STATE OF HAWAII

Department of Human Services

REQUEST FOR PROPOSALS (RFP)

QUEST Integration (QI)
Managed Care to Cover Medicaid and Other Eligible Individuals

RFP–MQD–2019-002

Med-QUEST Division

State of Hawaii

Department of Human Services

Med-QUEST Division

Request for Proposals

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Managed Care to Cover Medicaid and Other Eligible Individuals

August 26, 2019

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

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SECTION 1 – Administrative Overview & RFP Requirements

1.1 Purpose of the Request for Proposals

A. The State of Hawaii, Department of Human Services (DHS), has issued this Request for Proposals (RFP) with the intent of securing contracts with four (4) Health Plans for the provision of covered services to eligible Medicaid and Children's Health Insurance Program (CHIP) members for medically necessary medical, behavioral health, and long-term services and supports in a fully risk-based managed care environment. All four (4) Health Plans will service members on the island of Oahu, and two (2) of the four (4) Health Plans will service members statewide.

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

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

1.2 Authority for Issuance of RFP

A. This RFP is issued under the authority of Title XIX of the Social Security Act, 42 USC Section 1396, et. seq. as amended, the implementing regulations issued under the authority thereof, Section 346-14 of the Hawaii Revised Statutes (HRS), and the provisions of the Chapter 103F, HRS.

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

1.3 RFP Organization

This RFP is composed of 16 sections plus appendices:

- Section 1 – Administrative Overview & RFP Requirements – Provides general information on the purpose of the RFP, the authorities relating to the issuance of the RFP, the use of subcontractors and the organization of the RFP. Provides information on the rules and schedules for procurement.
- Section 2 – Background and Scope – Describes the current populations receiving medical assistance, definitions, and the background and scope of the RFP.
- Section 3 – Approach to Care Delivery & Coordination – Describes advanced primary care, stepped care approach to behavioral health, the care and service coordination system, Medicare alignment requirements, enhanced referral networks, and regional health partnerships.
- Section 4 – Covered Benefits and Services – Provides information on the medical, behavioral health, community integration, and long-term services and supports to be provided under the RFP.
- Section 5 – Quality, Utilization Management, and Administrative Requirements – Provides information on the MQD Quality Strategy, the Quality Assurance and Performance Improvement

(QAPI) Program, External Quality Review Organization (EQRO) requirements, and other issues surrounding quality.

- Section 6 – Health Plan Reporting and Encounter Data Responsibilities – Provides information on managed care organization (Health Plan) reporting requirements, submission requirements, and encounter data submission requirements.
- Section 7 – DHS and Health Plan Financial Responsibilities – Provides information on Health Plan reimbursement, provider reimbursement, incentives, and third party liability.
- Section 8 – Responsibilities and Requirements of DHS and Health Plans: Provider Networks; Provider Credentialing; Provider Contracts; and Other Functions for Providers – Provides information on provider network, credentialing, contracting, and provider services requirements.
- Section 9 – Responsibilities and Requirements of DHS and Health Plans: Eligibility, Enrollment, Disenrollment, Continuity of Care, and Grievance and Appeals - Provides information on the enrollment and disenrollment of beneficiaries, member services, grievances, and marketing and advertising.
- Section 10 – Information Systems and Information Technology – Provides information on information systems requirements.
- Section 11 – Health Plan Personnel – Provides information on Health Plan personnel requirements.
- Section 12 – Program Integrity – Provides information on fraud, waste, and abuse policies, and verification of services.
- Section 13 – Readiness Review and Contract Implementation – Provides information on readiness review requirements.

- Section 14 – Special Terms and Conditions – Describes the terms and conditions under which the work shall be performed, including penalties for non-compliance and poor performance.
- Section 15 – Mandatory and Technical Proposal – Defines the required format of the technical proposal and the minimum information to be provided in the proposal.
- Section 16 – Evaluation and Selection – Defines the evaluation criteria and explains the evaluation process.

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

1.4 Issuing Officer and Point of Contact

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

Mr. Jon Fujii
Department of Human Services
Med-QUEST Division
1001 Kamokila Boulevard, Suite 317
Kapolei, Hawaii 96707
Telephone: (808) 692-8083

1.5 RFP Timeline

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

Table 1. Schedule of RFP Events	Date
Issue RFP	August 26, 2019
Request teleconference number for orientation	September 9, 2019
Orientation	September 10, 2019
Submission of Technical Proposal Questions (Round 1)	September 13, 2019
Responses to Technical Proposal Questions (Round 1)	September 27, 2019
Submission of Technical Proposal Questions (Round 2)	October 11, 2019
Responses to Technical Proposal Questions (Round 2)	October 25, 2019
Proposal Due Date	November 8, 2019
Proposal Evaluation Period	November 12, 2019 – January 3, 2019
Discussions with Health Plans after proposal submittal deadline (optional)	Week of December 2, 2019 through December 6, 2019
Final Revised Proposals (optional)	December 20, 2020
Contract Award	January 6, 2020
Contract Effective Date	February 3, 2020
Date of Commencement of Services to Members	July 1, 2020

1.6 Orientation

A. An orientation for Health Plans in reference to this RFP will be held on the date identified in Section 1.5.

B. The orientation will be held on 9:00 am (H.S.T.) at the Med-QUEST Office, Kakuhihewa Building at 601 Kamokila Boulevard, #577A, Kapolei, Hawaii.

C. In addition, Health Plans may access the orientation via teleconference. Health Plans shall email to QUEST_Integration@dhs.hawaii.gov no later than 12:00 pm (H.S.T) on the date identified in Section 1.5 to receive the teleconference number. The email requesting the teleconference information shall identify each of the persons calling into the teleconference to include their name, organization, and position.

D. Impromptu questions will be permitted at the orientation and spontaneous answers provided at DHS's discretion. However, answers provided at the orientations are only intended as general direction and may not represent DHS' final position, which will be detailed in a formal official response. Formal official responses will be provided in writing. To ensure a written response, any oral questions must be submitted in writing on the date identified in Section 1.5 in accordance with the process identified in Section 1.7, Submission of Written Questions.

1.7 Submission of Written Questions

A. Health Plans shall submit all questions in writing via email or on Universal Serial Bus (USB) in Word 2013 format (.docx) or lower to the following mailing address or email address:

Mr. Jon Fujii
c/o Mr. Eric Nouchi

Department of Human Services
Med-QUEST Division-Finance Office
1001 Kamokila Boulevard, Suite 317
Kapolei, Hawaii 96707-2005

Email Address: QUEST_Integration@dhs.hawaii.gov

B. Technical Proposal Questions shall be submitted on the appropriate format provided in Appendix A by 12:00 p.m. (H.S.T.) on the applicable dates identified in Section 1.5.

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

1.8 Use of Subcontractors

A. In the event of one proposal submitted jointly or by multiple organizations, one organization shall be designated as the prime Health Plan. The project leader shall be an employee of the prime Health Plan. All other participants shall be designated as subcontractors. Subcontractors shall be identified by name and by a description of the services/functions they will be performing. The prime Health Plan shall be wholly responsible for the entire performance whether subcontractors are used. The prime Health Plan shall sign the contract with DHS.

1.9 Confidentiality of Information

A. DHS shall maintain the confidentiality of proposals only to the extent allowed or required by law, including but not limited to Section 92F-13, Hawaii Revised Statutes (HRS), and Sections 3-143-604 and 3-143-616, Hawaii Administrative Rules (HAR).

B. If the Health Plan seeks to maintain the confidentiality of sections of the proposal, each page of the section(s) shall be marked as "Proprietary" or "Confidential." An explanation to DHS of how substantial competitive harm would occur if the information were released is required. If the explanation is sufficient, then to the extent permitted by the exemptions in 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.

C. DHS shall maintain the confidentiality of the information to the extent allowed by law. Blanket labeling of the entire document as "proprietary," however, shall result in none of the document being considered proprietary.

1.10 Requirements to Conduct Business in the State of Hawaii

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

1. HRS Chapter 237, tax clearance
2. HRS Chapter 383, unemployment insurance
3. HRS Chapter 386, workers' compensation

4. HRS Chapter 392, temporary disability insurance
5. HRS Chapter 393, prepaid health care
6. One of the following:
    a. Be registered and incorporated or organized under the laws of the State (hereinafter referred to as a "Hawaii business"); or
    b. Be registered to do business in the State (hereinafter referred to as a "compliant non-Hawaii business").

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

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

1.11 Hawaii Compliance Express (HCE)

A. The DHS utilizes the HCE to verify compliance with the requirements to conduct business in the State, upon award of the contract. The HCE is an electronic system that allows vendors/contractors/service providers doing business with the State to quickly and easily demonstrate compliance with applicable laws. It is an online system that replaces the necessity of obtaining paper compliance certificates from the DOTAX and IRS tax clearance Department of Labor and Industrial Relations (DLIR) labor law compliance, and Department of Commerce and Consumer Affairs (DCCA) good standing compliance. There is a nominal annual fee for the service and is the responsibility of the Health Plan. The "Certificate of Vendor Compliance" issued online through HCE provides the registered Health Plan's current compliance status as of the issuance date, and is accepted for both contracting and final payment

purposes. See website: https://vendors.ehawaii.gov/hce/splash/welcome.html

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

1.12 Cost Principles

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

1.13 Campaign Contributions by State and County Contractors

A. Pursuant to section 11-355, HRS, campaign contributions are prohibited from specified State or county government contractors during the term of the contract if the contractors are paid with funds appropriated by a legislative body. For more information, refer to the Campaign Spending Commission webpage (http:ags.hawaii.gov/campaign/).

1.14 Documentation

A. Health Plans may review information describing Hawaii's QUEST Integration (QI) program in the Hawaii Medicaid Databook in Appendix C.

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

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

1.15 Rules of Procurement

A) *No Contingent Fees*

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

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

B) ***Discussions with Health Plans***

1. Prior to the submittal deadline, questions shall be submitted in writing follow section 1.7 and answers shall be provided in the SPO HANDS site.

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

C) ***RFP Amendments***

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

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

D) ***Costs of Preparing Proposal***

1. Any costs incurred by the Health Plan for the development and submittal of a proposal in response to this RFP are solely the responsibility of the Health Plan, whether or not any award results

from this solicitation. The DHS shall provide no reimbursement for such costs.

E) *Provider Participation in Planning*

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

F) *Disposition of Proposals*

1. All proposals become the property of DHS. The successful proposal shall be incorporated into the contract. A copy of successful and unsuccessful proposal(s) shall be public record as part of the procurement file as described in Section 3-143-616, HAR, pursuant to Chapter 103F, HRS. DHS shall have the right to use all ideas, or adaptations to those ideas, contained in any proposal received in response to this RFP. Selection or rejection of the proposal shall not affect this right.

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

G) *Rules for Withdrawal or Revision of Proposals*

1. A proposal may be withdrawn or revised at any time prior to, but not after, the Proposal Due Date specified in Section 1.5, provided that a request in writing executed by a Health Plan or its duly authorized representative stating its intent for the withdrawal or revision of such proposal is filed with DHS before the deadline for receipt of proposals. The withdrawal of a proposal shall not prejudice the right of a Health Plan to submit a new proposal before the Proposal Due Date.

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

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

1.16 Submission of Proposals

A. Each qualified Health Plan shall submit only one (1) proposal to provide Medicaid services statewide. More than one (1) proposal shall not be accepted from any Health Plan. The Proposal Application Identification (Form SPO-H-200) shall be completed and submitted with the proposal

(Appendix D). The format and content of the proposal is specified in section 15.

B. The Health Plan shall submit one (1) original bound technical proposal and two (2) additional bound copies and one (1) complete electronic version (in MS Word 2013 or lower or in PDF) of the technical proposal on a USB. If there are discrepancies between the hard copy and electronic copy, hard copy will be the final version. DHS reserves the right to allow the Provider to resubmit the digital version, as long as it is the same as the hard copy.

C. The Issuing Officer shall receive the technical proposals no later than 2:00 p.m. (H.S.T.) on the Proposal Due Date specified in Section 1.5 or postmarked by the U.S. Postal Service (USPS) no later than the Proposal Due date specified in Section 1.5 and received by the Department within ten (10) calendar days of the Proposal Due Date.

D. All mail-ins postmarked by USPS after the date specified in Section 1.5, shall be rejected. Hand deliveries shall not be accepted after 2:00 p.m., (H.S.T.), the Proposal Due date specified in Section 1.5 Deliveries by private mail services such as FEDEX shall be considered hand deliveries and shall not be accepted if received after 2:00 p.m., (H.S.T.), the Proposal Due date specified in Section 1.5. Proposals shall be mailed or delivered to:

Mr. Jon Fujii
c/o Mr. Eric Nouchi
Department of Human Services
Med-QUEST Division-Finance Office
1001 Kamokila Boulevard, Suite 317
Kapolei, Hawaii 96707

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

Hawaii DHS/RFP-MQD-2019-002
QUEST Integration (QI) Managed Care to Cover Medicaid and Other Eligible Individuals
Technical Proposal
(Name of Health Plan)

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

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

1.17 Multiple or Alternate Proposals

A. Multiple or alternate proposals shall not be accepted. If the Health Plan submits multiple proposals or alternate proposals, then all such proposals shall be rejected unless one of the proposals is clearly designated as the primary proposal, in which case the designated primary proposal will be retained and evaluated, and the other proposals shall be rejected.

1.18 Mistakes in Proposals

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

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

   1. That the error identified is a patent error;

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

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

1.19 Irregular Proposals

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

   1. If either the proposal letter or transmittal letter is unsigned by a Health Plan or does not include notarized evidence of authority of the officer submitting the proposal to submit such proposal.

2. If 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.

3. If a Health Plan adds any provisions reserving the right to accept or reject an award, or adds provisions contrary to those in the solicitation.

1.20 Disqualification of Proposals

A. A Health Plan shall be disqualified and the proposal automatically rejected for any one or more of the following reasons:

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

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

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

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

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

6. A Health Plan shows noncompliance with applicable laws.

7. A Health Plan's delivery of proposal after the proposal due date.

8. A Health Plan's failure to pay, or satisfactorily settle, all bills overdue for labor and material on former contracts with the State at the time of issuance of this RFP.

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

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

1.21 Rejection of Proposals

A. DHS 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 rejected without further notice.

B. A proposal may be rejected for any one or more of the following reasons:

1. Rejection for failure to cooperate or deal in good faith. (HAR §3-141-201)

2. Rejection for inadequate accounting system. (HAR §3-141-202)

3. Late proposals (HAR §3-143-603)

4. Inadequate response to request for proposals (HAR §3-143-609)
5. Proposal not responsive (HAR §3-143-610(a)(1))
6. Applicant not responsible (HAR §3-143-610(a)(2))

1.22 Acceptance of Proposals

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

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

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

D. DHS also reserves the right to 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.

1.23 Opening of Proposals

A. Proposals, modifications to proposals, and withdrawals of proposals shall be date-stamped and, when possible, time-stamped upon receipt by DHS. All documents so received shall be held in a secure

place by DHS and not opened until the Proposal Due Date as described in Section 1.5.

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

1.24 Additional Materials and Documentation

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

1.25 Final Revised Proposals

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

1.26 Cancellation of RFP

A. The RFP may be canceled and any or all proposals may be rejected in whole or in part, when it is determined to be in the best interests of the State. The State shall not be liable for any costs, expenses, loss of profits or damages whatsoever, incurred by the Health Plan in the event this RFP is cancelled or a proposal is rejected.

1.27 Award Notice

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

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

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

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

1.28 Protests

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

1. DHS's failure to follow procedures established by Chapter 103F, HRS;
2. DHS's failure to follow any rule established by Chapter 103F, HRS; and
3. DHS's failure to follow any procedure, requirement, or evaluation criterion in the RFP.

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

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

C. All Protest are pursuant to Chapter 148 of Title 3, Hawaii Administrative Rules.

SECTION 2 – Background and Scope

2.1 Scope of the RFP

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

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

2.2 Background

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

Quality care
Universal access
Efficient utilization
Stabilizing costs, and
Transforming the way health care is provided to QUEST members.

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

The QUEST program has gone through many changes since 1994. In 2009, DHS implemented its QUEST Expanded Access (QExA) program that allowed its aged, blind, or disabled (ABD) population to also benefit from managed care. In 2014, the QUEST Integration (QI) program combined several programs into one-Statewide program providing managed care services to all of Hawaii's Medicaid population.

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

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

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

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

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

1) Investing in primary care, prevention, and health promotion;
2) Improving outcomes for individuals with special health care needs;
3) Reforming and aligning payment to providers; and
4) Supporting community driven initiatives to improve population health.

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

1) Health information technology that drives transformation;
2) Increase workforce capacity and flexibility; and
3) Performance measurement and evaluation.

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

In Sections 5 and 6, DHS describes its approach to new quality improvement, measurement, and reporting strategies that support the HOPE initiative, including the development of HIT Innovation and Social Determinants of Health (SDOH) Transformation plans.

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

2.3 Definitions/Acronyms

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

1. **Abuse** - Any practices that are inconsistent with sound fiscal, business, or medical practice and result in unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or contractual obligations (including the terms of the RFP, contracts and requirements of state and federal regulations) for health care in the managed care setting, including incidents or practices of providers that are inconsistent with accepted sound medical practices.

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

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

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

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

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

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

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

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

and treat common minor illnesses and injuries consistent with §16-89, Subchapter 16, HAR.

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

    a) The denial or restriction of a requested service, including the type or level or service, based on requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

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

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

    d) The failure to provide services in a timely manner, as defined in Section 8.1(C) (availability of providers);

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

    f) For a rural area member or for islands with only one Health Plan or limited providers, the denial of a member's request to obtain services outside the network:

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

        2. From a provider not part of a network that is the main source of a service to the member, provided that the provider is given the same opportunity to become a participating provider as other similar providers;

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

4. Because the only Health Plan or provider does not provide the service because of moral or religious objections;

5. Because the member's provider determines that the member needs related services that would subject the member to unnecessary risk if received separately and not all related services are available within the network; and

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

g) The denial of an member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

11. **Adverse Childhood Experiences (ACE) –** ACE is a term used to describe all types of abuse, neglect and other potentially traumatic experiences that occur to people under the age of 18. ACEs have been linked to risky health behaviors, chronic health conditions, low life potential, and early death.

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

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

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

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

16. **Appeal** - A review by the Health Plan of an adverse benefit determination.

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

18. **Appointment** – A face-to-face interaction between a provider and a member. This does include interactions made possible using telemedicine but does not include telephone or e-mail interaction.

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

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

21. **Authorized Representative –** An individual or organization designated by an applicant or a beneficiary in writing with the designee's signature or by legal documentation of authority to act on behalf of an applicant or beneficiary, in compliance with federal and

state law and regulations. Designation of an authorized representative may be requested at time of application or at other times as required and will be accepted through the same modalities as applications for medical assistance.

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

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

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

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

26. **Beneficiary** - An individual who has been determined eligible and is currently receiving Medicaid.

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

28. **Benefits** - Those health services that the member is entitled to under the QUEST Integration program and that the Health Plan arranges to provide to its members.

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

30. **Care and Service Coordination System (CSC)** – CSC System is a program that is designed to address the care and service coordination needs of members with complex medical and social conditions. The Health Plan must have a CSC System that provides appropriate CSC support across multiple settings and across the continuum of care with the focus on improving health care outcomes and decreasing inappropriate utilization. The CSC System provides services to SHCN, SHCN+, LTSS, CIS and CCS members.

31. **Care Coordination –** A service that is provided to SHCN members. The service includes assessing, planning, coordinating, implementing, monitoring, and evaluating the options and services required to meet a member's healthcare needs using person-centered communication and all available resources to promote quality outcomes.

32. **Care Coordinator –** An individual who coordinates, monitors and ensures that appropriate and timely care is provided to SHCN and SHCN+ members.

33. **Care Plan –** A person-centered written plan that is based on the SHCN or SHCN+ assessment and is written for individuals receiving Care Coordination. A care plan includes, but is not limited to, the following:

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

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

    c) Describe how all clinical and non-clinical health-care related needs and services will be coordinated, including coordination with a service plan if applicable to the individual.

The care plan is regularly reviewed and updated and agreed upon by the member or authorized representative with the entity providing care coordination.

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

35. **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.

36. **Centers for Medicare & Medicaid Services (CMS)** – the United States federal agency which administers the Medicare program and, working jointly with State governments, the Medicaid program and the State Children's Health Insurance Program (CHIP).

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

38. **Children's Health Insurance Program (CHIP)-** A joint federal-state health care program for uninsured, targeted, low-income children, established pursuant to Title XXI of the Social Security Act that is implemented as a Medicaid expansion program in Hawaii.

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

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

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

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

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

44. **Collaborative Care –** A team-based model using a Stepped Care approach providing integrated primary and behavioral health care to effectively treat mild to moderate behavioral health conditions in primary care settings. The care team includes a behavioral care manager to provide assessment, brief intervention, and care management functions, and a psychiatric consultant to provide weekly caseload review, providing prescribing, diagnostic and treatment recommendations to the primary care team.

45. **Community Care Foster Family Home (CCFFH) -** A home that is certified by the department to provide an individual with twenty-four hour living accommodations and home and community based services.

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

47. **Community Care Services (CCS)** – A behavioral health program administered by DHS. CCS provides eligible adult members specialized behavioral health services to Severe Mental Illness (SMI) and Severe and Persistent Mental Illness (SPMI).

48. **Community Care Team (CCT)** - A locally-based, multidisciplinary team of paraprofessionals and providers who coordinate clinical and non-clinical services to manage whole-person care for members with complex health needs across providers, settings and systems. CCTs emphasize in-person contact with members, coordination of care between primary care/behavioral health providers and community resources, and routinely connect members with relevant community-based resources. A CCT includes, but is not limited to, Community Health Workers, Peer Support Specialists and Community Paramedics.

49. **Community Integration Services (CIS) –** Pre-tenancy supports and tenancy sustaining services that support individuals to be prepared and successful tenants in housing that is owned, rented or leased to the individual. Pre-Tenancy supports help to identify the individual's needs and preferences, assist in the housing search process, and help to arrange details of the move. Tenancy sustaining services help with independent living sustainability that includes tenant/landlord education, and tenant coaching and assistance with community integration and inclusion to help develop natural support networks.

50. **Community Health Worker (CHW)** - A frontline public health worker who is a trusted member of and/or has a close understanding of the community served to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW serves as an integral member of the care team, providing in-home

visits, accompanying members to provider visits as needed, and assisting members with healthcare needs.

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

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

53. **Comprehensive Risk Contract** – A risk contract that covers comprehensive services including, but not limited to inpatient hospital services, outpatient hospital services, rural health clinic services, Federally Qualified Health Center (FQHC) services, laboratory and X-ray services, early and periodic screening, diagnostic and treatment services, long-term services and supports, and family planning services.

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

55. **Consulting Psychiatric Provider —** A consulting psychiatric provider supports the primary care team with diagnosis, treatment planning, and psychiatric medication recommendations to improve mental health and substance use treatment in the primary care setting. They work primarily in a consultation capacity with little direct evaluation of the member. The role is a required part of the collaborative care model, however consulting psychiatric providers can also support practices without full integrated care models through one-time consultations, psychiatric access lines, Psychiatric Project ECHO, e-Consult and other initiatives.

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

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

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

59. **Co-Payment** – The amount that a beneficiary or member must pay, usually a fixed amount of the cost of a service.

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

61. **Covered Services** - Those services and benefits to which the member is entitled under Hawaii's Medicaid programs.

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

63. **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.

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

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

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

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

68. **Dental Emergency** - An oral condition that does not include services aimed at restoring or replacing teeth and shall include services for relief of dental pain, eliminate acute infection, treat acute injuries to teeth or supportive structures of the oral-facial complex.

69. **Department of Human Services (DHS)** – The department of human services of the state of Hawaii, which includes the single state agency responsible for administering the medical assistance program.

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

71. **Director** - The administrative head of the department of human services unless otherwise specifically noted.

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

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

74. **Early and Periodic Screening, Diagnostic and Treatment (EPSDT)** – Early and periodic screening, diagnosis, and treatment services, to identify physical or mental defects in individuals, and, to provide health care, treatment, and other measures to correct or

ameliorate any defects and chronic condition discovered in accordance with section 1905r of the Social Security Act. EPSDT includes services to:

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

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

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

75. **Effective Date Of Enrollment** - The date as of which a participating health plan is required to provide benefits to an enrollee.

76. **Eligibility Determination** - An approval or denial of eligibility for medical assistance as well as a redetermination or termination of eligibility for medical assistance.

77. **Emergency Medical Condition** – The sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms, substance abuse) such that a prudent layperson, who possesses an average knowledge of health and medicine, services or immediate medical attention to result in:

a) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

b) Serious impairment to body functions;

c) Serious dysfunction of any bodily functions;

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

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

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

1. That there is inadequate time to 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.

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

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

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

81. **Enhanced Referral —** A formalized and pre-planned referral process designed to support behavioral health integration. The enhanced referral is aimed at improving referral initiation and follow-up, shared information and treatment planning, and shared communication between providers. The process supports improved access to services as well as better health outcomes. In a Stepped Care approach, referrals are bidirectional and geared towards treatment at the lowest level of care needed for quality outcomes.

82. **Enrollee** – An individual who has selected or been assigned by the department to be a member of a participating health plan.

83. **Enrollee (Potential)** – A Medicaid member who is subject to mandatory enrollment or may voluntarily elect to enroll in a Health Plan, who must make a choice on which plan to enroll into within a specified time designated by DHS. See also Member (Potential).

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

85. **Enrollment Fee -** The amount a member is responsible to pay that is equal to the spenddown amount for a medically needy individual or cost share amount for an individual receiving long term care services.

86. **Expanded Adult Residential Care Home (E-ARCH) –** A facility, as defined in section 11-100.1.2, HAR, and licensed by the department of health, that provides twenty-four 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 a nursing facility.

There are two types of expanded care ARCHs in accordance with Section 321-15.62, HRS:

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

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

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

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

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

90. **Federally Qualified Health Center (FQHC)** – An entity that has been determined by the Secretary of the DHHS to meet the qualifications for a federally qualified health center, as defined in section 1861(aa)(4) of the Social Security Act.

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

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

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

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

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

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

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

98. **Hale Ola –** Hale Ola pilots will serve as advanced health homes to provide comprehensive and coordinated care to the Special Health Care Needs Plus (SHCN+) population in select pilot areas. More description can be found in Section 3.7(J)(2).

99. **Hawaii Prepaid Medicaid Management Information System (HPMMIS)** – Federally certified Medicaid Management Information System (MMIS) used for the processing, collecting, analysis and reporting of information needed to support Medicaid and CHIP functions.

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

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

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

103. **Health Information Technology (HIT)** - Hardware, software, integrated technologies or related licenses, intellectual property,

upgrades, or packaged solutions sold as services that are designed for or support the use by providers, health care entities or patients for the electronic creation, maintenance, access, or exchange of health information. Source is ARRA - H.R.1 -115 Sec. 3000 (5).

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

105. **Health Plan** - Any health care organization, insurance company, accountable care organization, health maintenance organization, or managed care organization that provides covered services on a risk basis to enrollees in exchange for capitated payments. A Health Plan must meet the definition of a Managed Care Organization under this Section 2.3.

In this RFP, the Applicant intending to contract with DHS to perform the requirements of this RFP is referred to as a Health Plan.

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

107. **Health Plan Manual, or State Health Plan Manual -** DHS manual describing policies and procedures used by DHS to oversee

and monitor the Health Plan's performance, and provide guidance to the Health Plan.

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

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

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

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

112. **HIPAA –** The Health Insurance Portability and Accountability Act that 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 AS provisions also address the security and privacy of health information.

113. **Home and Community Based Services (HCBS) -** Long-term services and supports provided to individuals who meet nursing facility level of care to allow those individuals to remain in their home or community.

114. **Hospital** - Any licensed acute care facility in the service area to which a member is admitted to receive inpatient services pursuant to arrangements made by a physician. Acute care hospitals may additionally be designated as Critical Access Hospitals (CAH), as defined by the Medicare Rural Hospital Flexibility Program.

115. **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.

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

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

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

119. **Incurred Costs** - (1) Costs actually paid by a Health Plan to its providers for eligible services (for Health Plans with provider contracts); or (2) a percentage of standard charge to be negotiated with DHS (for Health Plans that provide most services in-house or for

capitated facilities), whichever is less. Incurred costs are based on the service date or admission date in the case of hospitalization. For example, all hospital costs for a patient admitted on December 22, 2014 and discharged on January 5, 2015 would be associated with the 2014 benefit year because the admission date occurred during that benefit year. All other costs apply to the benefit year in which the service was rendered.

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

121. **Indian** - The term ‘‘Indians’’ or ‘‘Indian’’, unless otherwise designated, means any person who is a member of an Indian tribe, as defined in this Section 2.3, except that, for the purpose of sections 1612 and 1613 of title 25 of the U.S. Code, such terms shall mean any individual who:

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

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

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

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

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

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

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

125. **Interperiodic Screens** - EPSDT screens that occur between the comprehensive EPSDT periodic screens for determining the existence

of physical or mental illnesses or conditions. An example of an interperiodic screen is a school-required physical examination as a prerequisite for a child to participate in school sports when a comprehensive periodic screen was performed on the child more than three (3) months earlier.

126. **Kauhale (community) On-Line Eligibility Assistance (KOLEA) System** - The State of Hawaii certified system that maintains eligibility information for Medicaid and other medical assistance beneficiaries.

127. **Long-Term Services and Supports (LTSS) –** A continuum of care and assistance ranging from in-home and community-based services for individuals 65 years or older and individuals with a disability(ies) who need help in maintaining their independence, to institutional care for those who require that level of support.

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

129. **Managed Care Organization (MCO)** – An entity that has, or is seeking to qualify for, a comprehensive risk contract 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 non-Medicaid members within the area served by the entity and (b) meets the solvency standards of 42 CFR 438.116 and Section 432-D-8, HRS.

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

131. **Marketing Materials** – Materials that are produced in any medium by or on behalf of a Health Plan and can reasonably be interpreted as intending to market to potential enrollees.

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

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

b. The State children's health insurance program (CHIP) under Title XXI of the Social Security Act; and

c. The section 1115 demonstration project under Title XI of the Social Security Act (42 U.S.C. subchapters XIX, XXI and XI).

133. **Medication Assisted Treatment (MAT)** - The use of U.S. Federal Drug Administration approved medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders.

134. **Medical Expenses** - The costs (excluding administrative costs) associated with the provision of covered medical services under a Health Plan.

135. **Medical Facility** – An inpatient hospital or outpatient surgical facility.

136. **Medical Loss Ratio (MLR)** - The ratio of the numerator, as defined in accordance with 42 CFR 438.8(e) to the denominator, as defined in accordance with 42 CFR 438.8(f).

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

medical condition. Sufficient evidence is provided when evidence is sufficient to draw conclusions, if it is peer-reviewed, is well-controlled, directly or indirectly relates the intervention to health outcomes, and is reproducible both within and outside of research settings.

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

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

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

141. **Medicare** - means the health care insurance program for the aged and disabled administered by the Social Security Administration under title XVIII of the Social Security Act.

142. **Medicare Special Savings Program Members** – Qualified Severely Impaired Individuals, Medical Payments to Pensioners, Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), Qualifying Individuals (QIs) and Qualified Disabled Working Individuals (QDWIs) who may be eligible to receive assistance with some Medicare cost-sharing.

143. **Member** – An individual who has been designated by the Med-QUEST Division to receive medical services through the QUEST Integration program and is currently enrolled in a QUEST Integration Health Plan. See also Enrollee.

144. **Member (Potential)** – A Medicaid member who is subject to mandatory enrollment and must choose a Health Plan in which to enroll within a specified timeframe determined by DHS. See also Enrollee (Potential).

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

146. **Mild to Moderate Behavioral Health Conditions –** Behavioral health conditions vary in severity and level of impairment from mild to moderate to severe. One of the Health Plan requirements is to implement behavioral health integration, and mild and moderate behavioral health conditions often treated through behavioral health integration models. Examples of mild to moderate behavioral health

conditions may include, but are not limited, to depression, anxiety, substance misuse, and Attention-Deficit/Hyperactivity Disorder (ADHD).

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

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

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

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

151. **New Member -** A member (as defined in this section) who has not been enrolled in a Health Plan during the prior six (6) month period.

152. **Non-Managed Care Med-QUEST Division programs** - Programs administered by the Med-QUEST Division outside of the managed care program such as FFS or SHOTT.

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

154. **Nursing Facility (NF) –** A free-standing or a distinct part of a facility that is licensed and certified to provide appropriate care to individuals referred by a physician. Such individuals are those who need twenty-four hour a day assistance with the normal 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 hours of skilled nursing care on an extended basis and regular rehabilitation services.

155. **Paraprofessional –** An unlicensed, licensed, or certified health care team member that provides person centered care, patient engagement, community resources, and culturally-competent care. A paraprofessional may include a medical assistant, community health worker, a peer support specialist or other specific titles, and

provides basic health care services in settings such as hospitals, health clinics, physical offices, nursing care facilities and patient homes.

156. **Partial Screens** - EPSDT screenings focused on one (1) or more specific conditions. An example of a partial screen is a vision or hearing screen needed to confirm the school's report of abnormal vision or hearing for a child. A partial screen includes making the appropriate referrals for treatment.

157. **Participating** - When referring to a Health Plan it means a Health Plan that has entered into a contract with DHS to provide covered services to enrollees. When referring to a health care provider it means a provider who is employed by or who has entered into a contract with a Health Plan to provide covered services to enrollees. When referring to a facility it means a facility that has entered into a contract with a Health Plan for the provision of covered services to members.

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

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

160. **Pay for Infrastructure (P4I) -** Refers to LAN Category 2A payments: Reimbursement for foundational payments for infrastructure and operations (e.g., care coordination fees and payments for Health Information Technology investments). See Section 7.2(B) for information about LAN Category 2A.

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

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

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

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

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

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

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

168. **Physician** – A licensed doctor of medicine or doctor of osteopathy.

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

170. **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.

171. **Practice Transformation –** Practice Transformation is a process designed to assist providers and practices with implementing change. The process often involves adapting or further developing quality improvement strategies in an effort to improve the experience of care, improve the health of populations, and/or better managing health care costs.

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

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

174. **Presumptive Eligibility -** Initial Medicaid eligibility given to a potential member or enrollee for a specified period of time prior to the final determination of their eligibility.

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

    a. Immunizations;

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

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

d. Support for self-management of chronic disease;

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

f. Screening for pregnancy intention as appropriate;

g. Counseling to support healthy living;

h. Support for lifestyle change when needed; and

i. Screening for behavioral health conditions.

176. **Preventive Services (Pediatrics and Adolescent Health) –** Services that can prevent or detect illnesses and disease in earlier, more treatable stages, thereby significantly reducing the risk of illness, disability, early death, and medical costs. This includes evidence-based screening and preventive interventions such as those recognized in Bright Futures guidelines issued by HRSA and the CDC, all screening, assessment, and preventive services covered by EPSDT, and DOH screening guidelines for tuberculosis. Additional examples of preventive services include:

a. Immunizations;

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

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

d. Support for self-management of chronic disease;

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

f. Screening for pregnancy intention as appropriate;

g. Counseling to support healthy living;

h. Support for lifestyle change when needed; and

i. Screening for behavioral health and developmental conditions.

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

178. **Primary Care Provider (PCP)** - A practitioner selected by the beneficiary to manage the beneficiary's utilization of health care services who is licensed in Hawaii and is:

i. 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;

ii. An advanced practice registered nurse with prescriptive authority. PCPs have the responsibility for supervising, coordinating and providing initial and primary care to

enrolled individuals and for initiating referrals and maintaining the continuity of their care; or

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

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

180. **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.

181. **Project ECHO™ (Extension for Community Healthcare Outcomes)** – A collaborative model of medical education and care management that increases access to specialty treatment in rural and underserved areas by providing to front-line clinicians the evidence-based knowledge and information on available resources and supports they need to manage patients with complex conditions (e.g. hepatitis C, HIV, tuberculosis, chronic pain, endocrinology, behavioral health disorders) by engaging clinicians in continuous learning and partnering them with specialist mentors.

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

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

184. **Provider** - Any licensed or certified person or public or private institution, agency or business concern authorized by the department to provide health care, service or supplies to individuals receiving medical assistance.

185. **Provider Grievance –** An expression of dissatisfaction made by a provider as described in Section 8.4(B).

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

187. **Quality Strategy** - A comprehensive plan to systematically and iteratively assess the quality of care provided to beneficiaries, use data gathered to identify gaps and opportunities for improvement,

set measurable goals and targets, identify evidence-based interventions to conduct targeted quality improvement, implement interventions, track implementation progress and effectiveness, and evaluate improvements in outcomes.

188. **QUEST Integration (QI) -** QUEST Integration is the managed care program that provides health care benefits, including long-term services and supports, to individuals, families, and children; the program serves both non-aged, blind, or disabled (non-ABD) individuals and ABD individuals, with household income up to a specified federal poverty level (FPL).

189. **Regional Health Partnership (RHP) -** A local community based regional network of community members, healthcare providers, and social services providers that establish working relationships to support delivery of an integrated continuum of care, including connections to non-medical, social services to a specific geographic area or market.

190. **Resident of Hawaii** - A person who resides in the State of Hawaii or establishes his or her intent to reside in the State of Hawaii.

191. **Request For Proposal (RFP)** – This Request for Proposal number RFP-MQD-2019-002.

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

193. **Rural Health Center (RHC)** - an entity that meets the qualifications for a rural health clinic, as defined in section 1861(aa)(2) of the Social Security Act.

194. **Rural Providers** – Primary medical care, dental or mental health providers who serve in a HRSA-designated Health Professional Shortage Area (HPSA). HRSA-designated HPSA can be found using the following website: http://hpsafind.hrsa.gov/.

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

196. **Service Coordination –** A service provided to members receiving LTSS/HCBS services. The service includes assessing, planning, coordinating, implementing, monitoring, and evaluating the options and services required to meet a member's healthcare needs using communication and all available resources to promote quality outcomes. Proper service coordination occurs across a continuum of

care, addressing the ongoing individual needs of a member rather than being restricted to a single practice setting.

197. **Service Coordinator** – An individual who coordinates, monitors and ensures that appropriate and timely care is provided to members receiving LTSS. For members receiving HCBS, the service coordinator shall develop the person-centered plan consistent with 42 CFR §441.301(c).

198. **Service Plan** – A person-centered written plan that is based on the LTSS Assessment and is written for individuals receiving Service Coordination. A service plan includes, but is not limited to, the following:

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

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

    c. Include a description of how the service plan will be coordinated with a care plan, if applicable to the individual.

    d. For individuals receiving home and community-based services (HCBS), the service plan shall be developed consistent with 42 CFR §441.301(c).

    e. The service plan is regularly reviewed and updated and agreed upon by the member or authorized representative with the entity providing service coordination.

199. **Significant Change -** A change that may affect access, timeliness or quality of care for a member (i.e., loss of a large provider group, change in benefits, change in Health Plan operations, etc.) or that would affect the member's understanding and procedures for receiving care.

200. **Social Determinants of Health (SDOH) -** Conditions in which people are born, grow, live, work and age that shape health. Socio-economic status, discrimination, education, neighborhood and physical environment, employment, housing, food security and access to healthy food choices, access to transportation, social support networks and connection to culture, as well as access to health care are all determinants of health. Hawaii state law recognizes that all state agency planning should prioritize addressing these determinants to improve health and wellbeing for all, including Native Hawaiians (ACT 155 (2014) HRS §226-20).

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

202. **State** - The State of Hawaii.

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

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

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

206. **Sub-Acute Care –** A level of care that is needed by an individual not requiring acute care, but who needs more intensive skilled nursing care than is provided to the majority of patients in a skilled nursing facility.

207. **Subcontract** - Any written agreement between the Health Plan and another party to fulfill the requirements of this RFP and contract.

208. **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.

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

210. **Substance Abuse and Mental Health Services Administration (SAMHSA)** - The agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

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

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

information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purpose of delivering enhanced health care services and information while a patient is at an originating site and the health care provider is at a distant site. Standard telephone contacts, facsimile transmissions, or e-mail text, in combination or by itself, does not constitute a telehealth service for the purposes of this definition.

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

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

215. **Transitions of Care** - The movement of patients between health care practitioners, settings, and home as their conditions and care needs change. For example, a patient might receive care from a PCP or specialist in an outpatient setting, then transition to a hospital physician and nursing team during an inpatient admission before moving to another care team at a skilled nursing facility.

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

217. **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.

218. **Value-added Services** – Under the federal Medicaid managed care rules (438.3(e)(1)(i)), services that are not covered under the state plan, but that a Health Plan chooses to spend capitation dollars on to improve quality of care and/or reduce costs. Value-added Services seek to improve quality and health outcomes, and/or reduce costs by reducing the need for more expensive care. The cost of Value-added Services cannot be included in the Capitation Rates; it can, however, be included in the numerator of the medical loss ratio (MLR) if it is part of a quality initiative.

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

Payment to providers with assigned responsibility for patient care, or a hybrid model.

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

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

2.4 Program Populations

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

A) *Medicaid Covered Populations*

1) Children Group (HAR §17-1715)
2) Former Foster Care Children Group (HAR §17-1715.1)
3) Pregnant Women Group (HAR §17-1716)
4) Parent or Caretaker Relatives Group (HAR §17-1717)

5) Individuals Receiving Transition Medical Assistance (HAR §17-1717.1)
6) Adults Group (HAR §17-1718)
7) Aged, Blind, and Disabled Group (HAR §17-1719)
8) Non-citizens or refugees (HAR §17-1723.2)
9) Individuals with breast and cervical cancer (HAR §17-1733.1)

B) *Non-Medicaid Covered Populations*

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

C) *Excluded Populations*

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

    a) Repatriates (HAR §17-1723.3);
    b) Medicare Savings Program Members and Qualified Disabled Working Individuals not eligible for full Medicaid benefits (HAR §17-1700.1-2);
    c) Enrolled in the State of Hawaii Organ and Transplant Program (SHOTT) (Section 4.12(A));
    d) Retroactively eligible only (HAR §17-1735.1); and
    e) Eligible under non-ABD medically needy spenddown (HAR §17-1730.1-11(1)).

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

2.5 Overview of the Department of Human Services (DHS) Responsibilities

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

1. Establish and define the medical, behavioral health, community integration, and LTSS benefits to be provided by the Health Plan;
2. Develop the rules, policies, regulations and procedures governing the programs;
3. Establish the Health Plan capitation rates;
4. Negotiate and contract with the Health Plans;
5. Determine initial and continued eligibility of members;
6. Enroll and disenroll members;
7. Provide benefits and services as described in Section 4;
8. Conduct the readiness review as described in Section 13 and determine if Health Plan is ready to commence services on the date described in Section 1.5.
9. Review and monitor the adequacy of the Health Plan's provider networks;
10. Provide routine and responsive feedback to improve data quality;

11. Oversee the development of DHS Quality Strategy;
12. Monitor the quality assessment and performance improvement programs of, and quality of data and reports submitted by, the Health Plan and providers, and provide routine and responsive feedback as needed;
13. Review and analyze utilization of services and reports provided by the Health Plan;
14. Participate in the State Administrative Hearing processes;
15. Monitor the Health Plan's grievance processes;
16. Monitor the financial status of the programs;
17. Analyze the programs to ensure they are meeting the stated objectives;
18. Manage the Hawaii Prepaid Medicaid Management Information System (HPMMIS);
19. Provide member information to the Health Plan;
20. Review and approve the Health Plan's marketing materials;
21. Review and approve all Health Plan materials that are distributed to their members;
22. Establish Health Plan incentives when deemed appropriate;
23. Oversee the activities of other DHS contracts, including but not limited to the SHOTT program contractor;
24. Oversee the activities of the ombudsman program which will be available to all Medicaid providers and Medicaid members to assure access to care, to promote quality of care and to strive to achieve provider and member satisfaction with QI;
25. Impose civil or administrative monetary penalties and/or financial sanctions for violations or Health Plan non-compliance with contract provisions;

26. Report criminal conviction information disclosed by providers and report provider application denials pursuant to 42 CFR 455.106(b);
27. Verify out-of-state provider licenses during provider enrollment and review and monitor provider licenses on an on-going basis;
28. Ensure that the Health Plan is not located outside of the United States;
29. Refer member and provider fraud cases to appropriate law enforcement agencies; and
30. Coordinate with and monitor fraud and abuse activities of the Health Plan.

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

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

D. DHS shall issue policy memorandums to offer clarity on policy or operational issues or legal changes impacting the Health Plan.

2.6 The Health Plan's Role in Managed Care & Qualified Health Plans

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

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

C. The Health Plan shall be properly licensed as a Health Plan in the State of Hawaii (See Chapters 431, 432, and 432D, HRS). The Health Plan is not required to 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 DHS.

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

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

2.7 Role of Stakeholders

A. During contract implementation activities, DHS will lead the development and administration of a statewide stakeholder process. DHS will provide a forum for member stakeholders to share information and collaborate on topics important to the strategic development of the HOPE initiative and overall improvement of the healthcare system in Hawaii.

B. The Health Plan shall participate in and provide representation for stakeholder workgroups, as required to fulfill the mission and goals of the advisory body. Activities for which the Health Plan will provide support include the implementation of the new approach to care delivery and coordination (Section 3), DHS Quality Program, VBP efforts, statewide SDOH Transformation Plan, and statewide HIT Innovation Plan (Sections 5 and 7).

C. DHS will seek to have a stakeholder process that represents a cross section of stakeholders selected to represent various facets of State government, providers, Health Plans, advocacy organizations, medical and social services providers with demonstrated knowledge, skills, and ability to advise DHS in meeting healthcare transformation and system-wide outcome improvements.

SECTION 3 – Approach to Care Delivery & Coordination

3.1 Overview

As a part of the HOPE initiative (Section 2.1), DHS intends to implement five (5) initiatives designed to improve care delivery and care coordination. The initiatives include:

a) Advancing Primary Care;
b) Supporting team-based care;
c) Implementing Prevention and Health Promotion;
d) Implementing the Stepped Care Approach; and
e) Addressing Social Determinants of Health (SDOH).

These initiatives are integrated into the established care delivery system and care coordination services as described in the following Sections 3.3 through Section 3.6. The Social Determinants of Health are addressed in Section 5.1.

3.2 Background

Primary care is the essential backbone of any health care system particularly for low-income populations. A strong evidence base suggests that investment in accessible, effective, and high-quality primary care has the potential to increase access to care, improve health outcomes, reduce healthcare costs, and increase provider and patient satisfaction. A strong primary care model assesses and addresses patient social needs as part of a whole person care approach. The types of social needs addressed are referred to as SDOH.

SDOH are the conditions in which people are born, grow, live, work and age that shape health. Socio-economic status, discrimination,

education, neighborhood and physical environment, employment, housing, food security and access to healthy food choice, access to transportation, social support networks and connection to culture, as well as access to health care are all determinants of health.

Hawaii state law recognized that all state agency planning should prioritize addressing these determinants to improve health and wellbeing for all, including Native Hawaiians (ACT 155 (2014) HRS §226-20).

The goals of advancing primary care and addressing SDOH cannot be fully realized unless there is a team-based approach that involves a range of clinical providers as well as nonclinical providers (for example, medical assistants, peer support specialists, community health workers, etc.). There is a strong body of research that shows that well-implemented team-based care has the potential to improve the comprehensiveness, efficiency, and effectiveness of care, which is why strategies to supporting team-based care are a core component of DHS' care delivery approach.

Lifestyle factors such as regular physical activity, not smoking, adopting a healthy diet, and maintaining a healthy body mass index are strongly associated with increased lifespan and reduced onset of preventable chronic diseases. That is why there is a strong emphasis in this procurement on primary, secondary, and tertiary prevention, which emphasize preventing illnesses onset through adoption of healthy behaviors; increased detection of illnesses and disease in earlier, more treatable stages through greater screening; and increased disease management to avoid tertiary complications. These strategies together can significantly reduce the risk of illness, disability, early death, and medical costs.

Appropriate utilization of services is also a primary goal of QUEST Integration. Therefore, the advancing primary care, addressing SDOH, supporting team-based care, and prevention and health promotion interventions are nested within the stepped care framework. The concept of stepped care (Von Korff and Tiemens, 2000) is that members can move fluidly up and down a continuum of services and that treatment level and intervention will be paired with the member level of acuity to provide effective care without overutilization of resources.

The integration of these five (5) initiatives results in a focus on proactive identification of need, early intervention and treatment, and access to the most appropriate level of care across the continuum.

DHS's goals are to continue to support and reward quality and performance within the existing primary care delivery system. DHS supports the formalization of partnerships between, and the development of referral networks among, primary care providers and behavioral health providers; these collaborations are expected to enhance referrals for additional behavioral health support where necessary, while reducing stigma and barriers to seeking behavioral health services.

For members who require additional care coordination and case management, DHS supports the provision of team-based care approaches in the community setting to the extent feasible; these approaches will identify and address patient SDOH needs. DHS encourages community-based solutions to evolve naturally across the healthcare landscape through a variety of strategies intended to augment existing capacity, supplemented with additional team-based care resources and/or telehealth capacity within communities to the extent to which such infrastructure is lacking.

To augment community-based SDOH resources, DHS will collaborate with Health Plans on statewide- and Health Plan-level SDOH transformation and work plans, the principles of which are firmly embedded within a whole-person focused Medicaid Managed Care Strategy.

DHS intends to enhance overall investments by the Health Plan in primary care across all these areas, including necessary infrastructural supports.

More specifically, DHS intends to implement these activities:

a) Increasing the proportional investment in primary care;
b) Supporting and augmenting PCMHs, CHCs, and clinically integrated health systems, and other entities in the provision of optimal care;
c) Enhancing community-based approaches to team-based care delivery;
d) Supporting improved care coordination and supports for members with Special Health Care Needs (SHCN);
e) Creation of an advanced health home model called Hale Ola, to support those with more intensive needs within the Special Health Care Needs Plus (SHCN+) population;
f) Supporting behavioral health integration across the continuum;
g) Fostering the use of regional enhanced referral networks to formalize linkages from primary care to behavioral health providers;
h) Investing in prevention and health promotion;
i) Supporting strategies to address the social determinants of health at the community- and patient-level;
j) Using telehealth technology to improve access to care; and

k) Seeking authority from CMS to add or revise covered services to support these efforts.

3.3 Health Plan Requirements to Advance Primary Care

A) *Supporting Patient-Centered Medical Homes (PCMH)*

The PCMH is a model to facilitate the provision of high-quality, integrated, and efficient outpatient care. The health plan shall implement and expand a PCMH model that is based on the domains of patient-centered, accessible, comprehensive, coordinated, evidence-based, and performance measurement.

