provide eye and vision services provided by qualified optometry/ophthalmology professionals once in a twelve (12) month period for members under age twenty-one (21) and once in a twenty-four (24) month period for adults age twenty-one (21) and older. Visits done more frequently are payable when indicated by symptoms or medical condition. Emergency eye care, which meets the definition of an emergency medical condition, is covered for all members.

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

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

Visual aids prescribed by ophthalmologists or optometrists (eyeglasses, contact lenses and miscellaneous vision supplies) are covered by the Medicaid program, if medically necessary. These include costs for the lens, frames, or other parts of the glasses, as well as fittings and adjustments. New lenses are limited to once in a twenty-four (24) month period for adults and once in a twelve (12) month period for individuals under the age of twenty-one (21) years. Replacement glasses and/or new glasses with significant changes in prescription are covered within the benefit periods for both adults and children. Contact lenses are not covered for cosmetic reasons. Dispensing of the lenses or contacts from the new prescription begins a new twenty-four (24) month period.

40.750.2 *Primary and Acute Care Services - Behavioral Health*

a. *Overview*

The health plan shall provide all medically necessary behavioral health services, to QExA adults and child members. These services include:

- Twenty-four (24) hour care for acute psychiatric illnesses including:
 - Room and board
 - Nursing care
 - Medical supplies and equipment
 - Diagnostic services
 - Physician services
 - Other practitioner services as needed
 - Other medically necessary services;
- Ambulatory services including twenty-four (24) hours, seven (7) days per week crisis services;
- Acute day hospital/partial hospitalization including:
 - Medication management
 - Prescribed drugs
 - Medical supplies

- Diagnostic tests
- Therapeutic services including individual, family and group therapy and aftercare
- Other medically necessary services;
- Methadone treatment services which include the provision of methadone or a suitable alternative (e.g. LAAM), as well as outpatient counseling services;
- Prescribed drugs (excluding Clozaril or Clozapine) including medication management and patient counseling;
- Diagnostic/laboratory services including:
 - Psychological testing
 - Screening for drug and alcohol problems
 - Other medically necessary diagnostic services;
- Psychiatric or psychological evaluation;
- Physician services;
- Rehabilitation services;
- Occupational therapy; and
- Other medically necessary therapeutic services.

Individuals age twenty-one (21) and older are limited to thirty (30) days of hospitalization per benefit year. No limits exist for outpatient behavioral health services for individuals. A benefit year is defined as the period between July 1 through June 30. The health plan may, at its option, exceed the limits on inpatient behavioral health services. Individuals under age twenty-one (21) are not subject to the inpatient behavioral health limits.

The health plan may utilize a full array of effective interventions and qualified professionals such as psychiatrists, psychologists, counselors, social workers, registered nurses and others. Substance abuse counselors shall be comply with the State Department of Health Alcohol and Drug Abuse Division (ADAD) certification requirements.

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 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 plans are responsible for training residential care facilities on how to care for members who require behavioral health services.

The health plan is not obligated to provide behavioral health services to those members:

- Whose diagnostic, treatment or rehabilitative services are determined not to be medically necessary by the health plan; or
- Who have been determined eligible for and have been transferred to the DOH's Adult Mental Health Division (AMHD) for services, as described below; or
- Who have been determined eligible for and have been transferred to the behavioral health managed care (BHMC) plan, as described below; or
- Who have been determined eligible for and have been transferred to the DOH's Child and Adolescent Mental Health Division (CAMHD) for services, as described in below; or
- Who have been criminally committed for evaluation or treatment in an inpatient setting under the provisions of Chapter 706, HRS. These individuals will be disenrolled from the programs 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 healthcare 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 members.

Room and board in special treatment facilities for adolescents is not covered but therapy/treatment provided in the facility for this population is the responsibility of the health plan.

b. Health Plan Responsibilities for SMI Adults

Specialized mental health services for adults diagnosed with SMI will be carved out of QExA. The health plan shall continue to be responsible for all other Medicaid services (primary, acute and long-term care services) for the member who is receiving behavioral health services through another entity.

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 D). Once the health plan has made this determination, the health plan shall refer the adult member to the DOH AMHD for an evaluation to confirm the initial diagnosis and for appropriate services. During the referral process, the health plan shall continue to coordinate the member's care and provide any medically necessary services.

If AMHD denies the SMI designation, the health plan shall refer the member to the DHS for determination as to whether he or she is eligible for the BHMC program. Appendices D.2 and D.3 provide additional information on this process.

If a member's SMI designation is denied, the DHS or its designee must provide written denial and notification of appeal rights. With the approval

of the member, the health plan may appeal any denial of SMI determination to the DHS.

c. *Health Plan Responsibilities for Children and Adolescents Meeting SEBD Program Criteria*

Specialized mental health services for children determined to meet SEBD program criteria, will be carved out of QExA. Most children and adolescents age three (3) through twenty (20) 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 the DHS or its designee to determine if the child is eligible to receive services and for the delivery of these services. During the referral process, the health plan shall continue to coordinate the member's care and provide any medically necessary 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 as a part of the confirmation of the evaluation, the member must submit to an interview as part of the confirmation of the evaluation, the health plan shall provide and pay for transportation to the evaluation site for the child and the child's parent/guardian.

If a member's SEBD designation is denied, the DHS or its designee must provide written denial and notification of appeal rights. With the approval of the member, the health plan may appeal any denial of SEBD determination to the DHS.

There may be situations when an individual who is meeting SEBD program criteria presents to the health plan or provider for behavioral health services and the individual wishes to use health plan coverage for services. The health plan shall pay for these services if the following criteria are met:

- The individual is enrolled in the health plan;
- The provider is in the health plan's network;
- The health plan has determined that the service(s) meets the criteria of medical necessity; and
- The service is a covered Medicaid benefit.

Under these circumstances, the health plan shall be responsible for all behavioral health services provided to children who meet the criteria for SEBD. The individual can request the health plan to provide the services as opposed to DOE or DOH, in these circumstances, the DHS will reimburse the health plan for these services.

40.750.3 *Long-Term Care Services*

The health plan shall expand capacity for HCBS per requirements specified in Section 40.750.5.

a. *Adult Day Care*

Adult day care is defined as regular supportive care provided to four (4) or more disabled adult participants in accordance with HAR§17-1417. Services include observation and supervision by center staff, coordination of behavioral, medical and social plans, and implementation of the instructions as listed in the participant's care plan. Therapeutic, social, educational, recreational, and other activities are also provided as regular adult day care services.

Adult day care staff members may not perform healthcare related services such as medication administration, tube feedings, and other activities which require healthcare related training. All healthcare related activities must be performed by qualified and/or trained individuals only, including family members and professionals, such as an RN or LPN, from an authorized agency.

b. *Adult Day Health*

Adult day health refers to an organized day program of therapeutic, social, and health services provided to adults with physical, or mental impairments, or both which require nursing oversight or care in accordance with HAR §11-96. The purpose is to restore or maintain, to the fullest extent possible, an individual's capacity for remaining in the community.

Each program shall have nursing staff sufficient in number and qualifications to meet the needs of participants. Nursing services shall be provided under the supervision of a registered nurse. If there are members admitted who require skilled nursing services, the services will be provided by a registered nurse or under the direct supervision of a registered nurse.

In addition to nursing services, other components of adult day health may include: emergency care, dietetic services, occupational therapy, physical therapy, physician services, pharmaceutical services, psychiatric or psychological services, recreational and social activities, social services, speech-language pathology, and transportation services.

c. *Assisted Living Services*

Assisted living services include personal care and supportive care services (homemaker, chore, attendant services, meal preparation) that are furnished to members who reside in an assisted living facility.

Assisted living facilities are defined in Section 30.200. Payment for room and board is prohibited.

d. *Attendant Care*

Attendant care is the hands-on care, both supportive and health-related in nature, provided to medically fragile children. The service includes member supervision specific to the needs of a medically stable, physically handicapped child. Attendant care may include skilled or nursing care to the extent permitted by law. Housekeeping activities that are incidental to the performance of care may also be furnished as part of this activity. Supportive services, a component of attendant care, are those services that substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. Attendant care services may be self-directed.

e. *Community Care Management Agency (CCMA) Services*

CCMA services are provided to members living in Community Care Foster Family Homes and other community settings, as required. A health plan may, at its option, demonstrate the ability to provide CCMA services by contracting with an entity licensed under HAR subchapters 1 and 2. The following activities are provided by a CCMA: continuous and ongoing nurse delegation to the caregiver in accordance with HAR Chapter 16-89 Subchapter 15; initial and ongoing assessments to make recommendations to health plans for, at a minimum, indicated services, supplies, and equipment needs of members; ongoing face-to-face monitoring and implementation of the member's care plan; and interaction with the caregiver on adverse effects and/or changes in condition of members. CCMA's shall (1) communicate with a member's physician(s) regarding the member's needs including changes in medication and treatment orders, (2) work with families regarding service needs of member and serve as an advocate for their members, and (3) be

accessible to the member's caregiver twenty-four (24) hours a day, seven (7) days a week,

f. Community Care Foster Family Home (CCFFH) Services

CCFFH services is personal care and supportive services, homemaker, chore, attendant care and companion services and medication oversight (to the extent permitted under State law) provided in a certified private home by a principal care provider who lives in the home. The number of adults receiving services in CCFFH is determined by HAR, Title 17, Department of Human Services, Subtitle 9, Chapter 1454-43. CCFFH services are currently furnished to up to three (3) adults who receive these services in conjunction with residing in the home. All providers must provide individuals with their own bedroom. Each individual bedroom shall be limited to two (2) residents. Both occupants must consent to the arrangement. The total number of individuals living in the home, who are unrelated to the principal care provider, cannot exceed four (4).

In accordance with HAR, Title 17, Department of Human Services, Subtitle 9, Chapter 1454-42, members receiving CCFFH services must be receiving ongoing CCMA services.

g. Counseling and Training

Counseling and training activities include the following: member care training for members, family and caregivers regarding the nature of the disease and the disease process; methods of transmission and infection control measures; biological, psychological care and special treatment needs/regimens; employer training for consumer directed services; instruction about the treatment regimens; use of equipment specified in the service plan; employer skills updates as necessary to safely maintain the individual at home; crisis intervention; supportive counseling; family therapy; suicide risk assessments and intervention; death and dying

counseling; anticipatory grief counseling; substance abuse counseling; and/or nutritional assessment and counseling.

Counseling and training is a service provided to members, families/caregivers, and professional and paraprofessional caregivers on behalf of the member.

h. Environmental Accessibility Adaptations

Environmental accessibility adaptations are those physical adaptations to the home, required by the individual's care plan, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual. Window air conditioners may be installed when it is necessary for the health and safety of the member.

Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

i. Home Delivered Meals

Home delivered meals are nutritionally sound meals delivered to a location where an individual resides (excluding residential or institutional settings). The meals will not replace or substitute for a full day's nutritional regimen (i.e., no more than 2 meals per day). Home delivered

meals are provided to individuals who cannot prepare nutritionally sound meals without assistance and are determined, through an assessment, to require the service in order to remain independent in the community and to prevent institutionalization.

j. Home Maintenance

Home maintenance is a service necessary to maintain a safe, clean and sanitary environment. Home maintenance services are those services not included as a part of personal assistance and include: heavy duty cleaning, which is utilized only to bring a home up to acceptable standards of cleanliness at the inception of service to a member; minor repairs to essential appliances limited to stoves, refrigerators, and water heaters; and fumigation or extermination services. Home maintenance is provided to individuals who cannot perform cleaning and minor repairs without assistance and are determined, through an assessment, to require the service in order to prevent institutionalization.

k. Medically Fragile Day Care

Medically fragile day care is a non-residential service for children who are medically and/or technology dependent. The service includes activities focused on meeting the psychological as well as the physical, functional, nutritional and social needs of children.

Services are furnished four (4) or more hours per day on a regular scheduled basis for one (1) or more days per week in an outpatient setting encompassing both health and social services needed to ensure the optimal function of the individual.

l. Moving Assistance

Moving assistance is provided in rare instances when it is determined through an assessment by the care coordinator that an individual needs

to relocate to a new home. The following are the circumstances under which moving assistance can be provided to a member: unsafe home due to deterioration; the individual is wheel-chair bound living in a building with no elevator; multi-story building with no elevator, where the client lives above the first floor; member is evicted from their current living environment; or the member is no longer able to afford the home due to a rent increase. Moving expenses include packing and moving of belongings. Whenever possible, family, landlord, community and third party resources who can provide this service without charge will be utilized.

m. Non-Medical Transportation

Non-medical transportation is a service offered in order to enable individuals to gain access to community services, activities, and resources, specified by the care plan. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the Medicaid State Plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized. Members living in a residential care setting or a CCFFH are not eligible for this service.

n. Nursing Facility Services

Nursing facility services are provided to members who need twenty-four (24) hours a day assistance with ADLs and IADLs and need care provided by licensed nursing personnel and paramedical personnel on a regular, long-term basis. Nursing facility services are provided in a free-standing or a distinct part of a facility that is licensed and certified as meeting the requirements of participation to provide skilled nursing, health-related care and rehabilitative services on a regular basis in an inpatient facility in accordance with HAR§11-94. The care that is provided in a nursing facility includes independent and group activities, meals and

snacks, housekeeping and laundry services, nursing and social work services, nutritional monitoring and counseling, pharmaceutical services, and rehabilitative services.

o. Personal Assistance Services - Level II

Personal assistance services Level II are provided to individuals requiring assistance with moderate/substantial to total assistance to perform ADLs and health maintenance activities. Personal assistance services Level II shall be provided by a Home Health Aide (HHA), Personal Care Aide (PCA), Certified Nurse Aide (CNA) or Nurse Aide (NA) with applicable skills competency. The following activities may be included as a part of personal assistance services Level II:

- Personal hygiene and grooming, including bathing, skin care, oral hygiene, hair care, and dressing;
- Assistance with bowel and bladder care;
- Assistance with ambulation and mobility;
- Assistance with transfers;
- Assistance with medications, which are ordinarily self-administered when ordered by member's physician;
- Assistance with routine or maintenance healthcare services by a personal care provider with specific training, satisfactorily documented performance, care coordinator consent and when ordered by member's physician;
- Assistance with feeding, nutrition, meal preparation and other dietary activities;
- Assistance with exercise, positioning, and range of motion;
- Taking and recording vital signs, including blood pressure;
- Measuring and recording intake and output, when ordered;
- Collecting and testing specimens as directed;
- Special tasks of nursing care when delegated by a registered nurse, for members who have a medically stable condition and

who require indirect nursing supervision as defined in Chapter 16-89, Hawaii Administrative Rules;

- Proper utilization and maintenance of member's medical and adaptive equipment and supplies. Checking and reporting any equipment or supplies that need to be repaired or replenished;
- Reporting changes in the member's behavior, functioning, condition, or self-care abilities which necessitate more or less service; and
- Maintaining documentation of observations and services provided.

When personal assistance services Level II activities are the primary services, personal assistance services Level I activities identified on the care plan, which are incidental to the care furnished or that are essential to the health and welfare of the member, rather than the member's family, may also be provided.

Personal assistance services Level II may be self-directed.

p. Personal Emergency Response Systems (PERS)

PERS is a twenty-four (24) hour emergency assistance service which enables the member to secure immediate assistance in the event of an emotional, physical, or environmental emergency. PERS are individually designed to meet the needs and capabilities of the member and includes training, installation, repair, maintenance, and response needs. PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. The following are allowable types of PERS items:

- 24-hour answering/paging;

- Beepers;
- Med-alert bracelets;
- Intercoms;
- Life-lines;
- Fire/safety devices, such as fire extinguishers and rope ladders;
- Monitoring services;
- Light fixture adaptations (blinking lights, etc.);
- Telephone adaptive devices not available from the telephone company; and
- Other electronic devices/services designed for emergency assistance.

All types of PERS, described above, shall meet applicable standards of manufacture, design, and installation. Repairs to and maintenance of such equipment shall be performed by the manufacturer's authorized dealers whenever possible.

PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. PERS services will only be provided to a member residing in a non-licensed setting.

q. Private Duty Nursing

Private duty nursing is a service provided to individuals requiring ongoing nursing care (in contrast to part time, intermittent skilled nursing services under the Medicaid State Plan) listed in the care plan. The service is provided by licensed nurses within the scope of State law.

r. Residential Care Services

Residential care services are personal care services, homemaker, chore, attendant care and companion services and medication oversight (to the extent permitted by law) provided in a licensed private home by a principle care provider who lives in the home.

Residential care is furnished: 1) in a Type I Expanded Adult Residential Care Home (EARCH) to a maximum of six (6) individuals, no more than three (3) of whom may be NF LOC; or 2) in a Type II EARCH, for seven (7) or more individuals, no more than twenty percent (20%) of the home's licensed capacity may be individuals meeting a NF LOC who receive these services in conjunction with residing in the home.

s. *Respite Care*

Respite care services are provided to individuals unable to care for themselves and are furnished on a short-term basis because of the absence of or need for relief for those persons normally providing the care. Respite may be provided at three (3) different levels: hourly, daily, and overnight. Respite care may be provided in the following locations: individual's home or place of residence; foster home/expanded-care adult residential care home; Medicaid certified NF; licensed respite day care facility; or other community care residential facility approved by the State. Respite care services are authorized by the member's PCP as part of the member's care plan. Respite services may be self-directed.

t. *Specialized Medical Equipment and Supplies*

Specialized medical equipment and supplies entails the purchase, rental, lease, warranty costs, installation, repairs and removal of devices, controls, or appliances, specified in the care plan, that enable individuals to increase and/or maintain their abilities to perform activities of daily living, or to perceive, control, participate in, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. All items shall meet applicable standards of manufacture, design and installation and may include:

- Specialized infant car seats;
- Modification of parent-owned motor vehicle to accommodate the child, i.e. wheelchair lifts;
- Intercoms for monitoring the child's room;
- Shower seat;
- Portable humidifiers;
- Electric bills specific to electrical life support devices (ventilator, oxygen concentrator);
- Medical supplies;
 - Heavy duty items including but not limited to patient lifts or beds that exceed \$1,000 per month;
 - Rental of equipment that exceeds \$1,000 per month such as ventilators; and
 - Miscellaneous equipment such as customized wheelchairs, specialty orthotics, and bath equipment that exceeds \$1,000 per month.

Items reimbursed shall be in addition to any medical equipment and supplies furnished under the Medicaid State Plan and shall exclude those items which are not of direct medical or remedial benefit to the individual.

Specialized medical equipment and supplies shall be recommended by the member's PCP.

40.750.4 *Expanded Personal Assistance Services Level I Capacity*

The health plan shall provide all personal assistance services Level I to members receiving these services prior to enrollment in the health plan.

The health plan shall expand provision of personal assistance services Level I according to the following annual thresholds:

- SFY 2009 (first eight (8) months of implementation): reduce by one-half (1/2) the number of members on the State waiting list by providing these persons personal assistance services Level I, as appropriate;
- SFY 2010: eliminate the remaining one-half (1/2) of members on the State waiting list by providing these persons personal assistance services Level I, as appropriate, AND increase by 2% above the previous SFY the number of members receiving personal assistance services Level I;
- SFY 2011: 3% increase in the number of members receiving personal assistance services Level I above the previous SFY AND all members placed on the waiting list in the previous SFY must be taken off the waiting list and provided appropriate personal assistance services Level I; and
- SFY 2012: 4% increase in the number of members receiving personal assistance services Level I above the previous SFY AND all members placed on the waiting list in the previous SFY must be taken off the waiting list and provided appropriate personal assistance services Level I.

As a point of reference, as of the posting date of this RFP (as specified in Section 20.100) approximately 1,200 persons received personal assistance services Level I in the State. Approximately 400 recipients are on the State's waiting list for personal assistance services Level I.

The health plan may develop a waiting list for persons identified as needing personal assistance services Level I (as determined per the requirements of Section 40.820) following enrollment in the health plan, if

necessary. The health plan's personal assistance services Level I waiting list shall be separate and independent of any other waiting list following enrollment in the health plan.

The health plan shall provide all other medically necessary primary and acute care services to members on the waiting list.

The DHS or its designee shall regularly monitor the health plan's management of its personal assistance services Level I waiting list. As a part of these monitoring activities, on a quarterly basis, the health plan shall submit to the DHS or its designee the following information relevant to its waiting list:

- The names of members on the waiting list;
- The date the member's name was placed on the waiting list; and
- Progress notes on the status of providing needed care to the member.

For SFY 2009 and SFY 2010, the health plan shall meet with the DHS or its designee on a quarterly basis to discuss any issues associated with management of its personal assistance services Level I waiting list. The purpose of these meetings will be to discuss the health plan's progress towards meeting annual thresholds and any challenges with meeting the needs of specific members on the waiting list. The health plan shall adhere to the DHS established schedule for meetings during SFY 2011 and SFY 2012.

40.750.5 *Expanded HCBS Capacity*

The health plan shall provide all HCBS to members receiving these services prior to enrollment in the health plan. However, the health plan may provide comparable service(s) or change the mix of services provided to the member if the health plan's assessment of the member

(conducted according to the requirements in Section 40.820) determines that a comparable service(s) or mix of services is appropriate.

The health plan shall expand provision of HCBS annually according to the following thresholds.

- For SFY 2009 (the first eight (8) months of implementation), the health plan shall provide services to all members on the State's HCBS waiting list(s), if applicable; and
- For SFY 2010 and thereafter, the health plan shall increase the number of members receiving HCBS by 5% above the number of members receiving HCBS in the previous SFY AND all members placed on the waiting list must be taken off the waiting list and provided appropriate HCBS.

As a point of reference, as of the publication date of this RFP (as specified in Section 20.100) approximately 2,200 Medicaid recipients received long-term care services through an HCBS waiver. Approximately 100 recipients are on the State's waiting list(s) for HCBS.

The health plan may develop a waiting list for members identified as needing HCBS (as determined per the requirements of Section 40.820) following enrollment in the health plan, if necessary. The HCBS waiting list shall be separate and independent of any other waiting list. The health plan may subdivide its HCBS waiting list by service type.

The health plan shall continue to provide all other HCBS that are not the reason for placing the member on the waiting list as well as all medically necessary primary, acute care and institutional services to members on the waiting list. The health plan shall provide members with the choice of being placed on a waiting list for HCBS or institutional placement.

The DHS or its designee shall regularly monitor the health plan's management of its HCBS waiting list. As a part of these monitoring

activities, on a quarterly basis the health plan shall submit to the DHS or its designee the following information relevant to its waiting list:

- The names of members on the waiting list;
- The date the member's name was placed on the waiting list;
- The specific service(s) needed by the member; and
- Progress notes on the status of providing needed service(s) to the member.

For SFY 2009 and SFY 2010, the health plan shall meet with the DHS or its designee on a quarterly basis to discuss any issues associated with management of its HCBS waiting list. The purpose of these meetings will be to discuss the health plan's progress towards meeting annual thresholds and any challenges with meeting the needs of specific members on the waiting lists. The health plan shall adhere to the DHS established schedule for meetings during SFY 2011 and SFY 2012.

40.760 Services to Persons with Neurotrauma

QExA members who have been diagnosed with traumatic brain injury shall have access to all medically necessary primary, acute and long-term care services, as described in Sections 40.720, 40.730, and 40.740.

40.770 Self-Direction

The health plan shall provide all QExA members assessed to need personal assistance services Level I (as defined in Section 40.750.1) and personal assistance services Level II, attendant care and respite care services (as defined in Section 40.750.3) the opportunity to have choice and control over their providers (referred to as self-direction). A member choosing self-direction shall be responsible for fulfilling the following functions:

- Recruiting/selecting providers;
- Determining provider duties;
- Scheduling providers;
- Instructing and training providers in preferred duties;
- Supervising providers;
- Evaluating providers;
- Verifying time worked by provider and approving time sheets; and
- Discharging provider.

A member may choose to designate one (1) individual to act as a surrogate on his/her behalf. The surrogate assumes all self-direction responsibilities for the member and cannot be paid for performing these functions. The surrogate may not serve as a paid provider of services for the member.

The service coordinator shall assist the member in facilitating self-direction and in accessing available resources and supports. The service coordinator shall also be responsible for monitoring the care plan to ensure that assessed needs are addressed and to ensure members' overall well-being.

As a part of the care plan process, members assessed to need personal assistance services Level I and Level II, attendant care services or respite care, will be informed by the service coordinator of the self-direction option. Members expressing an interest in self-direction shall be required to complete the health plan's self-assessment form. The form is intended to determine a member's: 1) ability to make decisions regarding his/her healthcare and 2) knowledge of available resources to access for assistance. If the self-assessment results reveal that the member is unable to self-direct his/her care but he/she is still interested in electing the option, the member will be required to appoint a surrogate to assume the self-direction responsibilities on his/her behalf.