Patient Centered:

1. Include patient, and family as appropriate, in shared decision making with the provider
2. Provide culturally sensitive and competent care including language access
3. Provide processes to promote patient self-management
4. Refer to community resources/supports as indicated

Accessible:

- Address patients' concerns in a timely manner
- Maintain open scheduling and/or expanded office hours
- Maintain after hours accessibility
- Develop and maintain multiple options for communication

Comprehensive:

1. Maintain a whole person orientation

2. Be first contact for undifferentiated problems
3. Be responsible for addressing the vast majority of physical and behavioral health care needs
4. Provide preventive, acute, and chronic care

Coordinated:

1. Provide or ensure provision of care across health care spectrum of services and settings
2. Track and follow up on tests and referrals
3. Facilitate transition of care and reconcile service plans
4. Identify high-risk patients

Evidence-Based:

1. Adopt and implement evidence-based guidelines
2. Utilize evidence-based clinical decision support tools
3. Proactively manage evidence-based population health and disease management
4. Implement effective practice organization and workflow processes

Performance Measurement:

1. Utilize electronic health record with registry functionality
2. Utilize validated measures, particularly patient-oriented outcome measures when possible
3. Report on performance
4. Have continuous quality improvement processes

The health plan shall ensure that Tier 1 and Tier 2 PCMH appropriately support elements for each of these domains. The health plan shall at a minimum recognize the following medical home criteria:

Tier 1 PCMH: To be considered a Tier 1 PCMH, a provider/practice must meet three elements for each of the domains of patient centered, accessible, comprehensive, and coordinated; and must meet two elements for each for the domains of evidence-based and performance measurement. NCQA PCMH level 1 recognition, Accreditation Association for Ambulatory Health Care certification, and URAC's Patient Centered Medical Care Home achievement shall be considered to meet these requirements.

Tier 2 PCMH: To be considered a Tier 2 medical home, a provider/practice must meet all elements for each of the domains of patient centered, accessible, comprehensive, and coordinated; and must meet three elements for each for the domains of evidence-based and performance measurement. National Committee for Quality Assurance (NCQA) PCMH level 2 or 3 recognition and Accreditation Association for Ambulatory Health Care accreditation shall be considered to meet these requirements. In addition, the provider/practice must meet the Office of the National Coordinator requirements for meaningful use of an electronic health record that includes exchanging vaccination information with the Department of Health.

DHS will establish, and the health plan will participate in, a stakeholder process that will develop an aligned certification process for Tier 1 and Tier 2 providers. However, DHS shall make the final determination to certify a provider. In addition to establishing a recognition "floor," an exception process will be developed that will allow the health plan to submit a waiver from this requirement when the health plan can demonstrate that its Value-Based Payment strategy has moved PCPs further along the Healthcare Payment Learning and Action Network

Alternative Payment Model Framework continuum either in payment methodology or model sophistication in accordance with Section 7.2(B). The stakeholder process will determine the parameters of the waiver, including the methodology for determining progress along the LAN continuum. DHS shall make the final determination regarding the parameters of the waiver.

B) ***Advancing Primary Care Initiative***

To achieve DHS goals, the Health Plan shall support the vision of devoting resources to advancing primary care. To this end, the Health Plan must increase investment in, support of, and incentivization of, primary care in three concentric definitions.

a) In the narrowest sense, primary care is the provision of care in the outpatient setting by primary care providers.

b) A broader definition includes the provision of preventive services, including behavioral health integration, in the primary care setting.

c) In the broadest definition, primary care additionally includes the wrap-around support services including team-based care and SDOH supports that augment and enhance the provider's capacity to manage the patient's care in the outpatient setting.

The Health Plan shall be responsible for tracking its primary care spend using measures corresponding the concentric definitions provided by DHS. The Health Plan may be engaged in providing feedback and input on the measure definitions. For each definition of primary care spend, baseline spend will be used to set annual targets to enhance spending in primary care.

Once primary care measure definitions have been developed, Health Plans shall be accountable for demonstrating increased investment and spending across all three definitions. Health Plan results on Advancing Primary Care Initiative measures may be part of the Quality Program described in Section 5 and may be included in the Incentive Strategies for Health Plans described in Section 7.1(B).

DHS may modify the definitions as needed to accommodate initiatives that seek to expand primary care and support stabilization of members in the ambulatory care setting.

3.4 Health Plan Requirements for Supporting Team-Based Care

DHS' strategies to support team-based care are included in many sections in this procurement. Some of the strategies include allowing paraprofessionals to be a part of the care team, more flexibility in staffing requirements for CSC, more flexibility in value-based purchasing, etc.

Another way DHS supports team-based care is through Project ECHO. Project ECHO is an innovative medical education and mentoring model that builds provider capacity with multidisciplinary teams while improving access to specialty care. Project ECHO increases access to specialty treatment by providing front-line clinicians and non-clinicians with the knowledge and support needed to manage members with complex conditions.

The Health Plan shall support Project ECHO, in accordance with DHS guidance, requirements and standards, including but not limited to, paying its fair share of administrative costs to Project ECHO programs

serving Hawaii providers, as approved by DHS. In addition, the Health Plan shall:

- Work collaboratively with Project ECHO programs;
- Promote Project ECHO to providers; and
- Support the evaluation of Project ECHO programs.

DHS will provide additional guidance and information about the administrative costs and other programmatic information during the contract period.

3.5 Health Plan Requirements for Prevention and Health Promotion

A. In addition to preventive services that the Health Plan is required to provide to adults and children (Section 2.3 and Section 4.2), the Health Plan is required to have a Prevention and Health Promotion Program (PHPP).

B. The purpose of the PHPP is to:

1. Prevent or delay the onset of chronic diseases for members who are at risk of developing chronic diseases and would benefit from lifestyle change interventions; and
2. Improve self-management of chronic or medical conditions for members who have chronic condition(s) and would benefit from enhanced self-management (SM) strategies including SM plans and SM education.

C. The Health Plan shall have a program for the prevention and management of diabetes. The Health Plan shall have at least one (1) other prevention and management program starting the second year of the contract for one (1) of the following conditions: asthma, heart disease, hypertension, high-risk pregnancy, or obesity. However, the Health Plan may request approval from DHS to change the one (1) other program to address a different medical condition based upon member needs.

D. The Health Plan's PHPP shall:

1. Have a systematic method of identifying and enrolling members in each program;
2. Utilize evidence-based clinical practice guidelines to support enhanced disease prevention and self-management;
3. Emphasize the prevention of exacerbation and complications of pre-chronic and chronic/medical conditions;
4. Support members in adopting healthy lifestyle and self-management practices as appropriate;
5. Incorporate educational components for both members and providers;
6. Take a patient-centered approach to providing care by addressing psychological aspects, SDOH, 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 motivational interviewing, disease and dietary education, supports for tobacco cessation as appropriate, encouragement of increased physical activity, instruction in health self-management, and medical monitoring;

9. Have established measurable benchmarks and goals which are specific to the prevention and management of each disease and use these 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.

E. The Health Plan may collaborate with DOH, community organizations, national organizations, and other entities. The Health Plan is also allowed to collaborate with other Health Plans under DHS' supervision.

F. The Health Plan shall develop policies and procedures for its PHPP for DHS' review and approval in accordance with Section 13.3(B), Readiness Review. The Health Plan will be required to provide reports on PHPP to DHS. The Health Plan shall annually review the PHPP and revise as necessary based upon new treatments and innovations in the standard of care and submit the policies and procedures for DHS review and approval.

G. The Health Plan may contract with other entities and providers; however, the Health Plan is ultimately responsible for implementation

of its PHPP. The Health Plan shall have a plan to ensure duplicative services are not provided to members receiving CSC services.

H. DHS may provide additional guidance during the contract period.

3.6 Health Plan Requirements for a Stepped Approach to Behavioral Health

During the course of the contract period, Health Plans shall develop a stepped care approach to behavioral health needs for all adult and child members as described in Section 3.2.

Behavioral Health Stepped Care shall include a four-pronged strategy to strengthen primary care and behavioral health integration as a foundation of stepped care:

a) Regional Enhanced Referral Networks;
b) Hawaii Coordinated Additional Resource Entry System (CARES);
c) Effective Primary Care and Behavioral Health Integration; and
d) Ongoing Assessment of Stepped Care Approach to Behavioral Health

DHS will provide additional guidance on Stepped Approach to Care during the first year of the contract. Additionally, the development of the Hale Ola will be a support for the stepped care approach (See Section 3.7(J)(2)).

A) *Regional Enhanced Referral Networks*

The Health Plan shall develop regional enhanced referral networks of primary care and behavioral health providers. The Health Plan shall:

1) Identify the primary care, mental health and substance use providers in a shared geographic area to build an enhanced referral network. All service areas need to be included in at least one region.
2) Develop a process for relationship development between providers with a shared understanding of treatment service and capacity across organizations within the region.
3) Collaborate with other Health Plans to develop standardized resources to streamline administrative time for providers, including the following shared tools to support enhanced referral:
    a) Referral form
    b) Care compacts
    c) Tracking of referral outcomes
4) Provide support for provider-driven decisions about the need for referral (or a change in level of care) through care coordination and care management.
    a) Support identification, eligibility determination and referral for the Hale Ola (Section 3.7(J)(2)) in specific pilot regions.
5) Be accountable for bidirectional referral processes ensuring timely and effective referral and access to whole person services for members with behavioral health conditions (including access to primary care and specialty mental health and substance use services).
6) Provide access to a provider network that accommodates the members while reflecting the regional variation of services.
    a) The Health Plan shall take into account the following in developing of the networks:
        i) Utilization (including hot spotting of high need areas) and travel patterns;

ii) Availability of specialty behavioral health services and alternative solutions such as telehealth, Project ECHO, and other virtual innovations to support whole member care;
iii) Continuing of care; and
iv) Regional presence of the Hale Ola.

7) Collaborate with providers and other Health Plans to collect data on referral process and reporting to DHS. Sample process metrics regarding enhanced referral for reporting include:
   a) Screening of mental health, substance use and developmental progress in primary/pediatric services;
      i) Number of members identified with need for referral through screening;
      ii) Number of members identified with need for referral through other process (tracking process)
   b) Number of referrals between providers;
   c) Time between referral received and services initiated;
   d) Portion of referrals which result in a behavioral health visit; and
   e) Number of care compacts developed between providers.

DHS shall develop specific reporting requirements and submission formats as described in Section 6.

B) *Hawaii Coordinated Addiction Resource Entry System (CARES)*

DOH Alcohol and Drug Abuse Division (ADAD) is developing the Hawaii CARES program that will provide services such as addiction care coordination, screening, assessment, intake placement determination, and referral. The intent of the program is to provide a re-designed, coordinated and responsible system of care, and the goal is to reduce

all barriers to treatment and recovery support services in the continuum of care.

Health Plans shall collaborate with DOH on implementation of Hawaii CARES. Additionally, the Health Plans shall participate in the training, data collection, and evaluation when feasible to ensure that statewide substance abuse resources are utilized in the most effective and efficient manner possible.

DHS will provide additional guidance on how the Health Plans are to collaborate and support the effort during the first year of the contract.

C) *Effective Primary Care and Behavioral Health Integration*

DHS is invested in statewide implementation of integrated primary and behavioral health care. This requires support for PCPs and Behavioral Health Practices.

1. The Health Plan is responsible for supporting primary care provider implementation of effective integrated care using evidence-based models approved by DHS such as the Collaborative Care Model (CoCM).

   Across its service area, the Health Plan is responsible for identifying areas with higher prevalence of mild to moderate behavioral health need (potentially through hot-spotting or utilization-based techniques) and developing provider capacity for comprehensive integrated care services including primary care, mental health and substance use treatment services under a single entity.

DHS does not expect all primary care providers in the state to engage in full integrated care; however, by year 3 of the Contract all primary care practices are expected to have universal screening for mental health, substance use and developmental issues (in pediatric practices) and, at a minimum, enhanced referral for behavioral health services.

In areas with greater behavioral health need (identified by the Health Plan through hot-spotting and other risk stratification techniques), the Health Plan shall develop capacity for effective integrated care models to provide greater access to behavioral health services, treating mild to moderate behavioral health conditions (including but not limited to Medication Assisted Treatment (MAT)).

In support of these efforts, the Health Plan shall:

a. Develop practice transformation approach and plan for supporting statewide implementation of effective integrated care;
b. Conduct an assessment and plan for where effective integrated care is needed based on population risk stratification, analysis of behavioral health need, and regional provider capacity.
c. Develop plan for building primary care capacity to provide effective integrated care.
d. Develop plan for building statewide primary care capacity to provide MAT for substance use.

2. The Health Plan shall support effective implementation of integrated care through training and technical assistance for providers. Specifically, the health plan shall:

    a. In partnership with DHS and other Health Plans, develop shared learning collaboratives for providers to learn from one another and leverage successful implementation.
    b. Support effective implementation of collaborative and integrated care through development of infrastructure, data reporting, and billing capacity (including billing of CoCM codes).
    c. Develop paraprofessional training programs to support workforce for broader implementation. For example, in the CoCM, behavioral health manager roles can be filled by Medical Assistants and Peer Support Specialists.
    d. Develop telehealth and consultation solutions for practices in rural and neighbor islands to build integrated care through non-local workforce and expand provider capacity;
    e. Be accountable for effective integrated care and collect and report on data and process and outcome performance measures for integrated care defined by DHS such as the following metrics:
        i. Number of members identified with mild to moderate behavioral health need through screening; and
        ii. Prevalence of follow-up intervention (brief interventions) provided in primary care.

f. The Health Plan is responsible for sharing lessons learned in implementation (including challenges or adaptations required) with DHS, other Health Plans and providers to support provider development.

3. Technical Assistance for Behavioral Health Practice Transformation

   The Health Plan shall provide practice transformation for behavioral health providers, including both clinical and operational development, to advance the quality of behavioral health service statewide. Practice transformation for behavioral health providers include areas such as:

   a. Expanding evidence-based treatment approaches;
   b. Engaging measurement based care to inform treatment decisions;
   c. Expanding infrastructure in information technology, health information exchange, and data and reporting; and

   d. Preparation for value based payment.

D) *Ongoing Assessment of Stepped Care Approach to Behavioral Health*

In support of statewide implementation of integrated care in contract years 2 and 3, the Health Plan shall:

1) Assess the first two years of care coordination and stepped care transitions and provide DHS with a plan for enhancement or

changes to the model to support quality transitions to the right level of care.

2) Develop a report for DHS on existing gaps in the stepped care model (missing services) across mental health and substance use continuum of services.
3) Refine telehealth or other virtual solutions for effective integrated care.
4) Develop technical assistance for all primary care providers (even those without integrated care) to enhance treatment of mild to moderate behavioral health conditions (i.e. health promotion and self-management techniques, education on risky behaviors, and behavior change for well-being) to support lower level behavioral health needs.
5) The Health Plan shall work collaboratively with other Health Plans to:
    a) Provide continued training and technical assistance to primary care providers implementing collaborative care, including development of a provider manual for collaborative care;
    b) Streamline the administrative process for members transitioning from one plan to another to ensure that treatment within collaborative care is not disrupted and providers can continue to focus on delivering care;
    c) Develop standardized reporting templates so that data across providers is collected in the same format for all members.

3.7 Care and Service Coordination (CSC) System

A CSC System has the potential to improve the effectiveness, safety, and efficiency of the health care delivery system. A well-designed CSC System includes a whole-person/whole-family approach, while

synchronizing and integrating the delivery of health care from multiple entities throughout the continuum of care. An effective CSC System is able to address the multifaceted needs of populations with complex medical and social conditions including behavioral health conditions, and applies the Stepped Care approach (Section 3.6) which allows members to move up and down a continuum of services as needed. The Health Plan shall incorporate these characteristics throughout their CSC System.

The Health Plan shall have a CSC System that complies with the requirements in 42 CFR 438.208 and this Section (Section 3.7). The Health Plan's CSC System is subject to DHS approval. The Health Plan must provide appropriate CSC support across multiple settings and across the continuum of care with the focus on improving health care outcomes and decreasing inappropriate utilization. The Health Plan must provide whole-person and person-centered CSC services that meet the needs of vulnerable populations including but not limited to SHCN members and members receiving LTSS, HCBS, CCS, CIS, etc.

Any changes to CSC policies and procedures must be submitted to DHS thirty (30) days prior to implementation of the change(s). Changes must be approved by DHS prior to implementation.

A) *General Description of CSC System Services*

1) Care Coordination

a) Care Coordination shall be provided to members who meet the SHCN and SHCN+ criteria (Section 3.7(E)). There are two levels of Care Coordination:

1. Care Coordination

a) Care Coordination services are provided to all members that:

1. Are included in the target population described in (Section 3.7(E); or
2. Meet target SHCN+ population description (Section 3.7(E) but a Hale Ola isn't available where they reside; or
3. Meet the target SHCN+ population but opt out of enrolling with the Hale Ola.

2. Intensive Care Coordination

a) Intensive Care Coordination (ICC) services (Section 3.7(J)(2).) are provided to members that meet the SHCN+ target population description (Section 3.7(E)(4)), have access to a Hale Ola where they reside, and consent to enroll with the Hale Ola.

2) Service Coordination

Effective service coordination is important for members receiving LTSS or Home and Community Based Services (HCBS) because they interact frequently with the health care system, have physical or cognitive limitations that require ongoing supports, and often have chronic conditions that require continuous monitoring. Service coordination is a process to assess, plan, coordinate, and monitor LTSS and HCBS services. DHS expects that service coordination planning is coordinated with any care coordination planning, as is

applicable to the individual to ensure that the whole person needs are met.

The Health Plan must comply with conflict-free case management and other HCBS setting rules. Consistent with Medicaid HCBS requirements at 42 CFR §441.301(c)(1)(vi), providers of HCBS for a member, or those who have an interest in or are employed by a provider of HCBS for the member, must not provide case management or service coordination for that member, nor should such a provider develop the person-centered service plan. The Health Plan must also comply with all HCBS rules related to the Open Vendor Model (Section 12.2(B)).

B) ***CSC Services at the Site of Care***

The Health Plan must have the ability to provide a robust system of local CSC services that is performed at the site of care, in the home or in the community where face-to-face interaction is possible. CSC should be led by providers and located where the member and providers are located. The specific requirements include:

1. Care Coordination - The Health Plan shall subcontract care coordination services to providers and/or advanced PCMHs to the greatest extent possible. The Health Plan may subcontract some services to the PCP and some service to another provider. The Health Plan is encouraged to delegate SHCN Assessment responsibilities to PCPs when feasible. The Health Plan must provide payment to providers for these functions.

2. Intensive Care Coordination (ICC) - The Health Plan must delegate ICC services to Hale Ola where they exist. In instances when a PCP is willing and able to do the Assessment and is not within the Hale Ola, the Health Plan may delegate that responsibility to the PCP. The Health Plans must provide payment to providers for these functions.
3. Service Coordination – The Health Plan may delegate LTSS service coordination to qualified providers to the greatest extent possible. The Health Plan must be compliant with conflict-free case management rules and other HCBS rules (Section 3.7(A)(2)). The qualified providers may include Community Care Management Agencies (CCMA) when appropriate.

The Health Plan will complete a statewide assessment within the first quarter of the contract to determine which PCPs/PCMHs are willing and able to administer the SHCN Assessment and provide other care coordination services (including extent of services as applicable) for their members. The Health Plan may collaborate with other Health Plans under DHS' supervision to complete a statewide assessment. The Health Plan may be required to provide the results of assessment to DHS.

The Health Plan is accountable for the CSC System and responsible for oversight and monitoring of all functions. The Health Plan is also accountable for ensuring coordination among CSC services and providers and staff when the member is receiving multiple services.

The Health Plan shall ensure that Health Plan employees and staff of subcontracted entities involved in care and service coordination in the CCS System participate in ongoing training on person-centered practices. The Health Plan shall collaborate with other Health Plans

under DHS' supervision to develop such training programs and standards. DHS shall approve Health Plan training protocols and standards for person-centered practices. DHS will provide additional guidance on the person-centered training and practices during the contract period.

DHS may provide additional guidance regarding Health Plan accountabilities and responsibilities within the CSC System to align with Hawaii's implementation of innovative delivery systems that migrate these functions closer to the provider level as warranted. DHS shall inform the Health Plan of any changes at least ninety (90) days prior to implementing the change.

C) *Coordination across Services and Payers*

Members eligible for CSC services have complex conditions and frequently receive services through multiple entities and programs across the continuum of care. To facilitate the efficient administration of DHS' programs and other resources, and to enhance the treatment of members that need multiple services, the Health Plan must develop and implement a plan to efficiently coordinate services when members receive multiple services. Examples of the services, supports or programs include but are not limited to SHCN, LTSS, CIS, CCS, DHS and DOH services, hospice, and community-based programs and services.

In instances when a member is eligible for both SHCN and LTSS, I/DD, CIS or other services, the member may receive both Care Coordination and Service Coordination. The Health Plan is accountable for ensuring compliance with this Section (Section 3.7), the quality and appropriateness of care furnished, and that there is no duplication of

services. DHS will monitor Health Plan compliance to ensure the quality and appropriateness of care furnished, and an absence of duplication of services.

Dual eligible members that are found to have SHCNs or are receiving LTSS (to include At-Risk HCBS) shall receive their care coordination through the applicable category.

Dual eligible members that are in a D-SNP for both their Medicare and Medicaid services may have their CSC services through their D-SNP Health Plan.

The Health Plan must work with dual eligible members to coordinate Medicare fee-for-service services for dual eligible members that are not in a D-SNP.

DHS may provide additional guidance on coordination across multiple programs and expectations of roles and responsibilities during the contract period.

D) *Identification of Population*

The Health Plan shall have multiple methods to identify targeted populations that would benefit from CSC services. The Health Plan shall have:

i. Advanced data analytic capabilities to identify members that meet CSC criteria (Section 3.7(E)-(F)). The Health Plan may use risk scoring methodologies and stratification to identify the populations. The analytic methodology must take into account, at a minimum, the following information:
    a) Claims data and history;

b) Real-time data from hospital notifications, pharmacy utilization data and other sources to identify members who are accessing services but are not engaged in primary care;
c) CSC Assessments and screeners;
d) Lab results

ii. Welcome Call or member survey process to screen and identify members (Section 9.2(B));

iii. A process to accept referrals from external entities. The Health Plan does not have to approve the referral if the member does not meet the CSC criteria. Examples of external entities that may refer members to the Health Plan include:
a) Providers;
b) Hospitals;
c) Community-based organizations;
d) DHS and DOH agencies and programs (i.e. Child Welfare Services, CAMHD, ADAD, etc.); and
e) Members and their authorized representatives.

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

DHS may allow or require the Health Plan to use a standardized short eligibility screener (not an assessment) in instances when additional information is needed from the member, the member's PCP, or other sources to determine if the member meets the SHCN or SHCN+ target criteria.

Dual members shall be included in this analysis.

Health Plans shall have a process in place to identify and refer children/youth that are unstable, of moderate-high risk, and in need of the SEBD program to CAMHD (Section 4.4(A)). Additionally, the Health Plans shall have a process in place to identify and refer I/DD children and adults to DDD (Section 4.12(B)).

DHS will also use data analytics and other methods to identify members. DHS may require the Health Plan to provide or terminate CSC services to members based on DHS' analysis.

DHS may provide additional guidance on the requirements to identify CSC populations as the CSC System evolves during the contract period.

A bidirectional mechanism will be established to enable the health plan to notify DHS, and vice versa, about beneficiaries identified for and receiving various types of CSC services.

E) *Target Population – Care Coordination*

1) Special Health Care Needs (SHCN) and Special Health Care Needs Plus (SHCN Plus)

a) In general, individuals with SHCN are segmented into two levels:

1. **SHCN** - A member who has chronic physical, behavioral, developmental, or emotional conditions that require health related services of a type of amount that is beyond what is required of someone of their general age.

2. **SHCN Plus** - A member who has complex, costly health care needs and conditions, or whose risk of developing these conditions is imminent. The members that meet

the SHCN+ criteria are considered to be highly impactable, meaning they are likely to benefit from the Hale Ola services.

2) Special Health Care Needs – Children

a) A child with SHCN is a member under twenty-one (21) years of age who fall into one or more of the following groups:

1. Children who become pregnant;
2. Children with at least one chronic condition such as asthma, diabetes, hypertension, chronic obstructive lung disease;
3. Children with cancer, Hepatitis B, Hepatitis C, HIV/AIDS, or tuberculosis;
4. Children who take medications for any serious behavioral/medical conditions that has lasted, or is expected to last, at least (12) months (excludes vitamins and fluoride);
5. Children who are limited in their ability to do things that most children of the same age can do because of a serious medical/behavioral health condition that has lasted or is expected to last at least twelve (12) months (i.e. need assistance with one or more ADLs);
6. Children who need or receive treatment or counseling for an emotional, developmental, or behavioral problems that has lasted or is expected to last at least twelve (12) months;

7. Children who need or receive speech therapy, occupational therapy, and/or physical therapy for a medical condition that has lasted or is expected to last at least twelve (12) months;

8. Children with social conditions such as homelessness or who have multiple Adverse Childhood Events (ACE);

9. Children being discharged from an acute care setting when the length of is greater than ten (10) days during a six (6) month period;

10. Children with multiple hospital and emergency department visits during a six (6) month period.

11. Children that have any other combination of conditions that have a moderate to high level of severity, and those conditions are not included in the SHCN Plus target group populations.

3) Special Health Care Needs – Adults

a) An adult with SHCN is a member who is twenty-one (21) years of age or older that fall into one or more of the following populations:

b) Adults with high risk pregnancies;

c) Adults with an untreated or unmanaged chronic medical condition (i.e. asthma, diabetes, and chronic obstructive lung disease);

d) Adults with untreated or unmanaged behavioral health conditions, including substance use;

e) Adults with social conditions such as homelessness;

f) Adults whose use of prescription medication includes the use of atypical antipsychotics, the chronic use of opioids, the chronic use of polypharmacy (e.g. five (5) or more prescription medications), and other chronic usage of specific drugs that exceed the use by other adults in the Health Plan as identified by the Health Plan;

g) Adults with chronic Hepatitis B, chronic Hepatitis C, late stage HIV/AIDS, or active tuberculosis;

h) Adults being discharged from an acute care setting with a length of stay of ten (10) days or longer during a six (6) month period;

i) Adults with multiple hospital or emergency department admissions during a six (6) month period, with one or more admission occurring within 30 days of previous admission.

j) Adults that have any other combination of conditions that have a moderate to high level of severity, and those conditions are not included in the SHCN Plus target population groups.

4) Special Health Care Needs Plus – Adults and Children

A member of the SHCN+ population is a member who has:

a) A Serious Mental Illness (SMI) – Individuals with one or more serious and persistent behavioral health conditions, including a diagnosable mental, behavioral, or emotional disorder which

results in serious functional impairment and substantially interferes with or limits one of more major life activities; or

b) A Substance Use Disorder (SUD) – Individuals with SUD which include recurrent use of alcohol and/or drugs that causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school or home; or

c) Two or more of the following physical conditions:
    1) Asthma;
    2) Chronic obstructive pulmonary disease (COPD);
    3) Coronary heart disease (CAD);
    4) Congestive heart failure (CHF);
    5) Diabetes;
    6) Obesity;
    7) Chronic renal disease;
    8) Chronic liver disease;
    9) Members receiving palliative care; or

d) One of the identified chronic health conditions listed above and one impairment in an ADL; or

e) One of the identified chronic health conditions listed above and identified social determinant of health needs and/or high utilization of health services, including emergency department utilization; or

f) For members who have access to another form of CSC or other service, the following criteria must be met:
    1) The Hale Ola will provide additional services that otherwise are not available;
    2) The Hale Ola services are likely to have an impact on the member's health outcomes;

3) The Hale Ola services are not duplicative of the other services the member is receiving.

g) However, the SHCN+ population does not include members who meet the above SHCN+ criteria and meet one of the criteria listed below:

1) Members in a long-term nursing facility for more than ninety (90) days;
2) Members receiving hospice care;
3) Members in the transplant program; and/or
4) Fee-for-service members.

F) *Target Population – Service Coordination*

The Health Plan or subcontracted entity shall perform an assessment (Section 3.7(H)) to determine the health and functional capability of the member and the appropriate strategies and services to best meet the LTSS needs. The scope, duration and amount of HCBS should be based upon the individual assessment, medical necessity and person-centered service plan.

The member is eligible to receive Service Coordination for the entire duration the member is receiving LTSS benefits.

G) *Opting Out of Services*

Members, including dual eligible members, may opt out of care coordination either verbally or in writing.

Members, including dual eligible members, receiving LTSS may opt of service coordination. However, service coordination must be provided for members receiving HCBS.

The Health Plan must maintain documentation of members that have opted out of care or service coordination and report this information to DHS as requested.

H) *Assessments*

1) Assessments

a) The Health Plan must complete an assessment with all SHCN, SHCN+, and LTSS members. Assessments are instruments that are used to collect health status, health conditions, SDOH, and other information.

b) The Health Plan shall use three standardized assessments that are approved by DHS. Each assessment is tailored to the specific population needs (SHCN, SHNC+, and LTSS), will include sections tailored for adults and children, and the assessments will vary in length and complexity.

1. SHCN Assessment – This assessment will be completed with SHCN members.

2. SHCN+ Assessment – This assessment will be completed with SHCN+ members.

3. LTSS Assessment – This assessment will be completed with LTSS members. This assessment will include additional components to assess functional capability, including but not limited to:

a) A review of the member's physical, cognitive, and bodily systems including vital signs and blood pressure, if necessary;

b) A review of daily functioning in activities of daily living and instrumental activities of daily living, medications, treatments, risk for falls, history of emergency department visits, environment, available supports, and medical history of each member.

c) DHS will provide an opportunity for the Health Plans to provide comments on the SHCN, SHCN+, and LTSS assessments before the start of the Contract.

d) The Health Plan may request to use more comprehensive assessment tools approved by DHS for the SHCN, SHCN+, and LTSS population.

e) The assessments and screeners may be updated by DHS at least annually.

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

g) The SHCN, SHCN+ and LTSS assessments will be shared fully with the member's PCP and care team as needed to enhance communication and collaboration to serve the needs of the member with member consent.

h) If it is determined through the assessment process that the member does not require CSC services, the Health Plan shall document that determination and will not be required to provide CSC services. Members shall be re-evaluated if they are re-identified to be potentially eligible for CSC, or if SHCN members

are identified to be potentially eligible for SHCN+, due to health-related changes. Similarly, using a stepped care approach, re-evaluation is also expected as necessary to step down a member's eligibility for CSC services as needed.

2) Frequency and Timing of Assessments

a) For SHCN including Dual Eligible members receiving these services:

1. The Health Plan shall conduct an assessment within forty-five (45) calendar days of identification. The assessment can be done face-to-face or through an alternative communication method preferred by the member (e.g. telephone, email, text, video chat, etc.).

2. The reassessment shall occur through a face-to-face visit or through a communication method preferred by the member (e.g. telephone, text, email, video chat, etc.):

    a) At least every 12 months; or

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

    c) Within ten (10) days of when the reassessment is requested by the member.

b) For SHCN Plus, and LTSS Members, including Dual Eligible members receiving these services:

1. The Health Plans shall undertake best efforts to conduct a face-to-face assessment within fifteen (15) calendar days of identification of SHCN+, and LTSS members as described in Section 3.7(H).
2. The face-to-face reassessment shall occur:
    a) At least every 12 months; or
    b) Within ten (10) days when the member's circumstances or needs have changed significantly; or
    c) Within ten (10) days when member requests a reassessment.

I) *Provision of CSC Services*

1) Care Plans for SHCN and SHCN+ Populations

a) Care Plans shall be developed for each member receiving care coordination. The care plan will be based on the SHCN and SHCN+ Assessments and developed with the member and their family. The Care Plan shall be a person-centered written document that describes the medical, behavioral, and social needs of the members, and identifies all the services to be utilized to include but not be limited to the frequency, quantity and provider furnishing the services.

b) The Health Plan shall complete the Care Plan within thirty (30) days of the completion of the SHCN and SHCN+ Assessments.

c) The Health Plan shall ensure that the Care Plan is regularly updated to address gaps in care, incorporating input from the care team members and the member, verification of interventions completed, etc.

d) The Care Plan will be comprehensively updated:

    1. At a minimum every twelve (12) months; or
    2. When a member's circumstances or needs change significantly; or
    3. At the member's request; or
    4. When a reassessment occurs.

e) The Care Plan will be written in accordance with the requirements described in this Section (Section 3.7). At a minimum, the Care Plan must be signed and dated by the care coordinator and the member. The member's authorized representative or surrogate may sign for the member. The signature can be an electronic signature. A copy of the Care Plan shall be provided to the member, the PCP and the care team.

f) The standardized care plan template will be approved by DHS, and the Health Plan must have a process for completing the Care Plan.

g) There are additional requirements for SHCN+ care plans completed by the Hale Ola. SHCN+ care plans completed by Hale Ola shall extend beyond services provided by the Health Plans to include community resources to address SDOH. The Health Plan shall consider the appropriate mix of services and care team members that will enable the member to utilize appropriate level of service and reduce costs.

h) The Health Plan may also require or allow the Hale Ola to recommend for Health Plan approval the level of care coordination services needed based on the care plan. Some of the additional elements in the care plan may include:

1. Screening for behavioral health and other conditions;
2. Linking and integrating care with CoCM services, Hawaii CARES (Section 3.6(B)), and other behavioral health resources;
3. Addressing identified SDOH needs;
4. Applying the Stepped Care Approach concept to care planning; and
5. Prevention and health promotion.

i) DHS will provide additional guidance on Care Plans for the SHCN+ population during the contract period.

2) Service Plans for LTSS/HCBS

The Service Plan shall be based on the LTSS Assessment and be developed consistent with 42 CFR §441.301(c). In developing the Service Plan, and working with the PCP and other providers, 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 Service Plan shall provide a broad roadmap for service delivery and addressing the member's needs. Service Plans shall extend

beyond services provided by the Health Plan to include community resources. The Health Plan shall use a standardized plan template that at a minimum includes:

A. Problem identification;
B. Goals, objectives and desired outcomes;
C. Interventions; and
D. Needed services and service parameters.

The Service Plan shall include medical, behavioral, psychosocial, HCBS, and institutional services that the member will receive. The Health Plan shall develop goals that include longer term strategic planning. In addition, the Health Plan shall include information such as:

A. Health conditions and required course of treatment for specified conditions;
B. Medication regimen;
C. 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; and
D. Disaster planning.

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 Service Plan process. The Service Plan shall be written in accordance with the requirements described in this Section. At a minimum, the finalized Service Plan must be signed and dated by the service coordinator and the member. The member's authorized representative or surrogate may sign for the member. The

signature can be an electronic signature. A copy of the Service Plan shall be provided to the member and the member's PCP.

The Health Plan shall complete the Service Plan document within thirty (30) days of the completion of the LTSS Assessment.

The Health Plan shall ensure that the Service Plan is regularly updated to address gaps in care, incorporating input from the care team members and the member, verification of interventions completed, etc.

The Service Plan will be comprehensively updated:

A. At a minimum every twelve (12) months;
B. When a member's circumstances or needs change significantly; or
C. At the member's requests; or
D. When a reassessment occurs.

J) *CSC Services*

1) Care Coordination Services – SHCN

a) The Health Plan is accountable for coordinating care according to the Care Plan which is based upon the results of the SHCN Assessment for each member. The Health Plan is accountable for ensuring that the care coordination approach includes help for members in addressing unmet resource needs. The care coordinators shall assist with coordinating QI service across different programs and agencies.

b) Care Coordination responsibilities include:

1. Implementing the Care Coordination plan as written in collaboration with the member, member's family, and the care team.

2. The Health Plan shall regularly review and update the Care Plan with the member at a frequency that is mutually agreed upon with the member. The Health Plan can do this face-to-face or through alternative communication methods (e.g. telephone, text, email, video chat, etc.). While reviewing and updating the Care Plan with the member, the Health Plan shall at a minimum:

    a) Review the Care Plan goals, objectives, and actions with the member;

    b) Identify if significant changes have occurred; if they have, the Health Plan has to complete a reassessment.

    c) Verify receipt of services;

    d) Verify satisfaction with providers and services,

    e) Identify care gaps;

    f) Review if utilization patterns are appropriate;

    g) Coordinating a team of decision-makers to develop the care plan, including the PCP, other providers as appropriate, the member, and others;

    h) Facilitating timely communication across the care team to avoid duplication of services and medication error, including but not limited to discharge

instructions and discharge summaries for hospitalizations;

i) Coordination of physical, behavioral health and social services;

j) Progress tracking through routine care team reviews;

k) Referral follow up;

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

m) Monitoring progress with EPSDT requirements;

n) Training on self-management, as relevant;

o) Managing transitions of care;

p) Providing continuity of care when members are discharged from a hospital (e.g. resolving instances like the prescribed medication is not on the plan's formulary);

q) Utilizing compiled data received from member encounters to assure the services being provided meet member needs;

r) Facilitating access to services, including community services, and developing partnerships necessary to allow for access to and coordination with social and support services, including crisis management services, and community prevention and self-management programs;

s) Providing assistance in resolving any concerns about service delivery or providers; and

t) Assisting members to maintain continuous Medicaid benefits.

2) Intensive Care Coordination for SHCN+ Population

a) Hale Ola General Description

1. DHS intends to establish a specialized health home pilot concept called the Hale Ola (Appendix B). The Hale Ola is a type of advanced health home for the SHCN+ population. Pilots will be established in a minimum of three regions during the contract period.

2. The purpose of the Hale Ola will be to provide comprehensive and coordinated care to the SHCN+ population. The Hale Ola will integrate and coordinate all primary, acute, behavioral health, and LTSS supports to treat the whole person. The Hale Ola is created as a part of the Stepped Care Approach initiative and provides increased levels of coordination and support for members with complex needs (Section 3.2).

3. DHS may allow or require the Hale Ola to have tiered intensive care coordination levels. This may allow members to have a clear path to the highest tier of care coordination when needed, as well as a clear path to the lower-tiers as appropriate.

4. The Hale Ola will be required to provide all the care coordination services provided to the SHCN+ population. In addition, the Hale Ola will have responsibilities that emphasize

in-person contact with members. The Hale Ola will be expected to have Community Care Teams (CCTs), which could include Community Health Workers, Peer Support Specialists, Community Paramedicine, and other local community-based service providers. The CCT will be critical in engaging members in their care and will provide the services where the members are located.

5. The Hale Ola will have a strong focus on behavioral health, prevention, health promotion, disease management, medication management, and other services.

b) DHS Requirement Regarding the Hale Ola

a. DHS shall:

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

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

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

c) Health Plan Requirements Regarding the Hale Ola

1. The Health Plan is accountable for ensuring that quality care is provided through the Hale Ola. The Health Plan shall:

a) Provide monitoring and oversight for the Hale Ola.

b) Ensure the intensive care coordination services are provided according to the care plan.

c) Create a process for the SHCN+ population to be assigned to the Hale Ola, and a process to manage and monitor the services provided.

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

e) Develop an advanced system for sharing information with the Hale Ola including reports to the Hale Ola about the Hale Ola-enrolled population, both at the population-level and patient-level.

f) Collaborate with other Health Plans and DHS to align and develop information sharing and reporting standards.

g) Report on process and performance metrics on Hale Ola providers and members.

h) Pay the Hale Ola based on a common payment methodology to be developed by DHS.

3) Service Coordination Services

a) Service coordination responsibilities include:

b) Developing the Service Plan in collaboration with the care team and Ombudsman if requested by the member.

c) Implementing the Service Plan as written in collaboration with the member, member's family, and the care team.

d) The Health Plan shall regularly review and update the Care Plan with the member at a frequency that is mutually agreed upon with the member.

e) At a minimum, the Health Plan shall have a face-to-face visit with the member to review and update their Service Plan every ninety (90) days. The activities that occur during the face-to-face visit could include but are not limited to:

f) Identification of significant changes in the member's health or circumstances; if there are significant changes, the Health Plan will need to do a reassessment;

g) Review of the Service Plan goals, objectives, and actions;

h) Review of the status of interventions delivered under the Service Plan;

i) Verification of receipt of services;

j) Verification of satisfaction with services and providers;

k) Resolving issues or problems; and

l) Identification of service gaps.

m) Review if service utilization is appropriate.

n) Assuring institutional LOC assessment is completed in accordance with requirements established in Section 3.7(L), if applicable, and an eligibility determination for long-term care has been submitted to DHS;

o) Assuring that the members are receiving LTSS through assessment and service planning as described in this Section 3.7.

p) Providing options counseling regarding institutional placement and HCBS alternatives;

q) Coordinating services with providers, Medicare fee-for-service and/or Medicare Advantage Plans and their providers, behavioral health providers and DD/ID case managers;

r) Facilitating and arranging access to services;

s) Addressing social needs for the member and their family;

t) Assessing caregivers for potential burn-out for members living at home receiving HCBS; and

u) Assisting members in transition from nursing facilities/residential facilities.

v) Assuring that all dual eligible members have access to a service coordinator to assure coordination of Medicare and Medicaid services.

w) All authorized LTSS shall be documented in the member's service plan.

x) The Health Plan shall comply with all State and Federal laws pertaining to the provision of services and benefits.

K) *CSC Staffing Requirements*

The Health Plan shall maintain sufficient care and service coordinators to meet members' needs. Staff responsible for the development and implementation of the care plans and services plans shall participate in ongoing person-centered practices and training. The Health Plan shall determine how best to utilize Care and Service coordinators and other staff, and assign caseloads with the following parameters.

i. At a minimum, Care and Service Coordinators must meet all State requirements for a social worker, licensed nurse, or other healthcare professional with a minimum of one (1) year of relevant healthcare experience.

ii. The Health Plan shall take a patient-centered approach with a single primary contact per member receiving the service.

iii. The Health Plan shall require that care and service coordinators show competency in areas including:

   a. Person-centered needs assessment and care planning;
   b. Motivational interviewing;
   c. Self-management;
   d. Trauma-informed care;
   e. Cultural competency;
   f. Understanding and addressing unmet health-related resource and social needs, including expertise in identifying and utilizing available social supports and resources;
   g. Understanding and addressing Adverse Childhood Experiences and trauma.

iv. The Health Plan shall have policies and procedures for care and service coordinators that address:

   a. Qualifications;
   b. Methodology for assigning and monitoring caseloads;
   c. Member assignment changes;
   d. Supervision of staff;
   e. Training guidelines (including frequency of training courses, topics and course format) and sample program materials;
   f. Training standards related to person-centered practices;

g. Process for ensuring continuity of care when staff changes are made;
h. Ensuring each member's privacy is secured and protected consistent with the applicable State and Federal law confidentiality requirements; and
i. Training staff on how to educate members on accessing services and assisting members in making informed decisions about their care.

DHS will review the policies and procedures and may require the Health Plan to revise the policies and procedures if DHS determines the staffing plan is insufficient.

L) *Special Provisions for the Assessment of Institutional LOC*

If the LTSS Assessment identifies that the member will need institutional LOC services, the health plan shall be responsible for assessing QI members using the State's LOC evaluation tool (DHS 1147 or other form as determined by DHS) or the Health Plan may subcontract this responsibility to a qualified provider or subcontracted entity. The State's LOC Evaluation tool is the form used to determine institutional LOC. Once the LOC assessment is completed, the Health Plan or the delegated providers 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 instructions may be found at Appendix M.

The Health Plan shall offer and document in the member's record the choice of institutional services or HCBS to members who meet the

institutional LOC when HCBS are available and are cost-neutral. The Health Plan shall document its good faith efforts to establish cost-neutral service plans in the community. The Health Plan must receive prior approval from the DHS or its designee prior to disapproving a request for HCBS.

When the Health Plan identifies that the member will be receiving LTSS, the Health Plan shall submit a MEDICAID ELIGIBILITY FOR LONG-TERM CARE (LTC) SERVICES form (DHS 1148) to the DHS for long-term care eligibility determination. The health plan may start providing LTSS while the eligibility process is being conducted. The DHS 1148 form and instructions may be found in Appendix N.

The Health Plan is not required to provide HCBS if:

1. The member chooses institutional services;
2. The member cannot be served safely in the community;
3. The member (21 years or older) requires more than 90 days per benefit period of twenty-four (24) hours of HCBS (not including CCFFH or E-ARCH) per day; or
4. There are not adequate or appropriate providers for needed services.

For institutionalized members who are preparing for discharge to the community, the service coordinator shall complete the LTSS Assessment prior to the date of discharge. The Health Plan shall complete members' discharge planning prior to the member leaving the institution and makes sure all the necessary DME or related supplies are available to the member upon return home.

For those members who meet institutional LOC and are receiving LTSS, the Service Coordinator shall conduct a face-to-face assessment and

reassessment as described in Section 3.7(H). For members who are "at risk" and receiving HCBS, the Service Coordinator will conduct a face-to-face assessment as described in Section 3.7(H).

As noted in Section 9.1(B), the health plan receives the 834 file via the DHS SFTP service on a daily basis. The 834 file is the mechanism by which DHS conveys its decisions related to whether or not a particular member is determined to be eligible for LTC. The Health Plan is required to review 834 reports in a timely manner and make an initial contact with the newly eligible LTC members on their daily report. If the member expresses a desire for HCBS, the Health Plan shall schedule an LTSS Assessment with the member. The Health Plan shall conduct an LTSS Assessment within seven (7) calendar days of initial enrollment for members whose eligibility is based upon receipt of HCBS.

M)*Special Coordination Provisions for Self-Direction of LTSS*

1. The Health Plan shall provide all members assessed to need personal assistance services (as defined in Section 4.8(B)(14) and respite services (as defined in Section 4.8(B)(17)) 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:

    a) Recruiting/selecting Medicaid providers;

    b) Determining provider duties;

    c) Determining a rate of pay that is at least the Federal or State minimum wage, whichever is higher;

    d) Scheduling providers;

    e) Instructing and training providers in preferred duties;

f) Supervising providers;

g) Evaluating providers;

h) Verifying time worked by provider and approving time sheets; and

i) Discharging providers.

2. The Health Plan shall assure that members that receive nurse delegable personal assistance services- Level II (i.e., tube feeding, suctioning, medication administration, etc.) shall meet nurse delegation requirements in accordance with Chapter 16-89, Subchapter 15, HAR.

3. A member may choose to designate one (1) member 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.

4. 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 service plan to ensure that assessed needs are addressed and to ensure members' overall well-being.

5. As a part of the service plan process, members assessed to need personal assistance services or respite service, 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 health service; 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 service 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.

6. 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.

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

8. 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 service plan.

9. The budget for each member electing self-direction shall be sufficient to provide for the assessed service needs and to account for any employment taxes and withholdings. The member is not obligated to provide health insurance, worker's compensation or temporary disability insurance (TDI) benefits for his/her providers.

10. Self-directed providers shall receive overtime pay for authorized time-worked that exceeds forty (40) hours per week. The Health Plan shall educate the member that authorizing more than forty (40) hours per week for a member self-directed provider, except in extraordinary circumstances acknowledged by the Health Plan and incorporated into the member's budget by the service coordinator, will decrease the hours of service that they may receive in subsequent weeks. The Health Plan shall educate the member to choose either an additional self-directed provider or an agency (to prevent overtime) in instances where the member is assessed to need and is authorized for more than forty (40) hours a week of personal assistance or respite services.

11. 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 service coordinator shall educate the member on choosing the rate of pay based upon member's budget that meets State and Federal minimum wage requirements.

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

13. 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 or respite service services must meet all of the following authorization criteria and monitoring provisions.

14. The service must:

    a) Meet the definition of service as defined in Section 4.8(B).

    b) For personal assistance services Level II and respite service services, be necessary to avoid institutionalization;

    c) Be a service that is specified in the service plan;

    d) Be provided by a parent, spouse or child age eighteen (18) years or older who meets the State prescribed provider qualifications and training standards for that service;

    e) Be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service; and

    f) NOT be an activity that the family would ordinarily perform or is responsible to perform. The Health Plan will need to make this decision on a case by case basis and will need to consider the extent to which an member who is the same age without disability would need the requested level of service or assistance as the member with a disability.

15. The family member and other self-directed providers will comply with the following:

    a) 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 services;

b) The family member must maintain and submit all required documentation, such as time sheets, for hours worked; and

c) Married members must be offered a choice of providers. If he/she chooses a spouse as his/her provider, it must be documented in the service plan.

d) 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:

e) At least quarterly reviews of expenditures, and the health, safety and welfare status of the member;

f) Face-to-face visits with the member on at least a quarterly basis; and

g) Monthly reviews of hours billed for family provided service and the total amounts billed for all goods and services during the month.

16. 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.

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

a) Develop interview questions;

b) Screen and interview applicants; and

c) Include in the service agreement between the Health Plan and the provider, the roles and responsibilities of both the member and the provider.

18. Members choosing to hire his/her family member may elect to forego bullets #1 and #2 above. However, a service agreement delineating the roles and responsibilities of both the member and the provider is still required.

19. A member may terminate his/her self-direction provider for violating the terms of the service agreement.

20. The Health Plan shall have the ability to terminate provision of self-direction services on behalf of a member for health and welfare issues. Health Plans do not have the authority to terminate self-directed providers.

21. 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 service plan.

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

23. The Health Plan shall perform the administrative functions associated with employing self-direction providers for the member, who is the employer of record, including:

a) Paying providers;

b) Monitoring completion of all time sheets;

c) Assuring Tuberculosis (TB) test is completed;

d) Validating active Cardiopulmonary Resuscitation (CPR) and First Aid training;

e) Blood-borne pathogen training;

f) Reviewing and verifying results of the status of criminal history record checks of providers per State requirements (the members shall pay for the cost of background checks out of their budget);

g) Reviewing and approving payment for allowable services; and

h) Withholding, filing and paying applicable federal, State and employment taxes.

24. Members choosing to hire his/her friend or family member may elect to forego #3, #4, #5, and #6 above. This waiver does not apply to any agency or their personnel. The member must sign a document identifying the employment functions that they are waiving.

25. The Health Plan may delegate these functions to another entity through a subcontract. The subcontractor agreement shall comply with all requirements outlined in Section 14.4.

26. 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:

a) Understanding the role of members/surrogates in self-direction;

b) Selecting and terminating providers;

c) Being an employer and managing employees;

d) Conducting administrative tasks such as staff evaluations and approval of time sheets; and

e) Scheduling providers and back-up planning.

f) The Health Plan shall require that all self-directed providers participate in a training program prior to assuming self-direction. At a minimum, self-direction training programs shall address the following:

g) Understanding the role of members/surrogates in self-direction;

h) Understanding the role of the provider in self-direction, including criteria for job termination;

i) Understanding the tasks that they are being compensated for (i.e., personal assistance or respite);

j) Completing timesheets;

k) Payment schedules;

l) Process for notifying member if unable to perform assigned duties; and

m) Skills competency to perform PA II and delegated tasks, if applicable.

27. 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 contract 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 DHS for approval thirty (30) days prior to implementation.

28. Members assessed to need personal assistance services 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 or respite care services. Members may utilize self-direction and other services simultaneously.

29. The Health Plan shall establish and maintain self-direction policies and procedures that include forms utilized and shall submit these to DHS for review and approval in accordance with Section 13.3(B), Readiness Review. The policies and procedures shall include, at a minimum:

    a) Process to document choice of self-direction when member is assessed to need personal care or respite care services;

    b) Process to assess member's ability to implement self-direction, including a copy of the self-assessment form;

    c) Process to document member agreement to self-direct his/her service;

    d) Process for establishing and monitoring nurse delegation for required personal assistance services- Level II;

    e) Sample agreement between provider and Health Plan;

f) Process for paying providers (including verifying hours worked);

g) Topics, goals and frequency of member/surrogate training programs;

h) Topics, goals and frequency of self-directed provider training programs; and

i) Process for member termination from self-direction.

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

N) *Special Coordination Provisions for Community Integration Services (CIS)*

The Health Plan shall seek to link the coordination of services that help members secure housing with members' care plans and/or service plans as a way to promote whole person care. Rules surrounding the coordination of CIS is provided in this section. Service descriptions for CIS are described in Section 4.7.

1) Target Population

The Health Plan shall provide CIS to members eighteen (18) years of age or older if the member meets the following criteria.

Member is expected to benefit from community integration services and meets at least one of the following health needs-based criteria:

a) Member is assessed by the Health Plan to have a behavioral health need which is defined as one or both of the following criteria:
    a. Mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a serious mental illness; and/or
    b. Substance use need, where an assessment using American Society of Addiction Medicine (ASAM) criteria where that the member meets at least ASAM level 2.1 indicating, at minimum, the need for outpatient day treatment for Substance Use Disorder (SUD) treatment.
b) Member is assessed to have a complex physical health need, which is defined as a long continuing or indefinite physical condition requiring improvement, stabilization, or prevention of deterioration of functioning (including the ability to live independently without support).

AND

Member has at least one of the following risk factors:

a) Homelessness, defined as lacking a fixed, regular, and adequate night-time residence, meaning:
    a. Has a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; or

b. Living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low income members).

b) At risk of homelessness, defined as a member who will lose their primary nighttime residence:
    a. There is notification in writing that their residence will be lost within 21 days of the date of application for assistance; such that
        i. No subsequent residence has been identified; and
        ii. The member does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to or living in a place not meant for human habitation, a safe haven, or an emergency shelter; or
c) The member has a history of frequent and/or lengthy stays in a nursing facility:
    a. Frequent is defined as more than one contact in the past 12 months.
    b. Lengthy is defined as 60 or more consecutive days within an institutional care facility.

A bidirectional mechanism will be established to enable the health plan to notify DHS, and vice versa, about beneficiaries identified for and receiving various types of CIS services.

2) Assessment

The Health Plan will use a standardized housing assessment tool developed by DHS. Service coordinators who are social workers or registered nurses will be responsible for conducting assessments and re-assessments to determine whether a member is eligible for CIS services. Re-assessments will occur, at minimum, every ninety days.

3) Coordination Requirements for CIS

The level of coordination will vary in scope and frequency depending on the member's intensity of need. The Health Plan shall develop policies and procedures to ensure the following:

a) Coordinated provision of CIS activities and services with the goal of promoting community integration, member advocacy, optimal coordination and monitoring of resources, and self-sufficiency for members who meet the eligibility requirements for CIS.

b) An active, assertive system of outreach is in place that provides the flexibility needed to reach CIS members requiring services who might not access services without intervention due to language barriers, acuity of condition, dual diagnosis, physical/visual/hearing impairments, intellectual disability and/or lack of transportation.

In regard to conflict-free case management for the CIS population, the Health Plan service coordinator conducts the housing assessment and writes the plan of service with the member for services. The

Health Plan will maintain contracts with case management/homeless agencies that will provide the CIS services for the member.

O) *Coordination with Community Care Services (CCS)*

1. Members age eighteen (18) years or older with a diagnosis of serious mental illness (SMI) or serious and persistent mental illness (SPMI) may be eligible for additional behavioral health services within the Community Care Services (CCS) behavioral health program overseen by DHS.

2. CCS shall provide to its adult members a full range of behavioral health services including inpatient, outpatient therapy and tests to monitor the member's response to therapy, and intensive case management. Adult members who are receiving services through CCS that require alcohol and/or drug abuse treatment may also receive these services through CCS.

3. Health Plans shall have a process in place to identify adults with SMI or SPMI who are in need of additional behavioral health services based on the criteria listed in Section 4. Health Plans shall send a referral to DHS that they identify as meeting criteria for the CCS program.

4. The Health Plan and CCS shall coordinate on the medical and behavioral health needs of its members. Health Plans shall have business associates agreements with the CCS program contractor in order to share protected health information including but not limited to claims files and service plans. The Health Plan must provide DHS with a copy of the business associate agreements within 7 calendar

days of execution. Collaboration between the CSC System and CCS's case managers is expected.

P) ***Coordination with Department of Health Child and Adolescent Mental Health Division (CAMHD) and Developmental Disability Division (DDD)***

1. Health Plans are expected to jointly develop policies and procedures for assuring participation in and integration of service and care planning with member/guardian consent according to timelines and standards established by DHS with CAMHD, and separately with DDD.
2. DHS intends to establish a schedule for the development and implementation of coordination policies and processes. DHS will initially prioritize members with co-occurring chronic, acute, and/or serious conditions. DHS intends to implement this in three phases:
    a) Phase I: Identification of and Access to Data on Joint Members;
    b) Phase II: Development of Joint Care Coordination Standards and Processes; and
    c) Phase III: Implementation of Joint Care Coordination Processes.
3. As a part of this process, DHS, DDD, or CAMHD may provide training or education for the Health Plans on best practices.
4. This process is expected to be expanded to all members enrolled in the CAMHD and DDD in subsequent contract years.
5. Health Plans will be required to sign an agreement with CAMHD and DDD respectively to operationally define these processes, including:
    a) Exchange of Information;

b) Referral Procedures; and

c) Participating in a coordinated, integrated, and individualized patient-centered plan.

6. These programs are carved out of the Health Plan's responsibilities. The Health Plan shall work with the agencies in transitioning members in and out of the programs and for coordinating medical services. The Health Plan is required to exchange existing care plans during these transitions. Additionally, the Health Plan is required to exchange member data in a timely manner, including but not limited to, utilization management notifications, member specific utilization, quality data, information on medication adherence, and cost data. Data

7. DHS may provide additional guidance during the contract period.

3.8 Future Services

1. In order to accomplish the stated goals for care delivery, DHS may seek authority from CMS to add or revise covered services during the contract period. Health Plans will be responsible for covering the services if benefits are added or modified during the contract period. Examples of services that DHS may add or enhance include, but are not limited to:

    a) Health home (Hale Ola) services;
    b) Preventive services provided by community health workers and other paraprofessionals;
    c) Services provided by Community Paramedicine programs;
    d) Services provided in Institutions for Mental Disease (IMD);
    e) Medication Therapy Management;

f) Palliative care services;
g) Expansion of eligibility criteria for hospice services;
h) Advance Care Planning;
i) Prevention and health promotion education, classes, and coaching for chronic diseases and members at-risk for getting a chronic disease, including but not limited to such programs as:
    a. Centers for Disease Control and Prevention (CDC) recognized Diabetes Prevention Program;
    b. CDC recommended Asthma Self-Management Education programs;
j) Enhancements to the telehealth benefit;
k) E-consultations and/or E-referrals – An e-consultation or e-referral is an asynchronous, non-face-to-face consultation between a PCP and a specialist using a secure electronic communication platform;
l) Telehealth consulting – The use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance;
m) Transportation benefit expansion – for example, coverage for members to receive transportation services to and from pharmacies;
n) Services to support family caregiving; and
o) Administrative expenditures for Hawaii Tobacco QuitLine services.

3.9 Coordination with other State Programs

In addition to the care and service coordination requirements above, the Health Plan is also responsible for coordination with other governmental programs. Data use agreements will be required for any disclosure of Medicaid data. Other agencies, such as DOH, may provide direct services to Health Plan members. This section describes other agencies' services and responsibilities as well as the requirements of the Health Plan.

A) *Department of Human Services – State of Hawaii Organ and Tissue Transplant (SHOTT) Program*

1. The SHOTT program is described in Section 4.12(A). The Health Plan shall work with the transplant facility to submit a request for an evaluation by the SHOTT Program, to include the referral request (DHS 1144) as well as complete supporting documentation. For all SHOTT referrals, unless the member has already been determined disabled or the member is in the ACA Adult group, DHS 1144 and complete supporting documentation are required.

2. For members in the ACA Adult group, the Health Plan shall only submit a referral request (DHS 1144) with complete supporting documentation; the Health Plan shall not submit an ADRC packet for disability determination.

3. The State and the SHOTT Program contractor shall determine eligibility of members for transplants except those transplants provided by the Health Plan. If DHS and the SHOTT Program contractor determine that the member meets the transplant criteria,

the member shall be disenrolled from the Health Plan and transferred to the SHOTT program. If the member does not meet the criteria for transplantation, the member shall remain in the Health Plan.

4. The following shall occur if the member is no longer an active candidate for transplantation:

    a) The member shall be re-enrolled into the same Health Plan in which he/she was enrolled prior to the transplant evaluation, effective the 1st day of the following month based on DHS' determination that the member has been discharged from SHOTT.

    b) If the member's condition changes to make him/her a better candidate for a transplant, the Health Plan in which he/she belongs may resubmit him/her for re-consideration for the transplant program.

B) ***Department of Human Services – Women, Infants, and Children (WIC)***

1. The Health Plan shall coordinate the referral of potentially eligible women, infants, and children to the WIC Supplemental Nutrition Program and the provision of health data required by the WIC program, within the timeframe required by WIC, from their providers. The Health Plan shall cover the cost of specialty formula when medically indicated.

C) *Department of Human Services – Foster Care/Child Welfare Services (CWS) Children*

1. In addition to providing all medically necessary services under EPSDT, the Health Plan shall be responsible for providing the pre-placement physicals (prior to placement) and comprehensive examinations (within forty-five (45) days after placement into a foster care home) including medication dispensed when a physical examination shows a medical need, for children with an active case with CWS.

2. A comprehensive examination shall have all of the components of an EPSDT visit, including referrals for more in-depth developmental and behavioral assessment and management if needed, and the Health Plan shall reimburse the provider the same rate as for an EPSDT visit.

3. The Health Plan shall have procedures in place to assist CWS workers in obtaining a necessary physical examination within the established timeframe through a provider in its network. Physical examinations may take place in either an emergency department or physician's office.

4. A provider specializing in child protection, (e.g., provider from Kapi'olani Child Protection Center), may also perform the exams.

5. The Health Plan shall be responsible for the pre-placement and the forty-five (45) day comprehensive exams regardless of whether the provider is the child's primary care physician and regardless of whether the provider is in or out-of-network. Any out-of-network provider must be a licensed provider and must understand and perform all the components of a comprehensive EPSDT examination,

including referrals for more in-depth developmental and behavioral assessment and management if needed.

6. The Health Plan shall be familiar with the medical needs of CWS children and shall identify person(s) within the Health Plan that may assist the foster parent/guardian and case worker to obtain appropriate needed services for the foster child.

7. 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 timely restrictions.

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

D) ***Department of Health – Alcohol and Drug Abuse Administration (ADAD)***

1. ADAD provides substance abuse treatment programs, which may be accessed by the members. In addition to that described in Section 3.6(B), the Health Plan has the following responsibilities as it relates to coordinating with ADAD and providing services to its members:

    a) 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;

b) Providing appropriate medically necessary substance abuse treatment services while the member is awaiting an ADAD slot;

c) Covering all medical costs for the member while the member is in an ADAD slot;

d) Coordinating with the ADAD provider following the member's discharge from the residential treatment program; and

e) Coordinating with ADAD in referring members who meet criteria to substance use disorder providers through the Hawaii CARES platform;

f) Engaging in ADAD's efforts to promulgate Screening, Brief Intervention and Referral to Treatment (SBIRT) for substance use disorders, raising provider capacity to offer SBIRT screenings, and appropriately managing or referring patients who screen positive; and

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

E) ***Department of Health - Vaccines for Children***

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

2. As a result, the Health Plan shall not be reimbursed for any privately acquired vaccines that can be obtained through Hawaii VFC program. Although the cost of the vaccines is not included in the capitation payment paid to the Health Plans, the Health Plan is not prohibited from allowing privately acquired vaccines and may decide who, if any, and how it shall reimburse for these vaccines. The Health Plan shall receive the fee for the administration of the vaccine as part of the capitation payment.
3. The Health Plans shall be responsible for updating its vaccination records on members to include vaccinations provided by the VFC program.

F) ***Department of Health - Early Intervention Program (EIP)***

1. The DOH administers and manages the Early Intervention Program (EIP) services. The cost of those services is not included in the Health Plan's capitation rate.
2. The Early Intervention program provides services, including transportation, for developmentally delayed and biologically at risk children aged zero (0) to three (3) years old. The services are for screening, 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 shall evaluate and determine eligibility for these programs. The Health Plan is responsible for providing any medically necessary services prior to DOH eligibility determination and continuing to provide any medically necessary services if the child is not found eligible for the Early Intervention Program.

3. The Health Plan remains responsible for providing all other medically necessary services in the QI program; including but not limited to EPSDT screens, medically necessary Applied Behavioral Analysis (ABA) and any other medically necessary service. Prior to a member's exit from the Early Intervention Program, the Health Plan will collaborate with the Early intervention program, member, and member's caregiver to complete a Health and Functional Assessment. The Health Plan must collaborate with Early Intervention programs as members transition out of Early Intervention. Health plans will authorize continuation of medically necessary services provided by Early Intervention when the member transitions out of the Early Intervention Program.
4. DHS may provide additional guidance on care and service coordination during the Contract period.

G) ***Department of Education – School-Based Services***

1. The Department of Education (DOE) shall provide all school health services including transportation. The cost for school health services is not included in the capitation rate paid to the Health Plan. The Health Plan shall coordinate with DOE and schools as feasible.
2. DHS may provide additional guidance on care and service coordination during the Contract period.

H) ***Other - Kapi'olani Cleft and Craniofacial Center***

1. The Kapi'olani Cleft and Craniofacial Center is a multidisciplinary program that services children with cleft and craniofacial disorders

across the state. The clinic provides the services of pediatric dentists, orthodontists, oral surgeons, otorhinolaryngologists, pediatric psychiatrists, audiologists, speech and feeding specialists, neonatologists, geneticists, and genetic counselors. The Health Plans are responsible for reimbursing these covered services as well as coordinating with the clinic care for members receiving care at the clinic.

2. The Children with Special Health Needs CSHN Branch at DOH is the community component to the Kapi'olani Cleft and Craniofacial Center. It provides staff to assist the clinic in coordinating care for these children, including members. The CSHN Branch may link children receiving care at the clinic to the Early Intervention program and provide additional outreach or support to the children and their families, facilitate health plan authorizations for specialized feeding bottles, etc.

3. The Health Plan shall collaborate with both the Kapi'olani Cleft and Craniofacial Center and the CSHN Branch in coordinating care for their members with cleft and craniofacial disorders receiving care at the clinic.

4. The Health Plan shall also aid in coordination of care in cases involving coverage by more than one Health Plan and shall facilitate the processing of prior authorization requests and claims. If a member changes Health Plans, the originating Health Plan shall assist the accepting Health Plan by providing information on the clinic's multidisciplinary recommendations, treatment provided, and progress to date. The originating Health Plan shall coordinate with the accepting Health Plan to ensure a smooth transition.

3.10 Coordination and Alignment with Medicare for Dual Eligibles

A) *Alignment*

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

2. The Health Plan shall enter into a Coordination of Benefits Agreement with Medicare and participate in the automated claims crossover process for dual eligibles. The Health Plan shall be responsible for a dual eligible's coordination of benefits.

B) *Dual-Eligible Special Needs Plan (D-SNP)*

1. Health Plans shall have a dual-eligible special needs plan for Medicare and Medicaid members in Hawaii no later than January 1, 2021. The Health Plan's QUEST Integration contract shall include terms sufficient to meet any Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requirements identified by CMS.

2. If the Health Plan will not have an operational D-SNP by January 1, 2021, the Health Plan shall begin the D-SNP application process in accordance with the schedule and guidelines required by CMS

through the Health Plan Management System. The Health Plan shall provide DHS a quarterly report detailing progress made toward D-SNP approval in 2021. This report shall include:

a) A timeline that lists the timeframe for completing each of the required elements;

b) A status report indicating whether each task was completed (indicating on time or delayed); and

c) Notice of any barriers, issues, or setbacks that might negatively impact the D-SNP approval process, as well as a description of the Health Plan's mitigation strategies.

C) *Default Enrollment*

1. Health Plans are required to submit requests for default enrollment authority to Medicare. The Health Plan shall submit the request timely to ensure D-SNP default enrollment authority beginning January 1, 2021. The plan shall provide DHS a copy of all materials provided to CMS to support its default enrollment application.

D) *Plan Requests to Become a Fully Integrated Dual Eligible SNP (FIDESNP)*

1. DHS may support a Health Plan's request to be a FIDESNP plan beginning January 1, 2021. To be considered for FIDESNP, the Health Plan shall adhere to Medicare timelines and requirements for meeting this level.

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

E) *Medicare Supplemental Benefits*

1. Medicare supplemental benefits are meant to bridge Medicare and Medicaid services, not to supplant otherwise available Medicaid services. The Health Plan may, in adherence with Medicare requirements, provide supplemental services that support statewide efforts to address SDOH.
2. The Health Plan shall provide a copy of its plan benefits package for DHS review prior to submission to CMS. The Health Plan shall work with DHS to ensure that the supplemental services included support the overall goals of this program.
3. High performing D-SNPs are allowed greater flexibility by CMS in supplemental services than other Medicare Advantage plans. If the D-SNP qualifies as a high performing plan, DHS will review any supplemental benefits proposed by the Health Plan and work with the Health Plan to leverage those flexibilities to further support state efforts to address SDOH.
4. The Health Plan shall provide DHS a summary explaining how the supplemental benefits proposed will be aligned with the Health Plan's value-added, in-lieu-of services, and other supplemental benefits in its QI program. SDOH-related supplemental benefits provided as

part of D-SNP plans may be included in the Health Plan's SDOH Work Plan, as discussed in Section 5.

F) *Model of Care (MOC)*

1. To the extent possible, DHS shall work with CMS to jointly review and provide input on a Health Plan's MOC requirements for submission and approval to NCQA. This may include collaborating with CMS to develop review criteria. Based upon DHS direction, the Health Plan shall develop a MOC that includes long-term services and supports and coordinates the provision of all Medicare and Medicaid services. The Health Plan shall provide the MOC for DHS review no later than 45 days prior to the required submission for approval to NCQA.
2. In the event that the Health Plan receives a score below 70 percent on its initial MOC submission to NCQA, the Health Plan shall provide DHS the opportunity to review the second draft, prior to re-submission to NCQA.

G) *Star Quality Rating*

1. The Health Plan shall notify DHS if it receives less than a 3.0 Star Quality Rating on either its Part C or Part D scores. The Health Plan must provide a mitigation plan outlining the steps proposed or implemented and timeline to improve the score.
2. If the Health Plan receives less than a 3.0 Star Quality Rating for two consecutive rating periods, DHS may require the Health Plan to withdraw from default enrollment until such time as ratings improve to an acceptable level. DHS will not otherwise support the Health

Plan's default enrollment and/or dual eligible auto-assignment policies.

3.11 Regional Health Partnerships

1. In some communities, organizations have developed that include groups of providers, care coordinating entities, and community based organizations working together to support member patient care and/or population health through functions such as population health planning, improved care coordination, provider education, data analytics, and provision of resources to overcome SDOH-related barriers.

2. DHS intends to formalize the work of these existing, emerging, or to be created organically developed organizations under the term Regional Health Partnerships (RHPs). Health Plans will be expected to collaborate and coordinate with them.

3. DHS will implement an RHP pilot program. The purpose of the pilot program is to leverage RHPs as regional level resources for informing, developing, and supporting the Quality Program as described in Section 5, as well as serving as a resource for providers and members in the regions in which they operate. DHS will solicit stakeholder feedback on the development and implementation of RHP pilots.

4. RHPs are intended to be community-driven and community-focused in their approaches. Therefore, by definition, RHP pilots are likely to be diverse and in alignment with community needs. Health Plans are encouraged to support innovative community-based strategies

proposed by RHPs to improve care delivery and enhance SDOH efforts within their communities.

5. The activities, specific service requirements, and tasks for RHPs will be dependent on the nature of the organizations in regions where RHPs exist. Examples of activities of the RHP pilots for which the Health Plan will provide coordination and support are as follows:

    a) Screening, referral, and community navigation services which impact health care costs and reduce health care utilization;

    b) Identifying and partnering with clinical delivery sites (e.g., physician practices, behavioral health providers, clinics, hospitals) to conduct and capture systematic health-related social needs screenings of all members and make referrals to community services that may be able to address the identified health-related social needs;

    c) Coordinating and connecting members to community service providers through community service navigation; and

    d) Aligning partners to optimize community capacity to address health-related social needs.

6. The Health Plan shall support the development of RHPs. The Health Plan will support operational components of the RHP pilots through the following activities and others as defined by DHS:

    a) Facilitating connections between community partners;

    b) Educating providers and social services agencies about the RHP pilots and the focus on SDOH;

c) Developing community-level solutions that enhance awareness of and referrals from health systems to community based organizations;

d) Working with RHPs on aligned VBP strategies for the RHP region;

e) Providing data support and access to RHPs as necessary to facilitate SDOH work and other RHP initiatives;

f) Facilitating connections between community partners; and

g) Coordinating with other Health Plans and DHS to align strategies for incorporating RHPs into the statewide SDOH Transformation Plan and the Health Plan's SDOH work plan.

7. Health Plan activities in support of the development and operationalization of RHP pilots, and engagement of RHPs in SDOH activities, may be included in the Health Plan's SDOH work plan, as discussed in Section 5.

SECTION 4 – Covered Benefits and Services

4.1 Overview of Covered Benefits

A) *Overview of Medical Necessity and Amount, Duration, and Scope Requirements*

1. The Health Plan shall be responsible for providing all medically necessary covered services to all eligible members as defined in this section. These medically necessary covered services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to recipients under Medicaid 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.

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

B) *Overview of Utilization Controls*

1. The Health Plan may incorporate utilization controls as described in Section 5.2 as long as the services furnished to the member can be reasonably expected to achieve its purpose.

2. The Health Plan may place appropriate limits on a service for utilization control, provided the services supporting individuals with

ongoing or chronic conditions or who require LTSS are authorized in a manner that reflects the member's ongoing need for such services and supports.

3. The Health Plan may place appropriate limits on a service for utilization control, provided family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used.

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

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

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

C) *Overview of Coverage of Additional Services*

1. With the exception of services specifically excluded by the Federal Medicaid requirements, the Health Plan may, at its own option and as an administrative expense, choose to provide additional services, either non-covered services or services in excess of the required covered services or benefit limits for all members or on an individual consideration basis. The Health Plan may describe its Value-Added Services and proposals for In Lieu of Services in accordance with Section 4.11.

2. The Health Plan may choose to offer additional services later, but first shall submit the services to DHS for approval at least thirty (30) days prior to service implementation. The Health Plan shall also include in its notification to 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.

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

4.2 Coverage Provisions for Preventive Services

A) *Fluoride Varnish*

1. Topical fluoride varnish application by qualified primary care providers will be covered for children age >1 and <6 years who have not received a topical fluoride treatment, by a dentist or qualified primary care provider, within the previous six months. Qualified PCPs include physicians and nurse practitioners. These PCPs may delegate under direct supervision to a physician assistant (PA), registered nurse (RN), licensed practical nurse (LPN), or Certified Medical Assistant (CMA).

2. Prior to performing topical fluoride varnish applications, PCPs must receive either Continuing Medical Education (CME) or CME-equivalent training in fluoride varnish application approved by either the American Academy of Pediatrics (AAP) or the American Academy of Family Physicians (AAFP). Documentation of approved training must be provided upon request.

3. Topical fluoride varnish application shall be billed using HCPCS code D1206. This code shall be covered for children beginning at age one year until reaching age six years if they have not received a topical fluoride treatment in the previous six months.

B) *Immunizations*

1. The Health Plan shall provide any Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP) approved vaccine to include but not limited to influenza,

pneumococcal, diphtheria and tetanus vaccines. Refer to Section 3.9(E) for Health Plan responsibilities regarding the VFC Program.

C) *Nutrition Counseling*

1. This service is provided by a licensed dietitian. This preventive health service includes nutrition counseling for diabetes, obesity, and other metabolic conditions; and when medically necessary for other medical conditions. Nutrition counseling requires a physician's order and must be part of a treatment program to mitigate the effects of an illness or condition.

D) *Preventive Services*

1. The Health Plan is required to cover Preventive Services (Adult Health) and Preventive Services (Pediatrics and Adolescent Health) as defined in Section 2.3. The Health Plan is responsible for monitoring and maintaining current knowledge of these guidelines and standards. DHS will provide monitoring and oversight to ensure the Health Plan implemented the latest guidelines and standards.

E) *Diabetes Self-Management Education (DSME)*

1. The Health Plan shall cover American Diabetes Association (ADA) recognized or American Association of Diabetes Educators (AADE) accredited Diabetes Self-Management Education (DSME) programs for qualifying members with diabetes or gestational diabetes. DSME programs shall be encouraged to make education and marketing

materials culturally relevant by incorporating local languages and reflecting members' values, attitudes, practices, and beliefs.

F) *Smoking Cessation Services*

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

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

3. The Health Plan's smoking cessation program may be developed within the Health Plan, contracted to another entity, or a combination of both. Limits provided below may be exceeded based on medical necessity.

4. Smoking Cessation services shall include two (2) quit attempts per benefit period, shall be consistent with the Treating Tobacco Use and Dependence practice guidelines issued by the Agency for Healthcare Research and Quality, and consist of:

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

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

1. Physician;
2. Dentist;
3. Psychologist;
4. Clinical social worker in behavioral health;
5. Advanced Practice Registered Nurse;
6. Mental Health Counselor; and
7. Certified Tobacco Treatment Specialists under the supervision of a licensed provider.

c) Medications: All tobacco cessation medications approved by the FDA as effective for smoking cessation to include both nicotine and non-nicotine agents. Effective medication combinations shall also be covered.

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

A) *Overview*

1. The Health Plan shall provide EPSDT services to members younger than twenty-one (21) years of age (including foster children and adopted children receiving subsidies). The Health Plan shall comply with Sections 1902(a)(43) and 1905(r) of the Social Security Act and Federal regulations at 42 CFR Part 441, Subpart B, that require EPSDT services, including outreach and informing, screening, tracking, and diagnostic and treatment services.

2. The Health Plan shall develop an EPSDT plan that includes written policies and procedures for outreach, informing, tracking, and following-up with members, families, and providers to ensure compliance with the periodicity schedules. The EPSDT plan shall emphasize outreach and compliance monitoring for members under age twenty-one (21) years, 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 4.5(D).

3. The Health Plan shall submit its EPSDT plan to DHS for review and approval in accordance with Section 13.3(B), Readiness Review.

4. The Health Plan shall be responsible for training providers and monitoring compliance with EPSDT program requirements.

5. The Health Plan shall require that all providers participating in a Health Plan utilize the most current EPSDT screening form prescribed by DHS when performing an EPSDT exam on EPSDT eligible members in accordance with Appendix O.

B) ***Outreach and Education for EPSDT***

1. The Health Plan's outreach and information process shall include:

a) Notification to 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

b) Notification to EPSDT eligible members and their families about the benefits of preventive health care, about how to obtain timely EPSDT services (including translation and transportation services), and about receiving health education and anticipatory guidance. This includes informing pregnant women within twenty-one (21) days after confirmation of pregnancy and new mothers within fourteen (14) days after birth that EPSDT services are available.

2. The Health Plan's information shall:

a) Be provided orally (on the telephone, face-to-face or films/tapes), or in writing. Information may be provided by Health Plan personnel or health care providers. The Health Plan shall follow-up with families with EPSDT-eligible members who, after six (6) months of enrollment, have failed to access EPSDT screens and services;

b) Be provided in non-technical language at or below a 6th (6.9 grade level or below) grade reading level and use accepted methods for informing persons who are blind or deaf, or cannot read or understand the English language, in accordance with Section 9.4; and

c) 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; describe 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 information distribution by the Health Plan is required for EPSDT members who have not accessed services during the prior year.

C) *EPSDT Screens*

1. The Health Plan shall conduct the following three (3) types of screens on EPSDT eligible members:

    a) Complete periodic screens according to the EPSDT periodicity schedule can be found on the CMS EPSDT website (https://www.medicaid.gov/medicaid/benefits/epsdt/index.html). 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 percent (80%) of eligible members;

    b) Inter-periodic screens; and

    c) Partial screens.

2. The Health Plan shall provide all medically necessary diagnostic and treatment services to correct or ameliorate a medical, dental (as defined in Section 4.5(D), or behavioral health problem discovered

during an EPSDT screen (complete periodic, inter-periodic, or partial). This includes, but is not limited to:

a) initial or interval history;

b) measurements;

c) sensory screening;

d) developmental assessments (including general developmental and autism screening);

e) tuberculosis risk assessments and screening;

f) lead risk assessments;

g) psychosocial and behavioral assessments;

h) alcohol and drug use assessments for adolescents;

i) sexually transmitted infections and cervical dysplasia screening as appropriate;

j) complete physical examinations;

k) age appropriate surveillance;

l) timely immunizations;

m) procedures such as hemoglobin and lead level as appropriate;

n) referral to a "dental home;"

o) referral to State or specialty services;

p) service coordination assistance if needed;

q) age appropriate anticipatory guidance;

r) diagnosis and treatment of any issues found in general developmental and autism screening; AND

s) diagnosis and treatment of acute and chronic medical, dental (as defined in Section 4.5(D), and behavioral health conditions.

3. Screening for developmental delays and behavioral health conditions, shall be done using standardized, validated screening tools as recommended by current national guidelines and the State's EPSDT program.

4. If it is determined at the time of the screening that immunization is needed and appropriate to provide at that time, the Health Plan shall ensure 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 4.2.

D) *Coverage Requirements*

1. The Health Plan shall provide additional medical services determined as medically necessary to correct or ameliorate defects of physical, mental/emotional, or dental illness (as defined in Section 4.5(D) and conditions discovered as a result of EPSDT screens. Examples of additional services include, but are not limited to, prescription drugs not on the Health Plan's formulary if approved by the FDA for the indication for which prescribed, durable medical equipment typically not covered for adults, and certain non-experimental medical and surgical procedures.

2. Health Plans shall cover services under EPSDT if the services are determined to be medically necessary to treat a condition detected at an EPSDT screening visit or other medical appointment.

3. The Health Plan is responsible for behavioral health services for all children with mental and behavioral conditions. Some children who

meet criteria as identified in Section 4.4(B) require more intensive services, which can be provided through CAMHD's Support for Emotional and Behavioral Development (SEBD) program. Children who are eligible for the SEBD program can obtain their behavioral health needs through CAMHD's SEBD program.

4. If a child is determined ineligible for SEBD, the Health Plan is responsible for all medically necessary behavioral health services.

5. The Health Plan is not responsible for providing health interventions that are not medically necessary or deemed experimental as defined in Section 432E.1-4, HRS.

6. 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.

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

8. In addition to the CMS 416 report, the Health Plan shall also submit to DHS, EPSDT data in an electronic format, to be specified by DHS. This data will be aggregated by DHS and generated reports provided to the Health Plan for purposes of targeted provider and client oversight, education, and outreach.

9. Additional information on the EPSDT services can be found on the CMS EPSDT website (https://www.medicaid.gov/medicaid/benefits/epsdt/index.html).

4.4 Coverage Provisions for Behavioral Health

A) *Health Plan Coverage Responsibilities*

1) General Requirement for Behavioral Health Integration

a) For both adult and child members, the Health Plan shall develop capacity among primary care providers for identification, early intervention, and treatment of mild to moderate behavioral health conditions. Universal screening for behavioral health conditions as well as appropriate treatment (through integrated behavioral health or enhanced referral described in detail below) shall be provided using a stepped care approach as described in Section 3.6.

2) Standard Behavioral Health Services for Adults and Children

a) The Health Plan shall be responsible for providing standard behavioral health services to all members, both adults and children. The Health Plan is not responsible for standard behavioral health services for members that are receiving their behavioral health services from the Community Care Services (CCS) program as described in Section 4.4(B). The Health Plan shall provide 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. Even if court ordered diagnostic, treatment or rehabilitative services are not determined to be medically necessary, the costs of continuing care under court order shall be borne by the Health Plan.

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

c) The Health Plan is not obligated to provide behavioral health services to those *adults* who have been criminally committed for evaluation or treatment in an inpatient setting under the provisions of Section 706-607, HRS, or *children* who are committed to the Hawaii Youth Correctional Facility. These individuals shall be disenrolled from the program and shall become the clinical and financial responsibility of the appropriate State agency.

d) The psychiatric evaluation and treatment of members who have been criminally committed to ambulatory mental health care settings (i.e., those with legal encumbrances to the DOH) shall be the clinical responsibility of the appropriate State agency. The Health Plan shall remain responsible for providing medical services to these criminally committed members. In addition, the Health Plan may be billed for standard behavioral health services provided to these members.

e) The Health Plan shall provide the behavioral health services in accordance with the prescribed parameters and limitations. The Health Plan shall comply with all State and Federal laws pertaining to the provision of such services.

3) Ambulatory Mental Health Services

The Health Plan shall provide coverage for Ambulatory Mental Health Services, which includes twenty-four (24) hour access line, mobile crisis response, crisis stabilization, crisis management, and crisis residential services. Health Plans shall have a contract for crisis services with the Department of Health, Adult Mental Health Division.

4) Psychotropic Medications and Medication Management

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

5) Inpatient Psychiatric Hospitalizations

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

6) Psychiatric or Psychological Evaluation and Treatment

The Health Plan shall be responsible for providing coverage for psychiatric or psychological evaluation and treatment and may utilize a full array of effective interventions and qualified professionals such as psychiatrists, psychologists, licensed clinical social workers, licensed mental health counselors, licensed marriage family therapists, and behavioral health nurse practitioners to evaluate for and provide treatment of behavioral health services to include individual and group counseling and monitoring.

7) Medically Necessary Alcohol and Chemical Dependency services

a) The Health Plan shall provide coverage for both inpatient and outpatient substance abuse services. A member's access to substance abuse services shall be no more restrictive than for accessing medical services. Substance abuse services shall be provided in a treatment setting accredited according to the standards established by the State of Hawaii Department of Health Alcohol and Drug Abuse Division (ADAD). The Health Plan is encouraged to utilize currently existing publicly funded community-based substance abuse treatment programs, which have received ADAD oversight, through accreditation and monitoring. Substance abuse counselors shall be certified by ADAD. Medically necessary substance use disorder services do not include services provided in an IMD setting unless provided as an in-lieu of service as described in Section 4.11(A).

b) The Health Plan shall support practice utilization of medication assisted treatment for substance use conditions across the

continuum of services from primary care to specialty behavioral health services.

8) Methadone Management Services

The Health Plan shall provide coverage for Methadone/Levomethadyl acetate (LAAM) services for members for acute opiate detoxification as well as maintenance. The Health Plan may develop its own payment methodologies for Methadone/LAAM services.

9) Covered Benefit Requirements for Parity in Mental Health and Substance Use Disorders

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

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

c) If the Health Plan includes an aggregate lifetime or annual dollar limit on at least two-thirds of all medical/surgical benefits provided

to members through a contract with the state, it must either apply the aggregate lifetime or annual dollar limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health or substance use disorder benefits in a manner that does not distinguish between the medical/surgical benefits and mental health or substance use disorder benefits; or not include an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is more restrictive than the aggregate lifetime or annual dollar limit, respectively, on medical/surgical benefits in accordance with 42 CFR 438.905(c).

d) If the Health Plan includes an aggregate lifetime limit or annual dollar amount that applies to one-third or more but less than two-thirds of all medical/surgical benefits provided to members, it must either impose no aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits; or impose an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no more restrictive than an average limit calculated for medical/surgical benefits in accordance with 42 CFR 438.905(e)(ii).

e) The Health Plan must not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to enrollees (whether or not the benefits are furnished by the same Health Plan).

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

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

h) The Health Plan may not impose Non-Quantitative Treatment Limits (NQTL) for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of the Health Plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification.

B) ***DHS and DOH Specialized Behavioral Health Benefits***

The State provides for specialized behavioral health benefits in addition to the benefits the Health Plan must cover in Section 4.4(A). While

these benefits are not the responsibility of the Health Plan, the Health Plan does have coordination requirements for specialized behavioral health benefits as described in Section 3.7(O)-(P). This section describes the services themselves for the Health Plan's reference.

DHS may propose a Contract modification in accordance with Section 14.13 to include some or all of the Specialized Behavioral Health Benefits described in this Subsection 4.4(B) and Appendix E during the Contract period.

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

a) While the Health Plan is responsible for providing coverage for behavioral health services set forth in Section 4.4(A), children/youth less than twenty-one (21) years old with a diagnosis of serious emotional behavioral disorders are eligible for additional behavioral health services within the Department of Health, Child and Adolescent Mental Health Division (CAMHD) Support for Emotional and Behavioral Development (SEBD) program.

b) The DOH, through its Child and Adolescent Mental Health Division (CAMHD), provides behavioral health services, including transportation, to children and adolescents age three (3) through age twenty (20) determined to be eligible for the SEBD program through CAMHD and in need of intensive behavioral health services. The CAMHD program is carved out of the Health Plan responsibilities. The services covered for the SEBD program are described on the DOH CAMHD webpage: http://health.hawaii.gov/camhd/.

c) The eligibility criteria for the CAMHD program include:

    1. The member is age three through twenty (3-20) years;

    2. The member must have been diagnosed with a qualifying mental health diagnosis by a Qualified Mental Health Professional, documented in the past 12 months;

    3. The member must be experiencing moderate to severe impairments in their daily functioning because of their mental health diagnosis. This is determined by the CAMHD clinical lead as part of the eligibility process; and

    4. The CAMHD Medical Director or designated Qualified Mental Health Professional reviews and makes the determination of SEBD eligibility.

d) Members who do not meet the eligibility criteria, based upon assessment by the Health Plan's medical director, but who are determined to need additional services medically necessary for the member's health and safety, shall be referred to the CAMHD for provisional eligibility on a case-by-case basis.

e) The CAMHD criteria to end or suspend additional behavioral health services are based on clinical appropriateness. Members that meet the discharge criteria, but are assessed by CAMHD's medical director to need additional medically necessary services for the member's health and safety, may continue to stay in the CAMHD program for a specified additional length of time with approval by the Health Plan's medical director.

f) Members that are assessed as no longer needing additional intensive behavioral health services shall continue to have access to all other standard behavioral health services offered by the

health plan found in Section 4.4(A). Should a member again meet criteria for the provision of additional intensive behavioral health interventions, the member shall again be provided these services by CAMHD.

2) Comprehensive Behavioral Health Services for Adults

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

b) As noted in Section 3.7(O), CCS shall provide to its adult members a full range of specialized behavioral health services including inpatient, outpatient therapy and tests to monitor the member's response to therapy, and intensive case management. Adult members who are receiving services through CCS that require alcohol and/or drug abuse treatment may also receive these services through CCS.

c) Members may be eligible for additional behavioral health services within the CCS program if they meet the following criteria:

    1. The member is eligible for the QUEST Integration program;

    2. The member falls under one of the qualifying diagnoses (see Appendix G);

3. The member demonstrates the presence of a qualifying diagnosis for at least twelve (12) months or is expected to demonstrate the qualifying diagnosis for the next twelve (12) months; and

4. The member meets at least one of the criteria below demonstrating instability and/or functional impairment:

    a) Clinical records demonstrate that the member is currently unstable under current treatment or plan of care (e.g., multiple hospitalizations in the last year and currently unstable, substantial history of crises and currently unstable to include but not be limited to consistently noncompliant with medications and follow-up, unengaged with providers, significant and consistent isolation, resource deficit causing instability, significant co-occurring medical illness causing instability, poor coping/independent living/problem solving skills causing instability, at risk for hospitalization); or

    b) The member requires or is under Protective Services or intervention by housing or law enforcement officials.

d) Members that do not meet the requirements listed above, but are assessed by the Health Plan's medical director that additional services are medically necessary for the member's health and safety shall be evaluated on a case-by-case basis for provisional eligibility for CCS.

e) The Health Plan shall submit the designated DHS referral form, completed by a qualified mental health professional (QHMP), along with supporting documentation of SMI/SPMI and functional impairment consistent with eligibility criteria (i.e. admission and discharge summaries, day hospital admission and discharge summaries, outpatient admission and discharge summaries, psychiatric assessment, psychological test results, and other pertinent documents).

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

g) DHS has the sole authority to disenroll members from CCS. Reasons for disenrollment include but are not limited to the following:

1. Member no longer meets eligibility criteria for the Medicaid program or voluntarily leaves the program;
2. No contact with the member established for over four (4) months;
3. Member refuses services and requests disenrollment from the program;
4. Member no longer meets CCS eligibility criteria;
5. Member moves to another State;
6. Death of a member;
7. Incarceration of the member;

8. Transfer of the member to a long-term care nursing facility or an ICF-MR facility and the behavioral health care needs of the member will be assumed by the facility;

9. Member is waitlisted at an acute hospital for a long-term care bed and the behavioral health care needs of the member will be assumed by the facility;

10. Member is sent out–of-state for medical treatment by DHS or a Health Plan and DHS or the Health Plan will assume responsibility for the behavioral health care needs of the member;

11. Member is admitted to the Hawaii State Hospital; or

12. Member provides false information with the intent of enrolling in a DHS program under false pretenses.

h) Members that are assessed as no longer needing services through CCS shall continue to have access to all standard behavioral services offered by the Health Plan. Should a member meet criteria again for the provision of additional comprehensive behavioral health interventions, the Health Plan shall refer the member to DHS to assess for transition to the CCS program.

i) DHS may enact joint Health Plan/CCS performance incentives for their members with SMI or SPMI.

4.5 Coverage Provisions for Primary and Acute Care Services

The Health Plan shall provide the following primary and acute care services in accordance with the prescribed parameters and limitations

as part of their benefit package as described in Section 4.1. The Health Plan shall comply with all State and Federal laws pertaining to the provision of such services.

The Health Plan shall make available triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions, when applicable.

A) *Cognitive Rehabilitation Services*

1. The Health Plan shall provide coverage for Cognitive Rehabilitation Services. Cognitive Rehabilitation Services are services provided to cognitively impaired persons, most commonly those with traumatic brain injury, that assess and treat communication skills, cognitive and behavioral ability, and cognitive skills related to performing Activities of Daily Living (ADLs). Reassessments are completed at regular intervals, determined by the provider and according to the member's assessed needs, and treatment goals and objectives.
2. Five cognitive skills area should be comprehensively assessed and, as appropriate, treated:
    a) Attention Skills- sustained, selective, alternating, and divided;
    b) Visual Processing Skills- acuity, oculomotor control, fields, visual attention, scanning, pattern recognition, visual memory, or perception;
    c) Information Processing Skills- auditory or other sensory processing skills, organizational skills, speed, and capacity of processing;

d) Memory Skills- orientation, episodic, prospective, encoding, storage, consolidation, and recall; and

e) Executive Function Skills- self-awareness, goal setting, self-initiation, self-inhibition, planning and organization, self-monitoring, self-evaluation, flexible problem solving, and metacognition.

f) 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.

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

h) Education;

i) Process training;

j) Strategy development and implementation; and

k) Functional application.

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

4. Some of the approved cognitive rehabilitation techniques/strategies include:

a) 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.

b) 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.

c) Compensatory memory techniques - Strategies to improve functions of attention and concentration that can impact the member's ability to regain independence in ADLs as well as in auditory processing, planning, problem solving, decision making, and memory functions.

d) 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.

e) Reading/writing skills retraining – Process to relearn levels of writing and reading structure and content to member's maximum potential.

B) *Diagnostic Testing*

1. The Health Plan shall provide diagnostic testing to include but not limited to screening and diagnostic radiology and imaging; screening and diagnostic laboratory tests; and other medically necessary screening or diagnostic radiology or laboratory services.
2. Health Plans may not prior authorize any laboratory, imaging or diagnostic services other than the following:

    a) Magnetic Resonance Imaging (MRI);

b) Magnetic Resonance Angiogram (MRA);

c) Positron Emission Tomography (PET);

d) Reference lab tests that cannot be done in Hawaii and not specifically billable by clinical laboratories in Hawaii;

e) Disease specific new technology lab tests;

f) Chromosomal analysis;

g) Psychological testing;

h) Neuropsychological testing; or

i) Cognitive testing.

C) *Dialysis*

1. The Health Plan shall provide coverage of dialysis services when provided by participating Medicare certified hospitals and Medicare certified End Stage Renal Disease (ESRD) providers. The Health Plan shall assure that only services, equipment, supplies, diagnostic testing (including medically necessary laboratory tests) and drugs medically necessary for the dialysis treatment that are approved by Medicare are provided. The Health Plan shall allow for dialysis treatments in various settings: hospital inpatient, hospital outpatient, non-hospital renal dialysis facility or members' home. The Health Plan shall structure provision of home dialysis to include those items in Medicare’s global reimbursement for home dialysis. All facilities providing maintenance renal dialysis treatments to members must be certified as meeting the conditions for compliance with Medicare health, safety and other Medicare requirements.

a) The Health Plan shall include the following as part of dialysis services:

b) Laboratory Tests including Hepatitis B surface antigen (HBsAg) and Anti-HB testing for patients on Hemodialysis, Intermittent Peritoneal Dialysis (IPD), and Continuous Cycling Peritoneal Dialysis (CCPD);

c) Hepatitis B vaccines;

d) Alfa Epoetin (EPO) when provided during dialysis and the Health Plan is encouraged to follow evidence-based best practices about target hemoglobin/hematocrit levels;

e) Other drugs related to ESRD;

f) Home dialysis equipment and supplies prescribed by a physician;

g) Continuous ambulatory peritoneal dialysis (CAPD), a variation of peritoneal dialysis, that is an alternative mode for dialysis for home dialysis patients;

h) Physician's Services; and

i) Inpatient hospitalization when the hospitalization is for an acute medical condition requiring dialysis treatments; or when a patient receiving chronic outpatient dialysis is hospitalized for an unrelated medical condition, or for placement, replacement or repair of the chronic dialysis route.

D) *Dental Services to Treat Medical Conditions*

1. The Health Plan shall provide dental services that are medically necessary to treat medical conditions. The Health Plan shall be responsible for providing referrals, follow-ups, coordination, and provision of appropriate medical services related to medically necessary dental needs.

2. The Health Plan shall provide coverage for any dental or medical services resulting from a dental condition that are provided in a medical facility (e.g., inpatient hospital and ambulatory surgical center). This includes medical services provided to adults and children that are required as part of a dental treatment and certain dental procedures performed by both dentists (oral surgeons) and physicians (primarily plastic surgeons, otolaryngologists and general surgeons), as defined in Appendix F.

3. Specifically, the Health Plan shall be responsible for:

    a) Referring EPSDT eligible members to DHS Dental Program contractor for EPSDT dental services and other dental needs not provided by the Health Plan;

    b) 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 and compound), oral surgery to repair traumatic wounds, surgical supplies, blood transfusion services, ambulatory surgical center services, x-rays,

laboratory services, drugs, physician examinations, consultations, and second opinions;

c) Providing sedation services associated with dental treatment, when performed in an acute care setting, by a physician anesthesiologist. Sedation services administered by an oral and maxillofacial surgeon, or other qualified dental anesthetist, in a private office or hospital-based outpatient clinic for services that are not medically related shall be the responsibility of the Dental Program contractor;

d) 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

e) Providing dental services in relation to oral or facial trauma, oral pathology (including but not limited to infections of oral origin, cyst and tumor management) and craniofacial reconstructive surgery, performed on an inpatient basis in an acute care hospital setting.

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

5. 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.

6. In cases of medical disputes regarding coverage, the Health Plan's Medical Director shall consult with the Med-QUEST Division's Medical

Director to assist in defining and clarifying the respective responsibilities.

E) *Durable Medical Equipment and Medical Supplies*

1. The Health Plan is responsible for providing durable medical equipment and medical supplies which include, but are not limited to, the following: oxygen tanks and concentrators; ventilators; wheelchairs; crutches and canes; eyeglasses; orthotic devices; prosthetic devices; hearing aids; pacemakers; medical supplies such as surgical dressings, continence supplies and ostomy supplies; foot appliances (orthoses, prostheses); orthopedic shoes and casts; orthodigital prostheses and casts; and other medically necessary durable medical equipment covered by the Hawaii Medicaid program.

F) *Emergency and Post Stabilization Services*

1. 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, the availability of a 24/7 nurse triage line, and alternatives for members to receive non-emergent care outside of the emergency department.
2. The Health Plan shall establish a twenty-four (24) hour nurse triage phone line in accordance with Section 9.4(I). The Health Plan shall reports to DHS in a frequency and format determined by DHS on the

number of calls received, their times, reason for the call, and disposition. The report parameters will be part of the reporting package described in Section 6.2.

3. Through the requirements of Section 8.1(C) member access to providers through extended office hours or after-hours access will increase and is expected to decrease inappropriate emergency department usage. The Health Plan is encouraged to expand access beyond the minimum requirements of Section 8.1 to promote utilization of urgent care centers or after-hours care in order to prevent inappropriate emergency department usage.

4. An emergency medical condition is a medical condition manifesting itself by acute onset of 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:

    a) 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;

    b) Serious impairment of bodily functions;

    c) Serious dysfunction of any bodily organ or part;

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

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

    f) With respect to a pregnant woman having contractions: (1) that there is not 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.

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

6. 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 be furnished by a provider that is qualified to furnish such services.

7. 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 to be provided on an emergent basis until the member is stabilized. The Health Plan shall also pay any screening examination services to determine whether an emergency medical condition exists.

8. The Health Plan shall base coverage decisions for initial screening (examinations to determine whether an emergency medical condition exists) on the severity of the symptoms at the time of presentation and shall cover these examinations when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. The Health Plan shall not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergency in nature.

9. The emergency department physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Health Plan, which shall be responsible for coverage and payment. The Health Plan is responsible for coverage and payment of medically necessary emergency services. The Health Plan shall not refuse to cover emergency services based on the emergency department provider failing to notify the member's PCP or the Health Plan within ten (10) days of presentation for emergency services. However, the Health Plan may deny reimbursement for any services provided on an emergent basis to an individual after the provider could reasonably determine that the individual did not have an actual emergency medical condition.

10. The Health Plan, however, may establish arrangements with a hospital whereby the Health Plan may send one of its own physicians with appropriate emergency department privileges to assume the attending physician's responsibilities to stabilize, treat, and transfer the member, if such arrangement does not delay the provision of emergency services.

11. 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 for the screening examination shall be whether the member had acute symptoms of sufficient severity at the time of presentation. However, in this situation, the Health Plan shall deny reimbursement for any non-emergent diagnostic and treatments provided, with the exception below.

12. 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.

13. 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.

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

15. The Health Plan shall be responsible for providing post-stabilization care services twenty-four (24) hours a day, seven (7) 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. Post-stabilization services include follow up outpatient specialist care.

16. The Health Plan is financially responsible for post-stabilization services obtained from any provider that did not receive prior authorization or pre-certified by a Health Plan provider or organization representative, regardless of whether provider is within or outside the Health Plan's provider network, if these services are rendered to maintain, improve, or resolve the members' stabilized condition in the following situations:

a) The Health Plan does not respond to the provider's request for pre-certification or prior authorization within one (1) hour;

b) The Health Plan cannot be contacted; or

c) The Health Plan's representative and the attending physician cannot reach an agreement concerning the member's care, and a Health Plan physician is not available for consultation. In this situation, the Health Plan shall give the treating physician the opportunity to consult with an in-network physician, and the treating physician may continue with the care of the member until a Health Plan physician is reached or one of the criteria outlined below are met.

17. The Health Plan's responsibility for post-stabilization services that it has not approved shall end when:

a) An in-network provider with privileges at the treating hospital assumes responsibility for the member's care;

b) An in-network provider assumes responsibility for the member's care through transfer;

c) The Health Plan's representative and the treating physician reach an agreement concerning the member's care; or

d) The member is discharged.

18. 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.

G) *Family Planning Services*

1. The Health Plan shall provide access to family planning services within the network. However, member freedom of choice may not be restricted to in-network providers. The Health Plan may not restrict a member's free choice of family planning services and supplies providers. Family planning services include family planning drugs, supplies and devices to include but not limited to any Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all individuals with reproductive capacity; same day access to family planning services shall be provided as needed with no prior authorization.