Members who are not capable of completing a self-assessment form due to a physical or cognitive impairment or who choose not to complete the form but are interested in electing self-direction can do so if they appoint a surrogate to assume the responsibilities on their behalf.

The service coordinator shall document the member's decision to self-direct his/her care and the appointment of a surrogate (including the surrogate's name and relationship to the member) in the care plan.

A member can change a surrogate at any time. Changes in a surrogate shall be reported to the health plan within five (5) days. A service coordinator may recommend that a member change surrogates if he/she can document that the surrogate is not appropriately fulfilling his/her obligations. If, however, the member chooses to continue using the surrogate, the documented incident(s), the service coordinator's recommendation, and the member's decision shall be noted in the care plan.

The service coordinator shall develop a budget for each member electing self-direction. The budget shall be based upon the member's assessed needs, a factor of the number of the units of service (i.e. hours, days) the member requires for each allowable service and the historical fee-for-service average unit cost of each service. This combined total dollar value shall constitute the member's budget for self-direction and shall be discussed and shared with the member by the service coordinator. The member shall have the flexibility to negotiate provider rates within the allocated budget, the federal or state minimum wage, whichever is higher, being the floor.

The service coordinator shall closely monitor the adequacy and appropriateness of the services provided to determine the extent to which adjustments to the care plan will necessitate adjustments to the budget.

Members shall have the ability to hire family members (including spouses and parents of minors), neighbors, friends, etc. as service providers. For spouses or parents of minors (biological or adoptive parents of members under age eighteen (18)), to be paid as providers of self-directed services, the personal assistance services Level I and Level II, attendant care or respite care services must meet all of the following authorization criteria and monitoring provisions.

The service must:

- Meet the definition of service as defined in Sections 40.750.1 and 40.750.3;
- For personal assistance services Level II, attendant care and respite care services, be necessary to avoid institutionalization;
- Be a service that is specified in the care plan;
- Be provided by a parent or spouse who meets the State prescribed provider qualifications and training standards for that service;
- Be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service; and
- NOT be an activity that the family would ordinarily perform or is responsible to perform.

The family member who is a service provider will comply with the following:

- A parent or parents in combination or a spouse may not provide more than forty (40) hours of services in a seven (7) day period. For parents, forty (40) hours is the total amount regardless of the number of children who receive QExA services;
- The family member must maintain and submit all required documentation, such as time sheets, for hours worked; and

- Married individuals must be offered a choice of providers. If he/she chooses a spouse as his/her provider, it must be documented in the care plan.

The health plan shall be required to conduct the following additional monitoring activities when members elect to use a spouse or parents as paid providers:

- At least quarterly reviews of expenditures, and the health, safety and welfare status of the member;
- Face-to-face visits with the member on at least a semi-annual basis; and
- Monthly reviews of hours billed for family provided care and the total amounts billed for all goods and services during the month.

Providers of self-direction must meet all applicable provider requirements as established by the State. Providers are not required to be a part of the health plan's network. However, the health plan shall enter into an agreement with each self-direction provider. The agreement shall specify the roles and responsibilities of both parties.

As part of the interview and hiring process, members shall, with the aid of the service coordinator:

- Develop interview questions;
- Screen and interview applicants; and
- Develop a service agreement that delineates the roles and responsibilities of both the member as the employer and the provider.

A member may fire his/her self-direction provider for violating the terms of the service agreement. The health plan shall have the ability to fire a provider on behalf of a member for health and welfare issues. This term

and condition shall be specified in the agreement between the provider and the health plan. A member's release of his/her self-direction provider will be documented in the care plan.

A back-up plan outlining how members will address instances when regularly scheduled providers are not available shall be included in the member's care plan. Back-up plans may involve the use of non-paid caregivers and/or paid providers.

The health plan shall perform the administrative functions associated with employing self-direction providers for the member, who is the employer of record, including:

- Paying providers;
- Monitoring completion of time sheets;
- Assuring Tuberculosis (TB) test is completed;
- Validating active Cardiopulmonary Resuscitation (CPR) and First Aid training;
- Reviewing and verifying results of the status of criminal history and/or background investigation of providers per State requirements (the members shall pay for the cost of background checks out of their budget);
- Reviewing and approving payment for allowable services; and
- Withholding, filing and paying applicable federal, State and local income and employment taxes.

The health plan may delegate these functions to another entity through a subcontract. The subcontractor agreement shall comply with all requirements outlined in Section 70.500.

The health plan shall require that all members and/or surrogates participate in a training program prior to assuming self-direction. At a minimum, self-direction training programs shall address the following:

- Understanding the role of members/surrogates in self-direction;
- Selecting providers;
- Being an employer and managing employees;
- Conducting administrative tasks such as staff evaluations and approval of time sheets; and
- Scheduling providers and back-up planning.

All self-direction training programs must be developed as face-to-face presentations. The health plan may develop programs in alternative formats (i.e., web based) that may be made available upon request and per the recommendation of the service coordinator. The health plan may develop these programs internally or subcontract for this service. Additional and ongoing self-direction programs shall be made available at the request of a member, surrogate or service coordinator. All new training programs and materials and any changes to programs and materials shall be submitted to the DHS for approval thirty (30) days prior to implementation.

Members assessed to need personal assistance services Level I and Level II, attendant care or respite care services may choose to undertake self-direction at any time. The member may also choose to terminate self-direction at any time. Termination of self-direction must be documented in writing by the member or surrogate. In this event, the service coordinator shall assist the member in accessing available network providers for personal assistance services Level I and Level II, attendant care or respite care services. Members may utilize self-direction and other services simultaneously.

The health plan shall establish and maintain self-direction policies and procedures and shall submit these to the DHS for review and approval by the due date identified in Section 51.600, Readiness Review. The policies and procedures shall include, at a minimum:

- Process to assess member's ability to implement self-direction, including a copy of the self-assessment form;
- Process to document member agreement to self-direct his/her care;
- Sample agreement between provider and health plan;
- Process for paying providers (including verifying hours worked);
- Topics, goals and frequency of member/surrogate training programs; and
- Process for member termination from self-direction.

Changes to these policies and procedures shall be submitted for approval to the DHS thirty (30) days prior to implementation of the change(s).

40.780 Sub-Acute Level of Care

The health plan may establish a sub-acute level of care, as defined in Section 30.200, for payment purposes. Qualifying requirements for facilities to establish sub-acute levels of care, sub-acute patient care characteristics, and reimbursement principles are defined in the HAR Chapters 17-1737 and 17-1739.

40.800 Service Coordination, Assessments & Care Plans

40.810 Service Coordination System

The health plan shall have a Service Coordination System that complies with the requirements in 42 CFR 438.208, and is subject to DHS approval. The health plan shall submit to the DHS its Service Coordination System policies and procedures by the due date identified in Section 51.600, Readiness Review. Any changes to these policies and procedures must be submitted to the DHS thirty (30) days prior to implementation of the change(s).

The health plan shall be responsible for coordinating the primary, acute and long-term care services for all QExA members and ensuring the continuity of care. The health plan shall use a patient-centered, holistic, service delivery approach to coordinating member benefits across all providers and settings.

Each member shall be assigned a service coordinator who will assist in planning and coordinating his/her care. The service coordinator shall assist with coordinating QExA services with Medicare, the DOH programs excluded from QExA, and other community services to the extent they are available and appropriate for the member.

Service coordinator responsibilities for all members shall include:

- Coordinating a team of decision-makers to develop the care plan, including the PCP, other providers as appropriate, the member, and others as determined by the member including family members, caregivers and significant others;
- Conducting health and functional assessment;
- Developing the care plan based upon results of assessment;
- Monitoring progress with EPSDT requirements;
- Coordinating services with other providers such as Medicare, the DOH programs excluded from QExA, Medicare Advantage plans, other MCO providers, Zero-To-Three, Healthy Start, mental health and DD/MR providers at DOH;
- Utilizing compiled data received from member encounters to assure the services being provided meet member needs;
- Facilitating access to services; and
- Providing assistance in resolving any concerns about care delivery or providers.

In addition to the above requirements, service coordinator responsibilities for NF LOC members shall include:

- Completing NF LOC assessment and sending to the DHS or its designee for a functional eligibility determination;
- Providing options counseling regarding institutional placement and HCBS alternatives; and
- Assisting members in transitioning to and from nursing facilities/residential facilities.

A summary of service coordinator responsibilities with time frames for completion of responsibilities is located at Appendix G.

The service coordinator shall work closely with the member's PCP in updating and making changes to a member's care plan.

The health plan shall maintain sufficient service coordinators to meet members' needs. The health plan shall determine how best to utilize service coordinators and assign caseloads within the following parameters.

For purposes of establishing service coordinator ratios, the QExA population is divided into four (4) categories:

1. non-NF LOC members;
2. NF LOC members residing in the community;
3. NF LOC members residing in an institutional setting; and
4. members choosing self-direction.

Each service coordinator's caseload cannot exceed 1880 hours annually (full time employment in the State is 2080 hours – 1880 hours assumes 90% productivity). Based upon the intensity of need, the following service coordinator ratios are established for the QExA program.

- For non-NF LOC members, service coordinators may have up to 750 members (1:750). The assumption is that service

coordinators will devote approximately 2.5 hours annually to each member in this category (1880 hours/750 members = 2.5 hours).

- For NF LOC members residing in the community, service coordinators may have up to 50 members (1:50). The assumption is that service coordinators will devote approximately 37.6 hours annually to each member in this category (1880 hours/50 members = 37.6 hours).
- For NF LOC members residing in an institutional setting, service coordinators may have up to 120 members (1:120). The assumption is that service coordinators will devote approximately 15.7 hours annually to each member in this category (1880 hours/120 members = 15.7 hours).
- For members choosing self-direction, service coordinators may have up to 40 members (1:40). The assumption is that service coordinators will devote approximately 47 hours annually to each member in this category (1880 hours/40 members = 47 hours).

If a mixed caseload is assigned to a care coordinator, the following formula shall be used in determining the service coordinator's mixed caseload:

$$\begin{aligned} & (\# \text{ of non-NF LOC members} \times 2.5\text{hrs}) + \\ & (\# \text{ of NF LOC members residing in the community} \times 37.6 \text{ hrs}) + \\ & (\# \text{ of NF LOC members residing in an institutional setting} \times 15.7\text{hrs}) + \\ & \underline{(\# \text{ of members choosing self-direction} \times 47\text{hrs})} = \\ & 1880 \text{ hours or less} \end{aligned}$$

As part of its service coordination system policies and procedures, the health plan shall include information on established qualifications for service coordinators. At a minimum, service coordinators working with members who meet a NF LOC must meet all State certification and licensure requirements for a social worker, licensed nurse, or other healthcare professional with a minimum of three (3) years of relevant healthcare (preferably in long-term care) experience.

The health plan shall provide ongoing training to service coordinators about their roles and responsibilities. Information about this ongoing training shall be included in the service coordination system policies and procedures.

Members may request to change service coordinators at any time. Requests may be made in writing or verbally and shall be documented in the care plan.

As part of its Service Coordination System policies and procedures, the health plan shall include policies and procedures for service coordinators that address:

- Service coordinator qualifications for each of the four (4) categories of QExA population;
- Methodology for assigning and monitoring service coordinator caseloads;
- Training guidelines (including frequency of training courses, topics and course format) and sample program materials; and
- Process for ensuring continuity of care when service coordinator changes are made.

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 in Section 71.200.

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.

The health plan shall report on its Service Coordination System as required in Section 51.340, Reporting Requirements.

Assessments

The health plan shall provide members with services that are appropriate to their medical and LOC needs. Upon enrollment, the health plan shall conduct a face-to-face Health and Functional Assessment (HFA) to determine the health and functional capability of each QExA member and the appropriate strategies and services to best meet those needs. The HFA shall take into consideration the health status (including but not limited to medication management, risk for falls, history of emergency room visits), environment, available supports, medical history, and social history of each member.

The health plan shall use a standardized form developed by the health plan and have a process for conducting and completing the HFA. The process and HFA form shall be submitted to the DHS for review and approval by the due date identified in Section 51.600, Readiness Review. Changes to the assessment process shall be submitted to the DHS for approval at least thirty (30) days prior to implementation of the change(s).

If the HFA identifies that the member will need NF LOC services, the health plan shall be responsible for assessing QExA members using the State's LOC evaluation tool (DHS 1147) or the health plan may delegate this responsibility to a qualified provider or subcontracted entity. The State's LOC Evaluation tool is the form used to determine NF LOC. Once the LOC assessment is completed, the health plan shall forward the completed tool to the DHS, or its designee, for LOC determination. The DHS, or its designee, will make the LOC determination. The State's LOC evaluation tool and process may be found at Appendix H.

The health plan shall offer the choice of institutional services or HCBS to members who meet the NF LOC when HCBS are available and are cost-neutral. The health plan shall document good faith efforts to establish a cost-neutral care plan in the community. The health plan must receive

prior approval from the DHS or its designee prior to disapproving a request for HCBS.

The health plan is not required to provide HCBS if:

- The member chooses institutional services;
- The member cannot be served safely in the community; or
- There are not adequate or appropriate providers for needed services.

For members whose first day of enrollment into the health plan falls during the first ninety (90) days following Commencement of Delivery of Services as defined in Section 20.100, the service coordinator shall conduct the HFA and the LOC assessments (as needed) within the first ninety (90) days of enrollment into the health plan. The LOC assessment will remain in effect until expiration date. If the member has a change in condition which requires a revised LOC assessment under the State's LOC assessment process, a revised LOC assessment will be required. For this ninety (90) day period, QExA health plans shall use the following triage strategy for conducting the HFA:

- Priority #1 – HCBS members with a care plan who have nurse delegation in place;
- Priority #2 – HCBS members with a care plan without nurse delegation in place;
- Priority #3 – members in a nursing facility; and
- Priority #4 – members without a care plan in place.

If a member has a change in condition during the first ninety (90) days of enrollment into the health plan, the member shall be assessed to determine new service needs.

During this three (3) month period, prior to conducting a HFA and/or NF LOC assessment, the health plan shall:

- Ensure that members receive all medically necessary emergency services;
- Ensure that members receive all medically necessary long-term care services, including both HCBS and institutional services;
- Adhere to a member's prescribed prior authorization for medically necessary services, including prescription drugs, or courses of treatment; and
- Provide for the cost of care associated with a member transitioning to or from an institutional facility in accordance with the requirements prescribed in Section 40.800.

For members enrolling after the transition enrollment period, the health plan shall complete a HFA and LOC assessment within fifteen (15) business days following enrollment.

The health plan's service coordinators shall conduct annual HFA and NF LOC re-assessments. For those members who meet a NF LOC, the health plan may substitute the NF LOC assessment for the HFA.

For non-NF LOC members, at the member's request, the HFA annual re-assessment may be conducted by telephone. Within ten (10) days the care coordinator shall follow-up a telephone reassessment with a face-to-face reassessment when significant events occur in the life of a member, including but not limited to, the death of a caregiver, change in health status, change in living arrangement, institutionalization and change in provider (if the provider change affects the care plan).

40.830

Care Plan

A care plan shall be developed for each QExA member. For members who do not meet a NF LOC, the care plan shall provide the broad

roadmap for service delivery and addressing the member's assessed needs. At a minimum, the care plan shall include:

- Goals, objectives and desired outcomes; and
- Needed services and service parameters.

The care plan for members authorized at NF LOC shall be a more detailed guide that specifies the required measures to address the more complicated health issues and conditions and the strategies to maximize community placement. For members meeting a NF LOC, the minimum care plan requirements cited above will also apply. In addition, the health plan shall include information such as:

- Health conditions and required course of treatment for specified conditions;
- Medication regimen; and
- Back-up plan indicating alternative plans in instances when regularly scheduled providers are unavailable. Back-up plans may involve the use of non-paid caregivers and/or paid caregivers.

In developing the care plan, the health plan shall consider the appropriate services and mix of services that will enable the member to remain in his or her home or other community placement in order to prevent or delay institutionalization whenever possible.

The care plan shall be developed by the service coordinator in conjunction with the member and, as appropriate, the PCP and specialty providers. As appropriate and to the extent desired by the member, the health plan will allow the participation of family members, significant others, caregivers, etc, in the care plan process. At a minimum, the care plan must be signed and dated by the service coordinator and the member, his or her representative and any surrogate.

For members whose first day of enrollment into the health plan falls during the first three (3) months following Commencement of Delivery of Services as defined in Section 20.100, the health plan shall develop the care plan within the first 90 (ninety) days of enrollment into the plan, following the completion of the HFA. For members enrolling after this three (3) month period, the health plan shall complete the care plan within fifteen (15) business days following enrollment, following completion of the HFA.

Copies of the care plan must be forwarded to the member and the PCP within 15 (fifteen) days of development. Care plans for members not meeting NF LOC shall be reviewed and updated at the following times:

- When significant events occur in the life of a member, to include but not limited to the death of a caregiver, change in health status, change in living arrangement, institutionalization and change in provider (if the provider change affects the care plan); or
- Annually if a review and update has not occurred due to the occurrence of a significant event defined above.

Care plans for members at NF LOC must be reviewed and revised, as needed, every 90 days.

For members transitioning from the four (4) HCBS waivers into QExA, health plans will follow the existing HCBS care plan until the member is reassessed by the care coordinator for services under QExA. For members who reside in an institutional setting, the health plan will follow the existing care plan until the member is reassessed by the care coordinator for services under QExA.

The health plan shall develop standards for the care plan development process and submit these to the DHS for review and approval by the due date identified in Section 51.600, Readiness Review. Changes to the

process shall be forwarded to the DHS for approval thirty (30) days prior to implementation of any change(s).

40.900 Other Services to be Provided

40.910 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), and 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 by the due date identified in Section 51.600, Readiness Review.

40.920 Disease Management

The health plan shall have disease management programs for diabetes mellitus, obesity management, and cardiovascular disease. The health plan shall select at least one (1) other program from the following: behavioral health, drug abuse, or fall prevention.

The health plan's disease management programs shall:

1. Have a systematic method of identifying and enrolling members in each program;
2. Utilize evidence-based clinical practice guidelines;
3. Emphasize the prevention of exacerbation and complications of the diseases;
4. Incorporate educational components for both members and providers,
5. Utilize an integrated, comprehensive approach to patient care that extends beyond a focus on the prescription drug line item;
6. Takes a member-centered approach to providing care by addressing psychological aspects, caregiver issues and treatment of diseases using nationally recognized standards of care;
7. Incorporate culturally appropriate interventions, including but not limited to taking into account the multi-lingual, multi-cultural nature of the member population;
8. Focus interventions on the member through activities such as disease and dietary education, instruction in health self-management, and medical monitoring;

9. 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
10. 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. Disease management programs should be offered to members who require these services for better control of their current disease or who are at high risk of developing one of these diseases. The health plan shall submit these policies and procedures to the DHS for review and approval by the due date identified in Section 51.600, Readiness Review.

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

40.930 Children with a Disability who are Receiving Foster Care/Child Protective Services (CPS)

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 CPS. 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 CPS workers in obtaining a necessary physical examination within the established time frame 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 CPS children and shall identify person(s) within the health plan who may assist the foster parent/guardian and CPS 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 CPS worker may also request to the DHS for a change in health plan outside of the annual plan change period without limit if it is in the best interest of the child. Disenrollment shall be at the end of the month in which the request is made.

40.940 Vaccines for Children (VFC) Program

The health plan is responsible for ensuring that children receive all necessary vaccinations. The State of Hawaii participates in the VFC program, a federally funded program that replaces public and private vaccines for Medicaid children under the age of nineteen (19). These vaccines are distributed to qualified providers who administer them to children. The health plan may choose to provide vaccinations through the VFC program or instead use privately acquired vaccines. However, the health plan will not be reimbursed for any privately acquired vaccines that can be obtained through Hawaii VFC program. The health plan will receive the fee for the administration of the vaccine as part of the capitated rate.

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 Section 40.750.1.

The health plan shall submit its EPSDT plan to the DHS for review and approval by the due date identified in Section 51.600, Readiness Review.

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

The health plan shall require that all providers utilize the standard EPSDT screening form provided in Appendix I.

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 healthcare, how to obtain timely EPSDT services (including translation and transportation services), and providing 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 healthcare 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 Sections 50.330 and 50.395; 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 two (2) types of screens on EPSDT eligible members:

- Complete periodic screens according to the EPSDT periodicity schedule 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; and
- Interperiodic screens, which are screens that occur between the complete periodic screens and are medically necessary to determine the existence of suspected physical or mental illnesses or conditions. This includes, at a minimum, vision, hearing and dental services.

The health plan shall instruct PCP's to complete the EPSDT screening form at the periodic screening visit. If the entire screen cannot be completed in one sitting, the PCP should complete the Catch Up and Follow-up form when the EPSDT screening is completed.

The health plan shall provide all medically necessary diagnostic and treatment services to correct or ameliorate a medical, dental or behavioral health problem discovered during an EPSDT screen (complete periodic, interperiodic, or partial). This includes, but is not limited to, timely immunizations and tuberculosis screening; diagnosis and treatment of defects in vision and hearing; and, diagnosis and treatment of acute and chronic medical, dental and behavioral health conditions.

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 40.700 to EPSDT eligible members under EPSDT. Members under age twenty-one (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 illness 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 coordinating services with the DOE and DOH for individuals determined to be eligible for SEBD by the DHS or its contractor for medically necessary outpatient behavioral health services that are required for the educational needs of the member provided by DOE and DOH. However, the family does have the option of receiving therapeutic services from the health plan rather than DOE or DOH. In the event the family selects this option the health plan shall provide said therapeutic services. DOH and DOE will be responsible for providing the following services:

- Crisis Management;
- Crisis Residential Services;
- Biopsychosocial Rehabilitative Programs – Level 1;
- Biopsychosocial Rehabilitative Programs – Level 2;

- Partial Hospitalization;
- Intensive Family Intervention;
- Therapeutic Living Supports;
- Therapeutic Foster Supports; and
- Hospital-based residential services.

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 report on its EPSDT activities as required in Section 51.340.

41.100 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 healthcare 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 healthcare 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.

41.200**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 eighteen (18) years of age or older or an emancipated minor 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 maintain policies and procedures in accordance with HRS §327-E-5 regarding healthcare decision-makers for members who have or do not enact an advanced directive.

The health plan shall submit the advance directives policies and procedures to the DHS for review and approval by the due date identified in Section 51.600, Readiness Review. In addition, the health plan shall provide these policies and procedures to its providers and upon request to CMS.

41.300 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.

41.400 Other Coordination Activities

41.410 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.

41.420 Supplemental Nutrition Program for Women, Infants, and Children (WIC)
Coordination

The health plan shall coordinate the referral of potentially eligible women, infants, and children to the WIC program and the provision of health data within the time frame required by WIC, from their providers.

41.500 Transition of Care to and from the Health Plan

41.510 Transition to the Health Plan

In the event a member (who is not a medically fragile child) entering the health plan is receiving medically necessary covered services in addition to or other than prenatal services (see below for members in the second and third trimester receiving prenatal services) the day before enrollment into the health plan, the health plan shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided by contract or non-contract providers. The health plan shall provide continuation of such services for the lesser of: 1) ninety (90) days or 2) until the member has had a HFA from his or her service coordinator, had a care plan developed and has been seen by the assigned PCP who has authorized a course of treatment.

For medically fragile children, the health plan must provide continuation of such services for the lesser of: 1) one-hundred and twenty (120) days or 2) until the member has had a HFA from his or her service coordinator, had a care plan developed and has been seen by the assigned PCP who has authorized a course of treatment.

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

41.520 Transition from the Health Plan

In the event a member is transitioning from the health plan to another health plan (“new health plan”), the health plan shall cooperate and assist the new health plan with obtaining the member’s medical records and

other vital information. If the member moves to a different service area in the middle of the month, the existing health plan shall remain responsible for the care and the cost of the services provided to the member for the remainder of the month or through discharge if the member is hospitalized or in a long-term care residential facility for a short-stay (less than thirty (30) days. If the member is being discharged from an out-of-state or off-island facility, the old health plan is responsible for returning the individual to the island of residence and arranging for the transition services even if the individual is disenrolled from the health plan prior to discharge from the facility.

41.530 Transition of Care Policies and Procedures

The health plan shall develop transition of care policies and procedures that address all transition of care requirements in this RFP and submit these policies and procedures for review and approval by the due date identified in Section 51.600, Readiness Review.

SECTION 50 HEALTH PLAN ADMINISTRATIVE REQUIREMENTS

50.100 Health Plan Enrollment Responsibilities

50.110 General Overview

Enrollment into the health plan shall be effective on the date the DHS has determined eligibility; this includes prior period coverage as defined in Section 30.200.