2. The Health Plan shall inform members of the availability of family planning services and shall provide services to members wishing to prevent pregnancies, plan pregnancies, plan the spacing between pregnancies, or obtain confirmation of pregnancy. These services shall include, at a minimum, the following:

    a) Education and counseling necessary to make informed choices and understand contraceptive methods;

    b) Emergency contraception and counseling, as indicated;

    c) Follow-up, brief, and comprehensive visits;

    d) Pregnancy testing;

    e) Contraceptive supplies and follow-up care; and

    f) Counseling related to risk behaviors and preventive strategies, and diagnosis and treatment, of sexually transmitted infections.

3. The Health Plan shall furnish all services on a voluntary and confidential basis to all members.

H) ***Habilitation Services***

1. The Health Plan shall be responsible for coverage of habilitative services and devices. Habilitative services and devices develop, improve, or maintain skills and functioning for daily living that were never learned or acquired to a developmentally appropriate level. Skills and functioning for daily living, such as basic activities of daily living, are typically learned or acquired during childhood development.
2. Habilitative Services and Devices include:
    a) Audiology Services
    b) Occupational Therapy
    c) Physical Therapy
    d) Speech-Language Therapy
    e) Vision Services
    f) Devices associated with these services including augmentative communication devices, reading devices, and visual aids but exclude those devices used solely for activities at school.
3. When being provided as habilitative services and devices, these are covered when medically necessary, if not otherwise covered in the benefits package.
4. Habilitative services do not include routine vision services that are found in Section 4.5(V).

I) *Home Health Services*

1. The Health Plan shall provide coverage for 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.
2. Home health visits shall be covered as follows when part of a written plan of care:
    a) Daily visits permitted for home health aid and nursing services in the first two weeks of patient care if part of the written plan of care;
    b) No more than three visits per week for each service in the third to seventh week of care;
    c) No more than one visit per week for each service in the eighth to fifteenth week of care; and
    d) No more than one visit every other month for each service from the sixteenth week of care.
3. Services exceeding these parameters shall require prior authorization.
4. Home health services include, but are not limited to:
    a) Skilled nursing;
    b) Home health aides;
    c) Medical supplies and durable medical equipment;

d) Therapeutic services such as physical and occupational, therapy; and

e) Audiology and Speech-language pathology.

J) *Inpatient Hospital Services for Medical, Surgical, Maternity/Newborn Care, and Rehabilitation*

1. The Health Plan shall be responsible for coverage of inpatient hospital services for medical, surgical, maternity/newborn care, and rehabilitation services. These services include the cost of room and board for inpatient stays. The services include: nursing care; medical supplies, equipment and drugs; diagnostic services; physical therapy, occupational therapy, audiology, and speech-language pathology services; and other medically necessary services in this category.

K) *Other Practitioner Services*

1. The Health Plan shall be responsible for coverage of 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, and psychiatric health specialists), paraprofessionals including Peer Support Specialists, and other medically necessary practitioner services provided by a licensed or certified healthcare provider to include behavioral health providers such as psychologists, marriage and family therapists, mental health counselors and certified substance abuse counselors.

L) *Outpatient Hospital Services*

1. The Health Plan shall be responsible for coverage of outpatient hospital services. These services include: twenty-four (24) hours a day, seven (7) days per week, emergency services; outpatient surgical or other interventional procedures; urgent care services; medical supplies, equipment and drugs; diagnostic services; therapeutic services including chemotherapy and radiation therapy; and other medically necessary services in this category.

M)*Physician Services*

1. The Health Plan shall be responsible for coverage of physician services. Physician services are provided within the scope of practice of allopathic or osteopathic medicine as defined by State law. 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.

N)*Podiatry Services*

1. The Health Plan shall be responsible for coverage of podiatry services. Podiatry services shall include, but are not limited to, the treatment of conditions of the foot and ankle such as:

    a) Professional services, not involving surgery, provided in the office and clinic;

b) Professional services, not involving surgery, related to diabetic foot care in the outpatient and inpatient hospital;

c) Surgical procedures are limited to those involving the ankle and below;

d) Diagnostic radiology procedures limited to the ankle and below;

e) Foot and ankle care related to the treatment of infection or injury is covered in the office or an outpatient clinic setting; and

f) Bunionectomies are covered only when the bunion is present with overlying skin ulceration or neuroma secondary to the bunion.

O) ***Pregnancy-related Services - Services for Pregnant Women and Expectant Parents***

1. The Health Plan shall provide pregnant women with any medically necessary pregnancy-related services for the health of the woman and her fetus without limitation, during the woman's pregnancy and up to sixty (60) days post-partum.

2. The following services are covered under pregnancy-related services: prenatal care; radiology, laboratory, and other diagnostic tests; treatment of missed, threatened, and incomplete abortions; delivery of the infant; postpartum care; prenatal vitamins; lactation counseling (for six months); breast pump (purchased or rental for six months); inpatient hospital services, physician services, other practitioner services, and outpatient hospital services that impact pregnancy outcomes.

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

4. The Health Plan is prohibited from:

    a) 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);

    b) Penalizing, reducing, or limiting the reimbursement of an attending provider because the provider provided care in a manner consistent with NMHPA; or

    c) Providing incentives (monetary or otherwise) to an attending provider to induce the provider to provide care inconsistent with NMHPA.

5. 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:

    a) Access to appropriate levels of care based on medical need, including emergency care;

    b) Transfer and care of pregnant women, newborns, and infants to tertiary care facilities when necessary;

c) Availability and accessibility of OB/GYNs, anesthesiologists, and neonatologists capable of dealing with complicated perinatal problems; and

d) Availability and accessibility of appropriate outpatient and inpatient facilities capable of dealing with complicated perinatal problems.

P) ***Prescription Drugs***

1. The Health Plan shall cover medications that are determined medically necessary to optimize the member's medical condition, including behavioral health prescription drugs for children receiving services from CAMHD. Medication management and patient counseling are also included in this service.

2. The Health Plan shall develop a common formulary drug list for its program available in electronic and paper form. The Health Plans formulary drug list shall include medications covered (both generic and name brand), over-the-counter medications included in the Medicaid State Plan, and a medication tier list.

3. The Health Plan shall make available the formulary drug list on their website in a machine readable file and format as specified by CMS. In accordance with Section 346-59.9, HRS, a member shall not be denied access to, or have any limitations on, any medication that is required to be covered by statute, including antipsychotic medications and continuation of antidepressant and anti-anxiety medications prescribed by a licensed psychiatrist or physician duly licensed in the State for a U. S. Food and Drug Administration (FDA) approved indication as treatment of a mental or emotional disorder.

Similarly, in accordance with Section 346-352, HRS, any physician licensed in the State who treats a member suffering from the human immunodeficiency virus, acquired immune deficiency syndrome, or hepatitis C, or a member in need of transplant immunosuppressives, shall be able to prescribe any medications approved by the FDA, that are eligible pursuant to the Omnibus Budget Reconciliation Rebates Act, and necessary to treat the condition, without having to comply with the requirements of any preauthorization procedures.

4. The Health Plan shall inform its providers in writing, at least thirty (30) days in advance, of any drugs deleted from its formulary. The Health Plan shall establish and inform providers of the process for obtaining coverage of a drug not on the Health Plan's formulary. At a minimum, the Health Plan shall have a process to provide an emergency supply of medication for at least seven (7) days to the member until the Health Plan can make a medically necessary determination regarding new drugs.

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

6. The Health Plan shall cover treatment, such as medications, of non-pulmonary and latent tuberculosis that is not covered by DOH.

7. The Health Plan may require a prescriber's office to request a Prior Authorization (PA) as a condition of coverage or pharmacy payments; if so, the PA request must be approved or denied by the Health Plan within twenty-four (24) hours of receipt. If a prescription cannot be filled when presented to the pharmacist due to a PA requirement and the prescriber's office cannot be reached, then the Health Plan must

instruct the pharmacy to dispense a seventy-two (72) hour emergency supply of the prescription. The pharmacy is not required to dispense a seventy-two (72) hour supply if the dispensing pharmacist determines that taking the prescribed medication would jeopardize the member's health or safety, and he or she has made good faith efforts to contact the prescriber. The Health Plan must reimburse the pharmacy for dispensing the emergency supply of medication.

8. DHS may, at a future date, require that members pay co-payments for prescription drugs and/or may carve-out prescription drug coverage. DHS would provide at least three months' notice for either change.

9. For all covered outpatient drugs, as described in 42 CFR 438.3(s)(1), the Health Plan shall:

    a) Provide coverage of outpatient drugs as defined in section 1927(k)(2) of the Social Security Act (the Act), that meets the standards for such coverage imposed by section 1927 of the Act as if the standards applied directly to the Health Plan.

    b) Report drug utilization data that is necessary for States to bill manufacturers for rebates in accordance with section 1927(b)(1)(A) of the Act no later than 45 calendar days after the end of each quarterly rebate period. Such utilization information must include, at a minimum, information on the total number of units of each dosage form, strength, and package size by National Drug Code of each covered outpatient drug dispensed or covered by the Health Plan.

c) Establish procedures to exclude utilization data for covered outpatient drugs that are subject to discounts under the 340B drug pricing program form the reports required under section 1927(s)(2) of the Act when States do not require submission of managed care drug claims data from covered entities directly.

d) Operate a drug utilization review program that includes prospective drug review, retrospective drug use review, and an educational program as required in section 1927(g) of the Act and 42 CFR part 456, subpart K.

e) Provide a detailed description of its drug utilization review program activities to the State on an annual basis.

f) Conduct a prior authorization program that complies with the requirements of section 1927(d)(5) of the Act.

g) Provide notice of prior authorization decisions as described in section 1927(d)(5)(A) of the Act. Under this section, the Health Plan may only require, as a condition of coverage or payment for a covered outpatient drug for which Federal Financial Participation (FFP) is available, the approval of the drug before its dispensing for any medically accepted indication if the system providing such approval provides response by telephone or other telecommunication device within twenty-four (24) hours of a request for prior authorization.

Q) *Rehabilitation Services*

1. The Health Plan shall be responsible for coverage of rehabilitation services. These services include physical and occupational therapy,

audiology, and speech-language pathology. These services shall be provided by licensed physical therapist (PT), licensed occupational therapist registered (OTR), licensed audiologist, and licensed speech pathologist respectively. A physical therapist assistant (PTA) or a certified occupational therapy assistant (COTA) may be utilized as long as they are working under the direct supervision of either a PT or OTR, respectively.

2. Rehabilitation services are limited to those who expect to improve in a reasonable period of time. Prior authorization is required for all rehabilitation services except for the initial evaluation. Rehabilitation services for children under EPSDT have different requirements (see Section 4.3.

R) *Sterilizations and Hysterectomies*

1. In compliance with federal regulations, the Health Plan shall cover sterilizations for both men and women only if all the following requirements are met:

    a) The member is at least twenty-one (21) years of age at the time consent is obtained;

    b) The member is mentally competent;

    c) The member voluntarily gives informed consent by completing the Sterilization Required Consent Form (DHS 1146);

    d) The provider completes the Sterilization Required Consent Form (DHS 1146);

    e) 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);

f) 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;

g) The member is not institutionalized in a correctional facility, mental hospital or other rehabilitative facility; and

h) The member, if incapacitated, meets the requirements in accordance with Sections 560:5-601 to 612, HRS.

2. The Health Plan shall cover a hysterectomy only if the following requirements are met:

a) The member voluntarily gives informed consent by completing the Hysterectomy Acknowledgement form (DHS 1145);

b) 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);

c) The member has signed and dated a "Sterilization Required Consent Form" (DHS 1146) prior to the hysterectomy; and

d) 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.

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

   a) It is performed solely for the purpose of rendering a member permanently incapable of reproducing;

   b) 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

   c) It is performed for the purpose of cancer prophylaxis in the absence of the patient having BRCA gene mutations.

4. The Health Plan shall maintain documentation of all sterilizations and hysterectomies and provide documentation to DHS upon the request of DHS.

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

S) *Sleep Laboratory Services*

1. The Health Plan shall be responsible for coverage of sleep laboratory services. Sleep laboratory services are provided for the diagnosis and treatment of sleep disorders and shall be performed by sleep laboratories or sleep disorder centers.

2. Sleep laboratory service providers shall be accredited by the American Sleep Disorders Association.

T) *Transplants*

1. The Health Plan shall be responsible for coverage of cornea transplants and bone grafts. The Health Plan shall follow written standards that provide for similarly situated members to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high quality care to members. The Health Plan shall make their written standards available to DHS upon DHS's request.

U) *Urgent Care Services*

1. The Health Plan shall provide coverage for urgent care services as necessary. Such service may be subject to prior authorization or pre-certification.

V) *Vision and Hearing Services*

1. The Health Plan shall cover a routine eye exam provided by qualified optometrist once in a twelve (12) month period for members under age twenty-one (21) years and once in a twenty-four (24) month period for adults age twenty-one (21) years and older. Visits done more frequently may be allowed if prior authorization is approved and covered when medically necessary. Emergency eye care shall be covered without prior authorization.

2. The Health Plan shall provide coverage for prescription lenses, cataract removal, and prosthetic eyes for all members. Cornea (Keratoplasty) transplants shall be provided in accordance with the Hawaii Administrative Rules. Excluded vision services include:

    a) Orthoptic training;

    b) Prescription fee;

    c) Progress exams;

    d) Radial keratotomy;

    e) Visual training; and

    f) Lasik procedure.

3. Visual aids prescribed by ophthalmologists or optometrists (eyeglasses, contact lenses and miscellaneous vision supplies) are covered by the Health Plan, if medically necessary. These include costs for the lens, frames, or other parts of the glasses, as well as fittings and adjustments. Visual aids are covered once in a twenty-four (24) month period. Individuals under forty (40) years of age require a medical justification for bi-focals.

4. Replacement glasses and/or new glasses with significant changes in prescription are covered within the benefit periods for both adults and children with prior authorization. Contact lenses are not covered for cosmetic reasons. Dispensing of the visual aids begins anew after each twenty-four (24) month period since the prior dispensing.

5. The Health Plan shall also provide hearing services to include screening, diagnostic, or corrective services/equipment/supplies provided by, or under the direction of, an otorhinolaryngologist or an audiologist to whom a patient is referred by a physician.

6. Hearing services include, but are not limited to the following:

Service	≤ 3 years	≥ 4 years	< 21 years	≥ 21 years
Initial Evaluation/Selection			1X per year	1X per year
Electroacoustic Evaluation	4X per year	2X per year		
Fitting/Orientation/Hearing Aid Check			2X per 3 years	1X per 3 years

7. Hearing aid device coverage is for both analog and digital models. Hearing aids are covered once in a twenty-four (24) month period. Prior authorization is required for all hearing aid devices. The coverage of hearing devices shall include a service/loss/damage warranty, a trial or rental period, and reasonable reimbursement as set forth by DHS. In addition, there should be consideration of medically justified requests for services outside capped dollar amounts or frequency of replacement.

4.6 Coverage Provisions for Transportation Services

A. The Health Plan shall provide transportation to and from medically necessary Medicaid covered medical appointments for members who have no means of transportation and who reside in areas not served by public transportation or cannot access public transportation. Transportation services include both emergency and non-emergency ground and air services.

B. 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 is a minor or requires assistance, the Health Plan shall provide for one (1) 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 (airfare, ground transportation, lodging, and meals) for the member and the one (1) attendant (where applicable) associated with off-island or out-of-state travel due to medical necessity.

C. In the event there is insufficient access to specialty providers (including but not limited to psychiatrists and specialty physicians), the Health Plan shall arrange to transport providers.

D. Should the member be disenrolled from their Health Plan and enrolled into the Medicaid fee-for-service program or another Health Plan while off-island or out-of-state, the former Health Plan shall be responsible for the return of the member to the island of residence

and for transitioning care to the Medicaid fee-for-service program or the other Health Plan.

4.7 Coverage Provisions for Community Integration Services (CIS)

A) *Pre-tenancy supports*

The Health Plan shall cover the following pre-tenancy support services:

1. Conducting a functional needs assessment identifying the member's preferences related to housing (e.g., type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain community integration (including what type of setting works best for the individual); and providing assistance in budgeting for housing and living expenses.
2. Developing an individualized plan based upon the functional needs assessment as part of the overall person-centered plan. Identifying and establishing short and long-term measurable goal(s), and establishing how goals will be achieved and how concerns will be addressed.
3. Assisting the member with connecting to social services to help with finding and applying for housing necessary to support the individual in meeting their medical care needs.
4. Participating in person-centered plan meetings at redetermination and/or conducting revision plan meetings, as needed.
5. Providing supports and interventions per the person-centered plan.

B) ***Tenancy Sustaining Services***

The Health Plan shall cover the following tenancy sustaining services:

1. Service planning support and participation in person-centered plan meetings at redetermination and/or while conducting revision plan meetings, as needed.
2. Coordinating and linking the member to services and service providers including primary care and health homes; substance use treatment providers; mental health providers; medical, vision, nutritional and dental providers; vocational, education, employment and volunteer supports; hospitals and emergency rooms; probation and parole; crisis services; end of life planning; and other support groups and natural supports.
3. Entitlement assistance including assisting members in obtaining documentation, navigating and monitoring application process, and coordinating with the entitlement agency.
4. Assistance in accessing supports to preserve the most independent living such as individual and family counseling, support groups, and natural supports.
5. Providing supports to assist the member in the development of independent living skills, such as skills coaching, financial counseling, and anger management.
6. Providing supports to assist the member in communicating with the landlord and/or property manager regarding the participant's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of

emergency procedures involving the landlord and/or property manager.

7. Coordinating with the member to review, update and modify housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.

8. Connecting the member to training and resources that will assist the member in being a good tenant and achieving lease compliance, including ongoing support with activities related to household management.

C) ***Community Transition Services***

The Health Plan shall cover the following community transition services:

1. **Transitional Case Management Services**. Services that will assist the individual with moving into stable housing, including assisting the individual in arranging the move, assessing the unit's and individual's readiness for move-in, assisting the individual (excluding financial assistance) in obtaining furniture and commodities.

2. **Housing Quality and Safety Improvement Services**. Repairs or remediation for issues such as mold or pest infestation if repair or remediation provides a cost effective method of addressing occupant's health condition, as documented by a health care professional, and remediation is not covered under any other program.

3. **Legal Assistance**. Assisting the individual by connecting the enrollee to expert community resources to address legal issues

impacting housing and thereby adversely impacting health, such as assistance with breaking a lease due to unhealthy living conditions.

4. **Securing House Payments**. Provide a one-time payment for security deposit and/or first month's rent provided that such funding is not available through any other program. This payment may only be made once for each enrollee during the life of the demonstration, except for state determined extraordinary circumstances such as a natural disaster.

D) *Rules Surrounding CIS Provision*

1. The following are prohibited under CIS:
    a. Payment of ongoing rent or other room and board costs;
    b. Capital costs related to the development of housing;
    c. Expenses for ongoing regular utilities or other regular occurring bills;
    d. Goods or services intended for leisure or recreation;
    e. Duplicative services from other state or federal programs

4.8 Coverage Provisions for Long-Term Services and Supports (LTSS)

The Health Plan shall provide coverage of the LTSS for individuals in both HCBS and institutions as part of their benefit package when meeting the assessment requirements as described in Section 3. The

Health Plan shall make available triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions, when applicable. HCBS should be provided to individuals that choose to receive their LTSS in the community instead of in an institutional setting. Additional information on requirements for assessments and service plans shall be found in Section 3. The Health Plan shall comply with all State and Federal laws pertaining to the provision of such services, including, but not limited to the requirement that HCBS must be provided in a setting which complies with the 42 CFR 441.301(c)(4) requirements for home and community-based settings. All authorized LTSS shall be documented in the member's service plan as described in Section 3.7.

A) *Access to LTSS Benefits*

1) Access to HCBS When Not Meeting Institutional LOC

a) The Health Plan shall provide the following HCBS to individuals who are at risk of deteriorating to the institutional level of care (the "at risk" population):

1. Adult day care
2. Adult day health
3. Home delivered meals
4. Personal assistance
5. Personal emergency response system (PERS)
6. Private duty nursing

b) The DHS may impose limits on the number of hours of HCBS or the budget for such services. DHS will provide the Health Plan with information on "at risk" limits.

2) Access to LTSS When Meeting Institutional LOC

Once DHS approves the institutional level of care (LOC) for a member in accordance with Section 3.7(L), the Health Plan is responsible for covering the LTSS Benefits as medically necessary.

B) *Description of LTSS Benefits*

The Health Plan shall provide coverage of the following services.

1) Acute Waitlisted Intermediate Care Facility/Skilled Nursing Facility (ICF/SNF)

Acute waitlisted ICF/SNF means either ICF or SNF level of care services provided in an acute care hospital in an acute care hospital bed. The Health Plan shall identify individuals who are acute waitlisted for discharge to a more appropriate location for treatment.

2) Adult Day Care

a) Adult day care is defined as regular supportive care provided to four (4) or more disabled adult participants. Adult day care services include observation and supervision by center staff, coordination of behavioral, medical and social plans, and implementation of the instructions as listed in the participant's service plan. Therapeutic, social, educational, recreational, and

other activities are also provided as regular adult day care services.

b) 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.

3) Adult Day Health

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

b) 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.

c) In addition to nursing services, other components of adult day health services may include: emergency care, dietetic services, occupational therapy, physical therapy, physician services,

pharmaceutical services, psychiatric or psychological services, recreational and social activities, social services, speech-language pathology, and transportation services.

4) Assisted Living Facility Services

Assisted living facility (ALF) services include personal care and supportive care services (homemaker, chore, personal care services, meal preparation) that are furnished to members who reside in an ALF. ALFs are defined in Section 2.3. Payment for room and board is prohibited. Members receiving ALF services must be receiving ongoing CCMA services.

5) Community Care Management Agency (CCMA) Services

a) CCMA services are provided to members living in a provider-owned and controlled setting such as a Community Care Foster Family Homes (CCFFH), Expanded Adult Residential Care Homes (E-ARCHs), ALFs, and other community settings, as required.

b) The following activities are provided by a CCMA: continuous and ongoing nurse delegation to the caregiver in accordance with HRS Section 457-7.5; initial and ongoing assessments to make recommendations to the Health Plan for, at a minimum, indicated services, supplies, and equipment needs of members; service plan development in coordination with the member and/or their representative; ongoing face-to-face monitoring that includes "head to toe" physical assessment for skin breakdown, and implementation of the member's service plan; and interaction with

the caregiver on adverse events and/or changes in condition of members.

c) CCMAs shall:

1. communicate with a member's physician(s) regarding the member's needs including changes in medication and treatment orders,

2. work with families regarding service needs of member and serve as an advocate for their members, and

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

6) Community Care Foster Family Home (CCFFH) Services

a) CCFFH services are personal care, nursing, homemaker, chore, 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 CCFFHs is currently up to three (3) adults who receive these services in conjunction with residing in the home.

b) All CCFFH providers must provide individuals with their own bedroom unless the member consents to sharing a room with another resident. The total number of individuals living in the home, who are unrelated to the principal care provider, cannot exceed four (4). Members receiving CCFFH services must be receiving ongoing CCMA services.

7) Counseling and Training

a) 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 on coping skills to deal with the stress caused by member's deteriorating functional, medical or mental status.

b) Counseling and training is a service provided to members, families/caregivers, and professional and paraprofessional caregivers on behalf of the member. Counseling and training services may be provided individually or in groups. This service may be provided at the members residence or an alternative site. Training should be provided by qualified health professionals as defined in Appendix K.

8) Environmental Accessibility Adaptations

a) Environmental accessibility adaptations are those physical adaptations to the member's home, required by the individual's service 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, 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.

b) 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.

9) 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.

10) 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.

11) Moving Assistance

Moving assistance is provided in rare instances when it is determined, through an assessment by the service coordinator that a member 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 member is wheel-chair bound, living in a multi-story building with no elevator and where the member lives above the first floor; the home is unable to

support the member's additional needs for equipment; the member is evicted from their current living environment; or the member is no longer able to afford the home due to a rent increase. Moving expenses include packing and moving of belongings. Whenever possible, family, landlord, community and third-party resources who can provide this service without charge will be utilized.

12) Non-Medical Transportation

Non-medical transportation is a service offered to enable individuals to gain access to community services, activities, and resources, specified by the service plan. This service is to be used only when transportation is not included in the HCBS service being accessed. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the 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.

13) Nursing Facility (NF), Skilled Nursing Facility (SNF), or Intermediate Care Facility (ICF) Services

Nursing facility services are provided to members who need twenty-four (24) hours a day assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (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. 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.

14) Personal Assistance Services - Level I and Level II

a) Personal assistance, sometimes also called "attendant care" for children needing these services, are services provided in an individual's home to help them with their IADLs and ADLs.

b) Personal assistance services Level I are provided to individuals, requiring assistance with IADLs to prevent a decline in the health status and maintain the individuals safely in their home and communities. Personal assistance services Level I are for individuals who are not living with their family who would otherwise perform these duties as part of a natural support. Personal assistance services Level I is limited to ten (10) hours per week for individuals who do not meet institutional level of care. Personal assistance services Level I may be self-directed by the member and consist of the following:

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

    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) 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, and picking up medications;

h) Escorting the member 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) Providing 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 a change in service provided.

c) 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. Personal assistance services Level II may be self-directed and consist of the following:

1. Personal hygiene and grooming, including bathing, skin care, oral hygiene, hair care, and dressing;
2. Assistance with bowel and bladder care;
3. Assistance with ambulation and mobility;
4. Assistance with transfers;
5. Assistance with medications, which are ordinarily self-administered when ordered by member's physician;
6. 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;
7. Assistance with feeding, nutrition, meal preparation and other dietary activities;
8. Assistance with exercise, positioning, and range of motion;
9. Taking and recording vital signs, including blood pressure;
10. Measuring and recording intake and output, when ordered;
11. Collecting and testing specimens as directed;
12. Special tasks of nursing care when delegated by a registered nurse, for members who have a medically stable condition and who require indirect nursing supervision as defined in Chapter 16-89, HAR;
13. 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;

14. Reporting changes in the member's behavior, functioning, condition, or self-care abilities which necessitate more or less service; and

15. Maintaining documentation of observations and services provided.

16. When personal assistance services Level II activities are the primary services, personal assistance services Level I activities identified on the service 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.

15) Personal Emergency Response Systems (PERS)

a) 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.

b) A member may access PERS using an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The member may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. The following are allowable types of PERS items:

1. 24-hour answering/paging;
2. Beepers;
3. Med-alert bracelets;
4. Medication reminder services;
5. Intercoms;
6. Life-lines;
7. Fire/safety devices, such as fire extinguishers and rope ladders;
8. Monitoring services;
9. Light fixture adaptations (blinking lights, etc.);
10. Telephone adaptive devices not available from the telephone company; and
11. Other electronic devices/services designed for emergency assistance.

c) 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.

d) 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 except for an ALF.

16) Residential Care Services

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

b) Residential care is furnished: 1) in a Type I Expanded Adult Residential Care Home (E-ARCH), allowing five (5) or fewer residents provided that up to six (6) residents may be allowed at the discretion of DHS to live in a Type I home with no more than three (3) residents of whom may be NF LOC; or 2) in a Type II E-ARCH, allowing six (6) or more residents, where 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. Members receiving residential care services must be receiving ongoing CCMA services.

17) Respite Care

a) 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.

b) Respite care may be provided in the following locations: individual's home or place of residence; CCFFH; E-ARCH; 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 service plan. Respite services may be self-directed.

18) Private Duty Nursing

Private Duty Nursing is a service provided to individuals requiring ongoing nursing care (in contrast to Home Health or part time, intermittent skilled nursing services under the Medicaid State Plan) listed in the service plan. The service is provided by licensed nurses (as defined in HRS, Section 457) within the scope of State law and authorized in the member's service plan. Private Duty Nursing services may be self-directed under Personal Assistance Level II/Delegated using registered nurse delegation procedures as outlined in HRS, Section 457-7.5.

19) Specialized Medical Equipment and Supplies

a) Specialized medical equipment and supplies entails the purchase, rental, lease, warranty costs, assessment costs, installation, repairs and removal of devices, controls, or appliances, specified in the service 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 in the environment in which they live.

b) 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:

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

c) 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.

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

20) Subacute Facility services

Subacute facility services are provided in either a licensed nursing facility or a licensed and certified hospital in accordance with Hawaii Administrative Rules. Subacute facility services provide the member with services that meet a level of care that is needed by the member not requiring acute care, but who needs more intensive skilled nursing care than is provided to the majority of members in a skilled nursing facility. The subacute services shall be provided in accordance with the Hawaii Administrative Rules.

C) *Waiting List for members receiving HCBS and At-Risk services*

The Health Plan may have a waiting list for HCBS for both institutional level of care and the at-risk population based upon guidance provided by DHS. Health Plans shall submit their waiting list policies and procedures based upon objective criteria applied over all geographic areas served to DHS for review/approval at least sixty (60) days prior to implementation.

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

DHS shall regularly monitor the Health Plan's management of its waiting lists. As a part of these monitoring activities, on a monthly

basis, the Health Plan shall submit to DHS the following information relevant to its waiting list:

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

DHS shall meet with the Health Plans on a quarterly basis to discuss issues associated with management of the waiting list. DHS shall review the following at these quarterly meetings:

1. Health Plan's progress towards meeting annual thresholds; and
2. Any challenges with meeting needs of the specific members on the waiting list.

Members who are on a Health Plan's waiting list may change to another Health Plan that does not have a waiting list.

D) *Member Advisory Committee*

Each Health Plan must establish and maintain a member advisory committee to oversee care delivered to members receiving LTSS. The committee must include at least a reasonably representative sample of the LTSS populations, or other individuals representing those members, covered under the contract with the Health Plan.

4.9 Other Services to be Provided by the Health Plan

A) *Cultural Competency*

1. The Health Plan shall have a comprehensive written cultural competency plan that shall:

    a) Identify the health practices and behaviors of the members;

    b) Design programs, interventions, and services, which effectively address cultural and language barriers to the delivery of appropriate and necessary health services;

    c) 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;

    d) 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

    e) 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 438.6(d)(4), 438.6(f), 438.100(d), and 438.206(c)(2).

2. The Health Plan shall provide all in-network providers with a summary of the cultural competency plan that includes a summary

of information on how the provider may access the full cultural competency plan from the Health Plan at no charge to the provider.

3. The Health Plan shall submit the cultural competency plan to DHS for review and approval in accordance with Section 13.3(B), Readiness Review.

B) *Certification of Physical/Mental Impairment*

The Health Plan shall provide coverage for all evaluations and re-evaluations of disability (determinations of continued mental or physical impairment) for its members (evaluations submitted to the ADRC).

4.10 End of Life

A) *Advance Care Planning*

1. The Health Plan shall cover voluntary advance care planning services between a provider and a member with or without completing relevant legal forms.

B) *Advance Directives*

1. The Health Plan shall maintain written policies and procedures for advance directives as defined in Section 2.3 in compliance with 42 CFR 422.128, 438.3(j)(1) to (4), and in Subpart I of Part 489. For purposes of this section, the term "MA organization" in 42 CFR 422.128 shall refer to the Health Plan. Such advance directives shall be included in each member's medical record.

2. The Health Plan shall provide these policies on their website and through paper and/or electronic member communications to all members eighteen (18) years of age or older and shall advise members of:

    a) Their rights under the law of the State of Hawaii, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;

    b) The Health Plan's written policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience. See 42 CFR 422.128(b)(1)(ii); and

    c) The Health Plan shall inform members that complaints concerning noncompliance with the advance directive requirements may be filed with the State survey and certification agency found in the Office of Health Care Assurance in the Department of Health.

3. The information provided by the Health Plan to its members 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.

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

5. The Health Plan shall educate its staff about its advance directive policies and procedures, situations in which advance directives may be of benefit to members, and the Health Plan's responsibility to educate and assist members who choose to make use of advance directives. The Health Plan shall educate members about their ability to direct their care using this mechanism and shall specifically designate which staff members or network providers are responsible for providing this education. The Health Plan shall provide these policies and procedures to its providers and upon request to CMS and DHS.
6. The Health Plan shall work with providers to demonstrate achievement across the following areas:
    a) Higher rates of completion of advance directives; and
    b) Increased likelihood that clinicians understand and comply with a patient's wishes.

C) *Hospice Care*

1. The Health Plan shall cover hospice care for qualifying members. Hospice is a program that provides care to terminally ill patients who are not expected to live more than six (6) months. A participating hospice provider must meet Medicare requirements. Children under the age of twenty-one (21) years can receive treatment to manage or cure their disease while concurrently receiving hospice services.

4.11 Optional Services Provided by Health Plans

A) *In Lieu of Services*

1. The Health Plan may cover, for enrollees, services or settings that are in Lieu of Services or settings covered under the State Plan as follows:

    a) DHS determines that the alternative service or setting is a medically appropriate and cost effective substitute for the covered service or setting under the State Plan;

    b) The enrollee is not required by the Health Plan to use the alternative service or setting;

    c) The approved in Lieu of Services are authorized and identified in the Health Plan contract, and will be offered to enrollees at the option of the Health Plan; and

    d) The utilization and actual cost of in Lieu of Services is taken into account in developing the component of the Capitated Rates that represents the covered State Plan services, unless a statute or regulation explicitly requires otherwise.

B) *Value-Added Services*

1. The Health Plan may propose Value-added Services. Value-added Services may be actual health care services, benefits, or positive incentives that DHS determines will promote healthy lifestyles and improved health outcomes among members. Best practice approaches to delivering covered services are not considered Value-added Services.

2. Any Value-added Services that a Health Plan elects to provide must be provided at no additional cost to DHS. The cost of Value-added

Services are not reportable as allowable medical or administrative expenses, and therefore are not factored into the Capitated Rate setting process. In addition, the Health Plan must not pass on the cost of the Value-added Services to members or providers.

3. The Health Plan must ensure that providers do not charge members for any other cost-sharing for a Value-added Services, including copayments or deductibles. The Health Plan must specify the conditions and parameters regarding the delivery of each Value-added Services and must clearly describe any limitations or conditions specific to each Value-added Service in the Health Plan's member handbook. The Health Plan must also include a disclaimer in its marketing materials and provider directory indicating that restrictions and limitations may apply.
4. A Health Plan's proposal and subsequent requests to add a Value-added Service shall:
    a) Define and describe the proposed Value-added Service;
    b) Specify the service areas and Health Plan programs for the proposed Value-added Service;
    c) Identify the category or group of members eligible to receive the Value-added Service if it is a type of service that is not appropriate for all members;
    d) Note any limitations or restrictions that apply to the Value-added Services;
    e) Identify the providers or entities responsible for providing the Value-added Services;

f) Describe how the Health Plan will identify the Value-added Service in administrative data (e.g., Encounter Data) and/or in its financial reports, as applicable;

g) Propose how and when the Health Plan will notify providers and members about the availability of such Value-added Services; and

h) Describe the process by which a member may obtain or access the Value-added Services, including any action required by the member, as appropriate.

5. The Health Plan may not offer a Value-added Service without DHS approval, or advertise a Value-added Service if DHS has not approved it. If a Value-added Service is no longer offered, the Health Plan must notify each member that the service is no longer available through the Health Plan. The Health Plan must also revise all materials distributed to prospective members to reflect the change in Value-added Services. Materials are subject to review and approval by DHS.

4.12 Covered Benefits and Services Provided by DHS

The Health Plan is not responsible for the benefits described in this section, but may be required to coordinate activities with the governmental agencies that are responsible for the benefits.

A) *State of Hawaii Organ and Tissue Transplant (SHOTT) Program*

1. DHS shall provide medically necessary transplants through the SHOTT program, with the exception of cornea transplants and bone grafts, which shall be provided by the Health Plan to all enrollees requiring such services. The SHOTT Program covers adults and children (from birth through the month of their 21st birthday). Covered transplants must be non-experimental, non-investigational for the specific organ/tissue and specific medical condition being treated. These transplants may include liver, heart, heart-lung, lung, kidney, kidney-pancreas, and allogenic and autologous bone marrow transplants. In addition, children may be covered for transplants of the small bowel with or without liver. Children and adults must meet specific medical criteria as determined by the State and the SHOTT Program contractor.

B) *Services for Individuals with Intellectual and Developmental Disabilities (I/DD)*

1. The Department of Health (DOH), Developmental Disability Division (DDD) provides home and community-based services and supports to individuals with intellectual and developmental disabilities (I/DD) under the authority of §1915(c) of the Social Security Act, hereinafter program is referred to as the "I/DD Waiver".
2. DHS oversees and monitors all I/DD Waiver implementation, administration, and operation activities delegated to the DDD. The Health Plan's coordination responsibilities are described in Section 3.7(P).

3. DDD provides HCBS services to members who are eligible for the I/DD Waiver. Members will continue to access medical services though their health plans. The eligibility criteria for the I/DD Waiver include:

    a) The member is eligible for Medicaid long-term care services;

    b) The member meets the Medicaid Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) level of care as defined in 42 CFR §440.150; and

    c) The member meets the intellectual and/or developmental disability conditions as defined by the Hawaii Revised Statue (HRS) Chapter 333F-1 and detailed in the DOH Hawaii Administrative Rules (HAR) section 11-88.1-5.

4. The HCBS services approved under the I/DD Waiver are described in Appendix I.

5. HCBS services approved under I/DD Waiver are considered a "wrap-around" to the EPSDT benefit, not a replacement. The I/DD Waiver will not supplant any service that is the responsibility of the Medicaid coverable services under the Health Plans (for example, medically necessary services under Medicaid State plan home health benefit or the EPSDT benefit), another state agency or other insurance. There should be no duplication of services between the Health Plan and the I/DD Waiver.

6. If the member is no longer eligible for the I/DD Waiver, the Health Plan shall collaborate with DDD in transitioning members out of the I/DD Waiver to access medically necessary services. The Health Plan shall coordinate activities with DDD in accordance with DHS guidance.

C) *Dental Services*

1. DHS shall provide emergency and non-emergency dental services to Health Plan members through the month of their twenty-first (21st) birthday.
2. DHS shall provide emergency dental services for adult members age twenty-one (21) years and older. Covered adult dental emergencies are services to relieve dental pain, eliminate infections, and treat acute injuries to teeth and supporting structures.

D) *Intentional Termination of Pregnancies (ITOPs)*

1. The Health Plan shall not cover any ITOPs. The Health Plan shall instruct its providers to submit claims for ITOPs directly to DHS' fiscal agent. DHS shall cover all procedures, medications, transportation, meals, and lodging associated with ITOPs. All costs associated with ITOPs shall be covered with State-funds only.

2. The Health Plan shall cover treatment of medical complications occurring because of an elective termination and treatments for spontaneous, incomplete, or threatened terminations as well as for ectopic pregnancies.

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

SECTION 5 – Quality, Utilization Management, and Administrative Requirements

5.1 Quality

A) *Quality Strategy and Quality Program Background*

1. DHS is developing an updated Medicaid Managed Care Quality Strategy (DHS Quality Strategy) in accordance with 42 CFR 438.340 that will detail goals and objectives for quality management and improvement, as well as specific quality initiatives that are priorities; DHS Quality Strategy will be updated periodically as necessary.
2. Two interrelated subcomponents of DHS Quality Strategy will be: the Social Determinants of Health (SDOH) Transformation Plan; and the Health Information Technology (HIT) Innovation Plan.
3. DHS Quality Strategy shall address the health needs of the entire beneficiary population. DHS Quality Strategy may provide guidance on evidence-based and nationally-recommended approaches to addressing the desired goals and objectives.
4. In order to achieve the objectives of DHS Quality Strategy, the Health Plan shall collaborate with DHS, other state agencies, and as needed with other Health Plans, to:
    a) Develop and implement a data-driven, outcomes-based, continuous Quality Assessment and Performance Improvement Program (QAPI) plan focused on rigorous outcome measurement against relevant targets and benchmarks, and that appropriately supports providers and

beneficiaries for advancing quality goals and health outcomes. This process will include considerations for tracking outcomes and addressing deficiencies when improvement is not occurring.

b) Develop and adopt a SDOH Work Plan within its QAPI that adopts a whole person care approach throughout the QAPI through the provision of SDOH resources at the community and beneficiary levels.

c) Develop and implement a streamlined HIT Work Plan within its QAPI that employs a collaborative approach across Health Plans with input from the provider community, to support providers in increasing their use of HIT, enable interoperability, and enhance patient access to their health information.

5. In close alignment with DHS Quality Strategy, DHS will lead, and the Health Plan shall participate in, a comprehensive quality program (hereafter called Quality Program). The Quality Program may include one or more work groups tasked with systematically addressing, reporting on challenges with, and participating in a collaborative approach to advance the goals and objectives of the DHS Quality Strategy, including the SDOH Transformation Plan and HIT Innovation Plan.

6. **SDOH Transformation Plan.** The statewide SDOH Transformation Plan will be integrated into DHS Quality Strategy when completed, and will outline DHS goals in the following areas:

a) Collection of new, or collation of existing SDOH data, at the neighborhood and individual levels;

b) Enhanced use of SDOH data as inputs in predictive and actuarial models, as well as in hot spotting and other advanced analytic methods, leading in turn to:

    1. Improved identification of beneficiaries and beneficiary communities disproportionately impacted by SDOH and at high risk for poor health outcomes; and

    2. Improved application of SDOH-based adjustment factors into Value Based Payment arrangements.

c) Enhancing awareness of and access to community-based SDOH supports and resources;

d) Addressing social needs in the delivery of care and resources provided to beneficiaries;

e) Adapting the delivery of care and resources provided to beneficiaries based on their SDOH needs;

f) Developing targeted strategies to addressing the SDOH needs of special populations disproportionately impacted by SDOH and at high risk for adverse health outcomes;

g) Promoting statewide collaboration with the other Health Plans, DHS and other state agencies and/or partners in implementing SDOH strategies; and

h) Collecting and incorporating community input and establishment of effective partnerships with existing community resources, including a RHP if one exists, in the implementation of SDOH strategies.

7. The SDOH Transformation Plan will outline the supports, resources and improvements DHS will make to support the Health Plan's SDOH Work Plan and facilitate shared learning and statewide collaboration.

8. The SDOH Transformation Plan will be reviewed and updated as part of DHS Quality Strategy. The Health Plan will align its SDOH Work Plan to describe the "on the ground" community and beneficiary-level activities that will realize the overall goals and strategies of the SDOH Transformation Plan.

9. **HIT Innovation Plan**. The statewide HIT Innovation Plan will be integrated with DHS Quality Strategy when completed, and will outline DHS goals in the following areas:

    a) Development of infrastructure to enable providers to conveniently receive beneficiary health updates (for example, on recent hospitalizations, emergency department visits, or medications filled), population health updates (for example, aggregated metrics on their patient panel and comparisons to relevant benchmarks), and submit required information (for example, on quality measures) to Health Plans with a strong emphasis on promoting interoperability across systems and a de-emphasis on redundancy and provider burden;

    b) Development of a targeted strategy to support providers in the network who assume CSC services with all the data needed to support active identification and care provision of SHCN/SHCN+ patients in a consistent manner that is convenient and limits or eliminates the need for the providers to retrieve data manually or via multiple non-interoperable systems.

c) Adoption of the latest industry standards in interoperability (e.g. Fast Healthcare Interoperability Resources (FHIR) standards) across Health Plans and the provider community statewide;

d) Adoption of sophisticated and advanced methods to support predictive analytics;

e) Adoption of interoperable data exchange protocols with state public health registries, such as the immunization registry;

f) Collection and reporting of all data at the most granular level available, with an emphasis on maximizing automation and reducing redundancy, to the greatest extent feasible;

g) Development of a targeted strategy to drive through promotion, facilitation, and technical assistance, an enhanced referral network that enables closed-loop, bi-directional referrals to behavioral, substance use, and other providers in the community;

h) Support and expansion of telehealth efforts as a strategy to enhance care service delivery to rural areas;

i) Adoption of, and provision of technical assistance and other resources to the provider community to support the adoption of, health IT-based strategies to advance the HOPE initiative, including quality improvement;

j) Development of a Health Plan and provider agnostic experience for the beneficiary in accessing their complete health record; and

k) Advancement in state and national HIT efforts to enhance healthcare data transparency, sharing, and integration across systems.

10. DHS will lead the development of statewide HIT Innovation Plan with active input and engagement of the Health Plans; the HIT Innovation Plan must be responsive to current challenges and concerns of the provider and beneficiary communities, and offer a collaborative, non-redundant, efficient and affordable strategy for the state to advance interoperability to support DHS goals. The HIT Innovation Plan will set its own goals, benchmarks, timelines, and deliverables. A priority setting process will be used to set achievable goals and drive continuous HIT improvement. The HIT Innovation Plan will be updated annually, and is expected to evolve in each year of the Contract.

11. The Health Plan shall be involved in the development of the HIT Innovation Plan, and be responsible for receiving input from the provider and beneficiary community. In the event that a statewide HIT Innovation Plan that achieves the intended goals is not completed in the first year of the Contract, or adequate progress towards the shared HIT Innovation Plan has not been achieved in subsequent years, DHS reserves the right to develop shared solutions that all Health Plans will be required to adopt.

B) *Quality Assessment and Performance Improvement (QAPI) Program*

1) QAPI Program Plan – General Requirements

a) The Health Plan shall develop and implement a comprehensive QAPI Program that is focused on improving health outcomes through collaborative opportunities and use of evidence-based approaches to achieve quality assurance and improvement.

b) The QAPI shall meaningfully demonstrate alignment with DHS SDOH Transformation and the HIT Innovation Plans.

c) The QAPI Program shall cover all demographic groups, care settings, and types of services. It shall address the delivery and outcomes of clinical medical care, behavioral health care, member safety, and non-clinical aspects of service, including the availability, accessibility, coordination, and continuity of care. The principles of continuous quality improvement shall be applied throughout the plan and process described, from developing, implementing, monitoring, and evaluating the QAPI Program to identifying and addressing opportunities for improvement.

d) Health Plans will collaborate with DHS, other state agencies such as DOH, and other Health Plans, to develop aligned, collaborative strategies.

e) The QAPI Program must at a minimum address the following elements and requirements:

1. A detailed description of the QAPI Program addressing all required program elements;

2. A discussion of how the Health Plan will operate the program to implement innovative approaches to support DHS in achieving improved outcomes;

3. Clearly defined evidence-based approaches to Performance Improvement Projects (PIPs) and other quality improvement efforts that the Health Plan will implement;

4. A proposed plan for collaboration across Health Plans where expected;

5. A process to continually evaluate the impact and effectiveness of the QAPI program;

6. The approach to modifying the QAPI Program to address deficiencies where identified;

7. A detailed plan for conducting and assessing performance improvement projects (PIPs), including a demonstration of the alignment between the Health Plan's PIPs with other Health Plans for DHS-specified PIPs, as further described in Section 5.1(B)(5);

8. Collecting and submitting to DHS performance measurement data, including outputs, process and outcome measures, and other qualitative data, as required by DHS;

9. Submitting data as required by DHS that enables DHS to validate and contextualize the Health Plan's performance on required measures;

10. Submitting a report that identifies disparities in health services and health outcomes between subpopulations/groups (including, but not limited to, race/ethnicity and language); and includes a plan of action and a timeline to remediate the SDOH and health disparities identified through targeted interventions. The plan of action should include a performance measurement and evaluation component.
11. Establishing mechanisms for detecting and addressing both under-utilization and over-utilization of services;
12. Establishing mechanisms for detecting and addressing both under-utilization and over-utilization of prescription drugs including controlled substances;
13. Establishing a Prescription Monitoring Program (PMP) to improve patient care and stop prescription misuse for controlled substances;
14. Establishing mechanisms for assessing and addressing the quality and appropriateness of care furnished to special populations across care settings, including:
    a) members with special health care needs;
    b) members enrolled in D-SNPs; and
    c) members using long-term service supports.
15. Participating in DHS efforts to prevent, detect, and remediate critical incidents [consistent with assuring member health and welfare per 42 CFR 441.302 and 441.730(a)] that are based, at minimum, on the

requirements for home and community-based waiver programs per 42 CFR 441.302(h);

16. Establishing mechanisms to assess the quality and appropriateness of care furnished to enrollees using long-term services and supports, including assessment of care between care settings and a comparison of services and supports received with those set forth in the enrollee's treatment/service plan, if applicable;

17. Establishing mechanisms to assess and address the quality and appropriateness of care furnished to members receiving any type of specialized coordinated services, including but not limited to: children receiving services through DOH CAMHD, members enrolled in the DD/ID 1915(c) waiver, those receiving specialized behavioral health services through CCS, and beneficiaries receiving services from other DHS programs (i.e., Child Welfare and Adult Protective Services).

18. Methods for seeking and incorporating input from, and working with, members, providers, Med-QUEST staff and its designees, community agencies, other state agencies such as DOH, to actively improve the quality of care provided to members;

19. Methods for improving health outcomes across the continuum of care for the Medicaid beneficiary population in general using evidence-based and nationally recommended quality improvement approaches;

20. Practice guidelines as described in Section 5.1(B)(6);

21. Methods to improve the provider grievances and appeals process;

22. Methods for meaningfully incorporating a whole person approach through SDOH interventions; and

23. Use sophisticated IT infrastructure and data analytics to support DHS' vision and goals for quality improvement, measurement and evaluation, including the capability to identify sub-populations experiencing disparities (for example, by age, race, ethnicity, primary language or special populations), use predictive analytics to identify populations at risk for poor health outcomes and high cost, stratify and report metrics at the state and regional or service area level, and by sub-population, and be able to report data at the patient or provider level to DHS as required.

2) QAPI Program Plan – Submission Requirements

a) The Health Plan shall submit an annual QAPI Program Plan for review and approval by DHS. The QAPI Program Plan shall include the following;

b) The Health Plan's QAPI Plan shall include a narrative description and a detailed workplan of activities for operationalizing all elements of the QAPI Program that demonstrably reflect its alignment with DHS Quality Strategy.

c) The Health Plan shall review DHS Quality Strategy regularly for any updates, evaluate its QAPI Plan for alignment, and update it

as needed. The Health Plan shall submit updated QAPI Plans to DHS for review and approval.

d) Each subsequent year's QAPI plan will be submitted along with a progress report on the current year's QAPI plan to document the QAPI activities implemented and outcomes achieved for the year, along with remaining gaps and plan of action for the subsequent year as the "QAPI Program Progress Report and Annual Plan Update". The QAPI for each subsequent contract year should be adjusted to address the challenges identified in the prior QAPI report. The final year's QAPI report will not include the subsequent year's QAPI Plan, and will be submitted by the Health Plan within a period of six (6) months of completion or termination of the contract, whichever occurs first.

e) In addition to the annual progress report and plan update, the Health Plan shall also submit quarterly reports providing QAPI program updates and changes to the work plan in the QAPI as the "QAPI Program Quarterly Progress and Work Plan Update."

f) Upon request by DHS, the Health Plan shall submit other information about its QAPI program. Participation in the Quality Program will include informal updates and progress reports, and discussions on strategies, successes and challenges across various QAPI areas; it will provide an opportunity for engagement and collaboration across Health Plans for planning purposes, and an avenue to seek input from DHS. DHS may ask Health Plans to participate in training opportunities.

g) When establishing its QAPI Program standards, the Health Plan shall comply with applicable provisions of Federal and State laws

and current NCQA Standards/Guidelines for Accreditation of Managed Care Organizations.

h) DHS reserves the right to require additional standards or revisions to established standards and their respective elements to ensure compliance with changes to Federal or State statutes, rules, and regulations to clarify and address identified needs for improvement.

3) *SDOH Work Plan*

a) The Health Plan will develop a SDOH Work Plan as a component of its QAPI that is informed by the statewide SDOH Transformation Plan.

b) The Health Plan's SDOH Work Plan must be submitted as a sub-component of the QAPI plan, and include its own timelines, benchmarks, milestones and deliverables. The Health Plan's initial SDOH Work Plan, which will be prepared prior to the completion of the SDOH Transformation Plan, should include at a minimum:

1. Plans for increasing the systematic collection and documentation of beneficiary-level SDOH data through screening;
2. Plan for promoting the use of ICD-10 Z codes for SDOH documentation;
3. Plan to increase provider understanding of SDOH;
4. Plan for incorporating SDOH strategies into the overall QAPI by:

    a) Linking beneficiaries to identified SDOH needs; and

b) Providing relevant SDOH value-added services offerings;

5. Description of how the Health Plan will directly address and adapt its QAPI to accommodate SDOH needs for the following target populations:

    a) SHCN, SHCN+ and LTSS populations (adults and children), on whom social needs have been identified through the SHCN, SHCN+ and LTSS assessment;
    b) Other SHCN populations; and
    c) CIS populations.

c) The Health Plan is encouraged to expand upon its SDOH strategy beyond the minimum required elements for the initial plan. Each subsequent year's SDOH Work Plan is expected to iteratively build upon the accomplishments of the previous year's plan.

d) The Health Plan shall report on its progress on the SDOH Work Plan and describe its updated SDOH Work Plan quarterly and annually as part of the "QAPI Program Quarterly Progress and Work Plan Update" and "QAPI Program Progress Report and Annual Plan Update." DHS may amend the required elements of the SDOH Transformation Plan on an annual basis as progress is made on existing gaps, and as new gaps are identified. The Health Plan's SDOH Work Plan should accordingly be updated recognizing that transformation is a continuous process and that a Health Plan's SDOH Work Plan should evolve over time.

4) HIT Work Plan

a) The Health Plan shall describe its own HIT Work Plan as a sub-component of its QAPI plan, and include its own timelines, benchmarks, milestones and deliverables. The Health Plan's initial HIT Work Plan, which will be prepared prior to the completion of the statewide HIT Innovation Plan, should include at a minimum:

1. The Health Plan's current capacity for meeting or exceeding the data analytics, collection, reporting, exchange, and other HIT requirements set forth in the current contract, including but not limited to HIT infrastructure that integrally supports community-based care coordination, building of an enhanced referral network, and analytic capacity to support identification of potential SHCN beneficiaries;

2. A discussion of any HIT deficiencies and how the Health Plan will ensure that contractual obligations are met or exceeded within the first year of the contract period;

3. The resources the Health Plan will contribute to realizing the goals of the statewide HIT Innovation plan, both through plan-level enhancements and through providing support for shared community-wide strategies;

4. The Health Plan's commitment to the interoperability and transparency goals of, and ongoing investment towards, the vision of the HIT Innovation Plan; and

5. A narrative of the Health Plan's key concerns, experience with, and challenges encountered in achieving the goals of the statewide HIT Innovation Plan.

b) The Health Plan is encouraged to expand upon its HIT strategy beyond the minimum required elements for the initial plan. Each subsequent year's HIT Work Plan is expected iteratively build upon the accomplishments of the previous year's plan.

c) The Health Plan shall report on its progress on the HIT Work Plan and describe its updated HIT Work Plan both quarterly and annually, as part of the "QAPI Program Quarterly Progress and Work Plan Update" and "QAPI Program Progress Report and Annual Plan Update." DHS may update the statewide HIT Innovation Plan or amend the required elements of the Health Plan's HIT Work Plan on an annual basis, recognizing that transformation is a continuous process and that both the statewide HIT Innovation Plan and the Health Plan's HIT Work Plan should evolve over time.

5) Performance Improvement Projects (PIPs)

a) As part of its QAPI Program, the Health Plan shall conduct a minimum of three (3) PIPs year round in accordance with 42 CFR 438.330(d). PIP topics may vary from one cycle to the next. The PIPs shall be designed to achieve, through iterative implementation of evidence-based interventions using data-driven quality improvement methods, and ongoing tracking and measurement of both outputs and outcomes, demonstrably significant improvement, sustained over time, in clinical care and non-clinical care areas, including SDOH, that are expected to have a favorable effect on health outcomes and member satisfaction.

b) Each PIP shall include a measurement strategy of performance using objective quality indicators.

c) Each PIP shall include implementation of interventions to achieve improvement in the access to and quality of care.

d) The PIPs shall follow the "Plan, Study, Do, Act" (PDSA) cycle or other evidence-based methods. The study topics will be approved by DHS. The studies should follow standard quality improvement methods such as having a clearly identified study question and objective; a description of the methods that include the appropriate evidence-based intervention planned, as well as the evidence-based approach for conducting quality improvement; clear implementation plan; measurable indicators of output, process, and outcomes; valid sampling techniques (where applicable) and accurate data collection, including qualitative data collection where needed; data analysis; and a description of the findings, areas in need of improvement or refinement, and recommendations. The PIP should describe the iterative PDSA cycles and the lessons learned in each cycle that were implemented into the plan for the next cycle.

e) The PIP plan shall include a detailed description of the study question, approach, planned evaluation, and strategy for incorporation of findings into future PDSA cycles; be included in the QAPI plan; and is subject to review and approval by DHS prior to implementation. Updates on PIP activities, including results and outcomes, must be provided quarterly and annually, as part of the "QAPI Program Quarterly Progress and Work Plan Update" and "QAPI Program Progress Report and Annual Plan Update."

f) The Health Plan shall report the status and results of each project to the State as requested. The Health Plan must complete each PIP in the time period determined by DHS so as to allow

information on the progress of PIPs in aggregate to produce new information periodically on quality of care according to 42 CFR 438.330(d)(3).

g) PIPs may be specified by DHS. All DHS-selected PIPs shall have aligned interventions and quality improvement approaches across Health Plans, and be included as part of the Health Plan's overall QAPI plan. In these cases, the Health Plan shall meet the goals and objectives specified by DHS. The Health Plan may also submit recommended PIP topics, PIP standards, and proposed PIPs for the selected topics to DHS. DHS has final approval for selected PIP topics and methods.

h) The Health Plan shall submit to DHS and the EQRO any and all data necessary to enable validation of the Health Plan's performance under this section, including the status and results of each project. The Health Plan shall include in its submission the planned approach to sustaining or increasing improvements.

6) *Practice Guidelines*

a) The Health Plan shall include, as part of its QAPI Program, practice guidelines that meet the following requirements as stated in 42 CFR 438.236 and current NCQA standards. Each adopted practice guidelines shall be:

1. Relevant to the needs of the Health Plan's membership;
2. Based on valid and reliable clinical evidence, national recommendations, or a consensus of healthcare professionals in a particular field;

3. Aligned with the goals of this contract, DHS Quality Strategy, and the Health Plan's QAPI;

4. Designed as systematic strategies to enhance use and implementation of evidence-based practices in support of addressing disparities, improving quality, enhancing adoption of evidence-based models and practices, and increased adoption of HIT-based strategies;

5. Adopted in consultation with in-network healthcare professionals;

6. Reviewed and updated periodically as appropriate;

7. Disseminated broadly to all affected providers, and upon request, to members and potential members;

8. Evaluated for adoption and implementation through provider-based reporting;

9. Promoted by the Health Plan for adoption and implementation through provider-based education activities; practice transformation support including HIT-based strategies; and other incentives.

10. The Health Plan shall report data on implementation and adoption of each practice guideline across its provider network to DHS quarterly and annually, as part of the "QAPI Program Quarterly Progress and Work Plan Update" and "QAPI Program Progress Report and Annual Plan Update." Where there are gaps in adoption or implementation, the subsequent quarter or year's QAPI plan will include plans for continued support from the Health Plans towards greater adoption and implementation.

b) Practice guidelines policies and procedures and a list of all current practice guidelines shall be submitted to DHS for review in accordance with Section 13.3(B), Readiness Review.

c) 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.

d) The Health Plan shall disseminate practice guidelines to members and potential members upon request.

e) DHS shall issue guidance as needed and additionally develop practice guidelines based on emerging and evolving clinical practice. DHS may also specify topics for practice guidelines that Health Plans shall work collaboratively to develop.

f) The Health Plan may additionally issue its own practice guidelines. Health Plans shall follow current NCQA and BBA standards for adopting and disseminating guidelines. DHS may periodically review the clinical practice guidelines adopted by the Health Plan, request additional information as needed, and promulgate one or more clinical practice guidelines as a standard of practice.

g) For each practice guideline adopted, the Health Plan shall:

    1. Describe the clinical, evidentiary, and strategic basis upon which the practice guideline is chosen;

    2. Describe how the practice guideline takes into consideration the needs of the members;

3. Describe how the Health Plan shall ensure that practice guidelines are reviewed in consultation with health care providers;

4. Describe the process through which the practice guidelines are reviewed and updated periodically;

5. Describe how the practice guidelines are disseminated to all relevant providers and, upon request, to potential members;

6. Describe the Health Plan's strategies to promote adoption and implementation, as well as processes for monitoring; and

7. Describe how the Health Plan shall ensure that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

7) Delegation

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

    1. A written delegation agreement between the delegated organization and the Health Plan, describing the responsibilities of the delegation and the Health Plan; and

2. Policies and procedures detailing the Health Plan's process for evaluating and monitoring the delegated organization's performance. At a minimum, the following shall be completed by the Health Plan:

    a) Prior to execution of the delegation agreement there shall be provisions for a site visit and evaluation of the delegated organization's ability to perform the delegated activities;

    b) An annual on-site visit and/or documentation/record reviews to monitor/evaluate the quality of the delegated organization's assigned processes;

    c) The annual on-site visit may be deemed to have occurred if the delegate is accredited by NCQA; and

    d) Evaluation of the content and frequency of reports from the delegated organization.

8) DHS Review of Health Plan QAPI Program

a) In accordance with 42 CFR 438.330(e), Program Review by the State*,* DHS shall review, at least annually, the impact and effectiveness of the Health Plan's QAPI Program. The scope of DHS review also includes monitoring of the systematic processes developed and implemented by the Health Plan to conduct its own internal evaluation of the impact and effectiveness of its QAPI program as well as to effect necessary improvements.

    1. The Health Plan shall actively participate in DHS' review of the QAPI Program, and provide requested

materials within an agreed upon timeframe. The Health Plan shall also facilitate DHS requests for onsite visits to support the review.

2. DHS shall evaluate the Health Plan's QAPI Program utilizing a variety of methods, including but not limited to:

3. Reviewing QAPI documents;

4. Reviewing, validating, and evaluating the QAPI Program reports regularly required by DHS (e.g., member grievances and appeals reports, provider complaints and claims reports, reports of suspected cases of fraud and abuse, performance measures reports, performance improvement project (PIP) reports, QAPI program description, etc.);

5. Meeting with Health Plans regularly as part of the Quality Program activities, and gathering information on activities, progress ,and challenges;

6. Reviewing, evaluating, or validating implementation of specific policies and procedures or special reports relating to areas such as:

    a) Member rights and protections;

    b) Services provided to members with special health care needs, receiving LTSS, enrolled in D-SNPs, identified as having Special Health Care Needs, or requiring other types of specialized coordination;

    c) Utilization management (e.g., under-utilization and over-utilization of services);

d) Access to care standards, including:

1. Availability of services;
2. Adequate capacity and services;
3. Continuity and coordination of care;
4. Coverage and authorization of services;

e) Structure and Operation Standards, including:

1. Provider selection;
2. Member information;
3. Confidentiality;
4. Enrollment and disenrollment;
5. Grievance systems;
6. Subcontractual relationships and delegation;

f) Measurement and Improvement Standards;

g) Practice guidelines;

h) Health disparities and SDOH interventions;

i) Health information systems;

7. Conducting on-site reviews to interview Health Plan staff for clarification, to review records, or to validate implementation of processes/procedures; and

8. Reviewing medical records.

b. DHS may elect to monitor the activities of the Health Plan using its own personnel or may contract with qualified personnel to perform functions specified by DHS. Upon completion of its

review, DHS or its designee may submit a report of its findings to the Health Plan and to DHS. At the request of DHS, the Health Plan shall develop corrective actions for any identified areas of deficiency.

C) *Quality Rating System*

1. The Health Plan shall participate as necessary in any activities needed to support DHS in the design and implementation of a managed care quality rating system in accordance with 42 CFR 438.334.

D) *Performance Measures*

1. The Health Plan shall comply with all DHS quality management requirements to improve performance for DHS established performance measures. Performance measures may be based on CMS core measures or initiatives, State priorities, or areas of concern that arise from previous measurements. Performance measures will be aligned with DHS Quality Strategy and shall represent the key metrics that serve as the outputs and outcomes of the Health Plan's overall QAPI activities.
2. Clinical measures (e.g., comprehensive diabetes care measures, cardiovascular disease measures), utilization measures (e.g., emergency department visits, hospital readmissions), and other measures of program cost (e.g., total cost of care, primary care spend) may be included, in addition to process measures. DHS may require reporting of performance measure at any level of granularity

including beneficiary-, provider-, practice-, health system- or plan-level. The following include types of performance measures that the Health Plan shall be required to track and provide to DHS:

a) Clinical and Utilization Quality measures - a set of clinical and utilization measures are required from the Health Plan each year. DHS shall provide a list of the performance measures each calendar year for the next year's required measures. The measures may be HEDIS measures.

b) HEDIS-Like measures – a set of measures (both clinical and utilization measures) that are based on HEDIS measure definitions, but modified as needed to achieve such goals as alignment with the CMS Medicaid Core Set, or alignment with DHS priorities. DHS shall provide a list of the HEDIS-like performance measures each calendar year for the next year's required measures.

c) Other nationally developed quality measures - a set of measures (both clinical and utilization measures) with various measure stewards nationally that may or may not be endorsed by NCQA. DHS shall provide a list of nationally developed performance measures each calendar year for the next year's required measures.

d) Other Homegrown Quality measures – a set of measures (including clinical, utilization, or cost-based measures) that are defined by DHS to track DHS priorities for which a HEDIS, HEDIS-like, or other nationally defined measure is unavailable, inadequate, or inappropriate. DHS will design these measures as needed and provide Health Plans with a format and frequency for reporting.

e) Utilization dashboard - the Health Plan shall supply information that may include a variety of output measures and performance metrics designed to track volumes of patients or services, including hospital admissions and readmissions, call center statistics, provider network, member demographics, etc. DHS shall provide a list of the measures and a format and frequency for submission.

f) EPSDT data - the Health Plan shall report EPSDT information utilizing the CMS 416 format. This report includes information on EPSDT participation, percentage of children identified for referral, percentage of children receiving follow-up services in a timely manner, etc.

g) DHS shall identify the measures that may be used to support auto-assign algorithms as described in Section 9.1(C).

h) DHS shall also identify the measures that may be eligible for performance incentives.

3. The Health Plan shall submit to DHS and the EQRO any and all data necessary to enable validation of the Health Plan's performance under this section.

E) *Accreditation*

1. The Health Plan shall be accredited by the National Committee for Quality Assurance (NCQA) for its QUEST Integration program. The Health Plan must be accredited prior to the start of the Contract and maintain continuous accreditation throughout the Contract period,

with no lapse in accreditation. The Health Plan must proactively seek reaccreditation as needed to prevent lapses.

2. The Health Plan shall notify the DHS of any changes in its accreditation status within 7 days of the change.

3. In accordance with 42 CFR 438.332(b)(1), the Health Plan must submit and/or authorize NCQA to submit accreditation review information to the State, including:
    a) Accreditation status, survey type, and level;
    b) Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and
    c) Expiration date of the accreditation.

F) *Non-duplication Strategy*

1. In accordance with 42 CFR 438.360, DHS may use information from a Medicare and/or a private accreditation review to avoid duplication with the review of select standards required under an external quality review. This option may be used at the discretion of DHS. DHS will define the use of this option in DHS policies and in the DHS Quality Strategy if DHS decides to use this option. DHS may waive certain EQRO validation activities based on the Health Plan's NCQA accreditation.

G) *External Quality Review/Monitoring*

1. DHS contracts with an External Quality Review Organization (EQRO) to perform, on an annual basis, an external, independent review of the quality outcomes of, timeliness of, and access to the services provided for QI members by the Health Plans.

2. The Health Plan shall cooperate with DHS contracted EQRO in the external quality review (EQR) activities performed by the EQRO to assess the quality of care and services provided to members and to identify opportunities for Health Plan improvement. To facilitate this review process, the Health Plan shall provide all requested QAPI Program related documents and data to the EQRO.

3. The EQRO shall monitor the Health Plan's compliance with all applicable provisions of 42 CFR 438, Subpart E. Specifically, the EQRO may provide the following activities as described in 42 CFR 438.358 and 42 CFR 438.602(e):

    a) Validation of network adequacy during the preceding twelve (12) months to comply with requirements set forth in §§ 438.68 and § 438.14(b)(1).

    b) Validation of Performance Improvement Projects (PIP) required by DHS;

    c) Validation of Health Plan performance measures required by the State; and

    d) A review, conducted within the previous three-year period, to determine compliance with standards established by the State concerning access to care, structure and operations, and quality measurement and improvement.

4. The Health Plan shall submit to DHS and the EQRO its corrective action plans, which address identified issues requiring improvement, correction or resolution.

5. The Health Plan shall participate in any additional activities undertaken by the EQRO for DHS, which may include but are not limited to:

    a) Administration, analysis, and reporting the results of the CAHPS® Consumer Survey. The survey shall be conducted annually, administered to an NCQA-certified sample of members enrolled in each health plan and analyzed using NCQA guidelines. Adult and child surveys are conducted in alternate years using the most current CAHPS® survey for managed care plans. A CHIP specific CAHPS® Consumer Survey is conducted annually to meet Federal requirements. DHS may modify this schedule based upon the needs of the Department. The EQRO shall provide an overall report of survey results to the DHS. The DHS and the Health Plan shall receive a copy of their health plan-specific raw data by island;

    b) Administration, analysis, and reporting of the results of the Provider Satisfaction Survey. This survey shall be conducted every other year within the broad parameters of CMS protocols for conducting Medicaid EQR surveys (DHS, CMS 2002, Final Protocol, Version 1.0 -- *Administering of Validating Surveys: Two Protocols for Use in Conducting Medicaid External Quality Review Activities*). DHS may modify this schedule based upon the needs of the Department. The EQRO shall assist 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 shall provide DHS with a report of findings, including the raw data broken down by island. Each Health Plan shall receive an electronic version of the report with its plan-specific raw data per island from the EQRO;

c) Providing technical assistance to the Health Plan to assist them in conducting activities related to the mandatory and optional EQR activities according to 42 CFR 438.310(c)(2);

d) Assisting with the quality rating of the Health Plans consistent with 42 CFR 438.334;

e) Administration, analysis, reporting of the results of the Encounter Data Validation (EDV) per 42 CFR §438.358(c)(1), and optional activities related to external quality review. The EQRO is responsible for validating encounter data by using information derived during the preceding twelve (12) months reported by the Health Plans. The EQRO will be responsible for developing the methodology, generating and issuing the questionnaires, collecting data, and conducting a comparative analysis. Finally, the EQRO shall furnish a special report that summarizes the results to the State and the Health Plans; and

f) Assisting with the quality rating of Health Plans, PIHPs, and PAHPs consistent with § 438.334.

H) *Case Study Interviews*

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

5.2 Utilization Management

A) *Utilization Management Program (UMP)*

1. 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 continuously improve quality clinical care and services as well as maximize appropriate use of resources.

2. As part of the UMP, the Health Plan shall define its implementation of medically necessary services in a manner that:

    a) Is no more restrictive than the definition of medically necessary services as defined in Section 2.3; and

b) Addresses the extent that the Health Plan covers services related to the following:

1. The prevention, diagnosis, and treatment of health impairments;
2. The ability to achieve age-appropriate growth and development; and
3. The ability to attain, maintain, or regain functional capacity.

3. 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 description, workplan, policies, and procedures shall be submitted for DHS review in accordance with Section 13.3(B), Readiness Review..
4. The Health Plan's UMP shall include structured, systematic processes that employ objective evidenced-based criteria to ensure that qualified licensed health care professionals make utilization decisions regarding medical necessity and appropriateness of medical, behavioral health, and LTSS in a fair, impartial, and consistent manner.
5. The Health Plan shall ensure that applicable evidence-based criteria are applied with consideration given the characteristics of the local delivery system available for specific members as well as member-specific factors, such as member's age, co-morbidities, complications, progress of treatment, psychosocial situation, and home environment.

6. The Health Plan shall also have formal mechanisms to evaluate and address new developments in technology and new applications of existing technology for inclusion in the benefit package to keep pace with changes and to ensure equitable access to safe and effective care.

7. 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.

8. The Health Plan's utilization review/management activities shall include:

    a) Prior authorization/pre-certifications;

    b) Concurrent reviews;

    c) Retrospective reviews;

    d) Discharge planning;

    e) Care Coordination;

    f) Service Coordination; and

    g) Pharmacy Management.

9. The health plans shall conduct a Concurrent Review process. There shall be no retrospective denial(s). The health plans shall proactively work with provider(s) to ensure member's timely access to care,

inclusive of a member's continuation of care not limited to hospital services, post-acute services, transitional services, and DME and supplies.

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

    a) Routine, systematic monitoring of relevant utilization data;

    b) Routine analysis of all data collected to identify causes of inappropriate utilization patterns;

    c) Implementation of appropriate interventions to correct any patterns of potential or actual under-utilization or over-utilization; and

    d) Systematic measurement of the effectiveness of interventions aimed at achieving appropriate utilization.

11. 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.

12. The Health Plan shall ensure that pharmaceutical management activities promote the clinically appropriate use of pharmaceuticals, and align with the PMP as described in Section 5.1(B). There shall be policies, procedures, and mechanisms to ensure that the Health

Plan has criteria for adopting pharmaceutical management procedures and that there is clinical and scientifically-based evidence for all decisions. The policies must include an explanation of any limits or quotas and an explanation of how prescribing practitioners must provide information to support an exceptions request.

13. The Health Plan shall ensure that it has processes for determining and evaluating classes of pharmaceuticals, pharmaceuticals within the classes, and criteria for coverage and prior authorization of pharmaceuticals. The Health Plan shall ensure that it has processes for generic substitution, therapeutic interchange, and step-therapy protocols.

14. The Health Plan shall not develop a compensation structure that creates incentives for the individuals or entities conducting UMP (or service and/or care coordination) activities to deny, limit, or discontinue medically necessary services to any member.

B) ***Authorization of Services***

1. The Health Plan shall have in place written prior authorization/pre-certification policies and procedures for processing requests for initial and continuing authorization of services in a timely manner. The procedures shall be developed to reduce administrative burden on the providers. The Health Plan shall utilize any DHS-required standardized format for authorization of services. The Health Plan shall submit the policies and procedures for DHS review in accordance with Section 13.3(B), Readiness Review.

2. A member shall be able to make a request to the Health Plan for the provision of a service. As part of these prior authorization policies and procedures, the Health Plan shall have in effect mechanisms to:

    a) Ensure consistent application of review criteria for authorization decisions;

    b) Consult with the requesting provider when appropriate;

    c) Authorize service coordination/LTSS based on a member's assessment and consistent with the person-centered service plan; and

    d) Authorize care coordination services based on a SHCN/SHCN+ member's assessment and consistent with the person-centered care plan.

3. The Health Plan shall ensure that all prior authorization/ pre-certification decisions, including but not limited to any decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, shall be made by a health care professional who has appropriate clinical expertise in addressing the member's medical, behavioral health, or LTSS needs.

4. Medical necessity approvals may be made by licensed clinical staff or unlicensed staff under the supervision of licensed staff. Medical necessity denials must be made by licensed clinical staff. All denials of medical, behavioral health, and LTSS shall be reviewed and approved by the Health Plan medical director. In addition, all administrative denials for children under the age of twenty-one (21) years shall be reviewed and approved by the Health Plan medical director.

5. The Health Plan shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. The Health Plan may place appropriate limits on a service based on criteria such as medical necessity, or for utilization control provided that:

    a) the services furnished can reasonably be expected to achieve their purpose;

    b) the services supporting members with ongoing or chronic conditions or who require LTSS are authorized in a manner that reflects ongoing need for such services and supports; and

    c) family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20.

6. The Health Plan shall not require prior authorization of emergency services, but may require prior authorization of post-stabilization services and urgent care services as specified in Sections 4.5(F) and 4.5(U).

7. The Health Plan shall notify the provider of prior authorization/pre-certification determinations in accordance with the following timeframes:

    a) For standard authorization decisions, the Health Plan shall provide notice as expeditiously as the member's health condition requires but no longer than fourteen (14) calendar days following the receipt of the written request for service. An extension may be granted for up to fourteen (14)

additional calendar days if the member or the provider requests the extension, or if the Health Plan justifies a need for additional information and the extension is in the member's best interest. If the Health Plan extends the timeframe, it shall give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. The Health Plan shall issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

b) In the event a provider indicates, or the Health Plan determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the Health Plan shall make an expedited authorization determination and provide notice as expeditiously as the member's health condition requires but no later than seventy-two (72) hours after receipt of the request for service. The Health Plan may extend the seventy-two (72) hour timeframe by up to an additional fourteen (14) calendar days if the member requests an extension, or if the Health Plan justifies to DHS a need for additional information and the extension is in the member's best interest. If the Health Plan extends the timeframe, it shall give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. The Health Plan shall issue and carry out its determination as expeditiously as the member's

health condition requires and no later than the date the extension expires.

c) Authorization decisions related to coverage of: 1) environmental accessibility adaptations; 2) moving assistance; 3) specialized medical equipment, orthotics or prosthetics that require personalized fitting or customization specific to the member; or 4) out-of-network non-emergent procedures, including out-of-state procedures, shall be provided within the standard authorization timeframes set forth in the first bullet point of this section. The Health Plan will follow DHS policy guidance regarding implementation of authorization for these services. DHS will monitor timely provision of implementation of these services through an LTSS report that shall be designed in accordance with identified in Section 6.2(B).

8. Service authorization decisions not reached within the timeframes specified above and in accordance with the DHS policy guidance shall constitute an approval denial and thus not an adverse action.

9. The Health Plan's prior authorization requirements shall comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910(d).

C) *Prior Authorization Simplification Initiative*

1. DHS may require the Health Plans to implement administrative simplification best practices. DHS is committed to reducing administrative burden for providers and Health Plans, and consequently established the Prior Authorization Simplification Initiative. The Health Plan shall actively participate and assign a

representative to the Prior Authorization Simplification Initiative committee that is coordinated by DHS, and the Health Plan shall make best practice recommendations.

5.3 Administrative Requirements

A) *Medical Records Standards*

1. In alignment with its QAPI Program, the Health Plan shall establish medical records standards as well as a record review system to assess and assure conformity with standards. These standards shall be consistent with the minimum standards established by DHS identified below:

    a) Require that the medical record is maintained by the provider;
    b) Assure that DHS personnel or personnel contracted by DHS shall have access to all records, as long as access to the records is needed to perform the duties of this contract and to administer the QUEST Integration program for information released or exchanged pursuant to 42 CFR 431.300. The Health Plan shall be responsible for being in compliance with any and all State and Federal laws regarding confidentiality;
    c) Provide DHS or its designee(s) with prompt access to members' medical records;
    d) 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
    e) Allow for paper or electronic record keeping.

2. As part of the record standards, the Health Plan shall require that providers adhere to the requirements described in Appendix H.

3. The Health Plan shall encourage the capture of information on SDOH via ICD-10 Z-codes where applicable.

4. As part of its medical records standards, the Health Plan shall ensure that providers facilitate the transfer of the member's medical records (or copies) to the new PCP within seven (7) business days from receipt of the request.

5. As part of its medical records standards, the Health Plan shall comply with medical record retention requirements in Section 14.5.

6. The Health Plan shall submit its medical records standards to DHS for review in accordance with Section 13.3(B), Readiness Review.

B) *Second Opinion*

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

C) *Out of State/Off Island Coverage*

1. The Health Plan shall provide any medically necessary covered treatments or services that are required by the member. If these services are not available in the State or on the island where 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 one (1) attendant, if applicable. However, if the service is available on a member's island of residence, the Health Plan may require the member to obtain the needed services from specified providers as long as the provider is in the same geographic location as the member and the member can be transferred.

2. The Health Plan shall provide out-of-state and off-island emergency medical services and post-stabilization services within the United States for all members as well as all out-of-state and off-island medically necessary EPSDT covered services to members under age twenty-one (21) years. The Health Plan may require prior authorization for non-emergency out-of-state or off-island services.

3. The Health Plan shall be responsible for the transportation costs to return the individual and their one (1) attendant, if applicable, to the island of residence upon discharge from an off-island or out-of-state facility when services were approved by the Health Plan or from an out-of-state or off-island facility when the services were emergent or post-stabilization services. Transportation costs for the return of the

member to the island of residence shall be the Health Plan's responsibility even if the member is being or has been disenrolled from the Health Plan during the out-of-state or off-island stay.

4. Medical services outside of the United States or in a foreign country are not covered for either children or adults.

SECTION 6 – Health Plan Reporting and Encounter Data Responsibilities

6.1 Overview

The Health Plan shall comply with all reporting requirements established by DHS. Reporting requirements include data submitted to DHS in disaggregated format, as well as aggregated reports that may include both quantitative, qualitative, and identifying information. Reporting requirements related to disaggregated data are described within this RFP to facilitate planning and implementation.

With regard to aggregated reporting requirements, Health Plan shall participate in a collaborative process with DHS and other Health Plans to establish a reporting package which addresses the following at a minimum:

a) Detailed reporting specifications and consistent data definitions for all required reports.

b) Reports that provide statistical information in a format for which trends can be identified.

c) Detailed analysis by the Health Plan, where applicable, for identified trends, successes, risks, and mitigation strategies.

This process will result in identification of a detailed and comparable reporting package that the Health Plan and other Health Plans shall use without modification. The Health Plan shall submit to DHS all requested reports and in the time frames identified in this reporting package.

The Department reserves the right to modify the above described process should DHS and Health Plans not agree on standardized data

definitions and reporting specifications. Should this occur, DHS will set forth prescriptive requirements for all Health Plans to follow.

DHS has final approval for all reporting requirements, specifications and data definitions. Additionally, DHS reserves the right to modify the required reporting package at any time.

Data and reports received from the Health Plan shall be used for the administration of the Medicaid program, including but not limited to monitoring, public reporting, capitation rate setting, releasing financial withholds, implementing financial penalties, and assessing financial incentives. DHS may also share information among Health Plans to promote transparency and sharing of benchmarks/best practices. DHS shall publicly report measures in formats such as Health Plan report cards or score cards that include a variety of metrics, consumer guide, public report, or otherwise, on MQD's website in accordance with 42 CFR 438.602(g).

6.2 Report Descriptions

The Health Plan shall provide to DHS managerial, financial, delegation, utilization, quality, Program Integrity and enrollment reports in compliance with 42 C.F.R. 438.604 and in accordance with reporting package process described in Section 6.1. Reports, at a minimum, will cover following topics, although additional reporting requirements may be implemented by as needed.

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.

A) ***Provider Network/Services***

Submission of assessments of provider network adequacy, distribution, access, and capacity; provider education & training; Primary Care Provider attribution and distribution characteristics; geo and timely access to services; FQHC or RHC services; provider suspensions and terminations; provider grievances and claims; and participation in, maturity status, and receipt of incentives related to Value-Based Purchasing.

B) ***Covered Benefits and Services***

Submission of comprehensive information on identification, engagement, participation, services, utilization, and quality of care delivered under special programs such as EPSDT, and to special populations such as LTSS, SHCN and SHCN+, CIS, and Going Home Plus.

C) ***Member Services***

Submission of data on member services such as call center statistics, PCP assignment, EPSDT, LTSS, Special Health Care Needs, and services provided to beneficiaries with English as a Second Language needs. The Health Plan will also report on member grievances and appeals, information on beneficiary eligibility for and inclusion in various programs, and demographic changes. Finally, CAHPS® Consumer Survey data will be reported. Other beneficiary-level data shall include total cost of care indicators, total spend and spend by categories, beneficiary attribution to providers, and routine identification of beneficiaries with special needs newborns, pregnant women, etc. and those enrolled in programs such as LTSS, SHCN,

SHCN+, CIS, and Going Home Plus with varying levels of stratification as defined by DHS.

D) ***Quality***

Submission of quality-related plans and reports related to the QAPI program, SDOH, HIT, PIPs, and quality and performance metrics required by DHS. Reports on accreditation will also be submitted in this section. The "QAPI Program Quarterly Progress and Work Plan Update" and "QAPI Program Progress Report and Annual Plan Update" referenced in 5.1(B) shall also be required.

E) ***Utilization Management***

Submission of data on utilization and prior authorizations, including over- and under-utilization on services and drugs metrics. In addition, reporting on overall utilization and spending on primary care, and measures assessing relative utilization and spend across services (for example, Nursing Home vs. HCBS utilization) will be required.

F) ***Administration and Financial***

Submission of data on Fraud, Waste, and Abuse; employee suspensions and terminations; financial reporting; TPL cost avoidance; required Health Plan disclosures; encounter data submission; Medicaid Contract reporting, recoveries, reconciliation of encounter data to financial summaries; Medical Loss Ratio; Mental Health and Substance Use Disorder Parity; and overpayments.

G) ***Medicare Alignment***

Submission of Medicare D-SNP encounter data. Submission of annual HEDIS, HEDIS-like, nationally developed; or other home grown quality measures; CAHPS®; Medicare Health Outcomes Survey data; and shall make available upon request all information regarding performance of the D-SNP plan, including (but not limited to) Medicare Advantage Star Quality Ratings, including poor performing icons, notices of non-compliance, audit findings, and corrective action plans. If a Health Plan is under a national contract number, then it must submit data and reports specific to its members residing in Hawaii as requested by DHS.

H) ***Mental Health Evidence Based Practices***

Submission of data and reports that detail the delivery of mental health evidence/research based practices provided to members under the age of twenty-one (21) by a qualified medical provider. The reports shall include the number of children receiving the services, the number of mental health encounters using the services, and percentage of mental health encounters using these services.

6.3 Current Reporting Requirements

The Health Plan shall provide reporting to meet all federal regulations for Medicaid managed care programs as set forth in 42 CFR Part 438. The Health Plan shall comply with all revised reporting requirements implemented by CMS during the Contract period.

The Health Plan shall submit to DHS all data including encounter data, data to support MLR calculation, rate certification, risk solvency, data to demonstrate provider availability and accessibility of services, including network adequacy, ownership and control, and any other data requested by DHS.

Additionally, the Health Plan shall provide necessary data or other information as required by DHS to support its development of required and ad hoc reporting to CMS or other state or federal agencies.

A) ***Medical Loss Ratio Report***

The Health Plan shall submit an annual Medical Loss Ratio (MLR) Report in compliance with 42 CFR 438.74. Any retroactive changes to capitation rates after the contract year end will need to be incorporated into the MLR calculation. If the retroactive capitation rate adjustment occurs after the MLR report has been submitted to DHS, a new report incorporating the change will be required to be submitted within 30 days of the capitation rate adjustment payment by DHS.

The MLR standards are to ensure the Health Plan is directing a sufficient portion of the capitation payments received from DHS to services and activities that improve health in alignment with DHS's mission.

The Health Plan shall calculate and report the MLR in accordance to the following:

1. The MLR experienced for the Health Plan in a reporting year is the ratio of the numerator, as defined in accordance with 42 CFR 438.8(e) to the denominator, as defined in accordance with 42 CFR 438.8(f);

2. Each expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses;
3. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on pro rata basis;
4. Expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results;
5. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense;
6. Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by reporting entity and are not to be apportioned to the other entities;
7. The Health Plan may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible;
8. The credibility adjustment is added to the reported MLR calculation before calculating any remittances, if applicable;
9. The Health Plan may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible;
10. If the Health Plan's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards;
11. The Health Plan will aggregate data for all Medicaid eligibility groups covered under the contract;

12. The Health Plan shall provide a remittance for a MLR reporting year if the MLR for that reporting year does not meet the minimum MLR standard of eighty five (85) percent or higher;
13. The Health Plan must require any third party vender providing claims adjudication activities to provide all underlying data associated with MLR reporting to the Health Plan within one hundred eighty (180) days of the end of the MLR reporting year or within thirty (30) days of being requested by the Health Plan, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting;
14. In instances where the state makes a retroactive change to the capitation payments for a MLR reporting year where the report has already been submitted to the state;
    a) The Health Plan must re-calculate the MLR for all reporting years affected by the change; and
    b) The Health Plan must submit a new MLR report for each reporting year affected by the change, meeting the applicable requirements;

The Health Plan shall submit a Medical Loss Ratio (MLR) report to the Department of Human Services that includes at least the following information for each MLR reporting year:

1. Total incurred claims;
2. Expenditures on quality improving activities;
3. Expenditures related to activities compliant with 42 CFR 438.608(a)(1) through (5), (7), (8), and (b);
4. Non-claims costs;
5. Premium revenue as defined in 42 CFR 438.8;
6. Taxes, licensing and regulatory fees;

7. Methodology(ies) for allocation applied;
8. Any credibility adjustment applied;
9. The calculated MLR;
10. Any remittance owed to the State, at minimum, must be equal to or higher than eighty five (85) percent, if applicable;
11. A comparison of the information reported in this section with the audited financial report required under 42 CFR 438.3(m);
12. A description of the aggregation method used to calculate total incurred claims; and
13. The number of member months.

The Health Plan and its subcontractors shall retain all MLR data for a period of no less than ten (10) years in accordance with 42 CFR 438.3 (u). The Health Plan shall attest to the accuracy of the calculation of the MLR in accordance with MLR standards when submitting required MLR reports.

B) ***Overpayments Report***

The Health Plan is required to recover and report all overpayments. "Overpayment" as used in this section is defined in 42 CFR 438.2. All overpayments identified by the Health Plan shall be reported to DHS. The overpayment shall be reported in the reporting period in which the overpayment is identified. It is understood the Health Plan may not be able to complete recovery of overpayment until after the reporting period. The Health Plan must report to DHS the full overpayment identified. The Health Plan may negotiate and retain a lesser repayment amount with the provider, however, the full overpayment amount will be used when setting capitation rates for the Health Plan. The Health

Plan shall also maintain documentation of the education and training provided in addition to reporting the recovered amounts.

This report is an annual report which will document all overpayments, and all recovered and pending recovery amounts. Additionally, this report will specify/distinguish those overpayments which were identified as fraud, waste, and abuse, from all the rest of the overpayments included in the report. The Health Plan will check the reporting of overpayment recoveries for accuracy and will provide an accuracy report to the DHS upon request. The Health Plan will certify that the report contains all overpayments and those overpayments are reflected in either the claims data submitted in the report, or listed as an itemized recovery.

C) *Mental Health and Substance Use Disorder Parity Report*

The Health Plan shall provide an annual Mental Health and Substance Use Disorder Parity Report. This report shall be submitted in the format provided by DHS.

This report ensures that behavioral health or mental health (MH)/substance use disorder (SUD) services are comparable or not any more stringent than medical/surgical (M/S) services provided as per the Medicaid Parity Final Rule and MHPAEA of 2008.

This report shall include:

1. Aggregate lifetime and annual dollar limits.
2. Financial requirements and treatment limitations:
3. Copayments, coinsurance, deductibles, and out-of-pocket maximums;

4. Quantitative Treatment Limits (QTLs) are numerical limits on the scope or duration of a benefit (for example, 50 outpatient visits per year; and
5. Non-Quantitative Treatment Limits (NQTLs) or non-numerical limits on the scope or duration of benefits, such as prior authorization or network admission standards. These are "soft limits" that allows exceeding of numerical limits for medical/surgical or mental health/SUD benefits based on medical necessity.

6. Supporting documents requested by DHS.

Analysis and comparison of the information between DHS services (MH/SUD) and other Health Plans providing M/S services shall be done by DHS.

D) *Specific Federal Provider Network Requirements*

The Health Plan shall submit to State the following provider network reports.

1) Provider Network Adequacy and Capacity Report

The Health Plan shall submit a *Provider Network Adequacy and Capacity Report* that demonstrates that the Health Plan offers an appropriate range of preventive, primary care, specialty services, and LTSS that is adequate for the anticipated number of members for the service and that the network of providers is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.

The information shall, at a minimum, include:

a) A listing of all providers and include the specialty or type of practice of the provider;
b) The provider's location;
c) Mailing address including the zip code;
d) Telephone number;
e) Professional license number and expiration date;
f) Number of members from its plan that are currently assigned to the provider (PCPs only);
g) Indication as to whether the provider has a limit on the number of the patients he/she will accept;
h) Indication as to whether the provider is accepting new patients;
i) Foreign language spoken (if applicable);
j) Verification of valid license for in-state and out-of-state providers;
k) Verification that provider or affiliated provider is not on the Federal or State exclusions lists; and
l) Verification that officers/directors/anyone with a controlling interest/managing employees are not on the Federal or State exclusions lists.

The Health Plan shall provide a narrative that describes the Health Plan's strategy to maintain and develop their provider network to include but not limited to:

a) Take into account the numbers of network providers who are not accepting new patients;
b) 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;

c) Current network gaps and the methodology used to identify them;
d) Immediate short-term interventions when a gap occurs including expedited or temporary credentialing; and
e) Interventions to fill network gaps and barriers to those interventions.

2) GIS Reports

The Health Plan shall submit reports using GIS or similar software that allows DHS to analyze, at a minimum, the following:

a) The number of providers by specialty and by location with a comparison to the zip codes of members;

b) The number of providers by specialty and by location that are accepting new members with a comparison to the zip codes of members;

c) Number of members from its plan that are currently assigned to the provider (PCPs only);

d) Indication as to whether the provider has a limit on the number of QUEST Integration program members he/she will accept;

e) Indication as to whether the provider is accepting new patients; and

f) Non-English languages spoken (if applicable).

The Health Plan shall assure that the providers listed on the GIS reports are the same providers that are described in the Provider Network Adequacy and Capacity Report.

The reports shall be submitted to the DHS at the following times:

a) Upon the DHS request;

b) Upon changes in services, benefits, geographic service area, composition of or payment to its provider network; and

c) Any time there has been a significant change in the Health Plan's operations that would affect adequate provider capacity and services. A significant change is defined as any of the following:

    a. A decrease in the total number of PCPs by more than five percent (5%) per island (for the island of Hawaii the Health Plan shall report on this for East Hawaii and West Hawaii);

    b. A loss of providers in a specific specialty where another provider in that specialty is not available on the island;

    c. A loss of a hospital; or

    d. Enrollment of a new population.

3) PCP Assignment Report

The Health Plan shall submit monthly *PCP Assignment Reports* that provide the following information on activities from the previous month:

a) The total number serving as a PCP to include the PCP to member ratio;
b) The number and percent of members that chose or were auto-assigned to a PCP;
c) The number of PCP change requests received and processed;
d) The medical specialties with the largest number of PCP assignments; and
e) Information on the highest utilized PCP.

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 and provider surveys). Using data collected during the previous quarter, the report shall include the:

a) Total number of appointment requests;
b) Total number and percent of requests that meet the waiting time standards identified in Section 8.1(C) (for each provider type/class, e.g., specialists, PCP adult, PCP pediatric sick, etc.);
c) Total number and percent of requests that exceed the waiting time standards (for each provider type/class);
d) Average wait time for PCP routine visits; and
e) Average wait time for 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 (i.e., specialists), the DHS may require additional data collection (i.e., a report by specialty type).

5) FQHC or RHC Services Rendered Report

The Health Plan shall submit quarterly and annual *FQHC or RHC Services Rendered Reports.* The reports shall provide data on activities during the quarter and calendar year (January through December) and shall include the following information:

a) The contract status of the FQHC/RHC (i.e., if the FQHC is participating or non-participating as a provider in the Health Plan's network);
b) The total dollar amount of payments made to an FQHC/RHC, listed by FQHC/RHC;
c) 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
d) The number of unduplicated visits provided to the Health Plan's members.

6) Provider Suspensions and Termination Report

The Health Plan shall notify the DHS within three (3) business days of any provider suspensions and terminations, both voluntary and involuntary because of suspected or confirmed fraud or abuse. The immediate notification shall include provider's name, provider's specialty, reason for the action and the effective date of the suspension or termination. In addition, the Health Plan shall submit

a *Provider Suspensions and Terminations Report* that lists 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 shall be documented in the *Provider Suspensions and Terminations Report*. The Health Plan shall submit information on all providers that are denied credentialing for any reason on their quarterly report.

E) *Provider Preventable Conditions*

The Health Plan shall report all identified provider-preventable conditions through encounter data submissions.

F) *Prescription Drugs*

For all covered outpatient drugs, as described in 42 CFR 438.3 (s) and in accordance with Section 4.5(P), the Health Plan shall:

1) Report drug utilization data that is necessary for the State to bill manufacturers for rebates no later than 45 calendar days after the end of each quarterly rebate period.
2) Report drug utilization information that includes, at a minimum, information on the total number of units of each dosage form, strength, and package size by National Drug Code (NDC) of each covered outpatient drug dispensed or covered by the Health Plan.
3) Establish procedures to exclude utilization data for covered outpatient drugs that are subject to discounts under the 340B drug pricing program from drug utilization data reports when

states do not require submission of managed care drug claims data from covered entities directly.

4) Provide a detailed description of its drug utilization review program activities to DHS on an annual basis.

G) *Other Data Collection*

1. The Health Plan shall submit the following data to DHS to improve the performance of the Contract:

   a) Enrollment and disenrollment data;

   b) Member grievance and appeal logs;

   c) Provider complaint and appeal logs;

   d) Results of any member satisfaction survey conducted by the Health Plan;

   e) Results of any provider satisfaction survey conducted by the Health Plan;

   f) Medical management committee reports and minutes from the Health Plan; and

   g) Customer service performance data.

2. The Health Plan shall submit any other data, documentation, or information relating to the performance of the Health Plan's obligations under this contract as requested by DHS or the federal government.

6.4 Specialized Reporting

A. The Health Plan may recommend other reporting that it generates for internal use that would also be useful for DHS to review.

B. DHS may require the Health Plan to prepare and submit special or "ad hoc" reports for the administration of the State Medicaid Program. In addition, the Health Plan shall comply with all additional requests from DHS, or its designee, for additional data, information and reports for the administration of the State Medicaid Program.

C. DHS must give the Health Plan reasonable and sufficient notice prior to the submission of ad hoc reports to DHS. The notice must be reasonable relative to the nature of the ad hoc report requested by DHS. At a minimum, DHS must give Health Plan five (5) business days notice prior to submission of an ad hoc report. In the event the Health Plan is under a corrective action plan (CAP), the Health Plan may be required to submit certain reports more frequently than stated in this Section.

6.5 Encounter Data Reporting

A) *Encounter Data General Requirements*

1. DHS collects and uses encounter data for many reasons such as audits, investigations, identifications of improper payments, and other program integrity activities; federal reporting (42 CFR 438.242(b) (1)); rate setting and risk adjustment; analysis of denial patterns; verification of reported quality measure data prior to release of withhold, incentive payments; service verification, managed care quality improvement program, policy analysis, executive and legislative decision making, and assessment of

utilization patterns and access to care; hospital rate setting; pharmacy rebates; and research studies.

2. The Health Plan shall ensure that data received from providers and other subcontractors is accurate and complete by verifying the accuracy and timeliness of reported data; screening the data for completeness, logic, and consistency; and collecting service information in standardized format. The Health Plan shall make all collected data available to DHS, and upon request, to CMS.

3. The Health Plan shall submit encounter data for all services rendered to members under this contract, including encounters where the Health Plan determined no liability exists, and whether the encounter was processed as paid or denied, along with any adjustments, or voids of encounter records previously submitted.

4. The Health Plan shall submit encounter data even if the Health Plan did not make any payment for a claim, including claims for services to members provided under subcontract, capitation or special arrangement with another facility or program. Encounters related to value added services or additional benefits offered by the Health Plan shall be submitted, and appropriately flagged to enable them to be distinguished and parsed as necessary.

5. The Health Plan shall submit encounter data for all services provided under this contract to members who also have Medicare or other TPL coverage, if a claim has been submitted to the Health Plan. Encounter data for services paid by Medicare or other TPL shall be flagged to indicate source of payment.

6. The Health Plan shall submit encounter data to MQD at least once per month in accordance with the requirements and specifications

defined by the State and included in the HPMMIS Health Plan Manual ("Health Plan Manual"), published by DHS and incorporated by reference into this contract. DHS may periodically update the Health Plan Manual with ninety (90) calendar days written notice to the Health Plan. The Health Plan Manual may be changed with less than ninety (90) calendar days notice by mutual agreement of the Health Plans and DHS. The Health Plan shall, upon receipt of such notice from DHS, provide notice of changes to subcontractors.

7. The Health Plan must maintain appropriate systems and mechanisms to obtain all necessary data from its health care providers and subcontractors to ensure its ability to comply with all encounter data reporting requirements. The failure of a health care provider or subcontractor to provide the Health Plan with necessary encounter data shall not excuse the Health Plan's noncompliance with this requirement.

8. Encounters will be submitted via a DHS designated electronic mechanism such as a SFTP service and will be used to create a database that may be used for purposes described previously. DHS may edit encounter records to assure consistency and readability.

9. Encounter data submitted by the Health Plan may also be submitted by DHS to an all-payer claims database (APCD), or the Health Plan may be required to directly submit encounter data for all services rendered to members under this contract to an APCD. Encounter data submitted by the Health Plan may additionally be submitted to other agencies including but not limited to CMS as determined by DHS to support program integrity and other reporting functions that are directly related to the administration of the State Medicaid program.

10. The Health Plan and its subcontractors shall retain all encounter data for a period of no less than ten (10) years in accordance with 42 CFR 438.3(u). Provisions shall be made by the Health Plan to maintain permanent history by service date for those services identified as "once-in-a-lifetime" (e.g., hysterectomy).

B) ***Encounter Data Submission Content and Format***

1. Encounters shall be certified for completion and accuracy and submitted by the Health Plan as required in 42 CFR 438.604 and 438.606 and as specified in this Section 6.5(B) concurrently with each upload.

2. The Health Plan and its subcontractors must exclusively utilize the submission formats defined in the Health Plan Manual for the electronic communication of all encounter records submitted, regardless of date of service. Additionally, the Health Plan and its subcontractors must follow the instructions and guidelines set forth in the most current versions of ICD-10-CM, HCPCS, CPT, and other standard nomenclature and classification systems. When submitting encounter records, the Health Plan shall adhere to all requirements specified in the Health Plan Manual.

3. Submitted encounters and encounter data must pass all DHS HPMMIS system edits and audits as specified in the Health Plan Manual or as sent out in communications from DHS to the Health Plan; and submitted encounters or encounter records must not be a duplicate of a previously submitted and accepted encounter or encounter record unless submitted as an adjustment or void per HIPAA transaction standards. The Health Plan shall make changes or corrections to encounter data and/or any systems, processes, or

data transmission formats as needed to comply with DHS' data quality standards as defined and subsequently amended.

4. The Health Plan must make an adjustment to encounters within 30 days when the Health Plan discovers the data is missing, incorrect, no longer valid, or some element of the encounter not identified as part of the original encounter needs to be changed, except as noted otherwise. Specifically, for newborn encounters that are billed under the mother's beneficiary ID, the Health Plan shall correct the previously submitted encounter data with the newborn's assigned beneficiary ID within 30 days of receipt of the correct ID.