The health plan shall accept eligible individuals enrolled into its 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 healthcare 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 healthcare 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 the 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;
- A Member Handbook as described in Section 50.340;
- A flyer or other hand-out that is separate from the Member Handbook which explains:
 - The role of the PCP and the procedures to be followed to obtain needed services;

- How to receive services prior to selecting or being assigned a PCP;
- That the health plan will provide assistance in selecting a PCP and how the member can receive this assistance;
- The conditions under which a member may select a specialist as his or her PCP and the process for doing so; and
- That the health plan will auto-assign a member to a PCP if the member does not select a PCP within fifteen (15) days.
- A PCP selection form;
- A class schedule for member education classes as described in Section 50.320;
- A flyer or other hand-out that is separate from the Member Handbook which explains to the member where in the Member Handbook the member can find the following information:
 - 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
 - The written policies and procedures related to advance directives.

50.120 Hospitalizations and Short Stays (Less than 30 Days) in Long-Term Care Residential Facilities During Enrollment Changes

When a hospitalized member or a member with a short stay in a long-term care residential facility changes health plans (such as during the annual plan change period) or is disenrolled from the health plan and transferred to the Medicaid fee-for-service program, the health plan in which the member was enrolled on the date of admission to the hospital

or long-term care residential facility remains financially responsible for services, transportation, meals and lodging for an attendant, if applicable, through discharge as long as the member remains in the same facility regardless of a lowering of the LOC.

When an individual is determined eligible for QExA while hospitalized or is on a short stay in a long-term care residential facility the health plan shall provide covered health services starting on the effective date of enrollment as defined in Section 30.200. This includes payment for travel, meals and lodging for an attendant if necessary.

50.130 PCP Selection

The health plan shall provide assistance in selecting a PCP and shall provide the member fifteen (15) days to select a PCP. This fifteen (15) day period shall not include mail time. If a PCP is not selected within fifteen (15) days, the health plan shall assign a PCP to the member based first on historical utilization and second on the geographic area in which the member resides.

50.140 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. Examples of changes in the member's status are provided in Section 30.580.

50.150 Newborn Enrollment

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, the health plan shall notify the DHS on the next business day following the weekend or holiday. The health plan shall be responsible for providing all needed services for the newborn until the DHS notifies them that the newborn is enrolled in a different QExA health plan or in a QUEST health plan.

50.160 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 any other relevant federal law.

50.170 Informational Brochure

The health plan shall provide information to the DHS or its delegate for inclusion in the informational brochure distributed by the DHS to potential and current members at the time of health plan selection. This information shall be provided in the format and time frame prescribed by the DHS.

50.180 Collection of Spend-Down Amounts

The health plan shall be responsible for collecting all spend-down amounts as described in Section 60.250.

50.200 Disenrollment

50.210 Acceptable Reasons for Health Plan Disenrollment Requests

The DHS is solely responsible for making all disenrollment determinations and decisions. The health plan shall notify the DHS in the event it becomes aware of circumstances 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. The list of appropriate reasons for disenrollment is provided in Section 30.600.

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

For all non-experimental, non-investigational covered transplants, except for cornea transplants and bone grafts, the health plan shall notify the member that he or she should submit a 1144 form to the MQD for authorization for an evaluation by SHOTT. The health plan shall provide assistance to the member as needed.

If the member does not meet the criteria for a transplant, the health plan shall remain responsible for providing services to the member. If the member is determined to meet the eligibility criteria for the SHOTT transplant program, the health plan will no longer be responsible for the member, effective the date of notification from the DHS that the member has been accepted into the program. If the member is determined to meet the criteria for a transplant by SHOTT and has been disenrolled from the health plan, but the transplantation facility does not accept the member as a patient, the health plan shall become responsible for the member effective the 1st day of the following month.

The health plan may resubmit the member for reconsideration if the member's condition changes to make him/her a better candidate for a transplant.

50.230 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

50.310 General Requirements

The health plan shall ensure that members are aware of their rights and responsibilities, the role of PCPs, how to obtain care, what to do in an emergency or urgent medical situation, how to file a grievance or appeal, 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 that allow the members to ask questions and receive responses from the health plan.

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

The health plan shall develop member services policies and procedures that address all components of member services. The health plan shall submit these policies and procedures to the DHS for review and approval by the due date identified in Section 51.600, Readiness Review. These policies and procedures must include, but are not limited to, policies and procedures on:

- Member call center staffing and monitoring;
- Member call center activities to ensure metrics as required in Section 50.380 are met;
- The availability of translation services and services for non-English speakers and individuals with visual and hearing impairments and how to access these services;
- Member rights and how they are protected;
- Up-dating and ensuring accuracy of information on the member portal of the web-site; and
- Methods to ensure member materials are mailed in a timely manner.

50.320 Member Education

The health plan shall educate its members on the importance of good health and how to achieve and maintain good health. The health plan shall educate its members on:

- The availability and benefits of preventive healthcare;
- Available disease management programs;
- The efficacy of completing advanced directives;
- The aging process;
- The importance of and schedules for screenings for cancer, high blood pressure and diabetes;
- The risks associated with the use of alcohol, tobacco and other substances;
- The concepts of managed care;

- 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;
 - The role of the service coordinator and how to contact him or her;
 - The scope of services provided through the health plan;
- Member rights and responsibilities;
- 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 shall conduct an educational class once per month. This class shall provide an overview of all topics addressed above. The health plan shall notify members of the schedule of these classes in the new member packet and shall post the class schedule on its web-site. In addition, to the required class, the health plan may use individual meetings, videotapes, written material and media campaigns as part of its educational efforts.

The health plan shall submit all education materials, including the training plans and curricula, to the DHS for review and approval by the due date identified in Section 51.600, Readiness Review. During the course of the contract term, the health plan shall submit additional education materials to the DHS for review and approval prior to the health plan's use and distribution of them. At a minimum, the health plan shall submit these materials forty-five (45) days prior to the date on which it proposes to use or distribute them. The health plan is prohibited from using any unapproved education materials.

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, Mandarin 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 and 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. The health plan does not need to submit the translated member materials to the DHS; however, the health plan shall submit the certification that the transcriptions have been reviewed by a qualified individual. The health plan shall submit the certification within thirty (30) days of the DHS approval of the English version of materials. The health plan is responsible for ensuring the translation is accurate and culturally appropriate.

All written materials shall be worded such that the materials are understandable to a member who reads at the 6th grade reading level. Sixth grade reading level is defined as grade 6.9 or below. 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.

The health plan shall submit the reading level and the methodology used to measure it concurrent with all submissions of written materials to the DHS.

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. The health plan shall submit these changed materials at least thirty days prior to the scheduled distribution to ensure the DHS has sufficient time for review.

50.340 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.

The health plan shall update and re-print the member handbook at least annually. The health plan may request, from the DHS, a waiver of the re-print requirement if there have been no changes.

In addition, the health plan shall send updates to members as information in the member handbook changes.

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;
- General information on managed care;
- Information, including a complete list, of the rights and responsibilities of the member as described in Section 50.350;
- Information about the PCP, including:
 - The role of the PCP and the procedures to be followed to obtain needed services;
 - How to receive services prior to selecting or being assigned a PCP;
 - That the health plan will provide assistance in selecting a PCP and how the member can receive this assistance;
 - The conditions under which a member may select a specialist as his or her PCP and the process for doing so; and
 - That the health plan will auto-assign a member to a PCP if the member does not select a PCP within fifteen (15) days.
- Information about the role of the service coordinators, including but not limited to:
 - How to contact the service coordinator;
 - A statement that this person may be contacted as often as the member needs to;
 - The phone numbers of the service coordinators;
 - Information about yearly assessments/re-assessments;
 - How and when the member will be notified of who the assigned service coordinator is; and

- The procedures for making changes to the assigned service coordinator, whether initiated by the health plan or the member requests a change.
- Information on how to contact the toll-free call center during business hours and the toll-free nurses line twenty-four (24) hours a day/seven (7) days a week.
- Information about reporting changes in family status and family composition;
- Appointment procedures, including the minimum appointment standards as identified in Section 40.230;
- Information on benefits and services that includes basic definitions;
- Additional benefits provided by the health plan not required by this RFP;
- Information on how to access all services, including, but not limited to, EPSDT services, dental services, non-emergency transportation services and long-term care services (i.e., HCBS and nursing facilities);
- An explanation of any service limitations or exclusions from coverage;
- 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 including the requirement that the provider may not bill a member or assesses charges or fees except:
 - If a member self-refers to a specialist or other provider within the network without following health plan procedures

(e.g. obtaining prior authorization) and the health plan denies 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;
- 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;
 - Procedures for reporting suspected fraud and abuse;
 - Information on how to access interpreter and sign language services, how to obtain information in alternative languages and formats, and that these services are available at no charge;
 - The following information about 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 healthcare 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 time frames 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 time frames 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 DHS chooses to make available to providers to challenge the failure of the health plan to cover a service.
 - Information on the State's ombudsman program; and
 - 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 by the due date identified in Section 51.600, Readiness Review.

50.350 Member Rights

The health plan shall include, in its member services policies and procedures, a description of how it will ensure that the rights of members are safeguarded and how the health plan will comply with any applicable federal and state laws and regulations that pertain to member rights.

In addition, all member rights shall be listed in the member handbook and the provider manual. At a minimum, the member handbook and the provider manual shall specify the member's right to:

- Receive information pursuant to 42 CFR §438.100(a)(1)(2) and Sections 50.330 and 50.395 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 healthcare, including the right to refuse treatment;
- Be free from any form of restraint or seclusion as a means of coercion, discipline, convenience or retaliation, as specified in federal regulations on the use of restraints and seclusion;
- Request and receive a copy of his or her medical records pursuant to 45 CFR Parts 160 and 164, subparts A and E, and request to amend or correct the record as specified in 45 CFR §§164.524 and 164.526;
- Be furnished healthcare 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;
 - Have direct access to a women’s health specialist within the network;
 - Receive a second opinion at no cost to the member;
 - Receive services out-of-network if the health plan is unable to provide them in-network for as long as the health plan is unable to provide them in-network and not pay more than he or she would have if services were provided in-network;
 - Receive services according to the appointment waiting time standards;
 - Receive services in a culturally competent manner;
 - Receive services in a coordinated manner;
 - Have his or her privacy protected;
 - Be included in care plan development;
 - Have direct access to specialists (if he or she has a special healthcare need);
 - Not have services arbitrarily denied or reduced in amount, duration or scope solely because of diagnosis, type of illness, or condition;
 - Choose between institutional care and HCBS (if determined cost-neutral by the health plan);
 - Receive a description of cost sharing responsibilities, if any;
- Not be held liable for:
 - The health plan’s debts in the event of insolvency;
 - The covered services provided to the member by the health plan for which the DHS does not pay the health plan;
 - Covered services provided to the member for which the DHS or the health plan does not pay the healthcare provider that furnishes the services; and

- Payments of covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the member would owe if the health plan provided the services directly; and
- Only be responsible for cost sharing in accordance with 42 CFR §§447.50 through 447.60.

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

- The provider's complete name,
- All locations;
- Telephone numbers;
- Non-English languages spoken;
- Whether or not board certification has been attained;
- Web-site address (if available); and
- Whether the provider is accepting new patients (only applicable for updates of the provider directory; the provider directory used on the date of Commencement of Services to Members identified in Section 20.100 shall not have any providers not accepting new patients included in it).

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

member and provider service representatives who can access provider directory information for its members, providers and the State.

The health plan does not need to print a specified number of hard copies of the provider directory. However, the health plan shall, at no cost to the member, provide a hard copy upon request. This hard copy shall be sent to the member within twenty-four (24) hours of the request.

50.370 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;
- Third Party Liability (TPL) information; and
- EPSDT eligibility indicator.

The health plan shall re-issue a member ID card within ten (10) days of notice if a member reports a lost card or there is any change 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 by the due date identified in Section 51.600, Readiness Review.

50.380 Member Toll-Free Call Center

The health plan shall operate a toll-free call center to respond to member questions, comments and inquiries. The toll-free call center services shall

be available and accessible to members from all islands the health plan serves.

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

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

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

The health plan shall meet the following call center standards:

- Ninety-nine percent (99%) of calls are answered by the fourth ring;
- The call abandonment rate is five percent (5%) or less;
- The average hold time is two (2) minutes or less; and
- The blocked call rate does not exceed one percent (1%).

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

that representatives return all calls by close of business the following business day.

In addition, the health plan shall have a twenty-four (24) hour, seven (7) day a week, toll-free nurse line available to members. The health plan may use the same number as is used for the call center or may develop a different phone number. Staff on the toll-free nurse line must be either a registered nurse (R.N.), physician's assistant, nurse practitioner, or medical doctor. The toll-free nurse line shall meet the following standards:

- 99% of calls are answered by the fourth ring;
- The call abandonment rate is five percent (5%) or less;
- The average hold time is two (2) minutes or less; and
- The blocked call rate does not exceed one percent (1%).

50.390 Internet Presence/Web-Site

The health plan shall have a member portal on its web-site that is available to all members which contains accurate, up-to-date information about the health plan, services provided, the provider network, FAQs, and contact phone numbers and e-mail addresses. The section of the web-site relating to QExA shall comply with the marketing policies and procedures and requirements for written materials described in this contract and all applicable state and federal laws.

The health plan shall submit to the DHS, for review and prior approval, all screen shots relating to the QExA program by the due date identified in Section 51.600, Readiness Review.

50.395 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. In addition, the health plan shall provide sign language and TTD services to members with hearing impairments. The health plan shall notify its members of the availability of oral interpretation services, sign language and TDD services and inform them of how to access these services. There shall be no charge to the member for any translation, sign language or TDD 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 71.320, 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);
- 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 50.330 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 or to any potential members that relate to QExA that have not been prior approved by the DHS. All materials shall be submitted to the DHS for review and approval by the due date identified in Section 51.600, Readiness Review.

In addition, the health plan shall submit, to the DHS, any marketing materials it has received from provider for review and prior approval.

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

50.500 Quality Management

50.510 Accreditation

The health plan shall obtain NCQA or URAC accreditation for its QExA program by January 1, 2012. As part of the accreditation process, the health plan shall submit reports monitoring the accreditation process as required in Section 51.360.

50.520 General Provisions

The QExA health plan shall provide for the delivery of quality care that is: (1) accessible and efficient; (2) provided in the appropriate setting; (3) provided according to professionally accepted standards; and (4) provided in a coordinated and continuous rather than an 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 and care;
- Ensuring coordination and continuity of care;
- Ensuring members receive the services they need to maintain their highest functional level;
- Ensuring that members' rights are upheld and services are provided in a manner that is sensitive to the cultural needs of members, pursuant to Section 40.910 of this contract;
- 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 approach to quality improvement.

The health plan shall execute processes to assess, plan, implement, evaluate and, as mandated, report quality management and performance improvement activities as specified in the Medicaid State Health Plan Manual, that adheres to the requirements prescribed in 42 CFR §438.240(a)(1) and (e)(2), including:

- Seeking input from, and working with, members, providers, MQD staff and its designees and community resources and agencies to actively improve the quality of care provided to members;
- Conducting Performance Improvement Projects (PIPs);
- Conducting QM monitoring and evaluation activities;
- Investigating, analyzing, tracking and trending quality of care issues, abuse and/or complaints that includes:

- Sending acknowledgement letter to the originator of the concern;
- Documenting all steps utilized during the investigation and resolution process;
- Following-up with the member to assist in ensuring immediate healthcare needs are met;
- Sending closure/resolution letter that provides sufficient detail to ensure that the member has an understanding of the resolution of his/her issue, any responsibilities he/she has in ensuring all covered, medically necessary care needs are met, and a contact name and telephone number to call for assistance or to express any unresolved concerns;
- Documenting implemented corrective action plan(s) or action(s) taken to resolve the concern; and
- Determining and evaluating evidence of the resolution implemented;
- Implementing the DHS mandated performance measures; and
- Establishing and implementing credentialing, recredentialing and provisional credentialing processes for providers and organizations according to 42CFR 438.206(b)(6) and 42 CFR 438.214.

The health plan shall have a process in place to monitor services provided in home and community-based settings. The process shall be a collaborative one that involves quality management and service coordinators. The health plan shall develop a process that, at a minimum, meets the requirements specified in the Medicaid State Health Plan Manual instructions.

The health plan shall submit a written Quality Assessment and Performance Improvement (QAPI) plan, an evaluation of the previous year's QAPI program, and Quarterly QAPI report that addresses its strategies for performance improvement and conducting the quality management activities described in this section.

Quality Assessment and Performance Improvement (QAPI) Program

The health plan shall have an ongoing QAPI Program for all QExA services. The QAPI Program shall consist of the systematic internal processes and mechanisms used by the health plan for 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 health plan shall comply with the following requirements set forth in 42 CFR §438.240:

- Conducting performance improvement projects (PIPs) described in 42 CFR §438.240(d) and Section 50.540;
- Submitting performance measurement data described in 42 CFR §438.240(c) and Section 50.550;
- Establishing mechanisms for detecting both under utilization and over utilization of services as required in Section 50.600; and
- Establishing mechanisms for assessing the quality and appropriateness of care furnished to members.

For each year of the contract, the health plan shall comply with the QAPI Program standards established by the DHS as well as the NCQA Standards/Guidelines. The health plan shall monitor NCQA standards/guidelines and remain updated on the changes.

The DHS reserves the right to revise 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. The DHS will provide updates to established standards annually.

The health plan may be permitted to delegate certain QAPI Program activities and functions provided it submits, to the DHS for approval as required in Section 51.600, Readiness Review, the documents listed below. The health plan shall remain ultimately 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;
 - 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.

The health plan shall submit its QAPI Program for the up-coming year and its previous year's QAPI program evaluation as required in Sections 51.310 and 51.360.

50.540 Performance Improvement Projects (PIPs)

In accordance with 42 CFR § 438.240(d) and as part of its QAPI Program, the health plan shall conduct the PIPs required by the DHS or CMS. The DHS shall notify the health plan, no later than July 1 of the previous year, of the PIP topics for the up-coming year beginning on January 1. The

health plan's PIPs shall be 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 document a clearly defined study question and use objective, measurable and well-defined indicators (both of which may be selected by the DHS) to measure performance. The PIPs shall 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).

In addition, the PIPs shall implement system interventions to achieve improvement in quality.

The health plan shall comply with the DHS' PIP policy (as prescribed in the MQD Provider Manual). The health plan shall report the status and results of each project to the State as requested. Each PIP must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information annually on quality of care according to 42 CFR 438.240(d)(2).

The health plan shall submit its PIP standards to the State by the due date identified in Section 51.600, Readiness Review. In addition, the health plan shall submit its proposed PIPs no later than November 1 of each year and its PIP evaluation for the previous year to the DHS no later than April 1 of each year.

50.550 Performance Measures

The health plan shall comply with all of the DHS' quality management requirements to improve performance for all the DHS established performance measures. Complete descriptions of these measures can be found in the most recently published results and analysis of performance measures, or from the DHS upon request. These activities will be monitored by the DHS during the operational and financial review.

The health plan's performance measures shall be submitted to the State for review and approval by the due date identified in Section 51.600, Readiness Review, and annually thereafter as required in Sections 51.310 and 51.360.

CMS has been working in partnership with states in developing core performance measures for Medicaid and SCHIP programs. The current DHS established performance measures may be subject to change when these CMS core measures are finalized and implemented.

The following are the current QExA quality performance measures identified by the DHS. There are two (2) separate categories. The health plan shall report on each category annually. The health plan may elect to report on additional performance measures beyond the three (3) required in the clinical measures category.

50.550.1 *Clinical Measures*

The health plan may choose three (3) performance measures from the following:

- Comprehensive Diabetes Care- HEDIS measures
 - Annual HBA1C testing;
 - Biennial Lipid Profiles;

- Biennial Retinal exams; and
- Annual screening for renal disease to include:
 - Blood pressure monitoring
 - Urine albumin
 - Serum creatinine
 - Glomerular Filtration Rate (GFR)
- Obesity
 - Percent of members with diagnosis of obesity who are referred to obesity management program;
 - Percent of members with diagnosis of obesity who attended obesity management program;
 - Percent of members with diagnosis of obesity who received a behavioral health assessment; and
 - Percent of members with diagnosis of obesity who received behavioral health treatment.
- Cardiovascular Disease- HEDIS measures
 - Cholesterol Management for Patients With Cardiovascular Conditions (CMC) -- The percentage of members 18-75 years of age who, from January 1-November 1 of the year prior to the measurement year, were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous transluminal coronary angioplasty (PTCA), or who had a diagnosis of ischemic vascular disease (IVD), who had each of the following during the measurement year:
 - LDL-C screening performed; and
 - LDL-C control (<100 mg/dL); and
 - The percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year. Use the hybrid method for this measure.
- Institutional Utilization Data

The health plan shall report institutional utilization data for members, by age and gender, in the format and per the specifications prescribed by CMS and the State:

- Rate of acute hospital admissions;
 - Rate of preventable hospital admissions (e.g. pneumonia, COPD, CHF, dehydration and urinary tract infection);
 - Rate of nursing facility admissions;
 - Members discharged from a nursing facility;
 - Members residing in nursing facilities; and
 - Rate of chronic hospital admission.
- Functional Data (implemented in SFY 2012)
 - The health plan shall annually report the need for assistance with ADLs for all members, by age and gender, and place of residence (i.e., home/family's home, E-ARCH, Adult Foster Family home, and nursing facility). This data will be collected in accordance with the Minimum Data Set (MDS), and will include the number of members per 1,000 needing limited assistance and number of members per 1,000 needing extensive or total assistance with mobility, transfer, dressing, eating, toilet use, personal hygiene, or bathing.

50.550.2 EPSDT Participation

The health plan shall semi-annually report on EPSDT participation utilizing the CMS 416 format. In addition, the health plan shall report on:

- Percentage of children identified for referral to follow-up services in a timely manner; and
- Percentage of children identified who actually receive follow-up services in a timely manner.

Section 40.950 provides more detailed information about the EPSDT program.

Performance Standards

In accordance with the DHS prescribed standards, the health plan shall use the following performance standards to monitor the success of program implementation of the performance measures above. The health plan shall improve its performance measures outcomes from year to year. The performance standards will be provided to the health plans annually. The DHS has established three (3) levels of health plan performance:

- *Minimum Performance Standard (MPS)* –The minimal expected level of performance by the health plan. The health plan shall meet the DHS stated MPS for each performance measure it selects from the list in Section 50.550. If the health plan does not achieve this standard, or the measure rate declines to a level below the DHS MPS, the health plan shall be required to submit a corrective action plan and may be subject to sanctions.
- *Goal* – A reachable standard for a given performance measure for the health plan. If the health plan has already met or exceeded the DHS MPS for any measure, the health plan shall strive to meet the DHS established goal for the measure(s). The goal rate will be a percentage increase of the MPS. The DHS will increase the annual goal percentage each plan year. The DHS may require a corrective action plan of any health plan that shows a statistically significant decrease in its goal rate, even if it meets or exceeds the MPS.
- *Benchmark* – The ultimate standard to be achieved. Health plans shall strive to meet the benchmarks established by the DHS. A health plan that has achieved or exceeded the goal for any performance measure(s) shall strive to meet the benchmark for the measure(s). Health plans that have achieved the benchmark are expected to maintain this level of performance for future years.

A health plan shall show demonstrable and sustained improvement toward meeting the DHS performance standards. In addition to corrective action plans, the DHS may impose sanctions on health plans that do not meet the MPS and do not show statistically significant improvement in a goal rate. The DHS may also require health plans to demonstrate that they are allocating increased administrative resources to improving rates for a particular measure or service area.

The health plan shall submit the corrective action plan to the DHS for approval within thirty (30) days of receipt of notification from the DHS. The corrective action plan shall be approved by the DHS within thirty (30) days of submission. The DHS may conduct one or more follow-up on-site reviews to verify compliance with an approved corrective action plan.

50.560 Data Collection Procedures

When requested, the health plan shall submit data to the DHS and/or the EQRO for standardized performance measures and/or PIPs, as required by the State, within specified timelines and according to the established procedures data collection and reporting. The health plan shall collect valid and reliable data, using qualified staff and personnel to collect the data. Failure of the health plan to follow data collection and reporting requirements may result in sanctions.

50.570 Practice Guidelines

The health plan shall include, as part of its QAPI Program, practice guidelines related to diabetes mellitus, obesity management, behavioral health, renal disease (prior to end-stage), and cardiovascular disease. In addition, the health plan may adopt any other practice guidelines that are:

- Relevant to the health plan's membership;
- Based on valid and reliable clinical evidence or a consensus of healthcare professionals in a particular field;
- Adopted in consultation with in-network providers;

All practice guidelines, both those required by the DHS and those selected by the health plan, shall be:

- 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.