5. If DHS discovers errors or a conflict with a previously adjudicated encounter claim, the Health Plan shall be required to adjust or void the encounter claim within thirty (30) days of notification by DHS, or if circumstances exist that prevent the Health Plan from meeting this time frame, a specified date shall be approved by DHS.

6. In the event that an audit, investigation, or litigation by the Health Plan, DHS, recovery audit contractor (RAC), federal entity, other State contracted auditor, or other agency results in a recovery payment or payments inaccurately or inappropriately made to a provider or providers, the Contractor shall submit an amended encounter record(s) to the State within sixty (60) days of the recovery or by a timeframe determined and approved by the State if the (60) day period is not operationally feasible.

7. The Health Plan shall uniquely identify encounters paid under fee-for-service, capitated, and bundled arrangements for its network providers, including FQHCs and RHCs. For capitated arrangements, the Health Plan shall report each service encounter, including those

that resulted in a zero payment, when applicable. For bundled payments, including but not limited to EPSDT visits, FQHC and RHC visits, and hospital stays, the Health Plan shall submit encounter details on each service provided; each service rendered during an encounter shall be parsed into service lines to enable accurate computation of service utilization in these settings. Capitation detail records shall be required for each provider and enrollee combination for each time period in which a capitation payment is made to the provider. For encounters not uniquely tied to a payment (for example, encounters for services rendered under a capitation arrangement), the Health Plan shall submit a Medicaid fee-for-service equivalent valued amount for the encounter.

C) ***Accuracy, Completeness and Timeliness of Encounter Data Submissions***

1. DHS may conduct encounter data validation to assure accuracy, timeliness, and completeness for the populations served by the Health Plan under this contract for up to the three most recent and complete years prior to the rating period.

2. Timeliness – Encounter data must be submitted to DHS at a minimum monthly, no later than the end of the month following the month when the financial liability was processed (i.e. paid, denied, voided, or adjusted/corrected). Health Plans shall submit one hundred percent (100%) of encounter data within fifteen (15) months from the date of service, including all adjusted and resubmitted encounters. DHS will provide the Health Plan with error reports via the SFTP file server after each encounter submission.

3. The Health Plan shall additionally submit an encounter submission form to accompany every certified encounter submission; the template for the form shall be provided by DHS to standardize the reconciliation process; the encounter submission form will be used by the Health Plan to provide DHS with a high level summary of submitted encounters, including total claims, total claim lines, and total paid amounts by service category for all encounters included within a certified submission. Each program (e.g. QI, CCS, etc.) the Health Plan provides should be listed under a separate form.

4. At regular intervals in each contract year, the Health Plan shall validate the accuracy and completeness of all encounter data submitted in two ways. First, the Health Plan shall validate the aggregate totals of all encounter data submitted and accepted during that interval using an encounter/general ledger reconciliation form provided by DHS within thirty (30) days of the end of each interval. Second, the Health Plan shall reconcile the cumulative encounter data submitted and accepted for the intervals in the most recent 12-month period against the corresponding 12-month general ledger within sixty (60) days of the end of each interval. The encounter data reconciliation process interval will be set at the beginning of each contract year, and be no more frequent than quarterly and no less frequent than annually.

5. The Health Plan shall provide justification for any discrepancies revealed by the interval-specific or 12-month ledger reconciliation process. DHS will approve or reject the discrepancy justification(s) and notify the Health Plan of the decision within ninety (90) days of the end of each reconciliation period. The Health Plan is required to correct any discrepancies unless the justification(s) are approved by DHS.

6. DHS will additionally validate the Health Plan's interval-specific and 12-month encounter data/financial ledger reconciliation summary against the submitted and accepted data captured within HPMMIS.

7. DHS will determine the overall extent of the discrepancy between encounter data submitted and accepted within HPMMIS and the interval-specific and twelve (12) month ledger amounts, and determine whether the discrepancies are within the discrepancy tolerance thresholds of successfully accepted encounters captured by DHS; discrepancy tolerance thresholds for each interval and twelve (12) month encounter data submission will be revised annually by DHS.

8. The Health Plan shall be notified by DHS within sixty (60) days from the end of each reconciliation period if the Health Plan's encounter data submission has exceeded the discrepancy tolerance threshold for that interval. The Health Plan shall be granted a thirty (30) day period from the date of notification to explain differences between the interval-specific and twelve (12) month encounter/general ledger reconciliation summary and the encounter data submitted and accepted within HPMMIS. Within thirty (30) days, DHS will review any explanation(s) provided, and either approve or reject the Health Plan's explanations (if offered).

9. For any discrepancies between the interval-specific or 12-month submitted encounter data and the Health Plan general ledger, or between the interval-specific or 12-month submitted and accepted encounter data in HPMMIS and the Health Plan general ledger, for which DHS has rejected the explanation(s) offered by the Health Plan, the Health Plan has up to sixty (60) days to correct errors and resubmit the encounter data, submit revised interval-specific or 12-

month encounter/general ledger reconciliations, and provide an explanation for any remaining discrepancies. DHS will review any explanation(s) provided, conduct its reviews, and make a final determination on whether the Health Plan has exceeded the discrepancy threshold for the interval that cannot be justified for reasons other than encounter data quality and completeness.

10. If DHS approves the submission to be within acceptable thresholds of quality and completeness, the original or updated data provided in the Health Plan encounter/general ledger reconciliation summary (whichever is applicable) will be considered during rate setting and other purposes. If rejected, the submitted and accepted encounter data captured within HPMMIS may be used instead.

11. In subsequent years of the contract, the thirty (30) day error resolution period may be rescinded. If rescinded, the final determination on whether the Health Plan's encounter data submission has exceeded the discrepancy tolerance threshold will be made based on the calculated discrepancy value for that interval without further opportunity for error resolution by the Health Plan, and the submitted and accepted encounter data captured within HPMMIS will be used for rate setting and other purposes. Additionally, DHS reserves the right to change its encounter data validation process at any time, with at least sixty (60) day notice to the Health Plan.

12. As described in Section 7.1(B)(1), Health Plan Operational Effectiveness Program (OEP), withholds may be applied by DHS as needed to improve operational effectiveness in one or more areas. When applied to encounter data submissions, withholds will be based on the interval(s) established for the contract year.

13. 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.

6.6 Report Submission

A) *Report Submission General Requirements*

1. To support communication between the Health Plan and DHS, the Health Plan shall submit a listing, in writing, of the designated Health Plan staff developing and/or submitting required reporting to DHS.
2. The Health Plan agrees to provide DHS with the reports CMS has requested or requests in the future. Health Plans shall provide any additional reports requested by DHS.

3. The Health Plan shall respond to any DHS request for information or documents within the timeframe specified by DHS in its request. If the Health Plan is unable to respond within the specified timeframe, the Health Plan shall immediately notify DHS in writing and shall include an explanation for the inability to meet the timeframe and a request for approval of an extension of time. DHS may approve, within its sole discretion, any such extension of time upon a showing of good cause by the Health Plan. To avoid delayed responses by Health Plan caused by a high volume of information or document requests by DHS, both parties shall devise and agree upon a functional method of prioritizing requests so that urgent requests are given appropriate priority.

B) ***Health Plan Certification***

1. The Health Plan shall certify the accuracy, completeness, and truthfulness of any reports and data, including but not limited to, encounter data, data upon which payment is based, and other information required by the State, that may be submitted to determine the basis for payment from the State agency as required in 42 CFR 438.604 and 438.606. The Health Plan shall certify that it is in substantial compliance with the contract and provide a letter of certification attesting to the accuracy, completeness, and truthfulness of the data submitted based on best knowledge, information, and belief, and thereby certify that no material fact has been omitted from the certification and submission. The Health Plan shall submit the letter of certification to the MQD concurrent with the certified data and document submission. In the case of two (2) or more reports or encounter data submissions in one month, the Health Plan shall submit an equal number of letters of certification, with one letter of certification corresponding to each report or encounter data batch submitted to DHS. The certifications are to be based on best knowledge, information, and belief of the following Health Plan personnel.

2. The data shall be certified by:

    a) The Health Plan's Chief Executive Officer (CEO);

    b) The Health Plan's Chief Financial Officer (CFO); or

    c) An individual who has delegated authority to sign for, and who reports directly to, the Health Plan's CEO or CFO.

3. The Health Plan shall require claim certification from each provider submitting data to the Health Plan. Source, content, and timing of certification shall comply with the requirements set forth in 42 CFR 438.604 and 438.606.

4. Health Plan non-compliance as specified above will be considered a breach of contract and subject to sanctions as described in Section 14.

C) *Follow-Up by Health Plans/Corrective Action Plans/Policies and Procedures*

1. DHS shall provide a report of findings to the Health Plan after completion of each review, monitoring activity, etc.

2. Unless otherwise stated, the Health Plan shall have thirty (30) days from the date of receipt of a DHS report to respond to the MQD's request for follow-up, actions, information, etc. The Health Plan's response shall be in writing and address how the Health Plan resolved the issue(s). If the issues(s) has/have not been resolved, the Health Plan shall submit a corrective action plan including the timetable(s) for the correction of problems or issues to MQD. In certain circumstances (i.e., concerns or issues that remain unresolved or repeated from previous reviews or urgent quality issues), MQD may request a ten (10) day plan of correction as opposed to the thirty (30) day response time.

3. If the Health Plan fails to cure the deficiency as ordered, the department shall have the right to refuse to consider the Health Plan for future contracting.

4. For all medical record reviews, the Health Plan shall submit information prior to the scheduled review and arrange for MQD and/or 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 submission of records.

5. 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 formal policies or procedures for a specific area, the Health Plan may submit other written documentation such as workflow charts or other documents that accurately describe the course of action the Health Plan has adopted or shall take if circumstances should trigger the need for the action.

SECTION 7 – DHS and Health Plan Financial Responsibilities

7.1 DHS General Responsibilities

A) *Capitation Rates*

1) Overview of Capitation Rates

a) This section describes the rate structure and the guidelines for rate setting.

b) For any member of a given QUEST Integration contracted Health Plan, DHS shall pay a capitation rate which varies by aid category, island and age/gender band. Aid categories include the following:

1. Medicaid Expansion;
2. Aged/Blind/Disabled (ABD):
    a. ABD – Medicare Eligible, and
    b. ABD – Medicaid Only;
3. Other Populations:
    a. CHIP,
    b. Foster Care, and
    c. Families and Children.

c) The capitation rates shall assume an administrative load based on expected administrative costs. The administrative loads will be set separately for ABD and non-ABD populations, and will be inclusive of administrative expenses and risk margin expenses but will not include general excise and insurance premium tax, if applicable.

2) Rate Development

a) DHS shall provide final actuarially sound capitation rates to all selected Health Plans as part of the Contract. All selected Health Plans shall receive the same base capitation rates as described in Section 7.1(A). Due to the lag in rate development and application of rates, further adjustments may be required before implementation. If this is the case, DHS will provide documentation of the rate change similar to that provided during a rate renewal. The allowed administrative expenditures shall be increased to an amount as described in Section 7.1(A)(1) for those that serve Statewide. Allowed administrative expenses may vary for Health Plans that serve Oahu only and those that service all islands.

b) The capitation rates shall have three components of risk adjustment to the base rates.

1. The first part of the enhanced payment is based on FQHC and RHC use rates for enrolled members. The enhancement is intended to provide for the additional cost for services at these facilities due to the requirement that they be reimbursed at the PPS rate. Rates for Health Plans shall be increased to cover this additional cost based on historical use rates at these facilities for members enrolled in each plan. This enhancement shall vary by Health Plan, aid category, island and age/gender cohort.

2. The second adjustment will account for the distribution and acuity of the membership with long-term services and supports (LTSS) within the rate cells below.

a) Aged/Blind/Disabled (ABD)

    1. ABD – Medicare Eligible; and

    2. ABD – Medicaid Only.

b) The DHS anticipates that this will involve stratifying members determined to be members residing in a nursing facility, members receiving home and community based services (HCBS), members at risk of deteriorating to nursing home level of care (LOC) and receiving HCBS, and members without LTSS needs. DHS will further evaluate the risk within these populations.

3. Third, in order to account for risk selection between Health Plans, DHS may perform a diagnosis and/or pharmacy based, or other risk adjustment. This adjustment shall be performed in a budget neutral manner for each applicable rate category. That is, the result of the application of risk factors for each rate category shall be expected to shift revenue between the Health Plans, with no impact on aggregate state funding. Risk adjustment factors shall be applied as early as possible at program startup, with the expectation of being no later than the second month of enrollment. If the risk adjustment is delayed beyond the initial month of enrollment, no retroactive adjustments shall be made. Each year, the risk adjustment process shall be refreshed

with the target implementation for the next calendar year.

c) The capitation rates will comply with the applicable sections in 42 CFR Part 438, including but not limited to:

§438.4(b)(7), §438.4(b)(8), §438.4(b)(9), §438.5(b), §438.5(c), §438.5(d), §438.5(e), §438.5(f), §438.6(b)(3), §438.6(c), §438.6(d), §438.7(b), §438.7(c)(1), §438.7(c)(2), §438.8, §438.74.

3) Future Rate Setting

a) Subject to limitations imposed by CMS, legislative direction or other outside influence for which DHS shall comply, it is the intent of DHS to publish revised rates each CY throughout the term of the contract. DHS specifically does not commit to any particular methodology or formula, or to any particular benchmark or objective, for rate revisions.

4) Daily Rosters/Health Plan Reimbursement

a) DHS shall enroll and disenroll members through daily files (i.e., the 834 daily file). All payments and recoveries shall 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 Health Plan agrees to accept daily and monthly transaction files from DHS as the official enrollment record.

b) DHS shall make capitation payments, with each payment being for a month's services, 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 1.5. Capitation payments shall be in the amounts listed in the Health Plan's contract with DHS.

c) DHS shall pay the established capitation rates to the Health Plan for members enrolled for the entire month. Capitation payments shall be paid on rate codes that reflect the risk factor adjustments. Capitation payments for members enrolled/disenrolled on dates other than the first or last day of the month shall be prorated on a daily basis based on the number of days in a month.

d) DHS shall make a monthly capitation payment to the Health Plan for a member aged 21-64 years, receiving inpatient treatment in an Institution for Mental Diseases (IMD), as defined in 42 CFR 435.1010, so long as the facility is a hospital providing psychiatric or substance use disorder crisis residential services, and length of stay in the IMD is for a short term stay of no more than fifteen (15) calendar days during the period of the monthly capitation payment.

e) DHS shall make additional capitation payments or recover capitation payments from the Health Plan as a result of retroactive enrollments, retroactive disenrollments and prior period coverage.

f) DHS shall provide to the Health Plan a Monthly Payment Summary Report that summarizes capitation payments and recoveries made to the Health Plan (i.e., the 834 monthly report).

g) The Health Plan shall not change any of the information provided by DHS on the daily or monthly transaction files. Any inconsistencies between the Health Plan and DHS information shall be reported to DHS by the Health Plan for investigation and resolution. All payments and recoveries shall be detailed on the daily file and summarized on the Monthly Payment Summary Report.

h) The Health Plan and any subcontractor shall report to DHS within 60 calendar days when it has identified capitated payments or other payments in excess of amounts specified in the contract.

i) DHS shall notify the Health Plan prior to making changes in the capitation amount/rate code.

5) Health Insurance Provider Fees

a) DHS shall reimburse Health Plans for Health Insurance Provider Fees (HIPF) after Health Plans submit proof of payment of HIPF and DHS reviews the submissions. This process will apply to both retrospective and prospective activities.

6) Capitation Payment for Changes in Rate Codes

a) There are several situations in which a member may change eligibility categories, and therefore rate codes, that shall result in a different capitation payment amount or a disenrollment from the Health Plan.

b) Changes in the capitation payment amount/rate code paid shall become effective the next day after the enrollment change is processed.

7) Risk Share Program

a) DHS shall implement and manage a risk share arrangement and shall share in any significant aggregate Health Plan losses or individual Health Plan savings.

B) *Incentive Strategies for Health Plans*

1. Operational Effectiveness Program

a) DHS shall implement an Operational Effectiveness Program (OEP) focused on ensuring that Health Plans manage operations and performance effectively based on identified areas in need of improvement which will result in system, regional, provider, or member-level benefit.

b) DHS will define process measurement, performance measurement, and targets that will be maintained until sustained improvements are reached.

c) DHS will determine metrics for the OEP annually. DHS shall assign weights to each metric included in the OEP. The operational and performance metrics included in the OEP, the specific targets for each, and the time period of assessment for each metric, will be set annually by DHS, and may vary across plans. OEP metrics

may encompass items included by the Health Plan in its technical proposal and included as part of the Contract.

d) Funding for this program will be based on a withhold arrangement, with the potential for Health Plans to earn dollars back as the Health Plan meets performance and/or operational targets. The withheld amount is a fixed PMPM amount that varies by rating population but is roughly equal to a certain percentage of the total capitation revenue. DHS may also decide to prospectively pay all of the withheld amount and recover portions of the payment from the Health Plan that the Health Plan did not earn back by meeting performance and/or operational goals.

2. Quality Payment Program

a) DHS shall implement the Quality Payment Program so that Health Plans will be eligible for financial performance incentives or Pay for Performance (P4P) as long as the Health Plan is fully compliant with all terms of the Contract. All incentives shall be in compliance with the Federal managed care incentive arrangement requirements set forth in 42 CFR 438.6 and other applicable sub-regulatory guidance.

b) To be eligible to participate in the Quality Payment Program, a NCQA-licensed audit organization must have audited the reported Health Plan rates for the performance measurements following CMS protocol for validation. DHS contracts with an EQRO for validation of performance measures. The total of all payments paid to the Health Plan under this Contract shall be pursuant to 42 CFR Part 438.

c) The Quality Payment Program is comprised of multiple performance measures that align with the HOPE initiative and Quality Strategy. DHS shall assign weights to each performance measure. The performance measures and the targets/floors for each performance measure may vary each year, but DHS intends to maintain some consistency in performance measures to trend progress in achieving improved outcomes. Performance measures selected may include quality, VBP, and other financial metrics of interest. Each performance measure will be calculated independently of other performance measures, to determine if any performance incentive was earned for that performance measure.

d) The Quality Payment Program may be implemented based on a withhold arrangement with potential for Health Plans to earn dollars back as the Health Plan meets performance targets in accordance with 42 CFR 438.6(b)(3). DHS may also prospectively pay the withheld amount and recover portions of the payment from the Health Plan that the Health Plan did not earn back by meeting performance measure targets.

e) The Quality Payment Program may also be implemented as an incentive arrangement program in accordance with 42 CFR 438.6(b)(2). The incentive arrangement may also be prospectively paid and DHS may recover portions of the payment from the Health Plan that the Health Plan did not earn by meeting performance measure targets.

3. *Innovation Advancement Initiative*

a) DHS may implement the Innovation Advancement Initiative. Health Plans may be eligible for incentives under the Innovation Advancement Initiative by meeting targets for performance and process metrics tied to goals and strategies described in the Contract.

b) The goal of the program is to create performance incentives for Health Plans to succeed in implementing newer strategies in the RFP. Incentives may be designed around Health Plan performance on the Advancing Primary Care Initiative described in Section 3.3(B), supporting the delegation of CSC activities as described in Section 3.7(B), moving providers along the LAN continuum described in Section 7.2(B)(2), and successfully implementing a SDOH Work Plan as described in Section 5.1(B)(3). DHS may implement measures for different initiatives or strategies during the period of the Contract.

c) The Innovation Advancement Initiative may be implemented as an incentive arrangement program in accordance with 42 CFR 438.6(b)(2). The incentive arrangement payment may be prospectively paid and DHS may recover portions of the incentive from the Health Plan that the Health Plan did not earn by meeting performance measure targets.

4. *Community Investment Program*

a) DHS may, at its discretion, create a Community Investment Program made up of the remainder of the dollars allotted to the Quality Payment program and the Innovation Advancement Initiative, but not earned by Health Plans. DHS would consult with

Health Plans and stakeholders to make grants, payments, and similar spending strategies to entities and programs that would support the goals of the HOPE initiative.

7.2 Health Plan General Responsibilities

A) *Provider and Sub-Contractor Reimbursement*

1. General Provider and Sub-Contractor Reimbursement Strategies

a) With the exception of eligible services provided by hospice providers, FQHCs, RHCs, hospitals, critical access hospitals (CAHs), and nursing facilities, the Health Plan may reimburse its providers and subcontractors in any manner, subject to Federal rules and any directed payment policies implemented by DHS.

b) The Health Plan shall implement financial incentives for performance, or value-based payment arrangements for some providers in accordance with Federal rules and this RFP.

1. FQHCs and RHCs

a) The Health Plan shall reimburse non-contracted FQHCs and RHCs at rates no less than the Medicaid fee schedule if those providers are necessary for network adequacy. The Health Plan shall not be required to cover services at an FQHC or RHC if that provider is not contracted and not required for network adequacy. The Health Plan shall reimburse contracted FQHCs or RHCs for Prospective Payment System (PPS) eligible services at the PPS rate provided annually by DHS. Any other payment

methodology to these providers requires prior approval by DHS.

b) DHS shall calculate and reimburse FQHC/RHC's for any retroactive settlements involving a change in scope of services that result in an increased PPS rate that is not incorporated into the capitation rates. The Health Plans shall reimburse the FQHC/RHC the annual PPS increase when provided by DHS. This annual increase will be incorporated into the capitation rates. DHS shall perform reconciliation and make any necessary supplemental payments to FQHCs and RHCs.

c) The Health Plan shall report the number of unduplicated visits provided to its members by FQHCs and RHCs and the payments made by the Health Plan to FQHCs and RHCs. The Health Plan shall report this information to DHS in accordance with the reporting process described in Sections 6.1 and 6.2(A).

2. Hospitals

a) DHS may require Health Plans to reimburse hospitals for inpatient services through a diagnostic related group (DRG) method where acuity adjusted diagnosis-based reimbursement methodologies have been well developed.

b) At a minimum, the Health Plan shall reimburse critical access hospitals (CAHs) for hospital services and nursing

home services at rates calculated prospectively by DHS using Medicare reasonable cost principles in accordance with HRS § 346-59.

c) Health Plans shall incorporate VBP strategies for both hospitals and CAH in accordance with Section 7.2(B).

3. Ke Ola Mamo

a) The Health Plans shall reimburse Ke Ola Mamo (the facility that has a grant for the American Indian and Alaska Native Healthcare in Hawaii Project) for services provided to members who are qualified to receive services from an Indian Health Service Facility as set forth in Title 42, United States Code, Section 1396u-2(h)(2); and Title V of the American Recovery and Reinvestment Act of 2009, Section 5006.

b) The Health Plans shall pay Ke Ola Mamo for covered services at a negotiated rate, or in the absence of a negotiated rate, at a rate not less than the level and amount of payment the Health Plan would make for the services provided by non-participating providers.

4. Hospice

a) The Health Plan shall pay hospice providers Medicare hospice rates as calculated by DHS and CMS. The Health Plan shall implement these rates on October 1 of each year.

5. Nursing Facility

    a) The Health Plan shall reimburse nursing facilities in accordance with HRS § 346E and § 346D-1.5 utilizing an acuity-based system at rates comparable to the current Medicaid fee schedule.
    b) The Health Plan shall participate in nursing home quality payment programs as defined by DHS.

2. Co-Payment Responsibilities

a) The Health Plan shall pay Medicare co-payments for dual eligibles to both contracted and non-contracted providers. The Health Plan shall utilize the current Medicaid reimbursement methodology and rate structure (if applicable) for Medicare co-payments. MQD reimburses all Medicare co-payments up to 100% of the Medicare rate for outpatient services only.

b) The Health Plan shall pay co-payments for services covered by a TPL to include co-payments for a three-month supply of maintenance medications or supplies.

3. Out of Network Responsibilities

a) The Health Plan shall pay out-of-network providers who deliver emergency services the same as they would have been paid if the emergency services had been provided to an individual in the Medicaid fee-for-service program. These providers shall not balance-bill the member.

4. Clean Claims Requirements

a) The Health Plan shall pay its subcontractors and providers on a timely basis, consistent with the claims payment procedures described in Section 1902(a)(37)(A) of the Social Security Act. The Health Plans shall allow providers at least one year from date of service or discharge, whatever is the latter, to submit claims for reimbursement.

b) Ninety percent (90%) of all clean claims for payment (for which no further written information or substantiation is required in order to make payment) are required to be paid within thirty (30) days of the date of receipt of such claims; ninety-nine percent (99%) of all clean claims are required to be paid within ninety (90) days of the date of receipt of such claims; and 100% of all clean claims must be paid within fifteen (15) months from the date of service. The calculation of clean claim percentage paid is based on total claim count.

c) The clean claims payment requirements apply in the aggregate but also individually for, hospital inpatient, hospital outpatient, skilled nursing facilities, Community Care Foster Family Homes (CCFFH), hospices, home health agencies, and FQHCs. Health Plans shall also report to DHS timeliness of payment regarding claims submitted in the aggregate and also separately for hospital inpatient, hospital outpatient, skilled nursing facilities, CCFFHs, hospices, home health agencies, and FQHCs. The date of receipt is the date the Health Plan receives the claim, as

indicated by its date stamp on the claim and the date of payment is the date of the check or other form of payment. The Health Plan and the provider may, however, agree to an alternative payment schedule provided this alternative payment schedule is reviewed and approved by DHS.

d) Interest shall be allowed at a rate of fifteen percent (15%) a year for money owed by a Health Plan on payment of a clean claim exceeding the applicable time limitations under this section from the first calendar date after the thirty (30) day period.

5. Electronic Claims Payment

a) Health Plans shall incentivize electronic claims submission. The Health Plan shall require that providers use HIPAA standard 837I or 837P or NCPDP transactions for electronic claims and the CMS 1500 or UB-04 forms for paper claims.

6. Claims Payment & Remittance Requirements

a) The Health Plan shall develop and maintain a claims payment system and process capable of processing, cost avoiding, and paying claims accurately in accordance with reimbursement terms with the provider. The system must produce a remittance advice related to the Health Plan's payments to providers and must contain, at a minimum:

1. An adequate description of all denials and adjustments using HIPAA standard Claim Adjustment Reason Codes (CARCs). Denial and adjustment codes assigned must provide sufficient information to fully explain a denial or adjustment without requiring additional inquiry from the payor, and shall use language that explains in adequate detail and in language that a lay person could reasonably understand. Any payor specific or customized reason codes shall also be fully explained in the same manner;
2. The amount billed;
3. The amount paid;
4. Application of coordination of benefits (COB) and subrogation of claims (SOC); and
5. Provider rights for claim disputes.

b) The related remittance advice must be sent with the payment, unless the payment is made by electronic funds transfer. For payments made by electronic funds transfer, payor must provide remittance advice via HIPAA standard electronic remittance advice transactions (835). The Health Plan may opt to also provide a paper remittance advice. 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.

7. Health Plan Responsibility as Payer to Subcontractors and Providers

a) In no event shall the Health Plan's subcontractors and providers look directly to the State for payment.

b) The State and the Health Plan's members shall bear no liability for the Health Plan’s failure or refusal to pay valid claims of subcontractors or providers. The Health Plan shall include in all subcontractor and provider contracts a statement that the State and plan members bear no liability for the Health Plan’s failure or refusal to pay valid claims of subcontractors or providers for covered services.

c) Further, the State and Health Plan members shall bear no liability for covered services provided to a member for which the State does not pay the Health Plan; or for which the plan or State does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangement; or for payment for covered services furnished under a contract, referral, or other arrangement, to the extent that these payments are in excess of the amount that the member would owe if the Health Plan provided the services directly.

d) 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.

B) *Value-Based Payment (VBP)*

1. Background

a) Value-Based Payment (VBP) is an approach to payment reform that links provider reimbursement to improved performance or that aligns payment with quality and efficiency. This form of payment holds health care providers accountable for both the cost and quality of care they provide. VBP strives to reduce inappropriate care and to identify and reward the highest performing providers. VBP may include but not be limited to different reimbursement strategies such as Fee-for-Service with incentives for performance, Capitation Payment to providers with assigned responsibility for patient care, or a hybrid model.

b) DHS intends to build upon the existing VBP structure within the State and expand capacity for increased use of VBP strategies across Hawaii's health care system to encompass providers such as PCPs; hospitals; LTSS, behavioral health, and substance use disorder providers; rural health providers; and other specialty providers. The Health Plan shall support DHS in advancing providers along the VBP continuum toward VBP strategies that may encompass multi-payer efforts.

c) DHS may require the Health Plan to align standard metrics and reporting for providers participating in a VBP agreement with other payer, federal or community metrics and reporting to reduce administrative burden for the provider community. Health Plans shall submit data to DHS upon request to include but not be limited to timely, actionable reports on conditions or criteria determined by DHS.

2. *VBP Continuum*

a) Provider readiness and engagement for VBP occur along a continuum. At the earliest stages, providers and payers build infrastructure and tools, develop learning and communications strategies, establish outcomes and process goals, and build systems to support data and reporting needs. At the mature levels of the continuum, healthcare systems are integrated on multiple levels, providers are accountable for population health outcomes, assume greater financial risk, and multi-payer models support providers in efforts for practice transformation. DHS intends to adopt the Healthcare Payment Learning & Action Network (HCP LAN, or LAN) Alternative Payment Model (APM) framework to assess VBP engagement and levels of provider readiness within QI.

b) The schematic below provides a high level illustration of the LAN framework. The Health Plan will use the LAN Framework as the foundation for developing VBP strategies to meet the goals and requirements of the QI program.

Category 1	Category 2 Fee-for-Service – Link to Quality and Value	Category 3 APMs Built on Fee-for-Service Architecture	Category 4 Population-Based Payment
Fee-for-Service – No link to Quality and Value	**A**	**A**	**A**
	Foundational Payments for Infrastructure & Operations (e.g. care coordination fees and payments for HIT investments)	**APMs with Shared Savings** (e.g. shared savings with upside risk only)	**Condition-Specific Population-Based Payment** (e.g. per member per month payments, payments for specialty services, such as oncology or mental health)
	B	**B**	**B**
	Pay for Reporting (e.g. bonuses for reporting data or penalties for not reporting data)	**APMs with Shared Saving and Downside Risk** (e.g. episode-based payments for procedures and comprehensive payments with upside and downside risk)	**Comprehensive Population-Based Payment** (e.g. global budgets or full/percent of premium payments)
	C		**C**
	Pay-for-Performance (e.g. bonuses for quality performance)		**Integrated Finance & delivery System** (e.g. global budgets or full/percent of premium payments integrated systems)
		3N	**4N**

		Risk Based Payments NOT Linked to Quality	Capitated Payments NOT Linked to Quality

3. Value Driven Healthcare Schedule

a) The Health Plan shall incorporate value-driven healthcare concepts as described in this Section 7.2(B) and into its payment strategy and be required to attain VBP targets according to the following schedule below:

CY 2020	**CY 2021**	**CY 2022**
35% of spend by major provider type in LAN Category 2A (Pay for Infrastructure – P4I) or above.	50% of spend by major provider type in LAN Category 2A or above (P4I); 20% 2B or above (Pay for Reporting - P4R); 10% 2C or above (Pay for Performance - P4P).	Increasing over 50% of spend by major provider type in LAN Category 2A or above (P4I); 20% 2C or above (P4R); 10% 3A or above (population or condition-specific payments).

b) DHS may specify reporting requirements, performance measures and targets as standards to incentivize Health Plans to move along the continuum. Annually, the Health Plan must demonstrate and report compliance with this schedule. The specific requirements of reporting will be determined in accordance with Section 6. Elements may include:

1. Utilizing a standard assessment method provided by DHS to assess the level of VBP maturity for each of its models, by provider type, based on the LAN Framework;
2. Developing a tracking mechanism for monitoring spend to ensure compliance with the contract requirements;
3. Developing, maintaining, and reporting to DHS in a format to be specified in Section 6, an inventory of providers engaged in VBP, the model, and LAN category in which they are engaged;
4. Establishing a plan for how the Health Plan's VBP strategy will mature as required by the schedule, including a mechanism for tracking plan wide progression; and
5. Developing a strategy for incorporating providers other than primary care physicians and hospitals in the VBP strategy.

c) DHS will work with the Health Plans to define major provider types for purposes of meeting the requirement. Major provider types may include:

1. Primary care providers;
2. Hospitals (Including Critical Access Hospitals);
3. Behavioral health providers;
4. Specialists;
5. LTSS providers; and
6. Rural health providers.

d) The Health Plan shall conduct a comprehensive baseline assessment of VBP diffusion, including current adoption of various VBP models, and report this data to DHS by the second quarter of the first contract year. The baseline and subsequent assessments,

conducted at least annually by the Health Plan, shall use a standard assessment tool developed by DHS to support standardized data collection.

Performance on the Value-Driven Healthcare Schedule requirement may be part of the OEP as described in Section 7.1(B)(1), the Quality Payment Program as described in Section 7.1(B)(2), and/or the Innovation Advancement Initiative as described in Section 7.1(B)(3).

4. *Specific Requirements for VBP for Hospitals*

a) Health Plans shall incentivize the provision of high quality, highly efficient care.

b) The Health Plan shall support hospitals' engagement in VBP through the following at a minimum:

1. Investing in infrastructure to support hospital VBP engagement;
2. Providing technical assistance to hospitals engaged in VBP;
3. Offering a VBP guide path for hospitals interested in advancing along the VBP continuum, including small and rural providers;
4. Addressing Hawaii specific barriers to hospital VBP, including creative options for addressing workforce challenges;
5. Supporting hospital provider data capabilities, including collection, reporting, and analytics;
6. Collaborating with other Health Plans to establish a provider learning network to support sharing of best practices;

7. Educating hospital providers on VBP and opportunities to move along the VBP continuum toward multi-payer initiatives;
8. Creating opportunities for hospital providers to participate with RHPs; and
9. Supporting hospital providers in understanding and assessing SDOH, and connecting with social services providers to address patient SDOH needs.

c) The Health Plan will implement VBP on the schedule set forth in the table below, except for CAH. This schedule is not to be construed to reduce existing VBP practices, but to develop additional VBP practices where they may be limited or do not exist. In CY2020, the Health Plan will spend at least five percent of inpatient hospital dollars through VBP at the LAN Category level 2C or above. Under the current LAN framework, level 2C represents payments which incentivize improved provider performance. For the remainder of the contract, the Health Plan will incrementally increase the VBP investment to twenty percent by CY2023. The table below demonstrates the schedule.

CY 2020	**CY 2021**	**CY 2022**	**CY 2023**
5% of Non-Critical Access Hospital (CAH) spending based on VBP arrangement under LAN Category 2C or above (P4P).	10% of Non-Critical Access Hospital (CAH) spending based on VBP arrangement under LAN Category 2C or above (P4P).	15% of Non-Critical Access Hospital (CAH) spending based on VBP arrangement under LAN Category 2C or above (P4P).	20% of Non-Critical Access Hospital (CAH) spending based on VBP arrangement under LAN Category 2C or above (P4P).

Annually, the Health Plan must demonstrate and report compliance with this schedule. The requirements for the reporting will be determined in accordance with Section 6.

d) Critical-Access Hospital VBP Requirements

1. The Health Plan will implement a CAH-specific VBP on the schedule set forth in the table below. This schedule is not to be construed to reduce existing VBP practices, but to develop additional VBP practices where they may be limited or do not exist. In CY 2020, the Health Plan will spend one percent of total CAH dollars through VBP at the LAN Category level 2C or above (P4P). Under the current LAN framework, level 2C represents payments which incentivize improved provider performance. For the remainder of the contract, the Health Plan will incrementally increase the VBP investment to ten percent by CY 2023. The table below demonstrates the schedule by Calendar Year.

CY 2020	**CY 2021**	**CY 2022**	**CY 2023**
1% of CAH spending based on VBP arrangement under LAN Category 2C or above (P4P).	5% of CAH spending based on VBP arrangement under LAN Category 2C or above (P4P).	8% of CAH spending based on VBP arrangement under LAN Category 2C or above (P4P).	10% CAH spending based on VBP arrangement under LAN Category 2C or above (P4P).

2. Annually, the Health Plan must demonstrate and report compliance with this schedule. The requirements for the reporting will be determined in accordance with Section 6.

e) Advanced Hospital VBP Option

1. The Health Plan will work with DHS, providers, and the stakeholders to advance VBP within the healthcare system. In addition to following the schedule for implementing VBP for hospitals described in this Section, the Health Plan shall invite hospitals with advanced VBP capabilities to engage in multi-payer models, test evidence based models that address specific HOPE goals, require coordination with RHPs, and provide opportunities to advance along the VBP continuum.

2. In CY 2020, the Health Plan shall coordinate with DHS, stakeholders, and other Health Plans to begin to align strategies for interested hospitals to test models.

3. CY 2020 will be a planning year. The first year is a planning year only for purposes of planning for a new VBP model. Health Plans are still responsible for meeting the minimum VBP requirements described in this Section. During subsequent years, participating hospitals will move from Pay for Participation or infrastructure building models, to Pay for Performance. The table below provides a high level schedule.

Advanced VBP Option			
CY 2020	**CY 2021**	**CY 2022**	**CY 2023**
Planning Phase	Pay for Participation in APM test model.	Pay for Reporting in APM test model.	Pay for Performance in APM test model.

5. *Specific Requirements for Patient Centered Medical Homes*

   a) The Health Plan shall develop a reimbursement methodology that provides higher payment to the more advanced Tier 2 PCMH compared to the Tier 1 PCMH as defined in Section 3. The methodology may be reviewed by DHS to ensure plan compliance with this requirement.

   b) The Health Plan payment methodology shall be based on outcomes, including both patient-oriented outcomes and utilization in order to incentivize increased quality and efficiency of care including proactive population management. For example, the Health Plan may utilize a monthly patient management reimbursement to the PCMH that is reconciled with earned financial incentives. Such financial incentives could be based on achieving thresholds on certain quality measures and/or could be based on reduction in overall utilization compared to that predicted. The available incentive amount may be dependent on the degree of financial risk the provider assumes.

6. *Multipayer VBP Initiatives*

   Health Plans are encouraged and may be required to participate in multipayer VBP programs or initiatives through a directed payment program or other methods in accordance with other Federal and State law and authorities.

7. *Vertically Integrated Organizations*

   Health Plans are encouraged and may be required to pursue a shared risk and shared savings program with integrated care organizations

if available. Such a health care delivery model may be provider led, and the organization assumes responsibility (i.e., becomes accountable for providing at a minimum, primary, acute, and chronic care services).

8. Health Plan Support for VBP Transformation

a) To support continued provider development and system wide capacity for VBP, the Health Plan will collaborate with DHS, stakeholders, and other Health Plans to build system wide capacity for VBP, and to attempt to avoid overwhelming providers with misaligned VBP strategies, operational components, or reporting across payers.

b) DHS intends to leverage the existing collaborative spirit within the state in addressing work force shortages and the provision of care in remote locations. DHS will lead, and the Health Plan will participate in, a stakeholder process focused on the coordination of community efforts to creatively address Hawaii-specific challenges through coordinated efforts like leveraging joint data systems, aligning funding for PCP visits to rural areas, providing telehealth services using joint technology, or other strategies.

c) The Health Plan will support providers by:

1. Investing in infrastructure to support provider VBP engagement;
2. Providing technical assistance to providers engaged in VBP;
3. Adopting payment strategies and testing models that encourage specified provider participation, such as models

designed around a certain specialty provider or bundled payments for episodes of care;

4. Offering a VBP guide path for providers interested in advancing along the VBP continuum;
5. Addressing Hawaii-specific barriers to provider VBP engagement;
6. Supporting provider data capabilities, including collection, reporting, and analytics;
7. Collaborating with other Health Plans to establish a provider learning network to support sharing of best practices;
8. Educating providers on VBP and opportunities to move along the VBP continuum toward multi-payer initiatives;
9. Creating opportunities for providers to participate with RHPs;
10. Supporting providers in understanding and assessing SDOH, and connecting with social services providers to address patient SDOH needs; and
11. Routinely collecting, updating, and reporting to DHS, data on the Health Plan's efforts and progress towards achieving the goals of the VBP advancement initiative.

C) *Cost Share*

1. The Health Plan shall collect all enrollment fees and cost sharing amounts from members who have enrollment fees or cost sharing requirements. The Health Plan may delegate cost sharing collections to providers but shall be ultimately responsible for their collection.

2. Any cost-sharing imposed on member shall be in accordance with Medicaid fee-for-service requirements at 42 CFR 447.50 through 42 CFR 447.82. The Health Plan shall exempt from premiums any Indian who is eligible to receive or has received an item or service furnished by an Indian Health Care Provider or through referral under contract health services. The Health Plan shall exempt from all cost sharing any Indian who is currently receiving or has ever received an item or service furnished by an Indian Health Care Provider or through referral under contract health services.

D) *Non-Covered Services*

1. The Health Plan may collect fees directly from members for non-covered services or for services from unauthorized non-Health Plan providers. If a member self-refers to a specialist or other provider within the Health Plan's network without following procedures (i.e., obtaining prior authorization), the Health Plan may deny payment to the service provider.

2. The Health Plan shall educate providers about the processes that must be followed for billing a member when non-covered or unauthorized services are provided as described in Section 4.1. In addition, the Health Plan shall inform the member of instances when they may be billed by a provider as described in Section 4.1.

3. If the Health Plan later determines that a member has been billed and paid for Health Plan-covered services, the Health Plan shall refund the member directly.

E) ***Co-Payments***

Health Plans may be required to implement future co-payments for members as determined by DHS. This process may include tracking and limiting aggregate amounts of co-payment for a household.

F) ***Payment for Provider Preventable Conditions (PPC)***

The Health Plan shall not pay for health care-acquired conditions (HCAC) or other provider-preventable conditions (OPPC) identified by CMS and DHS. DHS shall update the Health Plans, as needed, of changes to the CMS and DHS required list. A current list of PPC is located in Appendix R.

G) ***Physician Incentives***

1. Additionally, in compliance with the requirements of Section 7.2(B), Health Plans may establish physician incentive plans and VBP arrangements pursuant to Federal and State regulations, including Section 1876(i)(8) of the Social Security Act and 42 CFR 417.479, 422.208, 422.210, and 438.6.

2. The Health Plan shall disclose any and all such arrangements to DHS for review and approval prior to implementing physician incentives, and upon request, to members. Such disclosure shall include:

    a) The LAN category;

    b) Whether services not furnished by the physician or group are covered by the incentive plan;

    c) The type of incentive arrangement including methodology;

d) The percent of withhold or bonus amount; and

e) The panel size and if patients are pooled, the method used.

3. Upon request, the Health Plan shall report adequate information specified by applicable regulations to DHS so that DHS can adequately monitor the Health Plan.

4. If the Health Plan's physician incentive plan includes services not furnished by the physician/group, the Health Plan shall: (1) ensure adequate stop loss protection to individual physicians and must provide to 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 DHS, and to members, upon request.

5. Such physician incentive plans may not provide for payment, directly or indirectly, either to a physician or to physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

7.3 Third Party Liability (TPL)

A) *Background*

1. TPL refers to any other health insurance plan or carrier (i.e., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance and worker's compensation) or program, that is, or may be, liable to pay all or part of the health care expenses of the member.

2. Pursuant to Section 1902(a)(25) of the Social Security Act, DHS authorizes the Health Plan as its agent to identify legally liable third parties and treat verified TPL as a resource of the member.

3. Reimbursement from the third party shall be sought unless the Health Plan determines that recovery would not be cost effective. For example, the Health Plan may determine that the amount it reasonably expects to recover will be less than the cost of recovery. In such situations, the Health Plan shall document the situation and provide adequate documentation to DHS.

4. Each quarter, the Health Plan shall report to DHS in a format specified by DHS all TPLs known for its members, including any of its QUEST Integration members that also have commercial insurance through the Health Plan. The Health Plan shall also comply with Section 431L-2.5, HRS. All services provided by TPLs shall be submitted in standard encounter data format.

B) ***Responsibilities of DHS***

1. DHS shall be responsible for coordination and recovery of accident and workers' compensation subrogation benefits;

2. DHS shall collect and provide member TPL information to the Health Plan. TPL information shall be provided to the Health Plan via the daily TPL roster, or another reporting mechanism as established in Section 6; and

3. DHS shall conduct TPL audits every six (6) months to ensure TPL responsibilities are being completed by the Health Plan.

C) *Responsibilities of the Health Plan*

1. The Health Plan shall enter into a Coordination of Benefits Agreement with Medicare and participate in the automated claims crossover process for individuals dually eligible for Medicaid and Medicare. Health Plans be responsible for dually eligible individuals' coordination of benefits.
2. The Health Plan shall coordinate health care benefits with other coverages, both public and private, which are or may be available to pay medical expenses on behalf of any member.
3. The Health Plan shall seek reimbursement from all other liable third parties to the limit of legal liability for the health services rendered. The Health Plan shall retain all health insurance benefits collected, including cost avoidance.
4. The Health Plan shall follow the mandatory pay and chase provisions described in 42 CFR 433.139(b)(3)(i)-(ii).
5. In addition, the Health Plan shall:

    a) Continue cost avoidance of the health insurance plans accident and workers' compensation benefits;

    b) Report all accident cases incurring medical and medically related dental expenses in excess of five-hundred dollars ($500) to DHS;

    c) Provide a list of medical and medically related dental expenses, in the format requested by DHS, for recovery purposes. "RUSH" requests shall be reported within three (3) business days of receipt and "ROUTINE" requests within seven (7)

business days of receipt. Listings shall also include claims received but not processed for payments or rejected;

d) Provide copies of claim forms with similar response time as the above;

e) Provide listings of medical and medically related dental expenses (including adjustments) according to the payment period or "as of" date. Adjustments shall be recorded on the date of adjustment and not on the date of service;

f) Inform DHS of TPL information uncovered during the course of normal business operations;

g) Provide DHS with monthly reports of the total cost avoidance and amounts collected from TPLs within thirty (30) days after the end of the month being reported;

h) Develop procedures for determining when to pursue TPL recovery; and

i) Provide health care services for members receiving motor vehicle insurance liability coverage at no cost through the Hawaii Joint Underwriting Plan (HJUP) in accordance with HRS § 431:10C-401, et seq.

SECTION 8 – Responsibilities and Requirements of DHS and Health Plans: Provider Networks; Provider Credentialing; Provider Contracts; and Other Functions for Providers

8.1 Provider Network

A) *General Provisions*

1. The Health Plan shall develop, maintain, and monitor a provider network that is sufficient to ensure that all medically necessary covered services are accessible and available for all members, including those with limited English proficiency or physical or mental disabilities. At a minimum, this means that the Health Plan shall have sufficient providers to ensure all access and appointment wait times defined in Sections 8.1(C) and 8.1(D) are met. This network of providers shall provide the benefits described in Sections 3 and 4.

2. The Health Plan shall contract with enough providers for their members to have timely access to medically necessary covered services. The Health Plan is responsible for assuring that members have access to providers listed in Section 8.1(B). 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 the member's residence, the Health Plan shall adequately, and in a timely manner, provide these services out-of-network or transport the member to another island or out-of-state to access the covered services for as long as the Health Plan's network is unable to provide the member with medically necessary covered services on the member's island of residence as described in Section 5.3(C).

3. The Health Plan shall notify the out-of-network providers providing covered services to its members that payment by the Health Plan is considered as "payment-in-full" and that those providers cannot "balance bill" the members for the covered services. The Health Plan is prohibited from charging the member more than it would have if the covered services were furnished within the network.

4. The Health Plan shall not discriminate with respect to participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely based on that license or certification. The Health Plan shall not discriminate against providers serving high-risk populations or those that specialize in conditions requiring costly treatments. This is not to be construed as:

    a) requiring that the Health Plan contract with providers beyond the number necessary to meet the needs of its members;

    b) precluding the Health Plan from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

    c) precluding the Health Plan from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members.

5. The Health Plan is not required to contract with every willing provider. If the Health Plan does not or will not include individuals or groups of providers of a specialty grouping in its network, it shall provide written notice of the reason for the decision.

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

7. The Health Plan shall require that all providers that submit claims to the Health Plans have a national provider identifier (NPI) number. This requirement should be consistent with 45 CFR 162.410.

8. The Health Plan shall not include in its network any providers when a person with an ownership or controlling interest in the provider (an owner including the provider himself or herself), or an agent or managing employee of the provider, has been excluded from participation by the Department of Health and Human Services (DHHS), Office of Inspector General (OIG) under section 1128 of the Social Security Act, or has been excluded by DHS from participating in the Hawaii Medicaid program.

9. The Health Plan shall conduct a monthly check with DHS to identify any providers excluded from the Hawaii Medicaid program. On a monthly basis, the Health Plan shall check the Federal exclusion lists, including but not limited to the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), List of Excluded Individuals and Entities (LEIE) maintained by the OIG, and System for Award Management (SAM).

10. The Health Plan shall immediately terminate any provider(s) or affiliated provider(s) whose owners, agents, or managing employees

who are found to be excluded on the State or Federal exclusion list(s). The Health Plan shall report provider application denials or terminations to DHS where individuals were on the exclusions list, including denial of credentialing for fraud-related concerns, as they occur.

11. The Health Plan shall not pay for items or services (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) as described in Section 1903(i)(2)(A)-(E) of the Social Security Act or with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997.

12. The Health Plan shall immediately comply if DHS requires that the Health Plan remove a provider from its network due to any of the following: (1) the provider fails to meet or violates any State or Federal laws, rules, or regulations; or (2) the provider's performance is deemed inadequate by the State based upon accepted community or professional standards.

13. The Health Plan shall have written policies and procedures for the selection and retention of providers. These policies and procedures shall include a process for identifying and assuring that excluded providers are not part of their network. The Health Plan shall submit these selection and retention of providers' policies and procedures in accordance with Section 13.3(B) Readiness Review.

14. The Health Plan shall have an established provider network that meets the requirements of this RFP at the time of proposal submission for all providers. In the event the Health Plan has deficiencies in its provider network, a corrective action plan must be submitted to DHS with defined timeframes for remedying the deficiencies.

B) ***Specific Minimum Requirements***

1. The Health Plan shall have and is solely responsible for having: (1) the network capacity to serve the expected enrollment in the service area; (2) the ability to offer an appropriate range of services and access to preventive, primary, acute, behavioral health, and long-term services and supports (LTSS); and (3) the ability to maintain a sufficient number, mix, and geographic distribution of providers of covered services.

2. The following is a listing of the minimum required components of the provider network. This is not meant to be an all-inclusive listing of the components of the network; rather, the Health Plan may add provider types, or DHS may require that the Health Plan add providers as required based on the needs of the members or due to changes in Federal or State law. At a minimum, the network shall include the following medical care provider types:

    a) Hospitals (a minimum of 5 on Oahu; 1 on Maui; 1 on Kauai; 2 on Hawaii (1 in East Hawaii and 1 in West Hawaii); 1 on Lanai and 1 on Molokai;
    b) Emergency transportation providers (both ground and air);
    c) Non-emergency transportation providers (both ground and air);
    d) Primary Care Providers (PCPs) (at least 1 per 300 members) as described in Section 8.1(E);
    e) Physician specialists, including but not limited to: cardiologists, endocrinologists, general surgeons, geriatricians, hematologists, infectious disease specialists, nephrologists, neurologists, obstetricians/ gynecologists,

oncologists, ophthalmologists, orthopedists, otolaryngology, pediatric specialists, plastic and reconstructive surgeons, pulmonologists, radiologists and urologists;

f) Laboratories which have either a CLIA certificate or a waiver of a certificate of registration;
g) Optometrists;
h) Pharmacies;
i) Physical and occupational therapists, audiologists, and speech-language pathologists;
j) Licensed dietitians;
k) Physician Assistants;
l) Community Health Workers;
m) Behavioral health providers:
    1. Psychiatrists (1 per 150 members with a SMI or SPMI diagnosis);
    2. Other behavioral health providers to include psychologists, licensed mental health counselors, licensed clinical social workers, Advanced Practice Registered Nurse (APRN) – behavioral health (1 to 100 members with a SMI or SPMI diagnosis); and
    3. Licensed therapists, counselors, and certified substance abuse counselors, and State licensed Special Treatment Facilities for the provision of substance abuse therapy/treatment.
n) Peer Support Specialists certified by AMDH as a part of their Hawaii certified peers specialist program or a program that meets the criteria established by AMHD;;
o) State licensed Special Treatment Facilities for the provision of substance abuse therapy/treatment;

p) Home health agencies and hospices;
q) Durable medical equipment;
r) Case management agencies;
s) Long-term services and supports (listed below);
t) State licensed Special Treatment Facilities for the provision of substance abuse therapy/treatment;
u) Providers of lodging and meals associated with obtaining necessary medical care;
v) Sign language interpreters and interpreters for languages other than English; and
w) Community Paramedics.

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

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

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

6. At a minimum, the network shall include the following long-term service and support (LTSS) providers:
    a) Adult day care facilities;
    b) Adult day health facilities;
    c) Assisted living facilities;
    d) Community care foster family homes (CCFFH);
    e) Community care management agencies (CCMA);
    f) Expanded adult residential care homes (E-ARCHs);
    g) Home delivered meal providers;
    h) Non-medical transportation providers;
    i) Nursing facilities;
    j) Personal care assistance providers;
    k) Personal emergency response systems providers;
    l) Private duty nursing;
    m) Respite care providers; and
    n) Specialized medical equipment and supply providers.

7. Due to the limited frequency of utilizing LTSS providers, Health Plans may contract with the following providers on an as needed basis:
    a) Environmental accessibility adaptation providers; AND
    b) Home maintenance providers.

C) *Availability of Providers*

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

    a) Emergency medical situations - Immediate care (twenty-four (24) hours a day, seven (7) days a week) and without prior authorization;

    b) Urgent care and PCP pediatric sick visits - Appointments within twenty-four (24) hours;

    c) PCP adult sick visits - Appointments within seventy-two (72) hours;

    d) Behavioral Health (routine visits for adults and children) - Appointments within twenty-one (21) days;

    e) PCP visits (routine visits for adults and children) - Appointments within twenty-one (21) days; and

    f) Visits with a specialist or Non-emergency hospital stays - Appointments within four (4) weeks or of sufficient timeliness to meet medical necessity.

2. The Health Plan shall ensure that:

    a) Network providers accept new members for treatment unless the provider has requested a waiver from the Health Plan from this provision;

b) Network providers do not segregate members in any way from other persons receiving services, except for health and safety reasons;

c) Members are provided services without regard to race, color, creed, ancestry, sex, including gender identity or expression, sexual orientation, religion, health status, income status, or physical or mental disability; and

d) Network providers offer hours of operation that are no less than the hours of operation offered to members covered by commercial plans or comparable to hours offered to members under Medicaid fee-for-service, if the provider has no commercial plan members.

3. The Health Plan shall ensure that its network includes sufficient family planning providers to ensure timely access to covered services.

4. The Health Plan shall establish policies and procedures to ensure that network providers comply with these acceptable wait times; monitor providers regularly to determine compliance; and take corrective action if there is a failure to comply. The Health Plan shall submit these availability of providers policies and procedures to DHS, in accordance with Section 13.3(B), Readiness Review.

5. The Health Plan shall ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.

D) *Geographic Access of Providers*

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

Provider Type	Honolulu metropolitan statistical area (MSA).	Rural
PCPs	30 minute driving time	60 minute driving time
Specialists	30 minute driving time	60 minute driving time
OB/GYN	30 minute driving time	60 minute driving time
Adult Day Care/Adult Day Health	30 minute driving time	60 minute driving time
Hospitals	30 minute driving time	60 minute driving time
Emergency Services Facilities	30 minute driving time	60 minute driving time
Behavioral Health 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

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

3. The Health Plan may submit to DHS a formal written request for a waiver of these requirements after contract award for areas where there are no providers within the required driving time. The Health Plan may also submit to DHS a formal written request for a waiver of

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

E) *Primary Care Providers (PCPs)*

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

2. Individuals who are enrolled in a Medicare Advantage plan are not required to have a PCP. However, members with fee-for-service Medicare shall choose a PCP. This PCP for a Medicare beneficiary does not have to be in the Health Plan's provider network. The Health Plan shall pay their co-payments or co-insurance as described in Section 7.2(A).

3. Each PCP shall be licensed in the State of Hawaii as:

    a) A physician, either an M.D. (Doctor of Medicine) or a D.O. (Doctor of Osteopathy), and shall have one of the following classifications: family practice, general practice, internal medicine, pediatrics, obstetrics & gynecology, preventive medicine, or family practice/internal medicine providers specialized in geriatric medicine;

    b) An advanced practice registered nurse with prescriptive authority (APRN-Rx) who is a registered professional nurse authorized by the State to practice as a nurse practitioner

in accordance with State law and Section 16-89, Subchapter 16, HAR; or

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

4. DHS may refine or revise the provider classifications and specializations comprising the definition of a PCP. The Health Plan may allow specialists or other health care practitioners to serve as PCPs for members with chronic conditions provided:

   a) The member has selected a specialist with whom he or she has a historical relationship as his or her PCP;

   b) The Health Plan has confirmed that the specialist agrees to assume the responsibilities of the PCP. Such confirmation may be in writing, electronically or verbally; and

   c) The Health Plan submits to DHS prior to implementation a plan for monitoring their performance as PCPs.

5. The Health Plan shall allow a clinic to serve as a PCP as long as the clinic is appropriately staffed to carry out the PCP functions.

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

7. The Health Plan shall monitor the number of members that are assigned to each PCP, maintaining the ratio of less than or equal to

1 to 300, and report this information to DHS in accordance with Section 6.3. The Health Plan may not restrict their members from choosing a PCP who reaches the 1 to 300 ratio. However, the Health Plan may not auto-assign any additional members to the PCP until the ratio has decreased below the 1 to 300 ratio. The Health Plan shall not apply this standard to clinics.

8. The Health Plan shall require that PCPs fulfill the responsibilities as described in this section for all members. If the PCP is unable to fulfill his or her responsibilities to the member, the Health Plan shall transition the member to another PCP in accordance with Section 9.2(C). The original PCP shall be responsible for continuing to provide services to the member until the other PCP has accepted the member except in situations where the PCP is terminated from either the Health Plan or Medicaid program. The Health Plan may support the transition and coordination of care by providing the PCP with the member's service plans and medication lists in the appropriate electronic format/s.

9. The Health Plan shall notify all members in writing within ten (10) days of selection, assignment, or processed PCP changes. Health Plan shall assure its auto-assign algorithm includes the following:

    a) Women over sixty-five (65) years of age shall not be auto-assigned to an obstetrician/gynecologist;

    b) Geriatricians shall not be auto-assigned to anyone under the age of sixty-five (65); and

    c) PCPs with a ratio of 1 to 275 members are removed from the algorithm.

d) The Health Plan shall establish PCP policies and procedures that shall, at a minimum:

e) Not establish any limits on how frequently and for what reasons a member may choose a new PCP;

f) Allow each member, to the extent possible and appropriate, to have freedom of choice in choosing his or her PCP;

g) Describe the steps taken to assist and encourage members to select a PCP;

h) Describe the process for informing members about available PCPs;

i) Describe the process for selecting a PCP;

j) Describe the process for auto-assigning a member to a PCP if one is not selected;

k) Describe the process for changing PCPs; and

l) Describe the process for monitoring PCPs, including specialists acting as PCPs, to ensure PCPs are fulfilling all required responsibilities described above.

10. The Health Plan shall describe the policies and procedures for selecting and changing PCPs in its Member Handbook as described in Section 9.4(E). The Health Plan shall also describe in its Member Handbook, how PCPs are auto-assigned, if necessary.

11. The Health Plan shall submit the PCP policies and procedures to DHS for review and approval in accordance with Section 13.3(B), Readiness Review. If the Health Plan revises its PCP policies and procedures during the term of the contract, DHS must be advised and copies of the revised policies and procedures must be submitted

to DHS for review and approval prior to implementation of the revised policies and procedures.

12. If a PCP ceases participation in the Health Plan's provider network the Health Plan shall send written notice to the members who have chosen the provider as their PCP or were seen on a regular basis by the provider. This notice shall be issued within fifteen (15) days after receipt or issuance of the termination notice, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. The Health Plan shall be responsible for ensuring a seamless transition for the member so that continuity of care is preserved until a new PCP has been selected. However, if a federally qualified health center (FQHC) is not participating in a Health Plan's provider network, but the FQHC is necessary for the Health Plan to have an adequate network, the Health Plan shall allow members to continue to use that FQHC as their PCP.

F) ***Direct Access to Women's Health Specialists***

1. The Health Plan shall provide female members with direct in-network access to a women's health specialist for covered care necessary to provide her routine and preventive healthcare services as well as management of obstetric and gynecologic conditions. Women's routine and preventive healthcare services include, but are not limited, to breast and cervical cancer screening. This direct in-network access is in addition to the member's designated source of primary care if the PCP is not a women's health specialist.

G) *Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)*

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

2. The Health Plan shall allow all members to receive covered services that are urgent in nature at any FQHC or RHC without prior authorization. The Health Plan shall require the FQHC to refer the patient back to and inform the assigned PCP or help the individual select a new PCP.

H) *Certified Nurse Midwives, Pediatric Nurse Practitioners, Family Nurse Practitioners and Behavioral Health Nurse Practitioners*

1. The Health Plan shall ensure 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.

2. 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 or fly the member to another island in a timely manner. The Health Plan may also fly the providers to the island where services needed. Alternatively, if the Health Plan chooses not to use out-of-network providers, the Health Plan must allow the member to change to a Health Plan that does have these providers in its network if the member expresses a desire for services rendered by one of these provider types.

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

I) ***Rural Exceptions***

1. In the event that there are areas in which there is only one Health Plan, any limitation the Health Plan imposes on the member's freedom to choose between PCPs may be no more restrictive than the limitation on disenrollment under 42 CFR 438.56(c) and this Contract. In this case, the member must have the freedom to:

    a) Choose from at least two (2) PCPs;

    b) Obtain services from any other provider under any of the following circumstances:

    c) The service or type of provider (in terms of training, experience, and specialization) is not available within the Health Plan;

    d) The provider is not part of the network but is the main source of a service to the member, and is given the opportunity to become a participating provider under the same requirements for participation in the Health Plan, and chooses to join the

network. If this provider chooses not to join the network, or does not meet the necessary qualifications to join, the Health Plan shall transition the member to an in-network provider within sixty (60) days. If the provider is not appropriately licensed or is sanctioned, the Health Plan shall transition the member to another provider immediately;

e) Select an out-of-network provider because the only provider in-network and available to the member does not, because of moral or religious objections provide the services the member seeks, or all related services are not available;

f) The member's PCP determines that the member needs related services that would subject the member to unnecessary risk if received separately and not all of the related services are available within the network; and

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

8.2 Provider Credentialing, Recredentialing and Other Certification

A) *Credentialing and Recredentialing Requirements*

1. The Health Plan shall demonstrate that its network providers are credentialed as required under 42 CFR 438.214. The Health Plan will follow the most current NCQA credentialing and re-credentialing standards including delegation and provider monitoring/oversight.

2. The Health Plan shall reserve the right to require approval of providers, with regard to standards and thresholds set by the Health Plan and/or DHS (e.g., with regards to performance standards, office

site criteria, medical record keeping, complaints triggering on-site visits). The Health Plan must also meet requirements of the RFP related to appointment availability and medical record keeping.

3. The Health Plan shall ensure that each primary care provider meets all applicable requirements of law and has the necessary and current license/certification/accreditation/designation approvals per State requirements.

4. The Health Plan shall ensure that each acute care provider meets all applicable requirements of law and has the necessary and current license/certification/accreditation/designation approvals per State requirements. The Health Plan shall ensure that all facilities and organizational providers including, but not limited to, hospitals, are certified or licensed as required by the State.

5. The Health Plan shall ensure that each service delivery site of each behavioral health provider meets all applicable requirements of law and has the necessary and current license, certification, accreditation, or designation approvals per State requirements. When individuals providing behavioral health treatment services are not required to be licensed or certified, it is the responsibility of the Health Plan to ensure, based upon applicable State licensure rules and/or program standards, that those individuals are appropriately educated, trained, qualified, and competent to perform said services and job responsibilities.

6. The Health Plan shall ensure that each service and service delivery site of each LTSS provider–meets all applicable requirements of law and has the necessary and current license, certification, accreditation, or designation approvals per State requirements.

When individuals providing LTSS services are not required to be licensed or certified, it is the responsibility of the Health Plan to ensure, based upon applicable State licensure rules and/or program standards, that those individuals are appropriately educated, trained, qualified, and competent to perform said services and job responsibilities.

7. Health Plans shall ensure that all criminal history record check requirements are conducted for all high-risk providers determined by the state.

8. The Health Plan shall ensure that all providers including, but not limited to, therapists, meet State licensure requirements.

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

10. The Health Plan shall submit its credentialing, re-credentialing and other certification policies and procedures to DHS for review and approval in accordance with Section 13.3(B), Readiness Review.

B) ***Provider Disclosures***

1. The Health Plan shall ensure that its providers submit full disclosures as identified in 42 CFR Part 455, Subpart B. Disclosures shall include, but are not limited to:

   a) The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address;

      1. Date of birth and Social Security Number of each person with an ownership or control interest in the disclosing entity; and
      2. Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has a five (5) percent or more interest.

   b) Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person with an ownership or control interest in any subcontractor in which the disclosing entity has a five (5) percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

   c) The name of any other disclosing entity in which an owner of the disclosing entity has an ownership or control interest.

d) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity.
e) The identity of any individual who has an ownership or control interest in the provider, or is an agent or managing employee of the provider, and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX Services Program since the inception of those programs. Providers must disclose such to the Health Plan, prior to entering into, or renewing, a provider agreement with the Health Plan, and at any time upon written request by the Health Plan.

2. The Health Plan shall obtain disclosures from its providers at the following times:
    a) When the provider submits a provider application;
    b) Upon execution of the provider agreement;
    c) During re-credentialing;
    d) Upon request from the Health Plan or DHS; and
    e) Within thirty-five (35) days after any change in ownership of the disclosing entity
3. The provider shall submit, within thirty-five (35) days of the date of a request by the Health Plan, DHS, or DHHS, full and complete information about:

    a) The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

b) Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

C) *Program Integrity Rules Governing Provider Agreements*

1. The Health Plan shall refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the Title XX Services Program. In addition, the Health Plan shall refuse to enter into, or may terminate, a provider agreement if it determines that the provider did not fully and accurately make any disclosure required above.

2. The Health Plan may execute network provider agreements, pending the outcome of State screening, enrollment, and revalidation for up to 120 days, but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one 120 day period without enrollment of the provider, and notify affected enrollees.

3. The Health Plan shall notify DHS through a Provider Suspension and Termination report to be determined in the reporting package described in Section 6 of any providers with whom the Health Plan refuses to enter into, or renew, an agreement.

8.3 Provider Contracts

A) *Provider Contract Requirements*

1. All contracts between providers and the Health Plan shall be in writing. The Health Plan's written provider contracts shall include all of the elements described in Appendix L.

2. The Health Plan must ensure providers' performance and compliance with what is listed in the provider contracts. The Health Plan shall conduct periodic reviews or audits as needed to ensure that providers are in compliance with all the terms and conditions of their contracts

3. The Health Plan may agree to an addendum to an already executed provider contract if the addendum and the provider agreement together include all requirements described in Appendix L. The addendum must be clearly state that if the terms and conditions in the addendum and the provider agreement conflict, the terms and conditions in the addendum shall apply.

4. The Health Plan shall submit to DHS for review and approval a model for each type of provider contract 10 days after the Contract effective date in accordance with Section 13.3(B), Readiness Review.

5. In addition, the Health Plan shall submit to DHS the signature page of all finalized and executed contracts in accordance with Section 13.3(B), Readiness Review.

6. The Health Plan shall continue to solicit provider participation throughout the contract term when provider network deficiencies are found.

7. Requirements for contracts with subcontractors (non-providers) are addressed in Section 14.4.

8.4 Provider Services

A) *Provider Education*

1. The Health Plan shall be responsible for educating the providers about managed care and all program requirements. The Health Plan shall conduct provider education sessions, either one-on-one or in a group setting, for all contracted providers during the two (2) month period prior to the Date of the Commencement of Services identified in Section 1.5. The Health Plan shall conduct education sessions at least every six (6) months for their contracted providers after Date of the Commencement of Services identified in Section 1.5.
2. The Health Plan shall provide one-on-one education to providers who are not fulfilling program requirements as outlined in the provider agreements and the provider manual (See Section 8.4(C)). One-on-one provider education includes educating providers on how to process their specific claims for payment. Specifically, the Health Plan shall educate providers on:

    a) The Health Plan's referral process and prior authorization process;

    b) The role of the PCP, if applicable;

    c) Claims processing;

    d) Availability of interpreter, auxiliary aids, and services for their patients;

    e) Availability of service coordination services and how to access these services;

f) Role of care coordination team, service coordination team and the Hale Ola;

g) The availability of programs that support members and providers including but not limited to CIS, CoCM, CSC services, RHPs, Project ECHO, access to SDOH supports for members, and the Regional Enhanced Referral Network;

h) The ways in which the Health Plan will support provider-level quality improvement initiatives, including practice guidelines, and available access to resources and incentives.

i) Members' rights and responsibilities, including the right to file a grievance or appeal and how a provider can assist members;

j) Reporting requirements;

k) Circumstances and situations under which the provider may bill a member for services or assess charges or fees;

l) The Health Plan's medical records documentation requirements including the requirement that this documentation must be tied to claims submission or encounter data;

m) The LAN framework and opportunities available to participate in VBP models including mechanisms to leverage Health Plan support to build capacity for VBP participation;

n) Methods the Health Plan will use to update providers on program and Health Plan changes (e.g., monthly newsletters, etc.);

o) Requirements for participating in and receiving payments from, as applicable, the Health Plan's quality program; and

p) The provider grievance, complaints, and appeals process.

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

a) The member's right to file grievances and appeals and their requirements, and timeframes for filing;

b) The member's right to a State administrative hearing, how to obtain a hearing and rules on representation at a hearing;

c) The availability of assistance in filing a grievance or an appeal;

d) The member's right to have a provider or authorized representative file a grievance and/or an appeal on his or her behalf, provided he or she has provided written consent to do so;

e) The toll-free numbers to file a grievance or an appeal; and

f) When an appeal or hearing has been requested by the member, the right of a member to receive benefits while

the appeal or hearing is pending and that the member may be held liable for the costs of those benefits if the Health Plan's adverse action is upheld.

4. The Health Plan shall ensure that the providers are aware of their responsibilities for compliance with the Americans with Disabilities Act (ADA), including how to access interpreter and sign language services as described in Section 9.4(D).

5. The Health Plan shall develop provider education curricula and schedules that shall be submitted to DHS for review and approval in accordance with the timeframes in accordance with Section 13.3(B), Readiness Review.

6. The Health Plan must educate network providers about how to access the formulary on the Health Plan website. In addition, the Health Plan may allow network providers access to the formulary through a free, point-of-care web-based application accessible on smart phones, tablets, or similar technology. The formulary must also identify preferred/non-preferred drugs, Clinical Prior Authorizations, and any preferred drugs that can be substituted for non-preferred drugs. The Health Plan must ensure that the providers have access to its current formulary that is updated at least monthly.

B) ***Provider Grievance and Appeals Process***

1. The Health Plan shall have policies and procedures for a provider grievance system that includes provider grievances and provider appeals. 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. Providers may utilize the provider grievance system to resolve issues and problems with the Health Plan (this includes a problem regarding a member). A provider may file a grievance or appeal on behalf of a member by following the procedures outlined in Section 9.5, Member Grievance System.

2. A provider, either contracted or non-contracted, may file a provider grievance. Below are some examples of items that may be filed as a grievance:

    a) Benefits and limits, for example, limits on behavioral health services or formulary;

    b) Eligibility and enrollment, for example long wait times or inability to confirm enrollment or identify the PCP;

    c) Member issues, including 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

    d) Health Plan issues, including difficulty contacting the Health Plan or its subcontractors due to long wait times, busy lines, etc.; problems with the Health Plan's staff behavior; delays in claims payments; denial of claims; claims not paid correctly; or other Health Plan issues.

    e) Issues related to availability of health services from the Health Plan to a member, for example delays in obtaining or inability to obtain emergent/urgent services,

medications, specialty care, ancillary services such as transportation, medical supplies, etc.;

f) Issues related to the delivery of health services, for example, the PCP was unable to make a referral to a specialist, medication was not provided by a pharmacy, the member did not receive services the provider believed were needed, provider is unable to treat member appropriately because the member is verbally abusive or threatens physical behavior; and

g) Issues related to the quality of service, for example, the provider reports that another provider did not appropriately evaluate, diagnose, prescribe or treat the member, the provider reports that another provider has issues with cleanliness of office, instruments, or other aseptic technique was used, the provider reports that another provider did not render services or items which the member needed, or the provider reports that the Health Plan's specialty network cannot provide adequate care for a member.

3. The Health Plan shall log all provider grievances and report to DHS in accordance with the report to be determined in the reporting package described in Section 6.

4. The grievance and appeals process shall provide for the timely and effective resolution of any disputes between the Health Plan and provider(s).

5. The Health Plan shall submit provider grievance system policies and procedures to DHS for review and approval in accordance with Section 13.3(B), Readiness Review.

C) *Provider Manual*

1. The Health Plan shall develop a provider manual that shall be made available to all providers. The Health Plan may provide an electronic version (via a link to the Health Plan's website) unless the provider requests a hard copy. If a provider requests a hard copy, the Health Plan shall provide it at no charge to the provider.
2. The provider manual shall contain all the elements described in Appendix J.
3. The Health Plan shall update the electronic version of the provider manual immediately, not more than five (5) days following a change to it. In addition, the Health Plan shall notify all providers, in writing, of any changes. These notifications may be electronic or hard copy, unless the provider specifically requests a hard copy, in which case it shall be provided without charge to the provider.
4. The Health Plan shall submit the provider manual to DHS for review and approval in accordance with the timeframes in accordance with Section 13.3(B), Readiness Review.

D) *Provider Call-Center/Prior Authorization (PA) Line*

1. The Health Plan shall operate a toll-free provider call center to respond to provider questions, comments, inquiries and requests for prior authorizations. The provider call center shall assure that prior

authorization staff is readily accessible. The toll-free provider call center shall be available and accessible to providers from all islands on which the Health Plan serves.

2. The Health Plan's provider call center systems shall have the capability to track call center metrics identified by DHS. The call center metrics for the provider call center shall be able to be reported to DHS separate from the member call center metrics.

3. The provider call center shall be fully staffed between the hours of 7:45 a.m. (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.

4. The Health Plan shall meet the following call center standards:

    a) The call abandonment rate is five percent (5%) or less;

    b) The average speed of answer is thirty (30) seconds or less;

    c) The average hold time is two (2) minutes or less;

    d) The blocked call rate does not exceed one percent (1%); and

    e) The longest wait in queue does not exceed four (4) minutes.

5. The Health Plan shall have, at a minimum, an automated system or answering service available between the hours of 4:30 p.m. (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. In emergency situations, the Health Plan

shall ensure that calls are returned to providers within thirty (30) minutes whether the message is left on the automated system or by the answering service.

6. The Health Plan shall develop provider call center/PA line policies and procedures. These policies and procedures shall permit a participating provider who treats a member after hours for an urgent or emergent condition and determines that the individual requires prompt outpatient specialist follow up and that requiring a visit to the member's primary care provider will delay the receipt of necessary care to refer the member for follow up specialty care.
7. The Health Plan shall submit these policies and procedures to DHS for review and approval in accordance with Section 13.3(B), Readiness Review.

E) *Website for Providers*

1. 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, updated 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 regarding care for the member, including real-time Health Plan membership verification, electronic prior authorization (PA) request and approval, filled medication list look-up, and electronic referrals requiring Health Plan authorization.

2. Health Plans are encouraged to develop a smart PA system, such that if a provider has a certain percentage of PA requests approved for certain services or overall, that subsequent PA requests from the provider could be waived in order to reduce administrative burden on high performing providers.

3. The Health Plan shall have policies and procedures in place to ensure the website is updated regularly and contains accurate information. The Health Plan shall submit these policies and procedures to DHS for review and approval in accordance with Section 13.3(B), Readiness Review.

4. The Health Plan shall provide DHS with access to the provider web-site (even if in a test environment) for review and approval in accordance with the timeframes in accordance with Section 13.3(B), Readiness Review.

8.5 Provider "Gag Rule" Prohibition

1. 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:

    a) The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

    b) Any information the member needs in order to decide among all relevant treatment options;

    c) The risks, benefits and consequences of treatment or non-treatment; and

d) 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.

2. 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.

3. The Health Plan shall take no punitive action against a provider that requests an expedited resolution or supports a member's appeal.

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

    a) DHS within one-hundred twenty (120) days prior to adopting the policy with respect to any service;

    b) DHS with the submission of its proposal to provide services under this RFP;

    c) Members at least thirty (30) days prior to the effective date of the policy for any particular service; and

    d) Members and potential members before and during enrollment.

SECTION 9 – Responsibilities and Requirements of DHS and Health Plans: Eligibility, Enrollment, Disenrollment, Continuity of Care, and Grievance and Appeals

9.1 DHS Eligibility and Enrollment Responsibilities

A) *Eligibility Determinations*

1. DHS is solely responsible for determining eligibility. Provided the individual applying for Medicaid meets all eligibility requirements, the individual shall become eligible for Medical Assistance, and be effectively enrolled in and covered by a Health Plan on:

    a. The date a completed application is received by the Department;
    b. If specified by the individual applying for Medicaid, any date on which Medicaid eligible medical expenses were incurred and is no earlier than the immediate ten (10) days immediately prior to the date of application;
    c. Any date specified by the individual for which Medicaid eligible LTSS were incurred and is no earlier than three (3) months immediately prior to the date of application; or
    d. The first day of the subsequent month in which all eligibility requirements are met.

B) *DHS Enrollment Responsibilities*

1. DHS must provide informational notices to potential members upon their approval of eligibility within a timeframe that allows them to use the information to choose a participating Health Plan. Upon

notification of application approval, eligible individuals who submitted their applications electronically shall be provided the opportunity to select a participating Health Plan on the date of notification. Notices shall include:

a) the available Health Plans from which they can choose,

b) clear instructions on how to inform DHS about their choice,

c) implications of actively choosing or not making an active choice of a Health Plan, and

d) an explanation of the length of the enrollment period, as well as disenrollment period, of 90 days without cause after initial enrollment, and all other disenrollment options.

2. Individuals who make a Health Plan selection upon eligibility notification will be enrolled in that Health Plan retroactively to date of eligibility, or prospectively, as applicable. Individuals who do not make a choice of Health Plans when notified of eligibility, and those who do not submit an application electronically, will be auto-assigned to a Health Plan retroactively to date of eligibility, or prospectively, as applicable.

a) The following exceptions shall apply for enrollments affecting:

b) Newborns, as described in Section 9.1(D)(1);

c) New member to an existing case, as described in Section 9.1(D)(2);

d) Foster Care Children, as described in Section 9.1(D)(3);

e) Changes made during Annual Plan Change (APC) period, as described in Section 9.1(E);

f) Individuals with gaps in eligibility for a period of less than six (6) months, as described further in the current section; and

g) Enrollment caps or limits, as identified in Section 9.1(F).

3. DHS shall provide new beneficiaries a Decision Assistance Booklet at time of approval to aid in Health Plan selection. This information and assistance includes information about the basics of managed care; benefits covered by the QI programs; and how to access information on the Health Plans' provider networks. The Decision Assistance Booklet shall be presented in a format and timeframe prescribed by DHS and the Health Plan shall provide complete, accurate, and timely information to DHS for inclusion in the decision assistance booklet. DHS shall prorate the total cost of printing the decision assistance booklet equally among the number of Health Plans participating in the QI program.

4. DHS or its agent shall provide information and assistance to individuals who are auto-assigned to a Health Plan. Individuals who are auto-assigned to a Health Plan will have fifteen (15) days to change their Health Plan. Their change shall be effective prospectively beginning the first day of the following month.

5. Individuals who have lost eligibility for a period of less than six (6) months shall be automatically reenrolled into their former Health Plan.

6. In addition, DHS shall allow all members to change Health Plans without cause for the first ninety (90) calendar days following their enrollment in a Health Plan, regardless of whether enrollment is a

result of selection or auto-assignment, and whether enrollment is from initial eligibility or from annual plan change. Members are only allowed one (1) change of Health Plan during the ninety (90) day grace period. DHS shall educate providers about the option for members to make Health Plan changes during the ninety (90) day grace period. This applies to all members, including aged, blind, and disabled members.

7. Health Plan change requests received during the ninety (90) day period following enrollment shall be effective beginning the first day of the following month in which the Health Plan change request was received by DHS. After the ninety (90) day grace period, members shall only be allowed to change plans during the Annual Plan Change Period, except for cause, as described in Section 9.1(H), or as outlined in Section 9.1(D).

8. DHS or its agent shall provide the member with written notification of the Health Plan in which the member is enrolled and the effective date of enrollment each time Health Plan enrollment changes. This notice shall serve as verification of enrollment until a membership card is received by the member from the Health Plan.

9. The Health Plan shall receive a daily file of enrollment/disenrollment information in a HIPAA-compliant 834 file format via DHS Secure File Transfer Protocol (SFTP) server. The enrollment information shall include at a minimum the case name, case number, member's name, mailing address, date of enrollment, TPL coverage, date of birth, sex, and other data that DHS deems pertinent and appropriate. The Health Plan is required to review 834 reports in a timely manner, and make prompt initial contact with the new members on its daily report.

C) *Auto-Assignment to a Health Plan*

1) Responsibilities

a) DHS is responsible for the development and implementation of Auto-Assignment algorithms, policies, and procedures and such algorithms, polices, and procedures are subject to change at the discretion of DHS.

b) DHS reserves the right to establish Auto-Assignment algorithms that are population based (e.g., ABD members).

c) The Health Plan is required to participate in Auto-Assignment unless an exception is permitted at the discretion of DHS.

2) Special Auto-Assignment Rules after Selection of Health Plans

a) DHS has established the following auto-assignment processes to enroll members in the Health Plan selected in this RFP, as described in Section 16, Evaluation and Selection. These processes account for all existing and returning Health Plans, a reduction in the overall selected number of Health Plans, and/or the selection of one (1) or more new Health Plans.

a. Members in Returning Plans: Members shall remain with their current Health Plan if that Health Plan is selected by DHS until the next APC.

b. Members in Non-Returning Plans: If the member's Health Plan is not selected by DHS, the member will have the choice of selecting another participating Health Plan. Members who do not select a

Health Plan will be Auto-Assigned and equitably distributed to the participating Health Plans.

c. All members may choose to change Health Plans during the APC.

3) General Auto-Assignment Rules and Process

a) DHS shall keep members enrolled in the same QI Health Plan if they remain eligible for QI benefits but their eligibility category changes. DHS shall not provide a choice to the member until the next Annual Change Period unless there is cause, as defined in Section 9.1(H). Nothing in this section negates the members' rights.

b) Members newly enrolled in QI who are enrolled in a contracted Health Plan's Medicare Advantage plan shall be auto-assigned into the same Health Plan's QI plan. The Health Plan is not precluded from encouraging the member to enroll into the Health Plan's D-SNP, as defined in Section 2.3, provided the member is within enrollment timeframes.

4) Auto-Assignment Algorithm

a) DHS shall determine auto-assignment based on an algorithm that may take into consideration Health Plan enrollment volume, distribution of enrollee sub-groups, Health Plan performance, Health Plan scorecard and quality metrics, and additional criteria to be specified. Auto-assignment methodologies, including the relative weight of each component included in the formula, may

be modified as needed. DHS may incorporate enrollment caps and limits into the auto-assignment methodology.

b) The auto-assignment algorithm to be implemented in the first Contract year shall be provided to the Health Plan no later than sixty days (60) prior to the commencement of services to members.

c) Thereafter, DHS shall notify the Health Plan at least six (6) months prior to a planned changed to the auto-assignment algorithm. DHS shall inform the Health Plan of the specifications of each performance or quality measure potentially incorporated into the auto-assign algorithm no less than six (6) months prior to the beginning of the time period from which the data is being measured.

D) *Enrollment Exceptions*

1) Newborn Enrollment

a) Throughout the term of the contract and to the extent possible, newborns shall be assigned to the same Health Plan as their mother, whether the mother was enrolled in a QI or commercial plan, retroactive to the newborn's date of birth. The newborn auto-assignment shall be effective for at least the first thirty (30) calendar days following the birth. DHS shall notify the mother that she may select a different Health Plan for her newborn at the end of the thirty (30) calendar day period. Choice of Health Plan shall be effective the first day of the following month.

b) If the newborn mother's health insurance is unknown or she is not enrolled in a Health Plan offered by a health insurer that also offers a QI plan, the newborn may be auto-assigned into a QI Health Plan in accordance with Section 9.1(C) until the member makes a choice of Health Plan. If auto-assignment is required, the newborn will be enrolled based on Health Plan enrollment of family members in the case. If the newborn does not have any family members in QI, then the newborn is auto-assigned based on the algorithm.

c) DHS reserves the right to disenroll the newborn if the newborn is later determined to be ineligible for QI. DHS shall notify the Health Plan of the disenrollment by electronic media. DHS shall make capitation payments to the Health Plan for the months in which the newborn was enrolled in the Health Plan.

2) Additions to Existing Cases

a) For any new case or new member added to an existing case, DHS shall promote family continuity. All members of a newly eligible case shall be auto-assigned to the same Health Plan. If the new member is less than 19 years old, he or she will be enrolled in the same Health Plan as the youngest family member. If the new member is 19 years old or older, he or she will be enrolled in the same Health Plan as the primary client.

3) Foster Children

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

E) *Annual Plan Change (APC) Period*

1) APC Period Timeframes

DHS shall hold an APC period at least annually to allow members the opportunity to change Health Plans without cause. DHS may establish additional APC periods as deemed necessary on a limited basis (e.g., termination of a Health Plan during the contract period).

2) APC Member Materials

At least sixty (60) days before the start of the enrollment period, DHS shall mail, to all households with individuals who are eligible to participate in the APC period, an information packet that describes the APC process, including benefits covered by the QI programs, how to select a Health Plan and a PCP, a description of Auto-Assignment, and information on how to access the Health Plans' provider networks. DHS shall include in the packet a newsletter that includes information about the Health Plans. DHS may provide this information via electronic means (i.e., e-mail) if this is the preferred form of communication of the member.

3) Ongoing APC Process

If during any APC period within this Contract period, no Health Plan selection is made and the member is enrolled in a returning Health Plan (i.e. the Health Plan has a current and new contract with DHS), the person shall remain in the current Health Plan.

For members changing from one Health Plan to another during the APC period, the effective date of enrollment shall be the first day of the second month after the APC period ends.

F) *Auto-assignment, Member Enrollment Limits and Caps*

1) Auto-Assignment Generally

The Health Plan shall accept all members selecting the Health Plan or auto-assigned by DHS to the Health Plan.

2) Population-based Enrollment Caps

a) At the discretion of DHS, a population-based membership (e.g., ABD members) enrollment cap may be imposed due to Health Plan performance deficiencies or other factors as determined by DHS. DHS reserves the right to lift the population-based enrollment cap at its discretion.

b) If a Health Plan has a population-based enrollment cap, it shall not be available during the APC period or to new members but will be available for existing members to continue with the Health Plan. Below are exceptions to this policy:

1. Enrollment of newborns in a QI plan that have the same health insurer as their mother, whether the mother was enrolled in a QI or commercial plan, shall be exempt from the performance-based enrollment cap;

2. Newly determined eligibles that have PCPs or behavioral health providers who are exclusive to the capped Health Plan within the previous twelve (12) months shall be allowed to enroll in the capped Health Plan. The capped Health Plan shall provide DHS with a listing of exclusive PCP and behavioral health providers, which shall be verified with the other Health Plans;

3. Members who have lost eligibility for a period of less than six (6) months may return to the capped Health Plan;

4. A child(ren) under foster care, kinship guardianship or subsidized adoption may enroll in a capped plan;

5. If a capped Health Plan does not have a waiting list for HCBS or "at risk" services when another Health Plan in the same service area open to new members does have a waitlist for these services, them members shall be able to enroll in a capped Health Plan;

6. A newly-eligible Medicare individual who enrolls in a D-SNP will be able to continue enrollment in the Health Plan he/she was already enrolled in for Medicaid, regardless of whether the D-SNP is offered by the same organization offering the Medicaid plan, or will be able to switch to another D-SNP (for both Medicare and Medicaid);

7. A newly eligible Medicaid individual who is already enrolled in a Medicare Advantage (MA) D-SNP will be able to continue enrollment in the MA plan D-SNP he/she was already enrolled in for Medicare; or

8. The population-based enrollment cap imposed under Hawaii's Medicaid program would not allow a current enrolled dual eligible to move his/her Medicaid portion of benefits from one plan to another, but will not limit a currently enrolled Medicare Beneficiary from switching his/her Medicare portion of benefits to another D-SNP.

3) Performance-based Enrollment Caps

a) At the discretion of DHS, a membership enrollment cap may be imposed due to Health Plan performance deficiencies. A performance-based enrollment cap will be reviewed at a frequency determined by DHS. At its discretion, DHS reserves the right to lift a performance-based enrollment cap based on evidence of sustained resolution of the Health Plan's performance deficiencies.

b) If a Health Plan has a performance-based enrollment cap, it shall not be available during the APC period or to new members but will be available for existing members to continue with the Health Plan. Below are exceptions to this policy:

    1. Enrollment of newborns in a QI plan that have the same health insurer as their mother, whether the mother was enrolled in a QI or commercial plan, shall be exempt from the performance-based enrollment cap;

2. Newly determined eligibles that have PCPs or behavioral health providers who are exclusive to the capped Health Plan within the previous twelve (12) months shall be allowed to enroll in the capped Health Plan. The capped Health Plan shall provide DHS with a listing of exclusive PCP and behavioral health providers, which shall be verified with the other Health Plans; or

3. Members who have lost eligibility for a period of less than six (6) months may return to the capped Health Plan;

4. A child(ren) under foster care, kinship guardianship or subsidized adoption;

5. If a capped Health Plan does not have a waiting list for HCBS or "at risk" services when another Health Plan in the same service area open to new members does have a waitlist for these services, them members shall be able to enroll in a capped Health Plan;

6. A newly-eligible Medicare individual who enrolls in a D-SNP will be able to continue enrollment in the Health Plan he/she was already enrolled in for Medicaid, regardless of whether the D-SNP is offered by the same organization offering the Medicaid plan, or will be able to switch to another D-SNP (for both Medicare and Medicaid);

7. A newly eligible Medicaid individual who is already enrolled in a Medicare Advantage (MA) D-SNP will be able to continue enrollment in the MA plan D-SNP he/she was already enrolled in for Medicare; or

8. The enrollment cap imposed under Hawaii's Medicaid program would not allow a current enrolled dual eligible to move his/her Medicaid portion of benefits from one plan to another, but will not limit a currently enrolled Medicare Beneficiary from switching his/her Medicare portion of benefits to another D-SNP.

4) Minimum Membership Levels

At the discretion of DHS, minimum membership level(s) may be established by DHS based on geography or other factors as determined by DHS.

G) *Member Education Regarding Status Changes*

1. DHS shall educate members concerning the necessity of providing to the Health Plan and DHS any information affecting their member status. Events that could affect the member's status and may affect the eligibility of the member include but are not limited to:

    a) Change in household (movements in and out of a household);
    b) Death of the member or family member (spouse or dependent);
    c) Birth;
    d) Marriage;
    e) Divorce;
    f) Adoption;
    g) Transfer to LTSS;
    h) Change in health status (e.g., pregnancy or permanent disability);

i) Change of residence or mailing address;
j) Institutionalization (e.g., state mental health hospital, Hawaii Youth Correctional Facility, or prison);
k) TPL coverage that includes accident related medical condition;
l) Inability of the member to meet citizenship, alien status, photo and identification documentation requirements as required in the Deficit Reduction Act (DRA) Section 6037 and in other federal law;
m) Change or addition of Social Security Number (SSN); or
n) Other household changes.

H) ***Disenrollment Requirements and Limitations***

1. DHS shall be the sole authority to disenroll a member from a Health Plan and from the programs. DHS shall process all disenrollment requests submitted orally or in writing by the member or his or her authorized representative.

2. Appropriate reasons for disenrollment include, but are not limited to the following items relating to program participation:

    a) Member no longer qualifies based on the medical assistance eligibility criteria or voluntarily leaves the program;
    b) Death of a member;
    c) Incarceration of the member;
    d) Member enters the State Hospital;
    e) Member enters the Hawaii Youth Correctional Facility;
    f) Member enters the State of Hawaii Organ and Tissue Transplant (SHOTT) program;
    g) Member is in foster care and has been moved out-of-state by DHS;

h) Member becomes a Medicare Special Savings Program member beneficiary;
i) Member provides false information with the intent of enrolling in the programs under false pretenses; or
j) Member is a medically needy individual who is two (2) full months in arrears in the payment of the designated spend down or cost share, unless the failure to pay occurs because:
    1. The enrollee is not in control of their personal finances, and the arrearage is caused by the party responsible for the enrollee's finances, and action is being taken to remediate the situation, including but not limited to:
        a) Appointment of a new responsible party for the enrollee's finances; or
        b) Recovery of the enrollee's funds from the responsible party which will be applied to the enrollee's enrollment fee obligation.
    2. The member is in control of their finances, and the arrearage is due to the unavailability of the enrollee's funds due to documented theft or financial exploitation, and action is being taken to:
        a) Ensure that theft or exploitation does not continue; or
        b) Recover the enrollee's funds to pay the enrollee's enrollment fee obligation.

3. Additional appropriate reasons for disenrollment from a Health Plan include, but are not limited to the following:
    a) Member chooses another Health Plan during the annual plan change period;

b) The member missed Annual Plan Change due to temporary loss of Medicaid eligibility and was reenrolled in their former Health Plan as described in Section 9.1(B);
c) Member's PCP, behavioral health provider, or LTSS residential facility is not in the Health Plan's provider network and is in the provider network of a different Health Plan;
d) Member is eligible to receive HCBS or "at risk" services and is enrolled in a Health Plan with a waiting list for HCBS or "at risk" services and another Health Plan does not have a waiting list for the necessary service(s);
e) DHS has imposed sanctions on the Health Plan as described in Section 14.20(B).
f) The Health Plan's contract with DHS is terminated or is suspended as described in Section 14.15;
g) Mutual agreement by participating Health Plans, the member, and DHS;
h) Member requests disenrollment for cause, at any time, due to:
    1. An administrative appeal decision;
    2. Provisions in administrative rules, Federal or State statutes;
    3. A legal decision;
    4. Relocation of the member to a service area where the Health Plan does not provide service;
    5. Change in foster placement if necessary for the best interest of the child;
    6. The Health Plan's refusal, because of moral or religious objections, to cover the service the member seeks as allowed for in Section 8.5;
    7. The member's need for related services (for example a cesarean section and a tubal ligation) to be performed at

the same time and not all related services are available within the network and the member's PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk;

8. The member does not have access to women's healthcare specialists for breast cancer screening, pap smears, or pelvic exams;
9. Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's health care needs, lack of direct access but not limited to certified nurse midwives, pediatric nurse practitioners, family nurse practitioners, women's health care specialists for breast cancer screenings, pap smears and pelvic exams, if available in the geographic area in which the member resides; or
10. Any member who uses LTSS that would experience a disruption in their residence or employment due to having to change their residential, institutional, or employment supports provider based on that provider's change in status from in-network to out-of-network.

4. DHS shall provide daily disenrollment data to the Health Plan via disenrollment roster on DHS Secure File Transfer Protocol (SFT) file server seven (7) days a week.

5. The effective date of all approved disenrollments shall be no later than the first day of the second month following the month that the member or the Health Plan files the request. If DHS fails to make a

determination in that time frame, the transfer or disenrollment shall be considered approved.

6. Any member dissatisfied with DHS' determination denying their request to disenroll from their Health Plans shall be given access to the State administrative hearing process.

7. The Health Plan shall not request disenrollment of a member for discriminating reasons, including:

    a) Pre-existing Medical Conditions;

    b) Missed appointments;

    c) Changes to the member's health status;

    d) Utilization of medical services;

    e) Diminished mental capacity; or

    f) Uncooperative or disruptive behavior resulting from the member's special needs.

8. Please refer to Section 4.12 for Health Plan administrative requirements for SHOTT.

I) *Health Plans must seek DHS' Disability Status Determination, for an Aid to Disabled Review Committee (ADRC) evaluation*

1. DHS, through the ADRC, determines the disability status of persons who are *not* in receipt of Retirement, Survivors and Disability Insurance (RSDI) and Supplemental Security Income (SSI) disability benefits. If the Health Plan has supporting documentation that a member is SSI eligible (copy of SSA letter, payment stub, or any other evidence of payment), this documentation shall be sent to DHS

in accordance with established procedures so that appropriate action can be taken to re-determine the member's eligibility status without going through the ADRC process.

2. The Health Plan needs to comply with the ADRC process for the following individuals who are not in the Adult group:

    a) Members who have had a decline in physical or mental functioning and require LTSS; and
    b) Members who qualify for SHOTT.

3. When a Health Plan identifies one of their members meeting the criteria, the Health Plan shall refer the member to DHS for an ADRC evaluation utilizing the ADRC packet (DHS Forms 1180, 1128, 1127). Specifically, the Health Plan shall submit to the ADRC Coordinator in DHS, the following completed forms and documentation:

    a) A DHS 1180, "ADRC Referral and Determination";

    b) A DHS 1127, "Medical History and Disability Statement";

    c) A DHS 1128 "Disability Report";

    d) Any current and additional documentation from the medical provider or the Health Plan, which provides supporting evidence for physical or mental disability, including diagnosis and prognosis (e.g. clinical progress notes, history and physical reports, discharge summaries); and

    e) A CMS 2728 may be substituted for DHS 1128 for ADRC referrals on clients with end stage renal disease.

4. The Health Plan shall submit an ADRC packet for members in the Adult group if the member:

    a) Meets nursing facility level of care on DHS 1147 and has chosen to receive home and community based services; and

    b) Has signed their agreement to have their assets reviewed on DHS 1127.

5. If the member is going through ADRC to obtain LTSS, then DHS shall conduct additional post-eligibility review on the approved ADRC packet.

6. If approved for SHOTT, the member shall be disenrolled from the Health Plan, converted to FFS, and transitioned to SHOTT.

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

9.2 Health Plan Enrollment Responsibilities

A) *General Requirements*

1. The Health Plan shall accept individuals enrolled into their Health Plan by DHS without restriction, unless otherwise authorized or prohibited by DHS. The Health Plan shall not discriminate against individuals enrolled, based upon health status or need for health care services, religion, race, color, creed, national origin, ancestry, sex, including gender identity or expression, sexual orientation, income status, or

disability. The Health Plan shall not use any policy or practice that has the effect of discriminating based upon race, religion, color, creed, national origin, ancestry, sex, including gender identity or expression, sexual orientation, income status, health care status, or disability.

2. DHS will make every effort to ensure that individuals who are ineligible for enrollment are not enrolled in the QI program. However, to ensure that such individuals are not enrolled in QI, the Health Plan shall assist DHS in the identification of individuals who are ineligible for enrollment, as set forth in Section 9.1(A), should such individuals inadvertently become enrolled in the QI program. The Health Plan shall also assist DHS in the identification of individuals who become ineligible for Medicaid or CHIP, including individuals who have moved out-of-State, been incarcerated, or are deceased.

3. The Health Plan shall accept daily and monthly transaction files from DHS as the official enrollment record.

4. The Health Plan shall issue a new member enrollment packet within ten (10) days of receiving the notification of enrollment from DHS. The new member packet shall include all of the elements described in Appendix P.

B) ***Member Survey for LTSS and Special Health Care Needs***

1. The Health Plan shall issue a written survey or a welcome call within ten (10) days of receiving the notification of enrollment from DHS to identify if the member (or their child) has any special health care

needs (SHCN) or long-term services and supports (LTSS). The Health Plan may send the written survey in the new member enrollment packet as described in Section 9.2(A). The Health Plan may choose to only utilize welcome calls instead of written surveys.

2. The Health Plan shall make a welcome call for those who do not respond to the survey, if applicable. If special health care needs are identified, the Health Plan will follow the process and requirements as described in Section 3.

3. The Health Plan shall submit its Member Survey for DHS review in accordance with Section 13.3(B), Readiness Review.

C) *Primary Care Provider (PCP) Selection*

1. The Health Plan shall provide assistance in selecting a PCP and shall provide the member ten (10) calendar days from the date identified on enrollment packet to select a PCP, not including mail time. The standard number of days the Health Plan shall use for mail time is five (5) days. If a member fails to select a PCP within ten (10) days, excluding mail time, or if the member has been auto-assigned to the Health Plan, the Health Plan shall auto-assign a member to a PCP based on the following algorithm:

   a) The Health Plan shall auto-assign members to the assigned PCP of an immediate family member enrolled in the Health Plan, if the provider is appropriate based on age and gender of the member.

   b) If no immediate family member has an existing relationship with a PCP, the Health Plan shall auto-assign the member based on age and gender and geographic proximity of the member's residence.

2. The Health Plan shall follow additional requirements identified in Section 8.1(E) when assigning a PCP.

D) ***Changes in Member Status***

1. The Health Plan shall forward to DHS in a timely manner, any information that affects the status of members in its Health Plan. The Health Plan shall complete the required form DHS 1179 for changes in member status and submit the information in an electronic format specified by DHS; for example, changes in address shall be communicated to DHS electronically on its SFT file server site on a monthly basis on the fifteenth (15) of the month or next business day utilizing the format provided by DHS. Where it is not feasible to submit changes in an electronic format (for example, when an urgent change is needed), information may also be submitted by phone, fax, courier services, or mail to the appropriate DHS eligibility office.

2. In addition, the Health Plan shall notify the member that it is also his or her responsibility to provide changes and updated information to DHS. Examples of changes in the member's status are provided in Section 9.1(G).

E) ***Enrollment for Newborns***

1. The Health Plan shall notify DHS of a member's birth of a newborn on form DHS 1179 when the Health Plan has access to the first name of the newborn or within thirty (30) days of birth, whichever is sooner. If the Health Plan submits the first name of the newborn as Baby Boy or Baby Girl at thirty (30) days, the Health Plan shall

submit the first name of the child to DHS on form DHS 1179 as soon as they receive it. The change will be submitted electronically to the extent feasible in a format specified by DHS.

F) *Documentation Requirements*

1. The Health Plan shall assist DHS in meeting all citizenship, alien status, photo and identification documentation requirements prescribed in Section 6037 of the Deficit Reduction Act (DRA) and in other federal law.

9.3 Health Plan Continuity of Care

A) *Transition to Different Health Plan*

1. In the event a member entering the Health Plan is receiving 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. Health Plans shall be responsible for medically necessary services provided during prior period coverage and retroactive enrollment.