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 healthcare providers;
- Describe the process by 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.

50.580 Medical Records Standards

As part of its QAPI Program, the health plan shall establish medical records standards. These standards shall:

- Require that the medical record is maintained by the PCP;
- 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 QExA program, approval or member consent is not needed for access by authorized DHS personnel or personnel contracted by the DHS. (See 42 CFR § 431.300 et seq.);
- 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 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 relates to 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 or 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 a mental health 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 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.

The health plan shall submit its medical records standards to the State by the due date identified in Section 51.600, Readiness Review. If the health plan includes the medical records standards in the QAPI, it is permissible to submit a memo identifying where, in the QAPI program description, the medical records standards appear.

50.590 External Quality Review Organization (EQRO)

As described in Section 30.930, the DHS works in conjunction with an EQRO that meets all federal requirements set forth in 42 CFR §438.354. The health plan's responsibilities as it relates to the EQRO include:

- Collaborating with the EQRO in the external quality review activities it performs to assess the quality of care and services provided to members and to identify opportunities for health plan improvement;
- Providing all requested QAPI program-related documents and data to the EQRO; and
- Submitting to the DHS and the EQRO any corrective action plan(s) that address identified issues requiring improvement, correction or resolution.

50.595 Performance Incentives

The health plan may be eligible for performance incentives as described in Section 60.120 of this contract.

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 developed to assist the health plan in objectively and systematically monitoring and evaluating the necessity, appropriateness, efficiency, timeliness and cost-effectiveness of care and services provided to members. The UMP shall be used by the health plan as a tool to determine and continuously improve the quality of clinical care and services and to maximize appropriate use of resources.

The health plan shall have a written UMP description, a corresponding workplan, UMP policies and procedures, and mechanisms to implement all UMP activities. The UMP description and workplan may be separate documents or may be integrated as part of the written QAPI Program description and workplan. The health plan's UMP shall include structured, systematic processes that employ objective evidenced-based criteria to ensure that utilization decisions regarding medical necessity and appropriateness of medical and behavioral healthcare/services are made in a fair, impartial and consistent manner by qualified licensed healthcare professionals.

The health plan shall annually review and update all UMP criteria and application procedures in conjunction with review of the health plan's clinical practice guidelines, disease management programs, and evaluation of new technologies. Practitioners with appropriate clinical expertise shall be involved in developing, adopting and reviewing the criteria used to make utilization decisions. The health plan shall provide UMP criteria to providers and shall ensure that members and providers seeking information about the UMP process and the authorization of care/services have access to UMP staff.

The health plan's utilization review/management activities shall include:

- Prior authorization/pre-certifications;
- Concurrent reviews;
- Retrospective reviews;
- Discharge planning; and
- Pharmacy Management.

The UMP shall include mechanisms to detect under-utilization, over-utilization, and inappropriate utilization as well as processes to address opportunities for improvement. The health plan shall perform:

- Routine, systematic monitoring of relevant utilization data;
- Routine analysis of all data collected to identify causes of inappropriate utilization patterns;
- Implementation of appropriate interventions to correct any patterns of potential or actual under- 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 not develop a compensation structure that creates incentives for the individuals or entities conducting UMP activities to deny, limit, or discontinue medically necessary services to any member.

The health plan shall submit its written UMP description, corresponding workplan, and UMP policies and procedures to the DHS for review and prior approval by the due date identified in Section 51.600, Readiness Review. If the health plan includes the UMP in the QAPI, it is permissible to submit a memo identifying where, in the QAPI program description, the UMP information appears.

50.700 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 submit these policies and procedures to MQD for review and approval by the due date identified in Section 51.600, Readiness Review.

The health plan shall ensure that all prior authorization/pre-certification decisions, including but not limited to any decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, shall be made by a healthcare professional who has appropriate clinical expertise in treating the member's condition or disease.

The health plan shall not arbitrarily deny or reduce the required scope of services solely because of the diagnosis, type of illness or condition. The health plan may place appropriate limits on a service based on criteria such as medical necessity or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose.

The health plan shall not require prior authorization of emergency services, post-stabilization services, or urgent care services.

The health plan shall notify the provider of prior authorization/pre-certification determinations in accordance with the following time frames:

- 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) days following the receipt of the request for service. An extension may be granted for up to fourteen (14) additional 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 time frame, it shall give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision. 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 time frame 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 time frame 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 time frame, it shall give the member written notice of the reason for the decision to extend the time frame 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 requirements of the State of Hawaii and, and 42 CFR Part 438 Subpart F. The member grievance system shall include an inquiry process, a grievance process and appeals process. In addition, the health plan's grievance system shall provide information to members on accessing to the State's administrative hearing system. The health plan shall require that members exhaust its internal grievance system prior to accessing the State's administrative hearing system.

The health plan shall develop policies and procedures for its grievance system and submit these to the DHS for review and approval by the due date identified in Section 51.600, Readiness Review. The health plan shall submit an updated copy of these policies and procedures within thirty (30) days of any modification for review and approval.

The health plan shall address, log, track and trend all expressions of dissatisfaction, regardless of the degree of seriousness or regardless of whether the member or provider expressly requests filing the concern or requests remedial action. The formal grievance system must be utilized for any expression of dissatisfaction and any unresolved issue.

The health plan shall give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

The health plan shall acknowledge receipt of each filed grievance and appeal in writing within five (5)¹ business days of receipt of the grievance or appeal. The health plan shall have procedures in place to notify all members in their primary language of grievance and appeal resolutions. These procedures may include written and oral translation activities.

The health plan shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made and reviewed by a healthcare professional that has appropriate medical knowledge and clinical expertise in treating the member's condition or disease.

The health plan shall ensure that individuals who make decisions on grievances and appeals were not involved in any previous level of review or decision-making and are healthcare professionals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease. This requirement applies specifically to reviewers of:

- An appeal of a denial that is based on a lack of medical necessity;
- A grievance regarding denial of expedited resolution of an appeal;
- or
- A grievance or appeal that involves clinical issues.

50.810 Recordkeeping

The health plan shall maintain records of its members' grievances and appeals in accordance with this RFP's requirements for recordkeeping and confidentiality of members' medical records.

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.

50.815 Inquiry Process

The health plan shall have an inquiry process to address all inquiries as defined in Section 30.200. As part of this process, the health plan shall ensure that, if at any point during the contact, the member expresses a complaint of any kind, the inquiry becomes a grievance or appeal and the health plan shall give the member, or provider acting on behalf of the member, their grievance and appeal rights. The inquiry can be in writing or as a verbal request over the telephone.

50.820 Grievance Process

A grievance may be filed about any matter other than an action, as defined in Section 30.200. Subjects for grievances include, but are not limited to:

- The quality of care of a provider;
- Rudeness of a provider or a provider's employee; or
- Failure to respect the member's rights.

A member or a member's representative (on behalf of a member with consent) may file a grievance orally or in writing. Members or their representatives must file grievances directly with the health plan.

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) days of the initial expression of dissatisfaction; and

- Include clear instructions as to how to access the State's grievance review process on the written disposition of the grievance.

The health plan's resolution of the grievance shall be final unless the member or member's representative wishes to file for a grievance review with the State.

50.825 State Grievance Review

As part of its grievance system, the health plan shall inform members of their rights to seek a grievance review from the State in the event the disposition of the grievance does not meet the satisfaction or expectations of the member. The health plan shall provide its members with the following information about the State grievance review process:

- Health plan members may request a State grievance review, within thirty (30) days of the member's receipt of the grievance disposition from the health plan. A State grievance review may be made by contacting the MQD office, 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) days from the day the request for a grievance review is received; and
- The grievance review determination made by MQD is final.

Appeals Process

An appeal may be filed when the health plan issues a notice of action to a health plan member.

A member, provider, or authorized representative on behalf of the member with the member's consent, may file an appeal within thirty (30) days of the notice of action. An oral appeal may be submitted in order to establish the appeal submission date; however, this must be followed by a written request. The health plan shall assist the member, provider or authorized representative in this process.

In addition to meeting the general requirements detailed in Section 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, member, or representative 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 or his or her representative a reasonable opportunity to present evidence, and evidence of allegations of fact or law, in person as well as in writing;
- Provide the member or his or her representative opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the appeal process; and
- Include as parties to the appeal, the member and his or her representative, or the representative of a deceased member's estate.

For standard resolution of an appeal, the health plan shall resolve the appeal and provide a written notice of disposition to the parties as

expeditiously as the member's health condition requires, but no more than thirty (30) days from the day the health plan receives the appeal.

The health plan may extend the resolution time frame by up to fourteen (14) 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 clear instructions about 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 within thirty (30) days 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, his or her representative or provider may file an expedited appeal either orally or in writing. No additional follow-up

shall be required. An expedited appeal is only appropriate when the health plan determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function.

The health plan shall ensure that punitive action is not taken against a provider who requests an expedited resolution or who supports a member's appeal.

For expedited resolution of an appeal, the health plan shall resolve the appeal and provide written notice to the affected parties as expeditiously as the member's health condition requires, but no more than three (3) business days from the time the health plan received the appeal. The health plan shall make reasonable efforts to also provide oral notice to the member with the appeal determination.

The health plan may extend the expedited appeal resolution time frame by up to fourteen (14) 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 time frame 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 to the MQD Health Plan Liaison. 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 time frame for standard resolution;
- Make reasonable efforts to give the member prompt oral notice of the denial;
- Follow-up within two (2) days of written notice; and
- Inform the member orally and in writing 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 allegations of fact or law, in person as well as in writing. The health plan shall inform the member of limited time available to present this information.

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) 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 member's representative, the provider acting on behalf of the member, or the representative of a deceased member's estate that he or she may access the State administrative hearing process. The member, or his or her representative, may access the state administrative hearing process by either calling the member's eligibility worker or submitting a letter to the Administrative Appeals Office (AAO) within thirty (30) days from the receipt of the member's appeal determination.

The health plan shall provide the following address to the members:

State of Hawaii Department of Human Services
Administrative Appeals Office
PO Box 339
Honolulu, HI 96809

The State shall reach its decision within ninety (90) days of the date the member filed the request for an administrative hearing with the State.

50.845 Expedited State Administrative Hearings

The member may file for an expedited state administrative hearing only when the member requested or the health plan has provided an expedited appeal and the action of the appeal was determined to be adverse to the member (Action Denied). 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.

Continuation of Benefits During an Appeal or State Administrative Hearing

The health plan shall continue the member's benefits if:

- The member requests an extension of benefits;
- The appeal or request for State administrative hearing is filed in a timely manner, meaning on or before the later of the following:
 - Within ten (10) days of the health plan mailing the notice of adverse action; or
 - The intended effective date of the health plan's proposed adverse action.
- The appeal or request for State administrative hearing involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider; and
- The original authorization period has not expired.

If the health plan continues or reinstates the member's benefits while the appeal or State administrative hearing is pending, the health plan shall continue all benefits until one of following occurs:

- The member withdraws the appeal;
- The member does not request a State administrative hearing within ten (10) days from when the health plan mails a notice of adverse action;
- A State administrative hearing decision adverse to the member is made; or
- The authorization expires or 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, then 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 within the health plan and the DHS, 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 Action

The health plan shall give the member and the referring provider a written notice of any action within the time frames specified below. The notice to the member or provider shall include the following information:

- The action the health plan has taken or intends to take;
- The reasons for the action;
- The member's or provider's right to an appeal with the health plan;
- The member's or provider's right to request an appeal;

- Procedures for filing an appeal with the health plan;
- The circumstances under which an expedited resolution is available and how to request it; and
- The member's right to have benefits continue pending resolution of an appeal, how to request that the benefits be continued, and the circumstances under which a member may be required to pay the costs of these services.

The notice of action to the member shall be written pursuant to the requirements in Section 50.330 of this RFP.

The health plan shall mail the notice within the following time frames:

- For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) days prior to the date the adverse action is to start except:
 - By the date of action for the following reasons:
 - The health plan has factual information confirming the death of a member;
 - The health plan receives a clear written statement signed by the member that he or she no longer wishes services or gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying that information;
 - The member has been admitted to an institution that makes him or her ineligible for further services;
 - The member's address is unknown and the post office returns health plan mail directed to the member indicating no forwarding address;
 - The member has been accepted for Medicaid services by another local jurisdiction;

- The member's provider prescribes a change in the level of medical care;
 - There has been an adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989; or
 - In the case of adverse actions for nursing facility transfers, the safety or health of individuals in the facility would be endangered, the member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the member's urgent medical needs, or the member has not resided in the nursing facility for thirty (30) days.
- The period of advanced notice is shortened to five (5) days if there is alleged fraud by the recipient and the facts have been verified, if possible, through secondary sources.
 - For denial of payment: at the time of any action affecting the claim.
 - For standard service authorization decisions that deny or limit services: as expeditiously as the member's health condition requires, but not more than fourteen (14) days following receipt of request for service, with a possible extension of up to fourteen (14) additional days (total time frame allowed with extension is twenty-eight (28) days from the date of the request for services) if (1) the recipient or provider requests an extension or (2) the health plan justifies a need for additional information and how the extension is in the member's interest. If the health plan extends the time frame, it must (1) give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision to extend the time frame and (2) issue and carry out

its determination as expeditiously as the member's health condition requires but no later than the date the extension expires.

- For expedited authorization decisions: as expeditiously as the member's health condition requires but no later than three (3) business days after receipt of the request for service.

Service authorization decisions not reached within the time frames specified above shall constitute a denial and, thus, an adverse action.

50.900 Information Technology

50.910 General Requirements

The health plan shall have information management systems that enable it to meet the DHS requirements, state and federal reporting requirements, all other contract requirements and any other applicable state and federal laws, rules and regulations, including HIPAA.

50.920 Expected Functionality

The DHS expects health plan information systems to facilitate and to integrate the following essential health plan case management and coordination of care functions: (1) member health status assessments, (2) determination of the optimal mix of health care services needed to improve the health status of said members, (3) coordination and oversight of the delivery of said services, and (4) the analysis and reporting of service utilization and outcomes data required to manage these functions effectively. The proper facilitation and integration of these functions should be consistent with the "patient-centered, holistic service delivery approach" described in Section 40.810.

To achieve this objective the health plan shall have a suite of properly interfaced, readily accessible yet secured information systems that enable the efficient execution of the aforementioned functions.

50.930 Method of Data Exchange with MQD

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.

50.940 Compliance with the Health Insurance Portability and Accountability Act (HIPAA)

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.

50.950 Possible Audits of Health Plan Information Technology

The health plan shall institute processes to ensure the validity and completeness of the data submitted to the DHS. The DHS or its contractors may conduct general data validity and completeness audits using industry standard sampling techniques. The DHS reserves the right to have access to the health plan's system at any time when deemed necessary under this contract.

50.960 Health Plan Information Technology 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.

50.970 Disaster Planning and Recovery Operations

The health plan shall have in place disaster planning and recovery operations appropriate for the health plan industry, and comply with all applicable federal and state laws relating to security and recovery of

confidential information and electronic data. The health plan shall provide the DHS with a copy of its documentation describing its disaster planning and recovery operations by the due date identified in Section 51.600, Readiness Review..

51.100 Fraud & Abuse

51.110 General Requirements

The health plan shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities. The health plan shall have a compliance officer and sufficient staffing (as required in Section 51.210) and resources to investigate unusual incidents and develop and implement corrective action plans to assist the health plan in preventing and detecting potential fraud and abuse activities. The health plan's fraud and abuse activities shall comply with the program integrity requirements outlined in 42 CFR 438.608.

The health plan and all subcontractors shall cooperate fully with federal and state agencies in investigations and subsequent legal actions. Such cooperation shall include providing, upon request, information, access to records, and access to interview health plan employees and consultants, including but not limited to those with expertise in the administration of the program and/or medical or pharmaceutical questions or in any matter related to an investigation.

51.120 Reporting and Investigating Suspected Fraud and Abuse

The health plan shall report all instances of suspected fraud or abuse to both 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 to be provided by the DHS to report or refer suspected cases of Medicaid fraud or abuse.

As part of its report, the health plan shall include the results of its preliminary investigation. This includes, but is not limited to, providing any evidence it has on the member's services or provider's billing

practices (unusual billing patterns, services not rendered as billed and same services billed differently or separately).

Once the health plan has filed its report, it shall not contact the subject of the investigation about any matters related to the investigation, enter into or attempt to negotiate any settlement or agreement, or accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

If the provider is not billing appropriately, but the health plan has found no evidence of fraud or abuse, the health plan shall provide education and training to the provider in question.

51.130 Compliance Plan

The health plan shall have a written fraud and abuse compliance plan 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 for reference regarding Compliance Plans. The health plan shall submit its compliance plan to the DHS for review and approval by the due date identified in Section 51.600, Readiness Review.

At a minimum, the health plan's fraud and abuse compliance plan shall:

- Require the reporting of suspected and/or confirmed fraud and abuse be done as required in Sections 51.310 and 51.380;
- Ensure that all of its officers, directors, managers and employees know and understand the provisions of the health plan's fraud and abuse compliance plan;

- Require the designation of a compliance officer and a compliance committee that are accountable to senior management;
- Ensure and describe effective training and education for the compliance officer and the organization's employees;
- Ensure that providers and members are educated about fraud and abuse identification and reporting in provider and member material;
- Ensure effective lines of communication between the compliance officer and the organization's employees;
- Ensure provision of internal monitoring and auditing with provisions for prompt response to potential offenses, and for the development of corrective action initiatives relating to the health plan's fraud and abuse efforts;
- Describe standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards;
- Ensure that no individual who reports health plan violations or suspected fraud and abuse is retaliated against; and
- Include a monitoring program that is designed to prevent and detect potential or suspected fraud and abuse. This monitoring program shall include but not be limited to:
 - Monitoring the billings of its providers to ensure members receive services for which the health plan is billed;
 - Requiring the investigation of all reports of suspected fraud and over billings (upcoding, unbundling, billing for services furnished by others, and other overbilling practices);
 - Reviewing providers for over or under-utilization;
 - Verifying with members the delivery of services as claimed; and
 - Reviewing and trending consumer complaints on providers.

51.140 Employee Education About False Claims Recovery

The health plan shall comply with all provisions of § 1902(a)(68) of the Social Security Act (SSA) as it relates to establishing written policies for all employees (including management), and of any subcontractor or designee of the health plan, that includes the information required by § 1902(a)(68) of the SSA.

51.150 Child and Adult Abuse Reporting Requirements

The health plan shall report all cases of suspected child abuse to the Child Protective Services Section of the DHS, and all suspected dependent adult abuse to the Adult Protective Services Section of the DHS as required by state and federal statutes.

The health plan shall ensure that its network providers report all cases of suspected child abuse to the Child Protective Services Section of the DHS, and all suspected dependent adult abuse to the Adult Protective Services Section of the DHS as required by state and federal statutes.

51.200 Health Plan Personnel

51.210 General Requirements

The health plan shall have in place, either directly or indirectly, the organizational, management and administrative systems capable of fulfilling all contractual requirements.

For the purposes of this contract, the health plan shall not employ or contract with any individual that has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under HRS § 103D-702.

The following table represents a listing of required staff. The health plan is responsible for maintaining a significant presence in the State of Hawaii. Specifically, the health plan shall have all positions with a “Yes” in the “Hawaii” column in the table below filled by individuals residing and working full-time in the State of Hawaii. The health plan may request, after contract award, to move functions outside the State of Hawaii but is prohibited from doing so if the DHS denies the request. As part of this request, the health plan shall include a description of the processes in place that assure rapid responsiveness to effect changes for contract compliance. The health plan shall be solely responsible for any additional charges associated with on-site audits or other oversight activities that result when required systems and activities are located outside of the State of Hawaii.

If there is a “Yes” in the “report if person in position changes” column in the table below, the health plan shall notify the MQD in writing within seven (7) days of learning of an intended resignation or other change in the status of the position. The health plan shall include the name of the interim contact person in the notification. In addition, the health plan shall, upon DHS request, provide a written plan for filling the vacant position, including expected timelines. The name of the permanent employee shall be submitted as soon as the new hire has occurred.

As part of the staffing plan and updates required during readiness review (requirements specified in Section 51.600), the health plan shall submit a resume for all positions with a “Yes” in the resume column. If the position is not filled at the time of submission, the health plan shall provide a job description or job posting that describes the job and identifies the education and experience requirements. For those positions not requiring a resume, the health plan shall submit job descriptions. In addition, as part of the staffing plan and updates, the health plan shall describe how it will ensure coordination between staff located in Hawaii and those located elsewhere.

Positions	Resume (Y/N)	Hawaii (Y/N)	Report if person in position changes (Y/N)
Administrator/CEO/COO/Executive Director (1 FTE)	Yes	Yes	Yes
Medical Director (.5 FTE)	Yes	Yes	Yes
Financial Officer/CFO	Yes	No	Yes
Quality Management Coordinator (.5 FTE)	Yes	Yes	Yes
Behavioral Health Coordinator	Yes	Yes	Yes
Service Coordination Manager (1 FTE)	Yes	Yes	Yes
Service Coordination Staff	No	Yes	No
Pharmacy Coordinator/Director/Manager	Yes	Yes	Yes
Prior Authorization/Utilization Management/Medical Management Director	Yes	Yes	Yes
Prior Authorization/Utilization Management/Medical Management Staff	No	Not less than 2 positions	No
EPSDT Coordinator	Yes	Yes	Yes
Member Services Director	Yes	Yes	Yes
Member Services' staff	No	Yes	No
Provider Services/Contract Manager	Yes	Yes	Yes
Provider Services/Contract staff	No	Yes	No
Claims Administrator/Manager*	No	No	Yes
Claims Processing Staff	No	No	No
Encounter processors	No	No	No
Grievance Coordinator	Yes	Yes	Yes
Credentialing Program Coordinator	Yes	No	Yes
Catastrophic Claims Coordinator (includes business continuity planning and recovery coordination)	Yes	No	Yes
Compliance Officer	Yes	Yes	Yes
Information Technology (IT) Director or Chief Information Officer (CIO)	Yes	No	Yes
IT Hawaii Manager	Yes	Yes	Yes
IT Staff	No	Not less than 2	No

		positions	
--	--	-----------	--

* The Claims Administrator/Manager does not need to reside in Hawaii as long as there is a manager in Hawaii (i.e., Provider Services Manager) who can address claims issues during Hawaii business hours.

The health plan shall ensure that all staff have the necessary qualifications (i.e., education, skills, and experience) to fulfill the requirements of their respective positions. The health plan shall conduct initial and ongoing training of all staff to ensure they have the education, knowledge and experience to fulfill the requirements of this contract.

Except as otherwise noted, a specific number of staff or FTEs are not required; the health plan shall only ensure that adequate staff is available and assigned to appropriate areas to fulfill the required functions specified in this contract.

The health plan shall submit both a staffing and training plan to the DHS for review and approval by the due date identified in Section 51.600, Readiness Review. In addition, the health plan shall provide an update of staffing and hiring activities by the due date identified in Section 51.600, Readiness Review.

51.220 Specific Descriptions

The health plan shall have an Administrator/CEO/COO/Executive Director who has clear authority over the general administration and day-to-day business activities of this RFP/contract.

The health plan shall have on staff a Hawaii based Medical Director licensed to practice medicine in the State of Hawaii. The Medical Director shall oversee the quality of care furnished by the health plan and ensure care is provided by qualified medical personnel. The Medical Director shall address any potential quality of care problems and direct QAPI activities. The Medical Director shall work closely with the MQD Medical Director and participate in quarterly DHS Medical Director meetings,

Provider Advisory Board meetings and any committee meetings relating to the programs when requested by the DHS.

The health plan shall have a chief financial officer who is responsible for all accounting and finance operations, including all audits.

The health plan shall have a quality management coordinator or director who is responsible for all quality improvement activities. This person shall be a physician or registered nurse licensed in the State of Hawaii.

The behavioral health coordinator shall be responsible for all behavioral health services. This person shall be a physician, psychologist, registered nurse (may have additional training, e.g., advanced practice nurse practitioner), or social worker licensed in the State of Hawaii with experience related to behavioral health population.

The health plan shall have a service coordination manager who is a registered nurse (may have additional training, e.g., advanced practice nurse practitioner) and is responsible for all service coordination activities and oversees the hiring, training and work of all health plan service coordinators.

The health plan shall have an employed or contracted pharmacy coordinator/director/manager. This person shall be a licensed pharmacist in the State of Hawaii and shall serve as a contact for the health plan's providers, pharmacists, and members.

The health plan shall have a prior authorization/utilization management/medical management director. This person shall oversee all activities related to prior authorizations and concurrent and post-payment reviews. In addition, this person shall be responsible for overseeing the hiring, training and work of all line personnel performing these functions.

The health plan shall have an EPSDT coordinator who is responsible for overseeing all EPSDT activities. This person shall serve as the liaison to the State of Hawaii for these activities.

The health plan shall have a member services director who is responsible for all member services activities, including but not limited to call center staffing, member handbook updates, and translation activities. In addition, this person shall oversee the hiring, training and work of all line personnel performing member services functions.

The health plan shall have a provider services manager who is responsible for the UM line, provider network activities and provider education. This person shall oversee the hiring, training and work of all line personnel performing member services functions.

The health plan shall have a grievance coordinator who oversees all member grievance system activities. This person shall also be responsible for the provider complaints, grievance and appeals system. The health plan may choose to instead delegate this function to the provider services manager.

The health plan shall have a compliance officer who is responsible for all fraud and abuse detection activities, including the fraud and abuse compliance plan.

The health plan shall have an IT director who is responsible for all IT activities. This person need not be located in the State of Hawaii, however, if he or she is not, the health plan shall have an IT Hawaii manager who is located in the State of Hawaii.

The health plan shall have a catastrophic claims coordinator who is responsible for monitoring all high dollar claims and communicating with the DHS' financial staff with regards to the DHS' catastrophic care program described in Section 60.270.

51.300 Reporting Requirements

51.310 General Requirements

The health plan shall submit to the DHS all requested reports identified below and in the time frames identified in this Section. In addition, the health plan shall comply with all additional requests from the DHS, or its designee, for additional data, information and reports. In the event the health plan is under a corrective action plan (CAP), the health plan may be required to submit certain reports more frequently than stated in this Section.

As described in Section 71.300, the State may impose financial penalties for failure to produce accurate reports according to the time frames identified.

The health plan shall submit the following reports both electronically and in hard copy to the DHS according to the specified schedule:

Category	Report	RFP Section	Due Dates	Recipient
Provider Network	Provider Network Development and Management Plan	51.320.1	July 1	Healthcare Management Branch (HCMB)
Provider Network	GeoAccess or Similar Report	51.320.2	October 31 January 31 April 30 July 31	HCMB
Provider Network	PCP Report	51.320.3	The 15 th of each month	HCMB
Provider Network	Timely Access Report	51.320.4	October 31 January 31 April 30 July 31	HCMB

Category	Report	RFP Section	Due Dates	Recipient
Provider Network	Services Rendered to Members by an FQHC or RHC Report	51.320.5	June 30	HCMB
Provider Network	Provider Suspensions and Terminations Report	51.320.6	October 31 January 31 April 30 July 31	HCMB
Provider Services	Provider Complaints Report	51.330.1	October 31 January 31 April 30 July 31	HCMB
Covered Benefits and Services	Long-Term Care Services Report	51.340.1	October 31 January 31 April 30 July 31	Medical Standards Branch (MSB)
Covered Benefits and Services	Personal Assistance Services Level I Report	51.340.2	October 31 January 31 April 30 July 31	HCMB
Covered Benefits and Services	HCBS Report	51.340.3	October 31 January 31 April 30 July 31	HCMB
Covered Benefits and Services	Service Coordinator Report	51.340.4	The 15 th of each month	HCMB
Covered Benefits and Services	CMS 416 Report- EPSDT	51.340.5	February 1 August 1	HCMB
Member Services	Call Center Report	51.350.1	The 15 th of each month	HCMB
Member Services	Translation/ Interpretation Services Report	51.350.2	October 31 January 31 April 30 July 31	HCMB
Member Services	Requests for Alternate Languages Report	51.350.3	October 31 January 31 April 30 July 31	HCMB

Category	Report	RFP Section	Due Dates	Recipient
Member Services	Member Grievance and Appeals Report	51.350.4	October 31 January 31 April 30 July 31	HCMB
QAPI Program	Accreditation Update	51.360.1	October 31 January 31 April 30 July 31	HCMB
QAPI Program	QAPI Program Description	51.360.2	October 1	MSB
QAPI Program	QAPI Program Evaluation	51.360.3	April 1	MSB
QAPI Program	Proposed PIPs Description	51.360.4	October 1	MSB
QAPI Program	PIP Evaluation	51.360.5	April 1	MSB
QAPI Program	Proposed Performance Measures Description	51.360.6	October 1	MSB
QAPI Program	Performance Measures	51.360.7		
QAPI Program	Performance Measures Evaluation	51.360.8	April 1	MSB
QAPI Program	Health Plan Employer Data and Information Set (HEDIS) Report	51.360.9	December 31	MSB
UM/PA	Prior Authorization Requests Denied/Deferred Report	51.370.1	March 1 September 1	MSB
UM/PA	Report of Over- and Under Utilization of Drugs	51.370.2	March 1 September 1	MSB

Category	Report	RFP Section	Due Dates	Recipient
UM/PA	Report of Over- and Under Utilization of Services	51.370.3	March 1 September 1	MSB
Adminstration & Financial	Fraud and Abuse Summary Report	51.380.1	October 31 January 31 April 30 July 31	HCMB
Adminstration & Financial	QExA Financial Reporting Guide	51.380.2	October 31 January 31 April 30 July 31 (shall also include information on the entire year)	Finance
Adminstration & Financial	TPL Cost Avoidance Report	51.380.3	The 15 th of each month	Finance
Adminstration & Financial	Disclosure of Info on Annual Business Transaction	51.380.4	Annually	Finance
Adminstration & Financial	Encounter Data/Financial Summary Reconciliation Report	51.380.5	October 31 January 31 April 30 July 31	Finance
Incentives	Personal Assistance Services Level I Incentive Report	51.390.1	July 1	HCMB
Incentives	HCBS Incentive Report	51.390.2	July 1	HCMB

Additional information about the contents of each report is provided below.

51.320 Provider Network Reports

51.320.1 *Provider Network Development and Management Plan*

The health plan shall submit *Provider Network Development and Management Plans* that provide the information detailed in Section 40.210.

51.320.2 *GeoAccess (Or Similar Program) Reports*

The health plan shall submit reports using GeoAccess or similar software that allow the State to analyze, at a minimum, the following:

- The number of providers by specialty and by location with a comparison to the zip codes of members;
- Number of members from its plan that are currently assigned to the provider (PCPs only);
- Indication as to whether the provider has a limit on the number of QExA program members he/she will accept;
- Indication as to whether the provider is accepting new patients; and
- Non-English language spoken (if applicable).

In addition to the due date as identified in Section 51.310, these reports shall be submitted to the DHS at the following times:

- Upon the DHS request;
- Upon enrollment of a new population in the health plan;
- Upon changes in services, benefits, geographic service area or payments; and
- Any time there has been a significant change in the health plan's operations that would impact adequate provider capacity and services. A significant change is defined as any of the following:

- A decrease in the total number of PCPs by more than five percent (5%) per island (for Hawaii the health plan shall report on this for East Hawaii and West Hawaii);
- A loss of providers in a specific specialty where another provider in that specialty is not available on the island; or
- A loss of a hospital.

51.320.3 *PCP Report*

The health plan shall submit *PCP Reports* that provide the following information on activities from the previous month:

- The names of newly enrolled members and the name of the PCP to which they are assigned or selected;
- The PCP to member ratio per 1,000 members;
- The percent of PCP panel slots open;
- The number of PCP visits per 1,000 members;
- The percent of new members who did not select a PCP and were assigned to one;
- The number of PCP change requests received and processes.

This report shall be provided in the format to be prescribed by the DHS.

51.320.4 *Timely Access Report*

The health plan shall submit *Timely Access Reports* that monitor the time lapsed between a member's initial request for an appointment and the date of the appointment. The data may be collected using statistically valid sampling methods (including periodic member or provider surveys). Using data collected during the previous quarter, the report shall include:

- Total number of appointment requests;

- Total number and percent of requests that meet the waiting time standards identified in Section 40.230 (for each provider type/class, e.g., specialists, PCP adult, PCP pediatric sick, etc.);
- Total number and percent of requests that exceed the waiting time standards (for each provider type/class);
- Average wait time for PCP routine visits; and
- Average wait time for those requests that exceed the waiting time standards (for each provider type/class).

If the health plan is not meeting timely access in any one area (e.g., specialists), the DHS may require additional data collection (e.g., a report by specialty type).

51.320.5 *Annual Report of Services Rendered to Members by an FQHC or RHC*

The health plan shall submit *Annual Reports of Services Rendered to Members by an FQHC or RHC*. The report shall provide data on activities during the prior calendar year (January through December) and 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.

51.320.6 *Provider Suspensions and Termination Report*

The health plan shall submit *Provider Suspensions and Terminations Reports* that list by name all provider suspensions or terminations. This report shall include all providers, each provider's specialty, their primary city and island of services, reason(s) for the action taken as well as the

effective date of the suspension or termination. If the health plan has taken no action against providers during the quarter this should be documented in the *Provider Suspensions and Terminations Report*. The health plan shall utilize the report format provided by the DHS.

51.330 Provider Services Reports

51.330.1 *Provider Complaints Report*

The health plan shall submit to the DHS *Provider Complaints Reports* that include the following information from the previous quarter:

- The total number of resolved complaints by category (benefits and limits; eligibility and enrollment; member issues; health plan issues);
- The total number of unresolved complaints by category (benefits and limits; eligibility and enrollment; member issues; health plan issues) and the reason code explaining the status (e.g., complaint is expected to be resolved by the reporting date and complaint is unlikely to be resolved by the reporting date);
- Status of provider complaints that had been reported as unresolved in previous report(s);
- Status of delays in claims payment, denials of claims payment, and claims not paid correctly which includes the following:
 - The number of claims processed for each month in the reporting quarter;
 - The number of claims paid for each month in the reporting quarter;
 - The percentage of claims processed (at 14, 30, 60, and 90 days) after date of service for each month of the reporting quarter;
 - The number of claims denied for each month in the reporting quarter; and

- The percentage of claims denied for each of the following reasons: (1) prior authorization/referral requirements were not met for each month in the reporting quarter; (2) submitted past the filing deadline for each month in the reporting quarter; (3) provider not eligible on date of service for each month in the reporting quarter; (4) member not eligible on date of service; and (5) member has another health insurer which should be billed first.

Reports shall be submitted using the matrix provided by the DHS.

51.340 Covered Benefits and Services Reports

51.340.1 *Long-Term Care Services Report*

The health plan shall submit *Long-Term Care Services Reports* that include the following data from the previous quarter:

- The number and percentage of members (all members and those who meet NF LOC) who transfer from community settings to nursing facilities;
- The number and percentage of members (all members and those who meet NF LOC) who transfer from nursing facilities to community settings;
- The number and days of acute care hospital admissions (all members including those meeting NF LOC);
- The number and percentage of members (all members and those who meet NF LOC) who access ER services;
- The number and percentage of members (all members including those who meet NF LOC) receiving HCBS; and
- The number and percentage of members (all members including those who meet NF LOC) placed in an institutional setting.

51.340.2 *Personal Assistance Services Level I Report*

The health plan shall submit to the DHS on a quarterly basis *Personal Assistance Services Level I Reports* that include the following information:

- Data elements specified in Section 40.750.4;
- Names of members assessed to need personal assistance services Level I since previous quarter; and
- Names of members assessed to need personal assistance services Level I since previous quarter who are receiving the services.

The health plan shall use the format provided by the DHS.

51.340.3 *HCBS Report*

The health plan shall submit to the DHS on a quarterly basis HCBS Reports that include the following information:

- Data elements specified in Section 40.750.5;
- Names of members assessed to need HCBS since previous quarter and the specific services assessed to need; and
- Names of members assessed to need HCBS since previous quarter who are receiving the services.

The health plan shall use the format provided by the DHS.

51.340.4 *Service Coordinator Report*

The health plan shall submit *Service Coordinator Reports* that, using data from the previous month, provide information on:

- The number and percent of new members (those enrolled during the last thirty (30) days) who met with their service coordinator;
- The number and percent of new members who received a HFA;
- The number and percent of new members who had a care plan developed; and
- The number of all members who requested a change in service coordinators.

The health plan shall use the format provided by the DHS.

51.340.5 *CMS 416 Report – EPSDT*

The health plan shall submit *CMS 416 Reports* that measure and document screening and participation rates in the EPSDT program. The health plan shall use the format provided in Appendix J. In addition to the requirements in the CMS 416 Report, the health plan shall report on any additional data that the DHS has determined is necessary for monitoring and compliance purposes.

The health plan's medical director shall review this report prior to submission to the DHS.

51.350 Member Services Reports

51.350.1 *Call Center Report*

The health plan shall submit a report on the utilization rate of the call center during the previous month that shall include, at a minimum, the following:

- Number of hotline calls (actual number and number reported per 1,000 members);
- Call abandonment rate;

- Longest wait in queue;
- Average talk time; and
- Type of call.

51.350.2 *Translation/Interpretation Services Report*

The health plan shall submit *Translation/Interpretation Services Reports* that include the following information on activities during the previous quarter:

- The name and member 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.

51.350.3 *Requests for Documents in Alternate Languages Report*

The health plan shall submit *Requests for Documents in Alternative Languages Reports* that include the following information on activities during the previous quarter:

- The name and member 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.

51.350.4 *Member Grievance and Appeals Report*

The health plan shall submit *Member Grievance and Appeals Reports*. These reports shall be submitted in the format provided by the DHS. At a minimum the reports shall include:

- The number of grievances and appeals by type;
- Type of assistance provided;
- Administrative disposition of the case;
- Overturn rates;
- Percentage of grievances and appeals that did not meet timeliness requirements;
- Ratio of grievances and appeals per 100 members; and
- Listing of unresolved appeals originally filed in previous quarters.

51.360 Quality Assessment and Performance Improvement (QAPI) Program Reports

51.360.1 *Accreditation Update*

The health plan shall submit *Accreditation Updates* in which it provides updates on its progress in achieving accreditation as required in Section 50.510. These updates shall detail activities undertaken and provide a synopsis of any issues that have arisen that may impede the accreditation process.

51.360.2 *QAPI Program Description*

The health plan shall provide a *QAPI Program Description*. The health plan's medical director shall review this description prior to submittal to the DHS. The *QAPI Program Description* 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;
- 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 subcontractors.

51.360.3 *QAPI Program Evaluation*

The health plan shall provide a QAPI Program Evaluation of the activities during the previous calendar year that includes, at a minimum:

- Summary of QAPI completed the previous year;
- Analysis of strengths and areas of improvement of the QAPI;
- Discussion of incorporation of strengths in health plan practices; and
- Corrective action for each area of improvement.

51.360.4 *Proposed Performance Improvement Projects (PIPs)*

The health plan shall submit, on the DHS designated reporting form, information about the PIPs it will be conducting during the next year. The health plan shall submit this information to both the DHS and its EQRO.

51.360.5 *PIP Evaluation*

The health plan shall provide a PIP Evaluation of the activities during the previous calendar year that includes, at a minimum:

- Summary of each PIP completed the previous year;
- Analysis of strengths and areas of improvement of each PIP;

- Discussion of incorporation of strengths in health plan practices; and
- Corrective action for each area of improvement.

51.360.6 *Proposed Performance Measures*

The health plan shall submit information about the performance measures that it will be conducting during the next year. The health plan shall submit this information to both the DHS and its EQRO.

51.360.7 *Performance Measures*

The health plan shall submit performance measure statistics semi-annually according to criteria outlined in Section 50.550.

51.360.8 *Performance Measures Evaluation*

The health plan shall provide a Performance Measures Evaluation of the activities during the previous calendar year that reports on the performance measures conducted during the previous year.

51.360.9 *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 July 1 to June 30 and shall be reviewed by the health plan's Medical Director prior to submittal to the DHS.

51.370 Utilization Management Reports

51.370.1 *Prior Authorization Requests Denied/Deferred*

The health plan shall submit *Prior Authorization Requests that have been Denied or Deferred Reports*. The specific reporting period, types of

services and due dates will be designated by the DHS. The report shall include the following data:

- Date of the request;
- Name of the requesting provider;
- Member's name and ID number;
- Date of birth;
- Diagnoses and service/medication being requested;
- Justification given by the provider for the member's need for the service/medication;
- Justification of the health plan's denial or the reason(s) for deferral of the request; and
- The date and method of notification of the provider and the member of the health plan's determination.

51.370.2 *Report of Over- and Under-Utilization of Drugs*

The health plan shall submit *Reports of Over- and Under Utilization of Drugs* that include:

- Listing of the top fifty (50) high cost drugs and the top fifty (50) highly utilized drugs, the criteria that is used/developed to evaluate their appropriate, safe and effective use, and the outcomes/results of the evaluations;
- Listing of the top fifty (50) highest utilized non-formulary drugs paid for by the plan including the charges and allowances for each drug as well as the criteria used/developed to evaluate the appropriate, safe and effective use of these medications and the outcomes/results of the evaluations;
- Listing of members who are high users of controlled substances but have no medical condition (i.e. malignancies, acute injuries, etc.) which would justify the high usage. Additionally, the health plan shall submit: (1) its procedures for referring for monitoring

and controlling their over-utilization; and (2) the results of the CC/CM services provided; and

- Results of pharmacy audits, including who performed the audits, what areas were audited, and if problems were found, the action(s) taken to address the issue(s), and the outcome of the corrective action(s).

51.370.3 *Report of Over- and Under-Utilization of Services*

The health plan shall submit *Reports of Over- and Under Utilization of Services*. These reports shall use data from the following two (2) periods: July 1-December 31 and January 1-June 30. The reports shall include information on the following six (6) measures.

- 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;
- 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;
- QI Investigations for Delay in Treatment: The measure to be reported is the rate (twenty percent (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;
- 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;

- 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; and
- 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.

51.380 Administration and Financial Reports

51.380.1 *Fraud and Abuse Summary Reports*

The health plan shall submit *Fraud and Abuse Reports* that include, at a minimum, the following information on all alleged fraud and abuse cases:

- A summary of all fraud and abuse referrals made to the State during the quarter, including the total number, the administrative disposition of the case, any disciplinary action imposed both before the filing of the referral and after, the approximate dollars involved for each incident and the total approximate dollars involved for the quarter;
- A summary of the fraud and abuse detection and investigative activities undertaken during the quarter, including but not limited to the training provided, provider monitoring and profiling activities,

review of providers' provision of services (under- and over-utilization of services), verification with members that services were delivered, and suspected fraud and abuse cases that were ultimately not fraud or abuse and steps taken to remedy the situation; and

- Trending and analysis as it applies to: utilization management, claims management, post-processing review of claims, and provider profiling.

51.380.2 *QExA Financial Reporting Guide*

The health plan shall submit financial information on a regular basis in accordance with the QExA Financial Reporting Guide to be provided by the DHS. For reference, the QUEST Financial Reporting Guide is available in documentation library as described in Section 20.700.

The financial information shall be analyzed and compared to industry standards and standards established by the DHS to ensure the financial solvency of the health plan. The DHS may also monitor the financial performance of the health plan with on-site inspections and audits.

The health plan shall, in accordance with generally accepted accounting practices, prepare financial reports that adequately reflect all direct and indirect expenditures and management and fiscal practices related to the health plan's performance of services under this contract.

51.380.3 *Third Party Liability (TPL) Cost Avoidance Report*

The health plan shall submit *Third Party Liability (TPL) Cost Avoidance Reports*, using the format received by the DHS, which identifies all cost-avoided claims for members with third party coverage from private insurance carriers and other responsible third parties.

The health plan shall submit *Disclosure of Information on Annual Business Transactions Reports* that disclose information on the following types of transactions:

- Any sale, exchange, or lease of any property between the health plan and a party in interest;
- Any lending of money or other extension of credit between the health plan and a party in interest; and
- Any furnishing for consideration of goods, services (including management services) or facilities between the health plan and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

The health plan shall include the following information regarding the transactions listed above:

- The name of the party in interest for each transaction;
- A description of each transaction and the quantity or units involved;
- The accrued dollar value of each transaction during the fiscal year; and
- Justification of the reasonableness of each transaction.

For the purposes of this section, a party in interest, as defined in Section 1318(b) of the Public Health Service Act, is:

- Any director, officer, partner, or employee responsible for management or administration of an HMO; any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of the HMO; any person who is the beneficial

owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than five percent (5%) of the HMO; or, in the case of an HMO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;

- Any organization in which a person described above is director, officer or partner; has directly or indirectly a beneficial interest of more than five percent (5%) of the equity of the HMO; or has a mortgage, deed of trust, note, or other interest valuing more than five percent (5%) of the assets of the HMO;
- Any person directly or indirectly controlling, controlled by, or under common control with a HMO; or
- Any spouse, child, or parent of an individual described in the foregoing bullets.

51.380.5 *Encounter Data/Financial Summary Reconciliation Report*

The health plan shall submit *Encounter Data/Financial Summary Reconciliation Reports* using the instructions and format provided by the DHS. For reference, the QUEST Encounter Data/Financial Summary Reconciliation Report and instructions are included in the documentation library described in Section 20.700.

51.390 Incentive Reports

51.390.1 *Personal Assistance Services Level I Report Incentive Report*

On an annual basis, the health plan shall submit to the DHS *Personal Assistance Services Level I Incentive Reports* that provide evidence of the health plan's ability to expand capacity for personal assistance services Level I, in accordance with requirements specified in Sections 40.750.4 and 60.120.2.

The health plan shall use the format provided by the DHS.

51.390.2 *HCBS Incentive Report*

On an annual basis, the health plan shall submit to the DHS *HCBS Incentive Reports* that provide evidence of the health plan's ability to expand capacity for HCBS, in accordance with requirements specified in Sections 40.750.5 and 60.120.3.

The health plan shall use the format provided by the DHS.

51.390.3 *Additional Incentive Reports*

The DHS may require health plans to submit reports providing data on any additional incentive programs implemented during SFY 2011 following program implementation.

51.395 Encounter Data Reporting

The health plan shall submit encounter data to MQD once per month in accordance with the requirements and specifications defined by the State and included in the Health Plan Manual. Encounters shall be certified and submitted by the health plan as required in 42 CFR 438.606 and as specified in Section 51.400.

51.395.1 *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.

51.400 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. The health plan shall certify that it is in substantial compliance with the contract and provide a letter of certification attesting to the accuracy, completeness, and truthfulness of the data submitted based on best knowledge, information, and belief. The health plan shall submit the letter of certification to its MQD plan liaison concurrent with the certified data and document submission. In the case of two (2) submissions in one month, the health plan shall submit two (2) letters of certification. The certifications are to be based on best knowledge, information, and belief of the following health plan personnel.

The data shall be certified by:

- The health plan's Chief Executive Officer (CEO);
- The health plan's Chief Financial Officer (CFO); or

- An individual who has delegated authority to sign for, and who reports directly to, the health plan's CEO or CFO.

The health plan shall require claim certification from each provider submitting data to the health plan.

51.500 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 issue(s) has/have not been resolved, the health plan shall submit a corrective action plan including the timetable(s) for the correction of problems or issues to MQD. In certain circumstances (i.e., concerns or issues that remain unresolved or repeated from previous reviews or urgent quality issues), MQD may request a ten (10) day plan of correction as opposed to the thirty (30) day response time.

For all medical record reviews, the health plan shall submit information prior to the scheduled review and arrange for MQD and the EQRO to access medical records through on-site review and provision of a copy of the requested records. The health plan shall submit this information within sixty (60) days of notification or sooner should circumstances dictate an expedited production of records.

The health plan shall submit the most current copy of any policies and procedures requested. In the event the health plan has previously submitted a copy of a specific policy or procedure and there have been no changes, the health plan shall state so in writing and include

information as to when and to whom the policy and procedure was submitted. If there are no 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.

51.600 Readiness Review

51.610 Required Review Documents

The health plan shall comply with all readiness review activities required by the DHS. This includes, but is not limited to, submitting all required review documents identified in the table below by the required due date, participating in any on-site review activities conducted by the DHS, and submitting updates on implementation activities. The DHS reserves the right to request additional documents for review and approval during readiness review.

Document	RFP Reference Section	Due Date
Provider Network Development and Management Plan	40.210 General Provisions	30 days after contract award
Availability of providers policies and procedures	40.230 Availability of Providers	30 days after contract award
PCP policies and procedures	40.260 PCPs	30 days after contract award
Credentialing, recredentialing and other certification policies and procedures	40.400 Provider Credentialing, Recredentialing and Other Certifications	60 days after contract award
Model for each type of provider contract	40.500 Provider Contracts	10 days after contract award

Document	RFP Reference Section	Due Date
The signature page of all finalized and executed contracts that have not been previously submitted	40.500 Provider Contracts	30 th day of every month from contract award to commencement of services
Provider education materials	40.610 Provider Education	At least 30 days prior to use of materials
Provider grievance, complaints and appeals system policies and procedures	40.620 Provider Grievance, Complaints and Appeals Process	75 days after contract award
Provider manual	40.630 Provider Manual	30 days after contract award
Provider call center policies and procedures	40.640 Provider Call Center/PA Line	90 days after contract award
Provider web-site screen shots	40.650 Web-site for Providers	60 days after contract award
Web-site (member and provider portals) update policies and procedures	40.650 Web-site for Providers	60 days after contract award
Description of any additional services	40.710 Covered Benefits and Services – General Overview	30 days after contract award
Self-direction policies and procedures	40.770 Self-Direction	30 days after contract award
Service Coordination System policies and procedures	40.810 Service Coordination System	30 days after contract award
HFA assessment process and instrument	40.820 Assessments	30 days after contract award
Standards for the care plan development process and two types of care plans	40.830 Care Plans	30 days after contract award
Cultural competency plan	40.910 Cultural Competency Plan	60 days after contract award

Document	RFP Reference Section	Due Date
EPSDT plan	40.950 Children's Medical and Behavioral Health Services (EPSDT Services)	60 days after contract award
Advance Directives policies and procedures	41.200 Advance Directives	90 days after contract award
Transition of care policies and procedures	41.530 Transition of Care Policies and Procedures	60 days after contract award
Member Services policies and procedures	50.300 Member Services	30 days after contract award
Member education materials, including the training plans and curricula	50.320 Member Education	90 days after contract award
Translation Certification	50.330 Requirements for Written Materials	Within 30 days of DHS approval of English versions of documents
Member handbook	50.340 Member Handbook Requirements	30 days after contract award
Sample member ID card	50.370 Member ID Card	30 days after contract award
Marketing materials (including all printed materials, advertisements, video presentations, and other information prepared by the health plan that pertain to or reference the programs or the health plan's program business)	50.430 State Approval of Materials	30 days after contract award
Request for delegation of QAPI Program functions or activities (if applicable)	50.530 QAPI Program	90 days after contract award
QAPI Program	50.530 QAPI Program	60 days after contract award
Performance improvement projects	50.540 PIPs	60 days after contract award

Document	RFP Reference Section	Due Date
Health plan's performance measures	50.550 Performance Measures	90 days after contract award
Medical records standards	50.580 Medical Records Standards	60 days after contract award
UMP description, corresponding workplan, and UMP policies and procedures	50.600 Utilization Management Program	60 days after contract award
Prior authorization/pre-certification policies and procedures	50.700 Authorization Services	60 days after contract award
Grievance system policies and procedures	50.800 Member Grievance System	75 days after contract award
Documentation describing its disaster planning and recovery operations	50.950 Disaster Planning and Recovery Operations	90 days after contract award
Staffing and training plan (plus resumes, where applicable)	51.210 Health Plan Personnel	30 days after contract award
Updates of staffing and hiring activities	51.210 Health Plan Personnel	60 and 90 days after contract award
Implementation plans	51.620 Implementation Plans	Every two weeks starting two weeks after contract award and continuing to commencement of services
A GeoAccess (or comparable program) report	51.630 Updated GeoAccess Reports	Every two weeks starting two weeks after contract award and continuing to commencement of services
Proof of License	80.230 Attachment, Other Documentation	May 15, 2008

Document	RFP Reference Section	Due Date
Updates on Status of License Application	80.230 Attachment, Other Documentation	February 15, 2008 March 15, 2008 April 15, 2008
Subcontractor agreements	70.500 Subcontractor Agreements	30 days after contract award

51.620 Implementation Plans

In addition to submitting the documents listed above, the health plan shall develop an implementation plan that will track all readiness and implementation activities and monitor ongoing progress each week. The health plan shall submit the first implementation plan to the DHS within two (2) weeks of the date of Contract Award identified in Section 20.100. There is no prescribed format (although implementation plans developed using programs such as Project are encouraged) for the implementation plan; the DHS shall review and approve the first implementation plan and determine whether it is sufficient to meet all requirements. Thereafter, implementation plans shall be submitted every two (2) weeks until the date of Commencement of Services to Members date identified in Section 20.100.

51.630 Updated GeoAccess Reports

The health plan shall submit, within two (2) weeks of the date of Contract Award identified in Section 20.100, updated GeoAccess reports (or reports generated by a similar program) that include all providers who have signed a provider agreement. Thereafter, the health plan shall submit updated reports every two (2) weeks. The updated reports shall include both the newly signed providers as well as those previously reported. The DHS will provide the specific format for these reports prior to the deadline for submission of the first report.

SECTION 60 FINANCIAL RESPONSIBILITIES

60.100 The DHS Responsibilities

60.110 Daily Rosters/Health Plan Reimbursement

The DHS will enroll and disenroll members through daily files. All payments and recoveries will be detailed on the daily file. The daily membership rosters identify the capitated fee amounts associated with mid-month enrollment and disenrollment transactions as well as prior period coverage transactions.

The DHS will make monthly capitation payments to the health plan for each enrolled member in the health plan beginning on the date of the Commencement of Services to Members identified in Section 20.100. Capitation payments will be in the amounts listed in the health plan's contract with the DHS.

The DHS will pay the established capitation rate to the health plan for members enrolled for the entire month. 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 DHS will make additional capitation payments or recover capitation payments from the health plan as a result of retroactive enrollments, retroactive disenrollments and prior period coverage.

The DHS will provide member spend-down amounts to health plans monthly. The DHS will pay the health plan the capitation payment less the spend-down amount for members who are Medically Needy with spend-down.

The DHS will provide to the health plan a Monthly Payment Summary Report which summarizes capitation payments and recoveries made to the health plan.

The DHS shall notify the health plan prior to making changes in the capitation amount/rate code.

60.120 Incentives for Health Plan Performance

The DHS has developed a program to make financial payment incentives to the health plan for meeting established performance and quality goals. The DHS will not make any incentive payments to the health plan if the health plan is not fully compliant with all terms of the contract. The DHS shall ensure that all incentives are in compliance with the federal managed care incentive arrangement requirements set forth in 42 CFR 438.6 and the State Health Plan Manual. The amount of financial performance incentive and allocation methodology will be developed solely by the DHS.

The total of all payments paid to the health plan under this contract shall not exceed one hundred and five percent (105%) of the capitation payment pursuant to 42 CFR §438.6.

The DHS shall pay a financial incentive that uses HEDIS measurements as a performance indicator demonstrating improvement only if the reported rate has been audited by a NCQA Certified Compliance Auditor.

The DHS shall pay a financial incentive that does not use HEDIS measurements as a performance indicator to demonstrate meaningful or statistically significant improvement(s) only if the health plan's data has been audited by the vendor selected by the DHS.

60.120.1 *Diabetes Mellitus*

For SFY 2010, the health plan may be eligible for a performance incentive payment if its performance:

- Is at or exceeds the DHS benchmark for annual HBA1C testing in accordance with the NCQA Medicaid and Medicare Quality Compass in the area of comprehensive diabetes care for members with a diagnosis of diabetes;
- Is at or exceeds the DHS benchmark for biennial lipid profiles testing in accordance with the NCQA Medicaid and Medicare Quality Compass in the area of comprehensive diabetes care for members with a diagnosis of diabetes; and
- Is at or exceeds the DHS benchmark for biennial retinal exams in accordance with the NCQA Medicaid and Medicare Quality Compass in the area of comprehensive diabetes care for members with a diagnosis of diabetes.

60.120.2 *Increase in Capacity for Personal Assistance Services Level I*

For SFY 2010, the health plan may receive an annual performance incentive for personal assistance services Level I (as described in Section 40.750.1) if the following conditions are met:

- The health plan increases the number of members receiving personal assistance services Level I per the annual thresholds described in Section 40.750.4;
- The health plan does not have a waiting list; and
- The health plan increases its personal assistance services Level I provider network by the following annual thresholds:
 - SFY 2010 – 3% increase above the previous SFY;
 - SFY 2011 – 4% increase above the previous SFY; and

- SFY 2012 – 5% increase above the previous SFY.

60.120.3 *Increase in Capacity for HCBS*

For SFY 2010, the health plan may receive an annual performance incentive for increasing the capacity for HCBS (as described in Section 40.750.3) if the following conditions are met:

- The health plan increases the number of members receiving HCBS per the annual thresholds described in Section 40.750.5;
- The health plan does not have a waiting list; and
- The health plan increases its HCBS provider network by the following annual thresholds:
 - SFY 2010 – 5% increase above the previous SFY;
 - SFY 2011 – 5% increase above the previous SFY; and
 - SFY 2012 – 5% increase above the previous SFY.

The DHS may impose sanctions against the health plan, as described in Section 71.320, if the health plan:

- Fails to meet the annual threshold requirements in Section 40.760.5; and
- Fails to meet the monitoring requirements as described in Section 40.760.5.

60.120.4 *Coordinating Care for High Acuity Level Members Meeting a Nursing Facility Level of Care*

For SFY 2009, the health plan shall collaborate with hospitals and nursing facilities to ensure that members with high acuity levels meeting a NF LOC are transitioned from a hospital placement to a nursing facility placement in a timely manner.

In SFY 2009, the QExA health plan shall collect baseline data on its members with high acuity levels that have experienced a hospital placement within the SFY. The data shall include at a minimum the amount of time members are served in a hospital and the reason for the stay. For subsequent contract years, the DHS or its designee will use the data to establish benchmarks, associated performance incentives and/or sanctions.

60.120.5 *Incentives for SFY 2011*

The DHS and the health plan will work collaboratively during SFY 2010 to develop benchmark data on:

- Institutional utilization and strategies to assure the right services are provided to members in the right location;
- Obesity prevalence and strategies to better manage the health of members with the diagnosis of obesity;
- Renal disease prevalence and strategies to better manage the health of members with the diagnosis of renal disease; and
- Assistance with ADL monitoring.

The DHS will establish performance targets at the end of SFY 2010, utilizing HEDIS, encounter data and other information deemed appropriate in establishing performance targets for SFY 2011.

The health plan may be eligible for a performance incentive in the above areas during SFY 2011.

60.130 Third-Party Liability (TPL)

As it relates to the third-party liability, 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.

60.140 Catastrophic Care

The State has implemented a catastrophic care reimbursement program. The DHS or its designee (catastrophic claims manager) will manage, administer and provide reimbursement to the health plan for the State's share of eligible medical catastrophic medical expenses. The DHS or its designee shall only reimburse the health plan for eligible members and services. The DHS or its designee shall not reimburse the health plan for experimental or investigational services.

The DHS or its designee will provide a policy and procedure manual to the health plan following contract award. This policy and procedure manual outlines the processes and requirements of the program.

60.150 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 B.

60.160 Acuity Information

In order that the health plan is in compliance with HRS § 346D-1.5 regarding Medicaid reimbursement equity, the DHS will provide to all health plans the acuity information on members residing in institutional facilities. The DHS will provide this information twice per year, on August 1 and February 1.

60.200 Health Plan Responsibilities

The health plan shall follow all rules governing payment to providers as described in the applicable sections of the HAR.

60.210 Daily Rosters/Health Plan Reimbursement

The health plan shall accept daily and monthly transaction files from the DHS as the official enrollment record. The health plan shall not change any of the information provided by the DHS on the daily or monthly transaction files. The health plan shall immediately report any inconsistencies between its information and the DHS information to the DHS for investigation and resolution.

60.220 Provider and Subcontractor Reimbursement

The health plan is responsible for reimbursing providers listed in Section 40.200. With the exception of FQHCs and RHCs, hospice providers, critical access hospitals (CAHs), and nursing facilities, the health plan may reimburse its providers and subcontractors in any manner, subject to Federal or State rules. Regardless of the payment methodology, the health plan shall require that all providers submit detailed encounter data.

The health plan shall reimburse providers at rates comparable to the Medicaid FFS rates in place on the date of Contract Award identified in Section 20.100.

The health plan shall reimburse 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 shall report the number of unduplicated visits provided to its members by FQHCs and RHCs and the payments made by the health plan to FQHCs and RHCs. The health plan shall report this information to the DHS quarterly and in the format required by the DHS.

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 reimburse critical access hospitals (CAHs) for hospital services and nursing home services at rates calculated prospectively by the DHS using Medicare reasonable cost principles in accordance with HRS § 346-59.

The health plan shall reimburse nursing facilities utilizing an acuity-based system in accordance with HRS § 346-D-1-5.

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 FFS 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 SSA.

This health plan shall ensure that ninety percent (90%) of clean claims for payment (a clean claim is one 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 clean 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. The health plan shall pay interest (according to the interest rate provided by the DHS) for all clean claims that are not paid within these required time frames.

The health plan shall require that providers use the CMS 1500 and UB-04 forms.

The health plan shall develop and maintain a claims payment system capable of processing, cost avoiding, and paying claims. The system must produce a remittance advice related to the health plan's payments to providers and must contain, at a minimum:

- An adequate description of all denials and adjustments;
- The reasons for such denials and adjustments;
- The amount billed;
- The amount paid;
- Application of coordination of benefits (COB) and subrogation of claims (SOC); and
- Provider rights for claim disputes.

The related remittance advice must be sent with the payment, unless the payment is made by electronic funds transfer. The remittance advice sent related to an electronic funds transfer must be mailed, or sent to the provider, not later than the date of the electronic funds transfer.

The health plan shall ensure that its subcontractors and providers do not look directly to the State for payment.

The health plan shall be responsible for ensuring that neither the State nor the health plan's members bear any liability for the health plan's failure or refusal to pay valid claims of subcontractors or providers. As required in Section 40.500 and Section 70.500, the health plan shall include in all provider contracts and subcontractor agreements a statement that the State and health 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 health plan shall ensure that 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 health plan or State does not pay the individual or 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.

60.230 Physician Incentives

The health plan may establish physician incentive plans pursuant to federal and state regulations, including 42 CFR §§422.208, 422.210 and 438.6.

The health plan shall disclose any and all such arrangements to the DHS for review and approval prior to implementing physician incentives, and upon request, to members. Such disclosure shall include:

- Whether services not furnished by the physician or group are covered by the incentive plan;

- The type of incentive arrangement;
- The percent of withhold or bonus; and
- The panel size and if patients are pooled, the method used.

Upon request, the health plan shall report adequate information specified by applicable regulations to the DHS so that the DHS can adequately monitor the health plan.

If the health plan's physician incentive plan includes services not furnished by the physician/group, the health plan shall: (1) ensure adequate stop loss protection to individual physicians, and must provide to the DHS proof of such stop loss coverage, including the amount and type of stop loss; and (2) conduct annual member surveys, with results disclosed to the DHS, and to members, upon request.

The health plan's 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.

60.240 Billing Members and Non-Payment to Providers

The health plan may collect fees directly from members for:

- Non-covered services; and
- Services received from unauthorized non-plan providers.

The health plan may deny payment to a provider:

- If the member self-refers to a specialist or other provider within the health plan's network without following procedures (e.g. obtaining prior authorization). If the health plan denies payment in this situation the provider may bill the member; and

- If a provider fails to follow plan procedures. The provider is prohibited from billing the member in this situation.

As provided for in Section 40.630, Provider Manual, the health plan shall require that all providers who bill a member for non-covered services or for self-referrals 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 health plan shall refund the member directly.

60.250 Collection of Spend-Down Amounts

The health plan shall collect all spend-down amounts from members who have spend-down requirements. The health plan may delegate spend-down collections to the providers, but shall be ultimately responsible for their collection.

60.260 Third-Party Liability (TPL)

Pursuant to Section 1902(a)(25) of the SSA the health plan is authorized by the DHS as its designee to identify legally liable third parties and treat verified TPL as a resource of the member.

The health plan shall coordinate healthcare benefits with other coverages, both public and private, which are or may be available to pay medical expenses on behalf of any member.

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 seek reimbursement from the third party unless the health plan determines that recovery would not be cost-effective. In such

situations, the health plan shall provide adequate documentation to the DHS. This documentation shall be provided to the DHS within fifteen (15) days of the health plan's decision to not seek reimbursement. 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 provided by the DHS, for recovery purposes. "RUSH" requests shall be reported within three (3) business days of receipt and "ROUTINE" requests within seven (7) business days of receipt. Listings shall also include claims received but not processed for payments or rejected;
- Provide copies of claim forms with similar response time as the above;
- Provide listings of medical and medically related dental expenses (including adjustments, e.g., payment corrections, refunds, etc.) according to the payment period or "as of" date. Adjustments shall be recorded on the date of adjustment and not on the date of service;
- Inform the DHS of TPL information uncovered during the course of normal business operations;

- Provide the DHS with monthly reports of the total cost avoidance and amounts collected from TPLs within thirty (30) days of the end of the month;
- Develop procedures for determining when to pursue TPL recovery; and
- Provide healthcare 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.

60.270 Catastrophic Care

The health plan shall be held solely responsible for incurred costs for eligible services for each member up to three hundred thousand dollars (\$300,000) in a benefit year for acute and primary care services. 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	15%	85%
\$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 DHS or its designee (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 DHS or its designee (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 DHS or its designee (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 LOC 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 § 346-10(a)(3), the health plan shall release medical records to both the DHS and its designee (catastrophic claims manager).

The health plan shall designate one (1) individual within its organization to be responsible for the coordination and communication of catastrophic care information to the designee (catastrophic claims manager) as required in Section 51.220.

If the health plan establishes a capitation payment methodology with a hospital, the health plan shall provide the DHS and its designee (catastrophic claims manager) with a copy of the portion of the hospital contract which outlines the payment terms. The health plan shall provide this to the DHS within ten (10) days of execution of the contract or amendment.

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 healthcare 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.

QExA Policy Memoranda are issued primarily to clarify process or operational issues with the health plan. 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 K 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 AG Form 103F-Comp (9/06)) including all general conditions, special conditions, attachments, and addenda; (2) the RFP, including all attachments and addenda; and (3) applicant'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 health plan shall comply with all laws, ordinances, codes, rules and regulations of the federal, state and local governments that in any way affect its performance under this contract. The standard State General Conditions found in Appendix K shall be incorporated into and become part of the contract between the contractor and DHS.

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

The health plan 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 health plan 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 health plan shall include notice of grantor agency requirements and regulations pertaining to reporting and patient rights under any contracts involving research, developmental, experimental or demonstration work with respect to any discovery or invention which arises or is developed in the course of or under such contract, and of grantor agency requirements and regulations pertaining to copyrights and rights in data.

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 term of February 15, 2008 to June 30, 2011, with services to members and capitated payments commencing on November 1, 2008. Unless terminated, the contract shall be extended without the necessity of

re-bidding, for not more than three (3) additional twelve (12) month periods or parts thereof, only upon mutual agreement of the parties in writing, at least sixty (60) days prior to expiration of the contract term, provided that the contract price for the extended period shall remain the same or lower than the initial bid price or as adjusted in accordance with the contract price adjustment provision herein.

The State of Hawaii operates on a fiscal year basis, which runs from July 1 to June 30 of each year. Funds are available for only the first fiscal period of the contract ending June 30 in the first year of the initial term. The contractual obligation of both parties in each fiscal period succeeding the first fiscal period is subject to the appropriation and availability of funds to DHS.

The contract will be terminated only if funds are not appropriated or otherwise made available to support continuation of performance in any fiscal period succeeding the initial fiscal period of the contract; however this does not affect either the State's rights or the health plan's rights under any termination clause of the contract. The State shall notify the health plan, in writing, at least sixty (60) days prior to the expiration of the contract whether funds are available or not available for the continuation of the contract for each succeeding contract extension period. In the event of termination, as provided in this paragraph, the health plan 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 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 Readiness Review

As described in Sections 30.960 and 51.600, prior to the health plan providing services to members, the DHS will conduct a comprehensive readiness review to verify the accuracy and appropriateness of information provided by the health plan in its proposal. In addition to the specific requirements outlined in this RFP, the DHS will provide additional guidance on readiness review activities following Contract Award.

70.420 Ongoing Inspection of Work Performed

In addition to the ongoing monitoring described in Section 30.900, 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 shall 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 enter into contracts or agreements with subcontractors to the benefit of the health plan and the State. All such agreements shall be in writing. No subcontract that the health plan enters into with respect to the performance under the contract shall in any

way relieve the health plan of any responsibility for any performance required of it by the contract.

The health plan shall submit, to the DHS for review and prior approval, all subcontractor agreements related to the provision of covered benefits and services and member services activities to members (e.g. call center) and provider services activities and payments to providers. The health plan shall submit these subcontractor agreements as required in Section 51.600, Readiness Review. In addition, the DHS reserves the right to inspect **all** subcontractor agreements at any time during the contract period.

The health plan shall notify the DHS at least fifteen (15) days prior to adding or deleting subcontractor agreements or making any change to any subcontractor agreements which may materially affect the health plan's ability to fulfill the terms of the contract.

The health plan shall provide the DHS with immediate notice in writing by registered or certified mail of any action or suit filed against it by any subcontractor, and prompt notice of any claim made against the health plan by any subcontractor that in the opinion of the health plan may result in litigation related in any way to the contract with the State of Hawaii.

Additionally, no assignment by the health plan of the health plan's right to compensation under the contract shall be effective unless and until the assignment is approved by the Comptroller of the State of Hawaii, as provided in Section 40-58, HRS, or its successor provision.

All subcontractor agreements must, at a minimum:

- Describe the activities, including reporting responsibilities, to be performed by the subcontractor and require that the subcontractor meet all established criteria prescribed and provide the services in

a manner consistent with the minimum standards specified in the health plan's contract with the State;

- Require that the subcontractor fulfill the requirements of 42 CFR § 438.6 that are appropriate to the service delegated under the subcontract;
- Include a provision that allows the health plan to:
 - Evaluate the subcontractor's ability to perform the activities to be delegated;
 - Monitor the subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule (the frequency should be stated in the agreement) established by the DHS and consistent with industry standards or State laws and regulations;
 - Identify deficiencies or areas for improvement; and
 - Take corrective action or impose other sanctions, including but not limited to revoking delegation, if the subcontractor's performance is inadequate.
- Require that the subcontractor submits to the health plan a tax clearance certificate from the Director of the 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;
- Fulfill the requirements of 42 CFR § 438.6 that are appropriate to the service delegated under the subcontract;
- Include a provision that the health plan shall designate itself as the sole point of recovery for any subcontractor;
- Include a provision that neither the State and nor the health plan members shall bear any liability of the health plan's failure or refusal to pay valid claims of subcontractors;
- Require that the subcontractor track and report complaints against them to the health plan;

- Require that the subcontractor fully adhere to the privacy, confidentiality and other related requirements stated in the RFP and in applicable federal and state law, including but not limited to:
- Require that the subcontractor follow all audit requirements as outlined in Section 70.900 inclusive. The actual requirements shall be detailed in the agreement;
- Require that the medical records be maintained in compliance with Section 71.100. The actual requirements shall be detailed in the agreement;
- Require that the subcontractor comply with all requirements related to confidentiality of information as outlined in Section 71.200. The actual requirements found in this section shall be detailed in the agreement.
- Require that the subcontractor notify the health plan and the MQD of all breaches of confidential information relating to Medicaid applicants and recipients, as health plan members. The notice to the State will be within two (2) business days of discovery of the breach and a written report of the investigation and resultant mitigation of the breach shall be provided to the State within thirty (30) business days of the discovery of the breach.

70.600 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 chapters 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 of 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 L pursuant to § 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 L, 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 HRS § 11-205.5,, 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 designees, contractors and programs conducted under contract are applicable to this subsection and are incorporated by reference into the contract. The DHS may inspect and audit any records of the health plan and its subcontractors or providers.

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 HRS §§ 622-51 and 622-58, 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 the following:

- 42 CFR Part 431, Subpart F;
- The Administrative Simplification provisions of HIPAA and the regulations promulgated thereunder, including but not limited to the Security and Privacy requirements set forth in 45 CFR Parts 160, 162 and 164, (if applicable);

- HRS Section 346-10; and
- All other applicable federal and State statutes and administrative rules, including but not limited to:
 - HRS § 325-101 relating to persons with HIV/AIDS;
 - HRS § 334-5 relating to persons receiving mental health services;
 - HRS § 577A relating to emergency and family planning services for minor females;
 - 42 CFR Part 2 relating to persons receiving substance abuse services.

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 listed above as well as any other applicable laws. 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 de-identification 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 above, are often more stringent than the HIPAA

regulations. Moreover, for purposes of this contract, the health plan agrees that the confidentiality provisions contained in HAR Chapter 17-1702 shall apply to the health plan to the same extent as they apply to MQD.

The health plan shall implement a secure electronic mail (email) encryption solution to ensure confidentiality, integrity, and authenticity of email communications that contain information relating to members.

The health plan shall notify the State within two (2) business days of discovery of the breach of confidentiality. In addition, the health plan shall provide to the State a written report of the investigation and resultant mitigation of the breach within thirty (30) business days of the discovery of the breach. All breaches of confidential information relating to Medicaid enrollees, as health plan members, shall be reported to the MQD. The actual requirements found in this section, Section 71.200, shall be detailed in all provider contracts and subcontractor agreements.

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, without limitation, the difference in the capitated rates paid to the health plan and the rates paid to a replacement health plan.

Notwithstanding the above, the health plan shall not be relieved of liability to the State for any damages sustained by the State due to the health plan's breach of the contract.

The DHS may withhold amounts for liquidated damages from payments to the health plan until such damages are paid in full.

71.320

Sanctions

The DHS may impose sanctions for non-performance or violations of contract requirements. Sanctions will be determined by the State and may include:

- Imposing civil monetary penalties (as described below);
- Suspending enrollment of new members with the health plan;
- Suspending payment;
- Notifying and allowing members to change plans without cause;
- Appointment of temporary management (as described in Section 71.330); or
- Terminating the contract (as described in Section 72.100).

The State will give the health plan timely written notice that explains the basis and nature of the sanction as outlined in 42 CFR Part 438, Subpart I. The health plan may follow DHS appeal procedures to contest the penalties or sanctions. The DHS shall provide these appeal procedures to the health plan prior to the Date of Commencement of Services identified in Section 20.100.

The civil or administrative monetary penalties imposed by the DHS shall not exceed the maximum amount established by federal statutes and regulations on the health plan.

The civil monetary penalties that may be imposed on the health plan by the State are as follows:

Number	Activity	Penalty
1	Misrepresentation of actions or falsification of information	A maximum of one hundred thousand dollars

	furnished the CMS or the State	(\$100,000) for each determination
2	Acts to discriminate among members on the basis of their health status or need for healthcare services	A maximum of one hundred thousand dollars (\$100,000) for each determination
3	Failure to implement requirements stated in the health plan's proposal, the RFP or the contract, or other material failures in the health plan's duties, including but not limited to failing to meet performance standards	A maximum of fifty thousand dollars (\$50,000) for each determination
4	Substantial failure to provide medically necessary services that are required under law or under contract, to an enrolled member	A maximum of twenty-five thousand dollars (\$25,000) for each determination
5	Imposition upon members premiums and charges that are in excess of the premiums or charges permitted under the program	A maximum of twenty-five thousand dollars (\$25,000) or double the amount of the excess charges (whichever is greater). The State shall deduct from the penalty the amount of overcharge and return it to the affected member(s)
6	Misrepresentation or false statements to members, potential members or providers	A maximum of twenty-five thousand dollars (\$25,000) for each determination
7	Violation of any of the other applicable requirements of Sections 1903(m), 1905(t)(3) or 1932 of the Social Security Act and any implementing regulations	A maximum of twenty-five thousand dollars (\$25,000) for each determination
8	Failure to comply with the requirements for physician incentive plans, as set forth in 42 CFR §§ 422.208 and 422.210	A maximum of twenty-five thousand dollars (\$25,000) for each determination
9	Distribution, directly or indirectly through any agent or independent contractor, of marketing materials that have not been approved by the State or that contain false or	A maximum of twenty-five thousand dollars (\$25,000) for each determination

	materially misleading information	
10	Not enrolling a member because of a discriminatory practice	A maximum of fifteen thousand dollars (\$15,000) for each member the State determines was not enrolled because of a discriminatory practice
11	Failure to resolve member appeals and grievances within the time frames specified in this RFP	A maximum of ten thousand dollars (\$10,000) for each determination of failure
12	Failure to comply with the claims processing standard required in Section 60.220	A maximum of five thousand dollars (\$5,000) for each determination of failure
13	Failure to meet minimum compliance of provision of periodic screens to EPSDT eligible members as described in Section 40.950	A maximum of five thousand dollars (\$5,000) for each determination of failure
14	Failure to provide a HFA for members enrolled after the transition period enrollment within the time frame required in Section 40.820	A maximum of five thousand dollars (\$5,000) for each determination of failure
15	Failure to comply with staffing requirements as outlined in Section 51.200	A maximum of five thousand dollars (\$5,000) for each determination of failure
16	Failure to provide accurate information, data, reports and medical records, including behavioral health and substance abuse records to the DHS by the specified deadlines provided in this RFP	\$200 per day until all required information, data, reports and medical records are received
17	Failure to report confidentiality breaches relating to Medicaid applicants and recipients to the DHS by the specific deadlines provided in this RFP	\$100.00 per day per applicant/recipient. A maximum of twenty-five thousands dollars (\$25,000) until the reports are received

Payments provided for under the contract 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.

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 Sections 1903(m) and 1932 of the SSA;
- There is substantial risk to the member's health; or
- The sanction is necessary to ensure the health of the health plan's members while improvements are made to remedy violations under 42 CFR § 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 the substantive requirements in Sections 1903(m) and 1932 of the SSA. 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 eighty percent (80%) of 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

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 L.

The health plan shall comply with General Condition 1.4 I Appendix K and submit to the DHS the insurance information requested in Appendix L.

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 K:

- 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 within fifteen (15) days, the DHS may, at its sole option, terminate the contract for default. Such termination shall be accomplished by written notice of termination forwarded to the health plan by certified or registered mail and shall be effective as of the date specified in the notice. If it is

determined, after notice of termination for default, that the health plan's failure was due to causes beyond the control of and without error or negligence of the health plan, the termination shall be deemed a termination for convenience under General Condition 4.3 in Appendix K.

The DHS' decision not to declare default shall not be deemed a waiver of such default for the purpose of any other remedy the health plan may have.

72.120 Termination for Expiration or Modification of the Programs by CMS

The DHS may terminate performance of work under the contract in whole or in part whenever, for any reason, CMS terminates or modifies the programs. In the event that CMS elects to terminate its agreement with the DHS, the DHS shall so notify the health plan by certified or registered mail, return receipt requested. The termination shall be effective as of the date specified in the notice.

72.130 Termination for Bankruptcy or Insolvency

In the event that the health plan shall cease conducting business in the normal course, become insolvent, make a general assignment for the benefit of creditors, suffer or permit the appointment of a receiver for its business or its assets or shall avail itself of, or become subject to, any proceeding under the Federal Bankruptcy Act or any other statute of any State relating to insolvency or the protection of the rights or creditors, the DHS may, at its option, terminate the contract. In the event the DHS elects to terminate the contract under this provision it shall do so by sending notice of termination to the health plan by registered or certified mail, return receipt requested. The termination shall be effective as of the date specified in the notice.

In the event of insolvency of the health plan, the health plan shall cover continuation of services to members for the duration of period for which

payment has been made, as well as for inpatient admissions up until discharge. Members shall not be liable for the debts of the health plan. In addition, in the event of insolvency of the health plan, members may not be held liable for the covered services provided to the member, for which the State does not pay the health plan.

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; and
- Give the health plan's members written notice of the intent to terminate the contract, notify members of the hearing, and allow them to disenroll immediately without cause.

Following the termination hearing, the State 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; and
- Within thirty (30) business days from the effective date of the termination, deliver to the DHS copies of all current data files, program documentation, and other documentation and procedures used in the performance of the contract at no cost to the DHS. The health plan agrees that the DHS or its designee shall have a non-exclusive, royalty-free right to the use of any such documentation.

The health plan shall create written procedures for the orderly termination of services to any members receiving the required services under the

contract, and for the transition to services supplied by another health plan upon termination of the contract, regardless of the circumstances of such termination. These procedures shall include, at the minimum, timely notice to the health plan's members of the termination of the contract, and appropriate counseling. The health plan shall submit these procedures to the DHS for approval upon their completion, but no later than one-hundred eighty (180) days after the effective date of the contract.

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. All officials or employees of the State of Hawaii shall be bound by HAR§ 84, State Ethics Code.

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 L) 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 QExA health plan, so long as the requesting health plan has offered payment terms that comply with the requirements of Section 60.220. 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 designee of the State of Hawaii, any gift, money or anything of value, or any promise, obligation, or contract for future reward or compensation at any time during the term of the contract.

72.600 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:

Healthcare Management Branch Administrator
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 contact and/or 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.

SECTION 80

MANDATORY AND TECHNICAL PROPOSAL

80.100 Introduction

The applicant shall comply with all content and format requirements for the technical proposal. The proposal shall be on standard 8 ½” by 11” paper, single spaced, singled sided and with text no smaller than 11-point font. The pages must have at least one-inch margins. All proposal pages must be numbered and identified with the applicant’s name.

All questions which are to be answered as part of the narrative must be answered in the order in which they appear in each sub-section. The question must be restated above the response. The questions related to any attachment do not need to be restated as long as it is clear from the heading the referenced attachment. Attachments may be placed, in the order in which they are requested, behind the narrative responses for that sub-section. Attachments do not count toward the maximum page limits.

Narratives in excess of the maximum page limits and any documentation not specifically requested will not be reviewed. Likewise, providing actual policies and procedures in lieu of a narrative may result in the applicant receiving a non-responsive score for that question.

80.200 Mandatory Requirements

80.210 Attachment: Transmittal Letter

The transmittal letter shall be on official business letterhead and shall be signed by an individual authorized to legally bind the applicant. It shall include:

- A. A statement indicating that the applicant is a corporation or other legal entity and is a properly licensed health plan 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 applicant and each subcontractor, as measured by percentage of total contract price;

- B. A statement that the applicant 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, and that this will be submitted to the DHS with the signed contracts (following the Contract Award date and prior to the Contract Effective Date identified in Section 20.100);
- 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 applicant 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 the mandatory or the technical proposal;
- F. A statement that no attempt has been made or will be made by the applicant to induce any other party to submit or refrain from submitting a proposal;
- G. A statement that the applicant has read, understands and agrees to all provisions of this RFP;
- H. A statement that it is understood that if awarded the contract, the applicant's organization will deliver the goods and services meeting or exceeding the specifications in the RFP and amendments;
- I. The applicant's Hawaii excise tax number (if applicable);
- J. A statement that the person signing this proposal certifies that he/she is the person in the applicant's organization responsible for, or authorized to make, decisions as to the prices quoted, that the offer is firm and binding, and that he/she has not participated and will not participate in any action contrary to the above conditions; and
- K. A statement of independent price determination as described in Section 20.980.

80.220

Company Background Narrative

The applicant shall provide a description of its company that includes:

- A. The legal name and any names under which the applicant has done business;
- B. Address, telephone number and e-mail address of the applicant's headquarter office;
- C. Date company was established;
- D. Date company began operations;
- E. Names and addresses of officers and directors;
- F. The size and resources, including the gross revenues and number of employees;
- G. A list of the states in which it is accredited by either National Committee for Quality Assurance (NCQA), American Accreditation Healthcare Commission/URAC or Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and indicate the accreditation status by product line. The applicant shall also list the states in which it has applied for accreditation by one (1) of the three (3) accrediting bodies listed and the status of the application(s) by product line; and
- H. A description of any services it objects to based on moral or religious grounds as described in Section 40.300 including a description of the grounds for the objection and information on how it will provide the required services. If there are no services to which it objects, the applicant shall state that.

The information required above shall be supplied for each affiliated company that serves Medicaid members and any subcontractors the applicant intends to use.

80.230

Attachment: Other Documentation

The applicant shall attach, in the following order, completed forms provided in Appendix L:

- A. The Proposal Application Identification form (Form SPO-H-200);

- B. The State of Hawaii DHS Proposal Letter;
- C. The Certification for Contracts, Grants, Loans and Cooperative Agreements form;
- D. The Disclosure Statement (CMS required) form;
- E. The Disclosure Statement (Ownership) form;
- F. The Organization Structure and Financial Planning form;
- G. The Financial Planning form;
- H. The Financial Performance form;
- I. The Controlling Interest form;
- J. The Background Check Information form;
- K. The Operational Certification Submission form;
- L. The Grievance System form;
- M. Applicant's Proof of Insurance;
- N. The Elimination of Barriers to Contracting Between FQHCs/RHC and Health Plans forms (if applicable) from both the health plan and all providers of any applicant that is owned or controlled by a provider or providers of health care services as defined in Section 72.400.
- O. The Wage Certification form;
- P. The Standards of Conduct Declaration form;
- Q. 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.); and
- R. 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 applicant does not have a Hawaii license, the applicant shall (1) include a copy of its filed application to operate as a health plan in the State of Hawaii, (2) include an update of the status of its application, (3) provide monthly status reports on the status of its application (if awarded a contract) on the dates identified in Section 51.600 and (4) provide proof of its license to serve as a health plan if awarded a contract) in the State of Hawaii by the date identified in Section 51.600.

80.240 Attachment: Financial Statements

Financial statements for the applicant 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; and
- G. Federal Income Tax returns.

If an applicant 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 shall be included. 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: Risk Based Capital

The applicant shall provide the most recent completed risk based capital (RBC) amount. Where applicable, the applicant shall submit separate RBC amounts for all affiliated companies and companies with the same parent company as the applicant.

80.300 Technical Proposal

80.310 Experience and References (10 pages maximum not including attachments)

The applicant shall provide:

- A. A narrative of its experience providing services to Medicaid and Medicare populations in Hawaii and in other states.
- B. A listing, in table format, of contacts for all Medicaid program clients (including those served by an affiliated company or a company with the same parent company as the applicant), 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 applicant has or had broken down by the type of membership (e.g. TANF and TANF related, ABD), and the number of years the applicant has been providing or had provided services for that program;
- C. Information on whether or not any contract (including those for an affiliate of the company or a company with the same parent company as the applicant) 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;
- D. Its most recent EQRO evaluations from all states in which it has previously or is currently operating. Note, this will be cross-checked with references to ensure all EQROs have been submitted. The EQRO evaluations do not count towards the page limit; and
- E. EPSDT measures for the last twelve (12) month period. Please provide reference to population reporting on and include geographic location and member demographics. The applicant shall indicate which measures were validated by an EQRO and provide the EQRO validation reports. Note: the EQRO validation reports do not count towards the page limit.

As part of the technical proposal evaluation, a member or members of the evaluation committee will contact all or some of the contacts listed to determine their satisfaction with the applicant and to confirm information provided by the

applicant as part of the response. In addition, a member or members of the evaluation committee will solicit, from the contacts, names and contact information for: (1) other individuals inside the contact's organization; (2) member advocacy groups in the State or service region; and (3) provider organizations in the State or service region. A member or members of the evaluation committee will contact these additional individuals to discuss the applicant.

This section will be scored based upon:

- A. The relevance of the experience, that is experience providing services to a large number of Medicaid ABD enrollees (i.e. 15,000 or more) will be worth more points than experience providing services to a smaller number of ABD enrollees or to TANF and TANF related enrollees only. Similarly, Medicare Advantage (including as a special needs plan) experience (not just prescription drug plan experience) with a significant number of beneficiaries (e.g. 15,000 or more) will be considered more relevant than experience with fewer beneficiaries;
- B. The relevance of the duration of the experience, i.e., the longer the duration of relevant experience (per Item #1 above), the more points the response will be awarded;
- C. Whether or not a contract has been terminated or not renewed for non-performance or for poor performance;
- D. The EQRO evaluations and EPSDT measures; and
- E. The level of satisfaction of the contacts and individuals with whom the member(s) of the evaluation committee spoke.

80.315 Provider Network (7 pages maximum not including attachments)

80.315.1 *Provider Network Narrative*

The applicant shall provide a narrative describing how it will develop and maintain a network in order to assure that all services are available to members. As part of this narrative, the applicant shall describe:

- A. In detail, how it will build and maintain a network that meets **all** required access standards to include capacity standards (for acute care, behavioral health, and long-term care services), including but not limited to the geographic access requirements;
- B. A description of how it will approach the current FFS provider community to meet network adequacy requirements;
- C. The areas it foresees as problems in developing a network in the State of Hawaii and the steps it will take to build network capacity in those areas;
- D. How it monitors the provider network to ensure that access and availability standards are being met. As part of this description, please specifically address how the applicant ensures that acceptable appointment wait times are met and steps taken, if any, in the past to address deficiencies in this area; and
- E. The activities it will undertake to increase home and community based service capacity.

80.315.2 *Provider Network Attachment: Letters of Intent (LOIs)*

The applicant shall obtain LOIs for providers. The applicant shall attach copies of the LOIs according to the following table. The applicant shall use the format for the LOI provided in Appendix M. No substitutions will be accepted. The LOI must be accompanied by the “Additional Provider and Services Information for LOI Between Providers and Applicants for Provision of Services to QExA Members” form that is also provided in Appendix M.

If a provider has multiple sites that offer identical services, only one (1) LOI should be signed, with additional service site information attached to the LOI. Only one (1) site will count toward fulfilling the LOI requirements. That is, a PCP with two sites on Oahu will count as one of the PCP LOIs from Oahu. If a provider has sites on multiple islands, the same LOI can be counted for all islands represented.

If a representative signs an LOI on behalf of a provider, evidence of authority for the representative must be available to the DHS upon request.

Applicants should complete the bracketed information in the LOI as applicable to the applicant's proposal.

Changes have been made to the table below since it was posted on the Hawaii State Procurement Office website on September 24, 2007. Requirements in this RFP supersede any original postings.

Provider Type	Number Required
<p>PCPs</p> <ol style="list-style-type: none"> 1. Family Practitioners, General Practitioners and General Internists 2. Pediatricians 3. Obstetrician/Gynecologists 4. Geriatricians 	<p>20 on Oahu (geographically dispersed on the island) – applicant must have LOIs from 3 PCPs (either MD or DO) in each of the 4 categories (the other 8 may be from any category)</p> <p>10 on all other islands (there must be PCPs from East Hawaii, West Hawaii, Kauai and Maui County; the 10 cannot all be from 1 island/geographic area of the island) – applicant must have LOIs from 2 PCPs in each of the 4 categories (the other 2 may be from any category)</p>
<p>Specialists</p> <ol style="list-style-type: none"> A. Cardiologists B. Ophthalmologists C. Oncologists D. Surgeons (any type) 	<p>20 on Oahu (geographically dispersed on the island) – applicant must have LOIs from 3 specialists in each of the 4 categories (the other 8 may be from any category)</p> <p>10 on all other islands (there must be specialists from East Hawaii, West Hawaii, Kauai and Maui County; the 10 cannot all be from 1 island/geographic area of the island) – applicant must have LOIs from 2 specialists in each of the 4 categories (the other 2 may be from any category)</p>
Hospitals	<p>5 on Oahu</p> <p>2 on Hawaii (1 in East and 1 in West)</p> <p>1 on Kauai</p> <p>1 in Maui County</p>
Nursing Facilities	<p>5 on Oahu</p> <p>2 on Hawaii (1 in East and 1 in West)</p> <p>1 on Kauai</p> <p>1 in Maui County</p>
Community Care Management Agencies or proof of licensed	<p>5 on Oahu</p> <p>2 on Hawaii (1 in East and 1 in West)</p>

in-house capacity to fulfill the function	1 on Kauai 1 in Maui County
Home Health Agencies	5 on Oahu 2 on Hawaii (1 in East and 1 in West) 1 on Kauai 1 in Maui County
Community Care Foster Family Homes	25 on Oahu 10 on Hawaii (5 in East and 5 in West) 3 on Kauai 5 in Maui County
Behavioral Health Providers (e.g. Licensed Clinical Social Workers, psychiatrists, psychologists)	10 on Oahu (geographically dispersed on the island) 3 on Hawaii (at least 1 in East and 1 in West) 3 on Kauai 3 in Maui County

The LOIs shall be ordered as they appear in the table above. In addition, the applicant shall include, at the front of the LOIs, a summary table using the format below. This table shall be completed in the order in which the LOIs are submitted. Examples of completed rows are provided for reference

Provider Type	Island/County (for Oahu include the city)	Provider Name
PCP – Family practitioners, General Practitioners and General Internists	Honolulu, Oahu	Dr. First Name Last Name
PCP – Ob/Gyn	Kapolei, Oahu	Dr. First Name Last Name
Specialist – Cardiologist	Maui County	Dr. First Name Last Name
Hospital	Kauai	Hospital Name
Home Health Agency	Hawaii- East	Agency Name

In the event the applicant is unable to obtain the required LOIs, the applicant shall provide a detailed explanation of why the LOIs were not obtained. As part of this explanation, the applicant shall include the documentation of efforts to obtain LOIs. Provider agreements will not be accepted as substitutes for the LOIs. If the applicant submits provider LOIs that are incomplete, e.g. some are not signed, the applicant shall receive lower scores during the evaluation process.

80.315.3 *Provider Network Attachment – PCP Policies & Procedures*

The applicant shall attach its PCP policies and procedures that address all responsibilities required in Section 40.260.

80.320 Provider Services (8 pages maximum not including attachments)

80.320.1 *Provider Services Narrative - Provider Credentialing and Recredentialing*

The applicant shall provide a comprehensive description of the credentialing and recredentialing policies and procedures it will use in order to comply with all requirements in Section 40.400.

80.320.2 *Provider Services Narrative – General Requirements*

The applicant shall provide a comprehensive explanation of how it intends to meet all provider services requirements outlined in Section 40.600. At a minimum, this shall include:

- A. A description of its ongoing training and education activities for providers, including frequency and type;
- B. A description of how it will transition current FFS providers into managed care environment;
- C. An example, from previous experience, of how the applicant has handled provider non-compliance with provider agreement and program requirements;
- D. A description of how it will update providers of major changes in the program; and
- E. A description of how it will train provider services staff responsible for manning the provider call-center and what monitoring and tracking activities it will use to ensure requirements in Section 40.640 are met.

80.325 Covered Benefits and Services (18 pages maximum)

80.325.1 *Covered Benefits and Services Narrative*

A. The applicant shall provide a comprehensive description of how it will approach delivering primary and acute care services (physical health and behavioral health) and long-term care services as described in section 40.700 to the QExA population. As part of this description, please provide information on:

1. Its experience providing, on both capitated and fee-for-service bases, the covered benefits and services as described in Section 40.700. For purposes of this description, the applicant shall also include the experience of an affiliated company or a company with the same parent company as the applicant;
2. The extent to which this experience is for a population comparable to the QExA population. For purposes of this description, the applicant shall also include the experience of an affiliated company or a company with the same parent company as the applicant;
3. Which covered benefits and services the applicant (or an affiliated company or a company with the same parent company as the applicant) does not have experience providing; and
4. The extent to which the applicant intends to use a subcontractor to provide any benefits and, if so, how the subcontractor will be selected and monitored to ensure compliance with all requirements.

B. The applicant shall describe how it will manage the waiting lists allowed for in Sections 40.750.4 and 40.750.5;

C. The applicant shall describe the process it will use to allow members the opportunity to self-direct personal assistance, attendant care and respite services. This description shall include the extent to which subcontractors will be used to fulfill any administrative functions and address the following:

1. The process used to inform members about the ability to self-direct;
2. How a member's decision to self-direct is documented;

3. The process used to assess a member's ability to self-direct;
4. Monitoring process to ensure timely implementation of self-direction;
5. The process used to document a member's surrogate;
6. Training programs; and
7. Process used to document termination of a member from self-direction.

80.330 Service Coordination, Assessments and Care Plans (18 pages maximum)

80.330.1 *Service Coordination, Assessments and Care Plans Narrative - Service Coordination*

The applicant shall provide a comprehensive description of its proposed Service Coordination System for QExA, including policies and procedures.

At a minimum, the applicant shall describe and address:

- A. The organizational structure of its Service Coordination System;
- B. The process used to assign members to service coordinators and the factors taken into consideration in making assignments;
- C. The process to inform members of assigned service coordinators and how to change service coordinators;
- D. How the applicant intends to track, monitor and evaluate the adequacy and appropriateness of service coordinator caseloads;
- E. The circumstances/conditions that trigger caseload reassignments and changing service coordinator assignments;
- F. How the Service Coordination System addresses:
 1. Coordination and follow up of outpatient and inpatient care/service needs;
 2. Referrals to, and coordination with, community-based resources/services that provide services that are not covered by QExA; and

- 3. Coordination of services with other providers such as Medicare, the DOH programs excluded from QExA, Medicare Advantage plans, other health plan providers, Zero-To-Three, Healthy Start, mental health and DD/MR providers at DOH.
- G. The process 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, to promote continuity of care and coordination of services. In addition, discuss how the applicant involves the member and/or the member's family in decisions regarding care; and
- H. The requirements for documentation of all service coordinator activities.

80.330.2 *Service Coordination, Assessments and Care Plans Narrative - Assessments*

The applicant shall describe its HFA and LOC processes, including the extent to which subcontractors will be used to conduct the LOC evaluation. The description shall also include those circumstances that would warrant an assessment outside of the time frames required by the RFP and the process the applicant will use to forward LOC evaluations to the State.

80.330.3 *Service Coordination, Assessments and Care Plans Narrative - Care Plans*

The applicant shall describe its process for developing and implementing care plans. The description shall include:

- A. A discussion of the distinction between the level of detail in an average care plan vs. a care plan for a QExA member with special health care needs and/or meeting a NF LOC. As a part of this narrative, please provide specific examples; and
- B. The mechanisms to ensure that the implementation of the member's care plan is monitored/evaluated for effectiveness, and is revised as frequently as the member's condition warrants.

80.335 Other Services Narrative (3 pages maximum)

The applicant shall describe in detail its proposed approach to disease management for at least one of the health conditions specified in Section 40.920. The description should include how the applicant will:

- A. Identify members;
- B. Inform and enroll members;
- C. Educate providers; and
- D. Monitor the results of the program.

80.340 Transition of Care Narrative (5 pages maximum)

The applicant shall describe how it will ensure that members transitioning into its health plan receive appropriate care, including how it will honor prior authorizations from the State's FFS program initially or from a different QExA health plan on an ongoing basis. The applicant shall also describe how it will coordinate with a new health plan when one of its members transitions out of its health plan and into FFS or a different QExA or QUEST health plan. As part of this narrative please provide specific examples.

80.345 Member Services (8 pages maximum)

80.345.1 *Member Services Narrative - General Member Services*

The applicant shall describe:

- A. How it will ensure that new member enrollment packets are mailed within ten (10) days of enrollment;
- B. How it will educate members as required in Section 50.320;
- C. How it will update members as information in the member handbook changes; and
- D. Its procedures for updating and maintaining the accuracy of the member portal on its web-site, including but not limited to the provider directory.

80.345.2 *Member Services Narrative - Toll-free Call Center and Twenty-Four Hour Nurse Line*

The applicant shall provide a comprehensive description explaining how it will operate the required toll-free call center and nurse line. At a minimum, the applicant shall describe for both the call center and the nurse line:

- A. Its training curricula and schedule for training call center staff for both the call center and the nurse line, including ongoing training and training when program changes occur;
- B. How it will route calls among staff to ensure timely and accurate response to member inquiries, including procedures for referring the calls to supervisors or managers;
- C. How it will ensure that the telephone call center and nurse line staff can handle calls from non-English speaking callers and from members who are hearing impaired, including the number of hotline staff that are fluent in one of the State-identified prevalent non-English languages; and
- D. How it will monitor compliance with performance standards outlined in Section 50.555 and what it will do in the event they are not being met.

80.350 Quality Assessment and Performance Improvement (QAPI) (20 pages maximum)

80.350.1 *QAPI Narrative – General Provisions*

The applicant shall describe:

- A. How it will address, evaluate, and review both the quality of clinical care and the quality of non-clinical aspects of service such as availability, accessibility, coordination and continuity of care; and
- 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 residential facility) and types of services (preventive, primary, specialty care, behavioral health care, and long-term care) to ensure quality, member safety, and appropriateness of care/services in pursuit of opportunities for improvement on an ongoing basis.

80.350.2 *QAPI Narrative – QAPI Program*

The applicant shall provide a comprehensive description of how it intends to conduct its QAPI program to ensure that all requirements in Section 50.530 are met. As part of this description, please include the following information:

- A. A description of the governing body accountable for providing organizational governance of the applicant's QAPI Program, a description of the governing body's responsibilities, a description of how it exercises these responsibilities, and the frequency of meetings;
- B. A description of the committee/group responsible for developing, implementing and overseeing QAPI Program activities/operations including a description of the committee's specific functions/responsibilities, how it exercises these responsibilities, and the frequency of its meetings and a description of the composition/membership of this committee;
- C. A description of how the applicant ensures that practitioners participate in the QAPI program through planning, design, implementation and/or review; and
- D. A description of how the applicant makes information about the QAPI program available to its practitioners and members, including a description of the QAPI program and a report on the organization's progress in meeting its goals.

80.350.3 *QAPI Narrative - Performance Measures*

The applicant shall:

- A. Describe how it will fulfill all requirements in Section 50.550 as it relates to performance measures; and
- B. Provide HEDIS measures for the last two (2), twelve (12) month periods for all Medicaid programs the applicant (or an affiliated company or a company with the same parent company as the applicant) was serving during that time period. Provide reference to population reporting on to

include geographic location and member demographics. The applicant shall indicate which measures were validated by an EQRO and provide the EQRO validation reports. Note: the EQRO validation reports do not count towards the page limit.

80.350.4 *QAPI Narrative - Medical Records Standards*

The applicant shall provide a narrative explaining how it maintains medical records, assures appropriate record retention and monitors provider compliance with its policies.

80.350.5 *QAPI Narrative - Performance Improvement Projects (PIPs)*

- A. The applicant shall describe its PIP standards and demonstrate how it will meet all requirements in Section 50.540; and
- B. The applicant 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. The PIP evaluations may be from the applicant, an affiliated company or a company with the same parent company as the applicant. Note: the PIP evaluations do not count towards the page limit.

80.350.6 *QAPI Narrative – Practice Guidelines*

The applicant shall indicate the practice guidelines it will select for use as part of its QAPI program. For each guideline, also include:

- A. The rationale for its relevance to the QExA population;
- B. The measures the applicant will take to increase compliance with practice guidelines and how compliance with practice guidelines will be monitored; and
- C. The process for developing, updating and disseminating practice guidelines to providers.

80.355 Utilization Management Program (UMP) and Authorization of Services (6 pages maximum)

80.355.1 *UMP and Authorization of Services Narrative - UMP*

The applicant shall provide a narrative describing its UMP. This narrative shall include:

- A. A description of the committee responsible for the UMP as well as its functions and responsibilities, and how it exercises these responsibilities;
- B. A description of how it detects, monitors and evaluates under-utilization, over-utilization and inappropriate utilization of services as well as processes to address opportunities for improvement; and
- C. A discussion of any special issues in applying UM guidelines for behavioral health and long-term care services.

80.355.2 *UMP and Authorization of Services Narrative - Prior Authorization (PA)*

The applicant shall provide a narrative describing its PA program. This narrative shall, at a minimum, provide the following:

- A. A description of the PA process, including how PAs will be applied for members requiring out-of-network services or services for conditions that threaten the member's life or health;
- B. A description of how it will ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope; and
- C. A description of how it will ensure consistent application of review criteria.

The applicant shall provide:

- A. A description of its information systems environment, including
1. Details on the systems which will be used to perform the key functions (“key production systems”) noted in Sections 50.920, 51.100, 51.395, 60.210 and 60.220. At a minimum include:
 - System name and version,
 - Number of users,
 - Who maintains the system and from what location,
 - The location of the data center where the system is housed,
 - Whether the system is currently in use or being implemented (if the system is being implemented, please indicate the expected go-live date), and
 - Major system functionality.
 2. How these key production systems are designed to *interoperate*: (a) how identical or closely related data elements in different systems are named, formatted and maintained; (b) data element update/refresh methods and frequency/periodicity; and (c) how data is exchanged between key production systems (i.e. how these systems are “interfaced” to facilitate work processes within your organization).
 3. How these systems can be accessed by health plan users (for instance, can field-based case managers access case management information via portable devices such as laptops and PDAs) to facilitate work, promote efficiencies and deliver services at the point of care.
 4. An explanation of how it will ensure that its systems can interface with the DHS systems and how it will institute processes to insure the validity and completeness of the data submitted to the DHS.

As part of its response, the applicant should support the narrative with diagrams that illustrate (a) point-to-point interfaces, (b) information flows, (c) internal controls and (d) the networking arrangement (AKA “network

diagram”) associated with the information systems profiled. These diagrams should provide insight into how its Systems will be organized and how they will interact with DHS systems for the purposes of exchanging Information and automating and/or facilitating specific functions associated with this contract.

- B. A description of how it 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.

80.365 General Administrative Requirements (12 pages maximum not including attachments)

80.365.1 *General Administrative Requirements Narrative - Fraud and Abuse*

The applicant shall provide a comprehensive description of how it will fulfill all fraud and abuse requirements in Section 51.100.

80.365.2 *General Administrative Requirements Narrative - Organization Charts and Narrative on Organization Charts*

The applicant shall provide organization chart(s) and a brief narrative explaining its organizational structure, including (1) whether it intends to use subcontractors for activities and functions other than those described in response to question 80.325.1 and, if so, how it will manage and monitor them and (2) how it will ensure coordination and collaboration among staff located in the State of Hawaii and those in the Continental United States.

80.365.3 *General Administrative Requirements Narrative - Organization and Staffing Table*

In a table format, the applicant shall describe its current or proposed staffing that includes the number of full-time equivalents (FTEs) for all positions described in the table in Section 51.310. Adequacy of proposed staff will be judged based on

an enrollment of approximately 20,000 members; the current maximum number any health plan can have.

80.365.4 *General Administrative Requirements Narrative - Staffing Requirements*

The applicant shall describe its monitoring functions to ensure that all staff meet all applicable laws, regulations and are in compliance with program policies and procedures. This description should include how monitoring will occur, the individuals responsible for monitoring and how non-complaint personnel are handled.

80.365.5 *General Administrative Requirements Narrative - Reporting Requirements*

- A. The applicant shall describe how it will ensure that all encounter data requirements are met and that encounter data is submitted to the State in a timely and accurate manner as described in Section 51.395. As part of this description, please provide a narrative of how you prepare encounter data reports and how you assure accuracy.
- B. Please provide a narrative on what trend analysis you perform on your encounter data.

80.370 Financial Responsibilities (6 pages maximum not including attachments)

80.370.1 *Financial Responsibilities Narrative - Collection of Spend-Down Amounts*

The applicant shall describe how it will ensure that all spend-down amounts are collected as required in Section 60.250.

80.370.2 *Financial Responsibilities Narrative - Third Party Liability*

The applicant shall describe how it will coordinate health care benefits with other coverages, its methods for obtaining reimbursement from other liable third parties, and how it will fulfill all requirements as detailed in Section 60.260.

80.370.3 *Financial Responsibilities Narrative - Compliance with Act 294*

The applicant shall describe how it will comply with the requirements in HRS §346D-1.5 which states that:

Not later than July 1, 2008, there shall be no distinction between hospital-based and non-hospital-based reimbursement rates for institutionalized long-term care under Medicaid. Reimbursement for institutionalized intermediate care facilities and institutionalized skilled nursing facilities shall be based solely on the LOC rather than the location. This section shall not apply to critical access hospitals.

80.375 Oral Presentations

The applicant shall participate in scheduled oral presentation meetings with the evaluation team. These meetings will last approximately two (2) hours each and will be scheduled with at least two (2) weeks advance notice of them. These meetings will be audio-taped. The applicant shall bring five (5) individuals to the face-to-face meetings. These individuals shall be:

- An IT person who can speak to the health plan's information technology architecture and to the functionality of the key information systems that the health plan would use in support of this contract;
- A clinician who represents or understands the integration of acute and long-term care services;
- A service coordination supervisor/manager;
- A provider recruitment/retention expert; and
- An individual of the applicant's choosing.

One (1) week prior to the scheduled meeting, the applicant shall submit resumes of these individuals to the State. On these resumes, it shall be clearly identified whether the individual is a contractor or employee of the applicant and what role the individual will play during the implementation phase and the first year of service provision. In addition, one (1) week prior to the scheduled oral

presentation meeting, the applicant shall submit five (5) copies of its presentation to the State.

During these oral presentation meetings, the applicant will be responsible for providing a presentation of fifteen (15) minutes on each of the following two (2) scenarios.

Scenario 1

Mary is a sixty-nine (69) year old female who has lived alone on Kauai since the death of her husband five (5) years ago. She was able to care for herself until recently when she experienced a cerebrovascular accident which resulted in limited mobility on her left side and placement in a nursing facility. Mary has made tremendous strides in regaining strength and with adequate supports and services could be successfully cared for in the community. Mary does not want to stay in the nursing facility.

Mary's daughter Connie lives nearby with her husband and two young children. Connie tries to visit her mother regularly at the nursing facility but her available time is limited due to the demands of her job and family.

Mary is also eligible for Medicare.

Questions for Scenario 1

Describe in detail the process you would use to provide services and supports to and coordinate the care for Mary; from enrollment through service delivery and all the steps in between.

Following the scenario, the evaluation team will ask follow-up questions to the scenario. These questions will not be provided in advance.

Scenario 2

Eddie is a forty-five (45) year old man with muscular dystrophy. He has used a wheelchair for mobility since he was twenty (20) years old and has lived in a group home for all of his adult life. His parents died in a car accident when he was twenty-one (21) years old and his only sibling, a sister, lives out of state. Eddie requires assistance with both ADLs and IADLs.

Eddie has lost the ability to speak but is able to communicate with the use of an assistive technology device. He has had the assistive technology device for only a few months. Prior to this time, it was very difficult to communicate to his caregivers his likes, dislikes, desires, goals, etc. Eddie has always wanted to have greater control over his personal assistance providers: the communication device gives him this opportunity.

Questions for Scenario 2

Describe in detail the process you would use to provide services and supports to and coordinate the care for Eddie; from enrollment through service delivery and all the steps in between.

Following the scenario, the evaluation team will ask follow-up questions to the scenario. These questions will not be provided in advance.

Additional Questions

The applicant shall respond to a series of questions from the evaluation team that will address processes and activities in place. These questions will not be provided in advance.

Follow-up questions may be asked to clarify written responses to question(s) asked in Sections 80.310 through 80.370.

SECTION 90

BUSINESS PROPOSAL/BID RATE SUBMISSIONS

90.100 Introduction

This section describes the rate structure, the guidelines for applicants with regard to bid rate submissions, the evaluation of bids to be performed by the DHS, and the guidelines for future rate setting.

90.200 Overview of the Rate Structure

For any given QExA managed care member, the DHS will pay a capitation rate computed as a base rate (with rating categories specific to the health plan, aid category and island of residence, as well as differentiating between rating classes defined as nursing facility, home and community based, and medical only members) multiplied by an age/gender factor (specific to aid category and rating class). Rates shall be pro-rated for partial month enrollments. The base rates will be bid by the applicants and are to be effective for the eight-month period from November 2008 through June 2009. Age/gender factors by aid category will be provided in advance of the business proposal submission date. Aid categories for base rates include the following:

- Aged – Medicare Eligible
- Aged – Medicaid Only
- Blind/Disabled – Medicare Eligible
- Blind/Disabled – Medicaid Only

Rating classes are administered as follows:

- Nursing Home – applies to clients residing in a long-term nursing facility at the time of managed care enrollment as well as those clients that are initially enrolled in another rating class and then have (12) twelve consecutive months in a long-term nursing facility setting.
- Home and Community – applies to clients that have been assessed as eligible to receive nursing facility or HCBS waiver services that are not

residing in a long-term nursing facility at the time of enrollment. In addition, clients that relocate into a long-term nursing facility after enrollment remain in this rating class until they remain in the nursing facility for (12) twelve consecutive months.

- Medical – applies to clients not eligible for either of the above rating classes.

Diagnosis and functionality based risk adjustment will also be applied at the health plan and island level for the medical component of the base rates for Medicaid Only aid categories and for the home and community based care component of each aid category.

Risk adjustment will be performed in a budget neutral manner for each applicable rate category. That is, the result of the application of risk factors for each rate category will be expected to shift revenue between the health plans, with no impact on aggregate state funding. Risk adjustment will not be applied to Molokai and Lanai. Risk adjustment factors will be applied as early as possible at program startup, with the expectation of being no later than the second month of enrollment. If the risk adjustment is delayed beyond the initial month of enrollment, no retroactive adjustments will be made. Each year, the risk adjustment process will be refreshed in June with the target implementation for the next fiscal year.

90.300 Bidding Rules and Requirements

In order to be considered complete and eligible for the evaluation, bids must fully comply with the following:

- Bids must be submitted using Bid Form 1 (contained in the data book).
- The applicant must bid all rating categories, including all islands, all aid categories and all rating classes (nursing facility, home and community, and medical only).
- The applicant must complete Bid Forms 2A – 2L for each island.

- The total capitation rates in Bid Forms 2A – 2L must tie to the corresponding capitation rates on Bid Form 1.
- The actuarial certification of rates (with specifications described below) must be completed and signed by a Member of the American Academy of Actuaries.
- Applicants must maintain comprehensive documentation of their rate development, although it is not required that this documentation be submitted with the proposal.

Bids that do not fully comply will be disqualified pursuant to Section 21.400.

90.400 Bid Rate Adjustments

The composite bid rate (weighted based on projected membership in each rating category) will be compared to the actuarially sound rate range computed by the DHS. To be acceptable, an applicant's composite bid rate must be within the rate range computed by the DHS. The rate range will not be disclosed.

Acceptable applicants will have any rate cell specific bid base rates that are above the rate range for that particular rating category lowered to the mid-point of that rate range. Apparent successful applicants with rates that have been reduced by the DHS to the mid-point of the rate range shall be required to revise assumptions and certify that these rates are acceptable. The DHS and their actuaries will provide limited feedback in such situations.

Applicants will be expected to submit their comprehensive documentation of assumptions and rate development for any rate cell specific bid base rates below the actuarially sound rate range computed by the DHS. If the rate development process and assumptions are deemed actuarially sound by the DHS, the applicant's bid rate will be increased to the minimum rate determined to be actuarially sound for that applicant by the DHS. Note that this rate may be lower than the original lower bound of the rate range established by the DHS based on the rate development work of the applicant. Rate development documentation deemed unreasonable by the DHS will result in the disqualification of the bid.

90.500 Future Rate Setting

Subject to limitations imposed by CMS, legislative direction or other outside influence for which the DHS shall comply, it is the intent of the DHS to publish revised rates each state fiscal year and, to the extent feasible, to maintain the relative rate differentials between awarded contractors (specific to each rating category) throughout the term of the contract. For example, if Health Plan A has a base rate for Aged – Medicare Eligible, nursing facility members on Maui that is three percent (3%) lower than Health Plan B, any DHS changes to Maui rates or to Aged – Medicare Eligible, nursing facility age/gender factors will, to the extent feasible be made such that Maui Aged – Medicare Eligible, nursing facility base rate for Health Plan A will remain three percent (3%) lower than that for Health Plan B. The DHS specifically does not commit to any particular methodology or formula, or to any particular benchmark or objective, for rate revisions.

90.600 Actuarial Certification Specifications

The actuarial certification must contain the following documentation:

- Changes in utilization from the underlying source data by category of service resulting from an assumed difference in the level of health care management.
- Annual unit cost and utilization trend rates by category of service.
- Assumptions regarding changes in utilization or average unit cost for each change in contractual requirements compared to the time period of the source data. Only contractual requirements that impact rates should be included in this list.
- Modifications resulting from perceived weaknesses in the underlying source data.
- Justification for any differences in assumptions between islands regarding administrative expenses.

- Confirmation that expected pharmacy rebates attributable to this population have been completely applied to the average pharmacy unit cost in the supporting documentation.
- Inclusion of the following statement:

“I certify that the submitted capitation rates were developed in accordance with generally accepted actuarial principles and practices. They are appropriate for the populations to be covered and the services to be provided under the contract.”
- Signature by an actuary who meets the qualification standards established by the American Academy of Actuaries, is a Member of the American Academy of Actuaries, and follows the practice standards established by the Actuarial Standards Board.

This certification may be submitted with electronic signature with the original proposal, but must be followed with a signed original and received by the DHS within one (1) week after the proposal submission deadline.

SECTION 100 EVALUATION AND SELECTION

100.100 Introduction

The DHS shall conduct a comprehensive, fair and impartial evaluation of proposals received in response to this RFP. The DHS shall be the sole judge in the selection of the applicant(s). The evaluation of the proposals shall be conducted as follows:

- Review of the proposals to ensure that all mandatory requirements detailed in Section 80.200 are met;
- Review and evaluation of the technical proposals for proposals that meet all mandatory requirements to determine whether the applicant meets the minimum technical criteria and requirements detailed in Section 80.300;
- Review and evaluation of the business proposals (Section 90) for proposals that pass the technical review and evaluation 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 applicants.

Failure of the applicant to comply with the instructions of this RFP or failure to submit a complete proposal shall be grounds for deeming the proposal non-responsive to the RFP. However, the DHS reserves the right to waive minor irregularities in proposals provided such action is in the best interest of the State. Where the DHS may waive minor irregularities, such waiver shall in no way modify the RFP requirements or excuse the applicant from full compliance with the RFP specifications and other contract requirements if the applicant is awarded the contract.

Proposals deemed by the evaluation committee(s) to be incomplete or not in accordance with the specified requirements shall be disqualified. Applicants may retrieve their proposal as described in Section 21. 400.

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 Proposal Evaluation

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:

- Proposal was submitted within the closing date and time for proposals as required in Section 20.100;
- Bid rates and technical proposal are in separate envelopes as required in Section 21.300;
- The proper number of separately bound copies are in sealed envelopes as required in Section 21.300;
- All information required in Section 80.200 has been submitted;
- Certified statement as specified in Section 21.600 regarding Independent Price Determination is included; and
- Proposal contains the necessary information in the proper order.

A proposal must meet all mandatory requirements prior to the technical evaluation. Any proposal that does not meet all mandatory requirements will not have the technical proposal opened; the technical proposal will be returned to the applicant.

100.400 Technical Proposal Evaluation

The technical proposals that have met the minimum mandatory requirements shall be evaluated in order to identify those applicants that meet the minimum technical requirements detailed in Section 80.300. Each applicant must obtain a minimum of seventy-five percent (75%) of the total points for each of the required review sections in the technical proposal.

The listing of criteria is not all-inclusive and the DHS reserves the right to add, delete or modify any criteria.

Section/Title	Total Points Possible	Points Needed to Pass
80.310 - Experience and References	300	225
80.315 - Provider Network	75	56
80.320 - Provider Services	40	30
80.325 - Covered Benefits and Services	70	52
80.330 - Service Coordination, Assessments and Care Plans	70	52
80.335 - Other Services	10	11
80.340 - Transition of Care	25	18
80.345 - Member Services	40	30
80.350 - Quality Assessment and Performance Improvement	55	37
80.355 - Utilization Management/ Prior Authorization	20	15
80.360 - Information Systems	30	22
80.365 - General Administration	40	30
80.370 – Financial Responsibilities	25	18
80.375 - Oral Presentations	200	150

For those applicants that meet all minimum technical requirements, the business proposal shall then be opened and evaluated.

For those applicants that cannot demonstrate compliance with all minimum technical requirements, the proposals shall be returned with a letter of explanation. The business proposals shall not be opened.

100.500 Business Proposal Evaluation

For the purpose of scoring the business proposal, any rate cell specific bid base rates above their respective DHS actuarially sound rate range will not be lowered as described in Section 90.400. Rate cell specific bid base rates that have been adjusted upward as described in Section 90.400 will be increased for the purpose of scoring the business proposal. After considering these increases, a composite statewide average bid base rate (composite rate) will be computed for each applicant. Rate cell specific membership weights for computing this composite are provided on Bid Form 1.

For the applicant with the lowest composite rate, business proposal points will be awarded equal to the highest technical point total from all acceptable applicants. For all other acceptable applicants, the business proposal points will be reduced from this level at a continuous rate of ten (10) points for each one percent (1%) differential in their composite rate when compared to the lowest composite rate.

100.600 Selection of Applicants

Upon completion of the Technical and Business Proposal evaluations, the DHS shall sum the scores from both evaluations to determine the applicants that will receive contracts from the State. The DHS will select the following number of applicants/health plans per island:

Oahu, Hawaii, Maui, Kauai	2 applicants/health plans per island
Molokai and Lanai	1 applicant/health plan per island (the health plan that receives the most points)

The applicant with the most points will be eligible to receive up to sixty percent (60%) of the island enrollment on Oahu. Enrollment on Hawaii, Maui and Kauai will be split at fifty percent (50%) per applicant.

100.700 Contract Award

Upon selection of the applicants that will receive contracts the DHS shall initiate the contracting process. The applicant shall be notified in writing that the RFP proposal has been accepted and that the DHS intends to contract with the applicant. This letter shall serve as notification that the applicant should begin to develop its programs, materials, policies and procedures for the programs.

The contracts will be awarded no later than the Contract Award date identified in Section 20.100. If an awarded applicant 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 Contract Award date identified in Section 20.100. After that date, the State will expect to enter into a contract with the applicant.

This RFP and the applicant's technical and business proposals shall become part of the contract.