2. Health Plans shall ensure that during transition of care, their new members:

    a) Receive all medically necessary emergency services;

b) Receive all prior authorized LTSS, including both HCBS and institutional services;
c) Adhere to a member's prescribed prior authorization for medically necessary services, including prescription drugs, or courses of treatment; and
d) Provide for the cost of care associated with a member transitioning to or from an institutional facility in accordance with the requirements prescribed in Section 9.2(A).

3. The Health Plan shall provide continuation of services for individuals with SHCN and LTSS for at least ninety (90) days or until the member has received an assessment by the new Health Plan as described in Section 3.

4. The Health Plan shall provide continuation of other services for all other members for at least forty-five (45) days or until the member's medical needs have been assessed or reassessed by the PCP who has authorized a course of treatment.

5. The Health Plan shall reimburse PCP services that the member may access during the forty-five (45) days prior to transition to their new PCP even if the former PCP is not in the network of the new Health Plan.

6. In the event the member entering the Health Plan is in her second or third trimester of pregnancy and is receiving 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.

B) ***Transition from the Health Plan***

1. If the member moves to a different service area in the middle of the month and enrolls in a different Health Plan, the former Health Plan shall remain responsible for the care and the cost of the inpatient services (as provided in Section 9.2(A)) provided to the member, if hospitalized at the time of transition, until discharge or level of care changes, whichever occurs first. Otherwise, the new Health Plan shall be responsible for all services to the member as of member's date of enrollment. If the member moves to a different service area and remains with the same Health Plan, the Health Plan shall remain responsible for the care and cost of the services provided to the member.

2. The former Health Plan shall cooperate with the member and the new Health Plan when notified in transitioning the care of a member who is enrolling in a new Health Plan. The former Health Plan shall submit transition of care information to DHS utilizing a format specified by DHS for transition to the new Health Plan within five (5) business days of the former Health Plan being notified of the transition.

3. The former Health Plan shall assure that DHS or the new Health Plan has access to the member's medical records and any other vital information that the former Health Plan has to facilitate transition of care.

C) ***Transition of Care Policies and Procedures***

1. The Health Plan shall develop transition of care policies and procedures that address all transition of care requirements in this

RFP and submit these policies and procedures for review and approval in accordance with Section 13.3(B), Readiness Review. The transition of care policy shall be consistent with the requirements set forth below.

2. The transition of care policy must include the following:
    a) The enrollee has access to services consistent with the access they previously had, and is permitted to retain their current provider for a period of time if that provider is not in the provider network;
    b) The enrollee is referred to appropriate providers of service that are in the new plan's provider network;
    c) The enrollee's previous provider(s) shall fully and timely comply with requests for historical utilization data from enrollee's new provider(s) in compliance with Federal and State law.
    d) The enrollee's new provider(s) shall be able to obtain copies of the enrollee's medical records consistent with Federal and State law, as appropriate.
    e) Any other necessary procedures as specified by the Secretary of DHHS to ensure continued access to services to prevent serious detriment to the enrollee's health or reduce the risk of hospitalization or institutionalization.
    f) The transition of care policy shall be publicly available and provide instructions to members on how to access continued services upon transition.

9.4 Notification to Members of Services, Responsibilities and Rights

A) *General Requirements*

1. The Health Plan shall have in place mechanisms to help members and potential members understand the requirements and benefits of their plan.

2. The Health Plan shall ensure that members and potential members are provided all required information in a manner and format that may be easily understood and is readily accessible. This includes but is not limited to members being informed of their rights and responsibilities, the role of PCPs, how to obtain care, what to do in an emergency or urgent medical situation, how to file a grievance or appeal, how to report suspected fraud and abuse, and how to access language assistance services for individuals with limited English proficiency.

3. The Health Plan shall make the following available in written format in the prevalent non-English languages in its relevant service area: provider directory, member handbook, appeal and grievance notices, and denial and termination notices.

4. The Health Plan shall convey this information via written materials and other readily accessible methods that may include but not be limited to electronic information and services, telephone, internet, or face-to-face communications that allow the members to ask questions and receive responses from the Health Plan.

5. When directed by DHS, and whenever there has been significant change, 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.

6. The Health Plan shall develop member services policies and procedures that address all components of member services. These policies and procedures must include, but are not limited to, policies and procedures on:
    a) Member call center staffing and monitoring;
    b) Member call center activities to ensure metrics as required in Section 9.4(I) are met;
    c) The availability and how to access interpretation services for non-English speakers, translation services, and services for individuals with visual and hearing impairments;
    d) Member rights and how they are protected;
    e) Up-dating and ensuring accuracy of information on the member portal of the web-site; and
    f) Methods to ensure member materials are mailed in a timely manner.

7. The Health Plan shall submit their member services policies and procedures for DHS review in accordance with Section 13.3(B), Readiness Review.

8. The Health Plan shall ensure members have access to Indian Health Services pursuant to, and shall comply with all requirements of Title 42, United States Code, Section 1396o(a), and Title V of the American Recovery and Reinvestment Act of 2009, Section 5006.

B) ***Member Education***

1. The Health Plan shall educate its members on the importance of good health and how to achieve and maintain good health. Educational efforts shall emphasize but not be limited to: the availability and benefits of preventive health care; the importance and schedules for preventive services for children and adults, as defined in Section 2.3, including but not limited to screenings receiving an A or B recommendation from the U.S. Preventive Services Task Force; the importance of early prenatal care; and the importance of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services including timely immunizations. The Health Plan shall also provide educational programs and activities that outline the risks associated with the use of alcohol, tobacco and other substances.

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

3. As part of these educational programs, the Health Plan may use classes, individual or group sessions, videotapes, written material and media campaigns. All instructional materials shall be provided in a manner and format that is easily understood.

4. DHS shall review and approve all educational and program materials prior to the Health Plan or their subcontractor distributing them or otherwise using them in educational programs. The Health Plan shall submit to DHS, for review and approval, any of its member education materials, including but not limited to training plans and curricula, in accordance with Section 13.3(B), Readiness Review

C) ***Language and Format Requirements for Written Materials***

1. The Health Plan shall use easily understood language and formats for all member written materials.

2. The Health Plan shall make all written materials available with taglines in the prevalent non-English languages in the state, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDY telephone number of Health Plan. Large print means printed in a font size no smaller than 18 point. Written materials must also be made available in alternative formats upon request of the potential enrollee or member at no cost, and in a manner that takes into consideration the member's special needs, including those who are visually impaired or have limited reading proficiency. Auxiliary aids and services must also be made available upon request of the potential member or member at no cost. The

Health Plan shall notify all members and potential members that information is available in alternative formats at no cost and provide information on how to access those formats.

3. The Health Plan shall make all written information for members available in languages that comply with Section 1557 of the Patient Protection and Affordable Care Act. When the Health Plan is aware that the member needs written information in one of these alternative languages, the Health Plan shall send all written information in this language (not English) to that member within seven (7) days of the request or within seven (7) days of the next business day following the request if the request is made outside of business hours. Small-sized publications and communications (i.e. post cards, brochures, and pamphlets) shall include at a minimum taglines in the following four non-English languages: Ilocano, Vietnamese, Chinese (Traditional), and Korean. The Health Plan may provide information in other prevalent non-English languages based upon its member population, and as required in Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d, 45 CFR Part 80.

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

5. The Health Plan shall certify that a qualified individual has reviewed the translation of the information into the different languages for accuracy.

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

    a) Fry Readability Index;

    b) PROSE The Readability Analyst (software developed by Education Activities, Inc.);

    c) McLaughlin SMOG Index; or

    d) Flesch-Kincaid Index.

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

D) *Interpretation Services*

1. The Health Plan shall provide oral interpretation services for any language to individuals with limited English proficiency and individuals with disabilities at no cost to the individual. The Health Plan shall notify its members and potential members of the availability of free interpretation services, sign language and TDD services, and inform them of how to access these services.

2. The Health Plan shall provide free language services to individuals whose primary language is not English. This can include services such as qualified interpreters.

3. Written translation is available in Ilocano, Vietnamese, Chinese (Traditional), and Korean.

4. The Health Plan shall provide free aids and services to individuals with disabilities. This shall include such services as:

    a) Qualified sign language interpreters;

    b) TTY/TDD services; and

    c) Written information in other formats (large print, audio, accessible electronic formats, other formats).

5. The Health Plan shall meet the following oral interpretation special requirements:

    a) Offer oral interpretation services to individuals with limited English proficiency (LEP) regardless of whether the individual speaks a language that meets the threshold of a prevalent non-English language; and

    b) Document the offer of an interpreter regardless of whether the member indicated an ability to provide his or her own, and whether an individual declined or accepted the interpreter service.

6. The Health Plan is prohibited from requiring or suggesting that individuals with Limited English Proficiency (LEP) provide their own interpreters or utilize friends or family members.

7. The Health Plan shall submit its policies and procedures on assuring both oral interpretation and written translation of materials for review and approval in accordance with Section 13.3(B), Readiness Review.

E) ***Member Handbook Requirements***

1. The Health Plan shall inform all newly enrolled members within ten (10) days of receiving the notice of member enrollment from DHS that the Member Handbook is available on their website. The Health Plan shall also inform enrolled members that the Member Handbook is available in paper form without charge and will be provided upon request within five (5) business days.

2. Annually, the Health Plan shall mail or provide a web-link to the electronic form of the Member Handbook to all enrolled members.

3. The Health Plan may consolidate the provision of Member Handbook to a family, including the parents and children (under the age of 19), as long as they are living in the same household.

4. The Member Handbook shall contain all of the elements described in Appendix Q.

5. The Health Plan shall submit the member handbook to DHS for review and approval in accordance with Section 13.3(B), Readiness Review.

F) ***Member Rights***

1. The Health Plan shall have written policies and procedures regarding the rights of members and shall comply with any applicable federal and State laws and regulations that pertain to member rights. These rights shall be included in the Member Handbook. At a minimum, said policies and procedures shall specify the member's right to:

a) Receive information pursuant to 42 CFR 438.100(a)(1)(2) and Sections 9.4(C) and 9.4(D) of this RFP;
b) 432E, HRS, Patients' Bill of Rights and Responsibilities;
c) Be treated with respect and with due consideration for the member's dignity and privacy;
d) Have all records and medical and personal information remain confidential;
e) Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;
f) Participate in decisions regarding his or her health care, including the right to refuse treatment;
g) Be free from any form of restraint or seclusion as a means of coercion, discipline, convenience or retaliation, as specified in federal regulations on the use of restraints and seclusion;
h) Request and receive a copy of his or her medical records pursuant to 45 CFR Parts 160 and 164, subparts A and E, and request to amend or correct the record as specified in 45 CFR 164.524 and 164.526;
i) Be furnished health care services in accordance with 42 CFR 438.206 through 438.210;
j) Freely exercise his or her rights, including those related to filing a grievance or appeal, and that the exercise of these rights shall not adversely affect the way the member is treated;
k) Have direct access to a women's health specialist within the network;
l) Receive a second opinion at no cost to the member;

m) Receive services out-of-network if the Health Plan is unable to provide them in-network for as long as the Health Plan is unable to provide them in-network and not pay more than he or she would have if services were provided in-network;
n) Receive services according to the appointment waiting time standards;
o) Receive services in a culturally competent manner;
p) Receive services in a coordinated manner;
q) Have his or her privacy protected;
r) Be included in service and care plan development, if applicable;
s) Have direct access to specialists (if he or she has a special healthcare need);
t) Not have services arbitrarily denied or reduced in amount, duration or scope solely because of diagnosis, type of illness, or condition;
u) Not be held liable for:
    1. The Health Plan's debts in the event of insolvency;
    2. The covered services provided to the member by the Health Plan for which DHS does not pay the Health Plan;
    3. Covered services provided to the member for which DHS or the Health Plan does not pay the healthcare provider that furnishes the services; and
    4. 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

v) Only be responsible for cost sharing in accordance with 42 CFR 447.50 through 447.57.

G) *Provider Directory*

1. The Health Plan shall make available a provider directory for DHS to assist members in selecting a Health Plan. The provider directory shall be available online and made available to the member in paper form upon member request. The Health Plan shall organize the provider directory by island and then by provider type/specialty. The Health Plan shall include the following in the provider directory:

    a) The provider's name, as well as any group affiliations;

    b) Street address(es);

    c) Telephone number(s);

    d) Web site URLs, as appropriate;

    e) Specialties, as appropriate;

    f) Whether the provider will accept new enrollees;

    g) Cultural and linguistic capabilities, including languages (including American Sign Language) by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training; and

    h) Whether the provider's facility/office has Americans with Disabilities (ADA) accommodations for people with physical disabilities, including offices, exam room and equipment.

2. The provider directory shall include above information for each of the following provider types.

a) Physicians, including specialists;

b) Hospitals;

c) Pharmacies;

d) Behavioral health providers; and

e) LTSS providers.

3. The Health Plan shall make available and maintain an updated provider directory on their web-site in a machine readable file and format as specified by HHS that includes all identified information above. This directory shall be updated at least monthly. Information on how to access this information shall be clearly stated in both the member and provider areas of the web-site. In addition, the Health Plan shall have member and provider service representatives who can access provider directory information for its members, providers and the State.

4. The Health Plan shall mail a hard copy or provide a weblink of its provider directory to their members as part of the new member enrollment packet as described in Section 9.2(A).

5. The Health Plan shall update its provider directory within 30 calendar days after the receipt of updated provider information. Annually, the Health Plan shall mail or provide a web-link to the electronic form of the provider directory to all enrolled members. The Member Handbook must state that the provider directory is either available electronically and provide the weblink, or by hard copy upon request. The Health Plan may be required to routinely submit its provider directory electronically to DHS to support the creation of a centralized directory, and to support reporting requirements.

H) *Member Identification (ID) Card*

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

    a) Member number;

    b) Member name;

    c) Effective date;

    d) PCP name and telephone number;

    e) Third Party Liability (TPL) information;

    f) Health Plan's call center telephone number; and

    g) 24-hour nurse call center telephone number.

2. The Health Plan shall reissue a member ID card within ten (10) days of notice that a member reports a lost card; there is a member name change; the member's PCP changes; or for any other reason that results in a change to the information on the member ID card, or for renewal with continuing eligibility.
3. The Health Plan shall submit a sample member ID to DHS for review and approval in accordance with Section 13.3(B), Readiness Review.

I) *Member Toll-Free Call Center*

1. The Health Plan shall operate a toll-free call center located in Hawaii to respond to member questions, comments and inquiries. The toll-free call center services shall be available and accessible to members from all islands the Health Plan serves.

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

3. The Health Plan's toll-free call center systems shall have the capacity to:

    a) Track call center metrics identified by DHS;

    b) Allow DHS to monitor remotely; and

    c) Have the ability for the calling member to receive an automatic call back so that the member does not need to remain on hold.

4. The call center shall be fully staffed between the hours of 7:45 a.m. (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 and the provider network.

5. The Health Plan shall meet the following call center standards:

    a) The call abandonment rate is five percent (5%) or less;

    b) The average speed of answer is thirty (30) seconds or less;

    c) The average hold time is two (2) minutes or less; and

d) The blocked call rate does not exceed one percent (1%).

6. The Health Plan may have an overflow call center located outside of Hawaii within the United States. However, this call center may not receive more than five percent (5%) of the calls coming into the Health Plans call center. In addition, the overflow call center shall meet all metrics identified above.

7. The Health Plan shall have an automated system or answering service available outside of Health Plan call-center hours, Monday through Friday, and during all hours on weekends and State holidays. This automated system or answering service shall provide callers with operating instructions on what to do in case of an emergency, shall provide an option to talk directly to a nurse or other clinician (as described below) and shall include a voice mailbox or other method for members to leave messages. The Health Plan shall ensure that the voice mailbox has adequate capacity to receive all messages. The Health Plan shall ensure that representatives return all calls by close of business the following business day.

8. In addition, the Health Plan shall have a twenty-four (24) hour, seven (7) day a week, toll-free nurse line available to members. The Health Plan may use the same number as is used for the call center or may develop a different phone number. Staff on the toll-free nurse line must be a registered nurse (R.N.), physician's assistant, nurse practitioner, or medical doctor. The primary intent of the toll-free nurse line is, through triage, to decrease inappropriate utilization of emergency department visits and improve coordination and continuity of care with an individual's PCP. However, having the phone line staffed by someone who is also able to provide treatment as appropriate is encouraged.

9. The toll-free nurse line shall meet the following standards:
    a) The call abandonment rate is five percent (5%) or less;
    b) The average speed of answer is thirty (30) seconds or less;
    c) The average hold time is two (2) minutes or less; and
    d) The blocked call rate does not exceed one percent (1%).
10. The Health Plan shall submit policies and procedures on the member call center to DHS for review and approval in accordance with Section 13.3(B), Readiness Review.

J) *Internet Presence/Website*

1. The Health Plan shall have a member portal on its web-site that is available to all members that contains accurate, up-to-date information about the Health Plan, services provided, the provider network, FAQs, and contact phone numbers and e-mail addresses.

2. The member web portal shall allow members to view explanation of benefits (EOB) for the past twelve (12) months, review prior authorization requests (approval or denials), contact their service coordinator, if applicable, review their service plan, if applicable, and communicate changes to the Health Plan (i.e., demographics, change in family size, change in PCP, request change in service coordinator, etc.).

3. The section of the web-site relating to QI shall comply with the marketing policies and procedures and requirements for written

materials described in this contract and all applicable State and Federal laws.

4. The information must be in a format that is readily accessible.

5. The information must be placed in a location on the MCP's website that is prominent and readily accessible.

6. The information must be provided in an electronic form which can be electronically retained and printed.

7. The information is consistent with content and language requirements.

8. The Health Plan must notify the enrollee that the information is available in paper form without charge upon request.

9. The Health Plan must provide, upon request, information in paper form within 5 business days

10. In addition, the Health Plan shall submit access to the member web-site (even if in a test environment) to DHS for review and approval.

9.5 Member Grievance and Appeals System

A) *General Requirements*

1. The Health Plan shall have a formal grievance and appeals system that is consistent with the requirements of the State of Hawaii and 42 CFR Part 438, Subpart F. The member grievance and appeals system shall include an inquiry process, a grievance process and an appeals process. In addition, the Health Plan's grievance system shall provide information to members on accessing the State's administrative hearing system. The Health Plan shall require that members exhaust its internal grievance system prior to accessing the State's administrative hearing system.

2. The Health Plan shall use templates developed by DHS for communication to members regarding grievance system processes.

3. The Health Plan shall develop policies and procedures for its appeals and grievance system and submit these to DHS for review and approval in accordance with Section 13.3(B), Readiness Review. The Health Plan shall submit to DHS any proposed updated copy of these policies and procedures within thirty (30) days of any modification for review and approval. Changes must be approved by DHS prior to implementation.

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

5. The Health Plan shall give members any reasonable assistance in completing forms and taking other procedural steps. This includes,

but is not limited to, auxiliary aids and services upon request such as providing interpreter services, and toll-free numbers that have adequate TTY/TTD and interpreter capability.

6. The Health Plan shall acknowledge receipt of each filed grievance and appeal in writing within five (5)[1] business days of receipt of the grievance or appeal. The Health Plan shall have procedures in place to notify all members in their primary language of grievance and appeal resolutions, as described in Sections 9.4(C) and 9.4(D). These procedures shall include written translation and oral interpretation.

7. 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 given timely and accessible peer to peer option that discusses the denial and be made and reviewed by a healthcare professional that has appropriate medical knowledge and clinical expertise in treating the member's condition or disease.

8. The Health Plan shall ensure that individuals who make decisions on grievances and appeals were not involved in any previous level of review or decision-making, nor is a subordinate of any such individual. The individual making decisions on grievances and appeals shall be healthcare professionals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease. These decision makers on grievances

[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.

and appeals of adverse benefit determination shall take into account all comments, documents, records, and other information submitted by the member and/or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. This requirement applies specifically to reviewers of:

a) An appeal of a denial based on issues of medically necessary or medical necessity;

b) A grievance regarding denial of expedited resolution of an appeal; or

c) A grievance or appeal that involves clinical issues.

9. A member, a member's authorized representative, or a provider acting on behalf of the member with the member's authorization, is deemed to have exhausted the Health Plan's grievance and appeal process if the Health Plan fails to adhere to the notice and timing requirements set by DHS, and may file for a State administrative hearing.

B) ***Grievance and Appeal Recordkeeping***

1. The Health Plan shall maintain records of its members' grievances and appeals for a period of no less than ten (10) years in accordance with 42 CFR 438.3(u) and this RFP's requirements for recordkeeping and confidentiality of members' medical records. Records must be accurately maintained in a manner accessible to the State and available upon request to CMS.

2. The record of each grievance or appeal must contain, at a minimum, all of the following information:

    a) A general description of the reason for the appeal or grievance;
    b) The date received;
    c) The date of each review or, if applicable, review meeting;
    d) Resolution at each level of the appeal or grievance, if applicable;
    e) Date of resolution at each level, if applicable; and
    f) Name of the covered person for whom the appeal or grievance was filed.

C) *Inquiry Process*

1. The Health Plan shall have an inquiry process to address all inquiries as defined in Section 2.3. As part of this process, the Health Plan shall ensure that, if at any point during the contact, the member expresses a complaint of any kind, the inquiry becomes a grievance or appeal and the Health Plan shall give the member, a member's authorized representative, or a provider acting on behalf of the member with the member's consent, their grievance and appeal rights. The inquiry can be in writing or made as a verbal request over the telephone.

D) *Authorized Representative of a Member*

1. Members shall be allowed to authorize another person to represent their interests during any stage of the grievance system process as their authorized representative.

2. Members shall be allowed, in person or by telephone, to verbally identify another person who may communicate with the Health Plan on the member's behalf, for any matter that does not require a written request or written designation of an authorized representative under this RFP and contract.

E) *Grievance Process*

1. A grievance may be filed about any matter other than an Adverse Benefit Determination, as defined in Section 2.3. Subjects for grievances include, but are not limited to:
    a) The quality of care of a provider;
    b) Rudeness of a provider or a provider's employee; or
    c) Failure to respect the member's rights regardless of whether remedial action is requested.

2. Grievance includes a member's right to dispute an extension of time proposed by the Health Plan to make an authorization decision.

3. A member or a member's Authorized Representative may file a grievance orally or in writing with the Health Plan at any time. The Health Plan shall accept any grievance filed on the member's behalf from a member's representative even without verbal or written consent of the member. However, the Health Plan shall send the outcome of any grievance filed by a member's representative without oral or written consent (i.e., AOR form) to the member.

4. The Health Plan shall ensure that decision makers on grievances take into account all comments, documents, records, and other information submitted by the enrollee or their representative without

regard to whether such information was submitted or considered in the initial adverse benefit determination.

5. The Health Plan shall have in place written policies and procedures for processing grievances in a timely manner to include processes pertaining to grievances filed by a provider or a member's authorized representative on behalf of the member, and protocols for addressing grievances filed by a member's representative when there is no documentation of a written form of authorization, such as an AOR form.

6. As part of the grievance system policies and procedures, the Health Plan shall have in effect mechanisms to: (1) ensure reasonable attempts were made to obtain a written form of authorization; and (2) consult with the requesting provider when appropriate.

7. The Health Plan shall:
    a) Send a written acknowledgement of the grievance within five (5) business days of the member's expression of dissatisfaction;
    b) Convey a disposition, in writing, of the grievance resolution as expeditiously as the member's health condition requires, but no later than thirty (30) days of the initial expression of dissatisfaction; and
    c) Include clear instructions as to how to access the State's grievance review process if the member is dissatisfied with the Health Plan's disposition.

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

9. The Health Plan may extend the timeframe for processing a grievance by up to 14 calendar days if the member requests the extension; or if the Health Plan shows that there is need for additional information and that the delay is in the member's interest.

10. If the Health Plan extends the timeline for a grievance not at the request of the member, the Health Plan must: make reasonable efforts to give the member prompt oral notice of the delay; give the member written notice, within 2 calendar days, of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision.

F) ***State Grievance Review***

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

    a) Health Plan members may request a State grievance review, within thirty (30) days of the member's receipt of the grievance disposition from the Health Plan. A State grievance review may be made by contacting the DHS office by phone or by mailing a request to:

Health Care Services Branch
PO Box 700190
Kapolei, HI 96709-0190
Telephone: 808-692-8094

b) DHS shall review the grievance and contact the member with a determination within ninety (90) days from the day the request for a grievance review is received; and
c) The grievance review determination made by DHS is final.

G) *Notice of Adverse Benefit Determination*

1. The Health Plan shall give the member and the referring provider a written notice of an adverse benefit determination within the time frames specified below. The notice to the member or provider shall include the following information:

    a) The adverse benefit determination the Health Plan has made or intends to make;

    b) The reason for the adverse benefit determination, including the right of the member to be provided, upon request and free of charge, with reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits;

    c) The member's or provider's right to an appeal with the Health Plan;

    d) The member's or provider's right to request an appeal;

e) Procedures for filing an appeal with the Health Plan;

f) The member's right to represent himself or herself, use legal counsel, or use an authorized representative;

g) The circumstances under which an appeal process can be expedited and how to request it; and

1. The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with State policy, under which the member may be required to pay the costs of these services.

2. The notice of action to the member shall be written pursuant to the requirements in Section 9.4(C) of this RFP.

3. The Health Plan shall mail the notice within the following time frames:

a) For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) days prior to the date the adverse benefit determination is to start except:

1. By the date of action for the following reasons:

a. The Health Plan has factual information confirming the death of a member;

b. The Health Plan receives a clear written statement signed by the member that he or she no longer wishes services or gives information that requires termination or reduction of services and indicates that he or she understands that termination or reduction of services will occur as a result of supplying that information;

c. The member has been admitted to an institution that makes him or her ineligible for further services;

d. The member's address is unknown and the post office returns Health Plan mail directed to the member indicating no forwarding address;

e. The member has been accepted for Medicaid services by another local jurisdiction;

f. The member's provider prescribes a change in the level of medical care;

g. There has been an adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989; or

h. In the case of adverse actions for nursing facility transfers, the safety or health of other individuals in the facility would be endangered, the member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the member's urgent medical needs, or the member has not resided in the nursing facility for thirty (30) days.

b) The period of advanced notice is shortened to five (5) days if there is alleged fraud by the member and the facts have been verified, if possible, through secondary sources.

c) For denial of payment: advance notice at the time of any action affecting the claim.

d) For standard service authorization decisions that deny or limit services: as expeditiously as the member's health condition requires, but not more than 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 member or provider requests an extension; or (2) the Health Plan justifies a need for additional information and how the extension is in the member's best interest. 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.

e) For expedited authorization decisions: as expeditiously as the member's health condition requires but no later than seventy two (72) hours after receipt of the request for service. The Health Plan may extend the seventy two (72) hour timeframe by up to an additional fourteen (14) calendar days if the member requests an extension, or if the Health Plan justifies to DHS a need for additional information and how the extension is in the member's best interest.

4. For service authorization decisions not reached within the time frames specified above (which constitute a denial and, thus, an adverse benefit determination), on the date that the timeframes expire.

H) ***Health Plan Appeals Process***

1. An appeal may be filed when the Health Plan issues an Adverse Benefit Determination, as defined in Section 2.3, to a Health Plan member.

2. A member, a member's authorized representative, or a provider acting on behalf of the member with the member's authorization, may file an appeal within sixty (60) calendar days of the Notice of Adverse Benefit Determination. An oral appeal may be submitted in order to establish the appeal submission date; however, this must be followed by a written signed appeal request. The Health Plan shall assist the member, provider or other authorized representative in this process.

3. The Health Plan shall ensure that decision makers on appeals take into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

4. In addition to meeting the general requirements detailed in Section 9.5, the Health Plan shall:

    a) Ensure that oral inquiries seeking to appeal an action are treated as appeals and confirmed in writing, unless the member, provider or other authorized representative requests expedited resolutions;
    b) As part of the grievance system policies and procedures, the Health Plan shall have in effect mechanisms to ensure

reasonable attempts were made to obtain a written confirmation of the appeal;

c) 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;
d) Provide the member and his or her authorized representative a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The Health Plan must inform the member about the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in 42 CFR 438.408(b) and (c) in the case of expedited resolution;
e) Provide the member and his or her authorized representative, upon request, the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the Health Plan. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals; and
f) Include as parties to the appeal, the member and his or her authorized representative, or the legal representative in the case of a deceased member's estate.

5. For standard resolution of an appeal, the Health Plan shall resolve the appeal and provide a written notice of disposition to the parties as expeditiously as the member's health condition requires, but no more than thirty (30) calendar days from the day the Health Plan receives the appeal.

6. The Health Plan may extend the resolution time frame by up to fourteen (14) additional calendar days if the member requests the extension, or the Health Plan shows (to the satisfaction of DHS, upon its request for review) that there is need for additional information that justifies the delay, and how the delay shall be in the member's best interest.

7. For any extension not requested by a member, the Health Plan shall make reasonable efforts to give the enrollee prompt oral notice of the delay. The Health Plan shall give the member written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision within two (2) calendar days. The Health Plan shall resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

8. The Health Plan shall notify the member, provider or other authorized representative in writing within thirty (30) calendar days of the resolution.

9. The Health Plan shall include the following in the written notice of the resolution:

    a) The results of the appeal process and the date it was completed; and
    b) For appeals not resolved wholly in favor of the member:
        1. The right to request a State administrative hearing with the Administrative Appeals Office (AAO), and clear instructions about how to access this process;
        2. The right to request to receive benefits while the hearing is pending and how to make the request; and

3. A statement that the member may be held liable for the cost of those benefits if the hearing decision is not in the member's favor.

I) *Expedited Appeal Process*

1. The Health Plan shall establish and maintain an expedited review process for appeals. The member, his or her provider or other authorized representative acting on behalf of the member with the member's written authorization may file an expedited appeal either orally or in writing. No additional follow-up shall be required.

2. An expedited appeal is only appropriate when the Health Plan determines (based upon a request from the member) or the provider indicates (in making the request on the member's behalf) that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

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

4. The Health Plan shall inform members of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments in the case of an expedited appeal resolution. The MCP must inform members of this sufficiently in advance of the resolution timeframe for appeals.

5. For expedited resolution of an appeal, the Health Plan shall resolve the appeal and provide written notice to the affected parties as

expeditiously as the member's health condition requires, but no more than seventy two (72) hours from the time the Health Plan received the appeal. The Health Plan shall make reasonable efforts to also provide oral notice of the appeal determination to the member.

6. The Health Plan shall provide written notice, and make reasonable efforts to provide oral notice, of the resolution of an expedited appeal. The Health Plan shall include the following in the written notice of the resolution:

    a) The results of the appeal process and the date it was completed; and
    b) For appeals not resolved wholly in favor of the member:
        1. The right to request a State administrative hearing as described in Section 9.5(J), and clear instructions about how to access this process;
        2. The right to request an expedited State administrative hearing;
        3. The right to request to receive benefits while the hearing is pending, and how to make the request; and
        4. A statement that the member may be held liable for the cost of those benefits if the hearing decision upholds the Health Plan's action.

7. The Health Plan may extend the expedited appeal resolution time frame by up to fourteen additional (14) calendar days if the member requests the extension or the Health Plan needs additional information and demonstrates to DHS how the delay shall be in the member's best interest. For any extension not requested by the member, or if the Health Plan denies a request for expedited resolution of an appeal, it shall:

a) Transfer the appeal to the time frame for standard resolution;

b) Make reasonable efforts to give the member prompt oral notice of the delay or denial;

c) Within two (2) calendar days give the member written notice of the reason for the decision to extend the timeframe or deny a request for expedited resolution of an appeal;

d) Inform the member orally and in writing that they may file a grievance with the Health Plan for the delay or denial of the expedited process, if he or she disagrees with that decision; and

e) Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

8. The Health Plan shall notify DHS within twenty-four (24) hours if an expedited appeal has been granted by the Health Plan or if an expedited appeal time frame has been requested by the member or the provider. The Health Plan shall provide the reason it is requesting a fourteen additional (14) calendar day extension to DHS. The Health Plan shall notify DHS within twenty-four (24) hours (or sooner if possible) from the time the expedited appeal is upheld. The Health Plan shall provide information on the method of notification to DHS.

9. If the Health Plan denies a request for expedited resolution of an appeal, it must transfer the appeal to the standard timeframe of no longer than 30 calendar days from the day the Health Plan receives the appeal (with a possible 14-day extension).

J) *State Administrative Appeals Office Hearing for Regular Appeals*

1. If the member is not satisfied with the Health Plan's written notice of disposition of an appeal, the member may file for a State administrative hearing within one hundred and twenty (120) calendar days of the receipt of the notice of disposition (denial) as part of the member's internal appeal procedure.

2. At the time of the denied appeal determination, the Health Plan shall inform the member, the member's provider or other authorized representative, or the legal representative of a deceased member's estate that (1) he or she may request information on how to exhaust the Health Plan's one level of appeal and the right to a state fair hearing after receiving notice that the adverse benefit determination is upheld. The member, or his or her authorized representative, may access the State administrative hearing process by submitting a letter to the Administrative Appeals Office (AAO) within one hundred and twenty (120) calendar days from the receipt of the member's appeal determination.

3. In addition to the hearing guidance listed in the Hawaii Administrative Rules (HAR) §17-1703.1, the following bases shall be added in accordance with 42 CFR 431.220 and 42 CFR 431.244:

    a) Member's claim for services is denied or is not acted upon with reasonable promptness;

    b) Member believes the Health Plan has taken an action erroneously;

c) Member believes a skilled nursing facility or nursing facility has erroneously determined that he or she must be transferred or discharged;

d) Member believes the State has made an erroneous determination with regards to the preadmission and annual resident review requirement of section 1919(e)(7) of the Social Security Act.

4. Hearing Decisions must be based exclusively on evidence introduced at the hearing as reiterated below:

   a) The transcript or recording of testimony and exhibits, or an official report containing the substance of what happened at the hearing;

   b) All papers and requests filed in the proceeding; and

   c) The recommendation or decision of the hearing officer.

5. The Health Plan shall provide the following address to members:

   State of Hawaii Department of Human Services

   Administrative Appeals Office

   PO Box 339

   Honolulu, HI 96809-0339

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

K) *Expedited State Administrative Hearings*

1. The member may file for an expedited State administrative hearing only when the member requested or the Health Plan provided an expedited appeal and the action of the appeal was determined to be adverse to the member (Action Denied). The member may file for an expedited State administrative hearing process by submitting a letter to the Administrative Appeals Office (AAO) within one hundred and twenty (120) days from the receipt of the member's appeal determination.

2. The Health Plan shall provide the following address to members:

   State of Hawaii Department of Human Services
   Administrative Appeals Office
   PO Box 339
   Honolulu, HI 96809-0339

3. An expedited State administrative hearing must be heard and determined within three (3) business days after the date the member filed the request for an expedited State administrative hearing with no opportunity for extension on behalf of the State. The Health Plan shall collaborate with the State to ensure that the best results are provided for the member and to ensure that the procedures comply with State and Federal regulations.

4. 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 DHS within twenty-four (24) hours of the decision denying the expedited appeal.

L) ***Continuation of Benefits during an Appeal or State Administrative Hearing***

1. A member or a member's authorized representative may request for a continuation of benefits during a Health Plan Appeal or a State Administrative Hearing process. The Health Plan shall continue the member's benefits if the following conditions have been met:

    a) an appeal within 60 days following the date on the adverse benefit determination notice;

    b) The appeal or request for State administrative hearing involves the termination, suspension, or reduction of a previously authorized services;

    c) The services were ordered by an authorized provider;

    d) The original authorization period has not expired; and

    e) The member timely files for continuation of benefits on or before the later of the following:

        1. Within ten (10) days of the Health Plan mailing the notice of adverse benefit determination; or

        2. The intended effective date of the Health Plan's proposed adverse benefit determination.

2. If the Health Plan continues or reinstates the member's benefits while the appeal or State administrative hearing is pending, the Health Plan shall not discontinue the benefits until one of the following occurs:

    a) The member withdraws the appeal or request for a State administrative hearing;

b) The member does not request a State administrative hearing within ten (10) days from when the Health Plan mails a notice of an adverse benefit determination; or

c) A State administrative hearing decision unfavorable to the member is made.

3. If the final resolution of the appeal or State administrative hearing is adverse to the member, that is, upholds the Health Plan's adverse benefit determination, the Health Plan may, consistent with the State's usual policy on recoveries and as specified in the Health Plan's contract, recover the cost of services furnished to the member while the appeal and State administrative hearing were pending, to the extent that they were furnished solely because of the requirements of this section.

4. If the Health Plan or the State reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Health Plan shall authorize or provide these disputed services promptly, and as expeditiously as the member's health condition requires, but no later than seventy two (72) hours from the date it receives notice reversing the determination.

5. If the Health Plan or the State reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the Health Plan shall pay for those services.

9.6 Marketing and Advertising

A) *Allowable Activities*

1. The Health Plan shall be permitted to perform the following marketing activities:

    a) Distributing general information through mass media (i.e., newspapers, magazines and other periodicals, radio, television, the Internet, public transportation advertising, and other media outlets);

    b) Distributing brochures and displaying posters at provider offices and clinics that inform patients that the clinic or provider is part of the Health Plan's provider network, provided that all Health Plans in which the provider participates have an equal opportunity to be represented; and

    c) Attending activities that benefit the entire community such as health fairs or other health education and promotion activities.

2. If the Health Plan performs an allowable activity, the Health Plan shall conduct these activities in all of the regions in which it is operating.

3. All materials shall comply with the information requirements in 42 CFR 438.10 and as detailed in Section 9.4(C) of this RFP.

B) *Prohibited Activities*

1. The Health Plan is prohibited from directly or indirectly engaging in door-to-door, telephone, mailings or other cold-call marketing activities to potential members.

2. The Health Plan is prohibited from offering any favors, inducements or gifts, promotions, or other insurance products that are designed to induce enrollment in the Health Plan without prior approval of DHS.

3. The Health Plan is prohibited from distributing information that contains any assertion or statement (whether written or oral) that the Health Plan is endorsed by CMS, the Federal or State government, or DHS.

4. Distributing information or materials that seek to influence enrollment in conjunction with the sale or offering of any private insurance.

5. The Health Plan is prohibited from distributing information and materials that contain statements that DHS determines are inaccurate, false, or misleading. Statements considered false or misleading include, but are not limited to, any assertion or statement (whether written or oral) that the member must enroll in a specific Health Plan to obtain benefits, or to avoid losing benefits, or that any particular Health Plan is endorsed by the federal or state government, or similar entity.

6. The Health Plan is prohibited from distributing materials that, according to DHS, mislead or falsely describe the Health Plan's provider network, its performance/quality, the participation or availability of network providers, the qualifications and skills of network providers (including their bilingual skills), or the hours and location of network services.

7. The Health Plan is prohibited from failing to receive DHS approval on all marketing materials.

8. The Health Plan is prohibited from editing, modifying, or changing in any manner marketing materials previously approved by DHS without the consent and approval of DHS.

9. DHS may impose financial sanctions, as described in Section 14.20, up to the federal limit, on the Health Plan for any violations of the marketing and advertising policies.

C) *State Approval of Materials*

1. All printed materials, advertisements, video presentations, and other information prepared by the Health Plan that pertain to or reference the programs or the Health Plan's program business shall be reviewed and approved by DHS before use and distribution by the Health Plan. The Health Plan shall not advertise, distribute or provide any materials to its members or to any potential members that relate to QI that have not been approved by DHS.

2. The Health Plan shall submit to DHS any marketing materials it has received from a provider or subcontractor for review and prior approval.

D) *Marketing for Initial Enrollment and Annual Plan Change (APC)*

1. The Health Plan shall submit all potential marketing materials to DHS for review and approval. DHS shall utilize criteria identified in Section 9.6(A) and Section 9.4(C) to approve materials.

2. The Health Plan shall only use DHS approved materials for marketing during APC. Health Plans that do not follow this policy shall be subject to sanctions as described in Section 14.20.

SECTION 10 – Information Systems and Information Technology

10.1 DHS Responsibilities

A) *Hawaii Prepaid Medicaid Management Information Systems (HPMMIS)*

1) To effectively and efficiently administer the programs, DHS shall operate the HPMMIS. HPMMIS is an integrated Medicaid Management Information System that supports the administration of the program. The major functional areas of HPMMIS include:

    a) Receiving daily eligibility files from KOLEA and processing enrollment/disenrollment of members into/from the Health Plans based on established enrollment/disenrollment rules;

    b) Processing member Health Plan choices submitted to the MQD enrollment call center;

    c) Producing daily enrollment/disenrollment rosters, monthly enrollment rosters, and TPL rosters;

    d) Processing bi-monthly encounter submissions from Health Plans and generating encounter error reports for Health Plan correction. Accepting and processing monthly Health Plan provider network submissions to assign Medicaid provider IDs for Health Plan use. Errors associated with these submissions are generated and returned to the Health Plans on a monthly basis for correction;

    e) Processing additional reports submitted by Health Plans;

f) Monitoring the access and utilization of services provided to the members by the Health Plans and the activities or movement of the members within and between the Health Plans;

g) Monitoring the activities of the Health Plans through information and data received from the Health Plans and generating management reports;

h) Evaluating Health Plan quality and performance through a variety of metrics and analyses;

i) Calculating capitation rates and adjustments;

j) Determining the amount due to the Health Plans for the monthly capitated rate for enrolled members;

k) Producing a monthly provider master registry file for the Health Plans to use for assigning Medicaid provider IDs to Health Plan providers for the purpose of submitting encounters to DHS;

l) Generating required CMS reports and submitting data to other entities as permitted and necessary; and

m) Generating management information reports.

2) Receiving/transmitting of data files between the Health Plans and HPMMIS is done via the MQD SFTP service. The SFTP service allows the MQD and Health Plans to securely transfer member, provider, and encounter data via the internet.

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

4) The HPMMIS processes and reports on Medicaid fee-for-service payments. This includes Medicaid fee-for-service payments that are

authorized under the program. The HPMMIS and reporting subsystems provide the following:

a) Member processing (ID cards, eligibility, buy-in, etc.);

b) Fee-For-Service Claims processing (input preparation, electronic media claim capture, claim disposition, claim adjudication, claim distribution, and payments);

c) Provider support (certification, edit and update, rate change, and reporting);

d) Management and Administrative Reporting Subsystem (MARS) and Surveillance and Utilization Reporting Subsystem (SURS) reports;

e) Reference files for the validation of procedures, diagnosis, and drug formularies; and

f) Other miscellaneous support modules (TPL, EPSDT, DUR, MQC, etc.).

10.2 Health Plan Responsibilities

A) *General Requirements*

1. The Health Plan shall have information management systems that enable it to meet DHS requirements, State and Federal reporting requirements, all other contract requirements and any other applicable State and Federal laws, rules and regulations, including the Health Insurance Portability and Accountability Act (HIPAA). The Health Plan is responsible for adopting national standards and code

sets, and up-to-date protocols and formats for claims data submission, validation, and adjudication. The Health Plan shall maintain a written manual of its claims adjudication protocol and submit to DHS for review and approval; the Health Plan shall routinely review its claims processing protocols and update the protocols and manual as needed. The Health Plan shall notify DHS of updates and revisions to its claims processing protocols.

2. The Health Plan shall have a system or systems that collect, analyze, integrate, and report data and can achieve the objectives of 42 CFR 438.242. The system or systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility

B) ***Specific Requirements***

1. The Health Plan shall have a system or systems able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by DHS to meet the requirements of section 1903(r)(1)(F) of the Social Security Act.
2. The Health Plan shall have a system or systems able to data on enrollee and provider characteristics as specified by DHS, and on all services furnished to enrollees through an encounter data system or other methods as may be specified by DHS.
3. The Health Plan shall have a system or systems that will ensure that data received from providers is accurate and complete by:

a) Verifying the accuracy and timeliness of reported data, including data from network providers the Health Plan is compensating on the basis of capitation payments.

b) Screening the data for completeness, logic, and consistency.

c) Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts.

C) *Expected Functionality*

1. The Health Plan shall have information systems and supports that, at a minimum, facilitate and integrate the following essential Health Plan service coordination functions:

    a) analytics to support identification of members who are likely to benefit from special program services including but not limited to CSC, CIS, and LTSS, and SDOH supports;

    b) administration of and collection of data on various member health status screeners and assessments and data to support quality reporting;

    c) documentation and sharing of member's assessment, service and care plan(s) in a concise, understandable, and printable or electronic format;

    d) coordination and oversight of the data elements to support the delivery of optimal health services;

e) provision of essential and actionable health information on members and patient panels to providers and service coordinators in the community to facilitate care;

f) collection and analysis of data on the health and service utilization of the beneficiary population;

g) collection, analysis, and reporting of provider-level data to support a variety of quality, value-based purchasing, and other efforts;

h) collection, analysis, and reporting of member attribution information, where relevant, to contextualize differences in health outcomes; and

i) collection, analysis, and reporting, at the member-level, of encounter data, and additional data that extend beyond encounter submissions to support contextualization and evaluation of various DHS programs and services.

2. The Health Plan must adhere to all reporting requirements, including those that extend beyond the required information systems functionality described herein.

3. The Health Plan shall have a systems capable of adapting to DHS formats and sharing information electronically with DHS and service providers in the community that are readily accessible yet secured to enable the efficient execution of the aforementioned functions.

4. The Health Plan is not expected to have met the minimum functionality expectations fully prior to the start of the contract.

5. As specified in Section 5.1, the Health Plan shall contribute to the statewide HIT Innovation Plan, and develop its own aligned HIT Work

Plan to support DHS' HIT goals and objectives. The first year of the Health Plan HIT Work Plan will serve as a needs assessment of the Health Plan's current HIT capacity, and the Health Plan's strategy to meet minimum reporting requirements prior to the end of the first year of the contract.

6. Additionally, DHS will work closely with the Health Plans on specific data collection and reporting requirements to enhance streamlined, simplified reporting that balances data needs with feasibility and data availability. Subsequent contributions to the statewide HIT Innovation Plan and the Health Plan HIT Work Plan are designed to promote interoperability and collaboration, reduce administrative burden, and enhance access to timely and actionable data across the spectrum of entities with data needs.

D) *Method of Data Exchange with MQD*

1. The MQD SFTP service is the primary but not the only mechanism for file transfers between MQD and trading partners, including Health Plans. Specific technical specifications and instructions are provided in the HPMMIS Health Plan Manual available on the Med-QUEST web site. The SFTP service allows the MQD and the Health Plan to securely transfer electronic member, provider, and encounter data.

E) *Compliance with the Health Insurance Portability and Accountability Act (HIPAA)*

1. The Health Plan shall implement the electronic transaction and code set standards and other "Administrative Simplification" provisions,

privacy provisions, and security provisions of HIPAA, Public Law 104-191, as specified by CMS.

F) *Possible Audits of Health Plan Information Technology*

1. The Health Plan shall institute processes to ensure the validity and completeness of the data submitted to DHS. DHS or its contractors may conduct general data validity and completeness audits using industry standard sampling techniques. DHS reserves the right to have access to the Health Plan's system at any time.

G) *Health Plan Information Technology Changes*

1. The Health Plan shall notify DHS and obtain prior approval for any proposed changes to its information system that could impact any process or program under this contract.

H) *Disaster Planning and Recovery Operations*

1. 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.

2. The Health Plan shall submit documentation of its disaster planning and recovery operations for DHS review in accordance with Section 13.3(B), Readiness Review.

I) *Health Information Exchange*

1. The Health Plan shall invest in efforts that enhance interoperability and data exchange through its contributions to the development and implementation of the HIT Innovation Plan at the state level and HIT Work Plan at the Health Plan levels in accordance with the State Quality Program described in Section 5.1.

2. Through these efforts, the Health Plan shall build capacity to be able to electronically exchange administrative and clinical data on a patient's utilization with MQD and providers.

3. The Health Plan shall participate in and support the state-designated entity's health information exchange to the extent feasible.

SECTION 11 – Health Plan Personnel

11.1 General Requirements

A) *Overview*

1. The Health Plan shall have in place the organizational, management, and administrative arrangements, procedures and systems capable of fulfilling all contractual requirements, pursuant to 42 CFR 438.608.

2. For purposes of this contract, the Health Plan shall not knowingly have an employment or contractual relationship or affiliation of the types addressed in 42 CFR 438.610, involving any individual, affiliate or entity that:

    a) is debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, pursuant to 42 CFR 438.610(a)(1);

    b) is excluded from participation in any Federal health care program undersection 1128 or 1128A of the Act, pursuant to 42 CFR 438.610(b);

    c) has been debarred, suspended or otherwise lawfully prohibited from participating in non-procurement activities under Section 103D-702, HRS;

d) has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, Title XX Services Programs or Title XXI Program in the last 10 years; or

e) has been excluded through Federal databases including, but not limited to, List of Excluded Individuals/Entities (LEIE), System for Award Management (SAM), or any such databases.

3. The Health Plan is responsible for operating its Health Plan in the State of Hawaii. The Health Plan shall be solely responsible for any additional charges associated with on-site audits or other oversight activities that result when required systems and operations are located outside of the State of Hawaii.

4. The Health Plan shall have an office on each island on which it provides services to at least 5,000 beneficiaries. The office shall be open during regular business hours (i.e., Monday to Friday 7:45 am to 4:30 pm, excluding State holidays) to provide face-to-face customer service to beneficiaries.

11.2 Staffing Requirements

A) *Staffing Table*

1. The following table (QI Staffing Table) contains a list of mandated QI staff and requirements regarding each staff position.

	Mandated QI Staff	**Requirements**				
	Position	**FTE or # of Positions**	**HI**	**Resume**	**References**	**Change Notification**

1	**Administrator/CEO/COO/ Executive Director**	1.0	✓	✓	✓	✓
2	**LTSS Director**	1.0	✓	✓	✓	✓
3	**Medical Director**	1.0	✓	✓	✓	✓
4	**Financial Officer/CFO**	0.5 to 1.0	✓	✓	✓	✓
5	**Quality Management Coordinator**	1.0	✓	✓	✓	✓
6	**Behavioral Health Coordinator**	1.0	✓	✓	✓	✓
7	**Pharmacy Coordinator/ Director/Manager**	1.0	✓	✓	✓	✓
8	**Prior Authorization/ Utilization Management/ Medical Management Director**	0 1.0	✓	✓	✓	✓
9	**Prior Authorization/ Utilization Management/ Medical Management/ Concurrent Review Staff**	Adequate to meet Contract requirements	✓			
10	**EPSDT Coordinator**	1.0	✓	✓		✓
11	**Member Services Director**	1.0	✓	✓	✓	✓
12	**Member Services Staff** (To include Call Center Staff)	Adequate to meet Contract requirements	✓			
13	**Special Health Care Needs Coordinator**	1.0	✓			
14	**CIS Coordinator**	1.0	✓			
15	**Service Coordinator Director**	1.0	✓	✓	✓	✓
16	**Service Coordinator Managers**	Adequate to meet Contract requirements	✓	✓		✓
17	**Service Coordinators**	Adequate to meet	✓			

		Contract requirements				
18	**Provider Services/Contract Manager**	1.0	✓	✓	✓	✓
19	**Provider Services/Contract Staff**	Adequate to meet Contract requirements	✓			
20	**Claims Administrator/Manager**		✓			✓
21	**Claims Processing Staff**					
22	**Member Grievance Coordinator**	0.5	✓	✓		✓
23	**Provider Grievance Coordinator**	0.5	✓	✓		✓
24	**Credentialing Program Coordinator**			✓		✓
25	**Business Continuity Planning and Recovery Coordinator**			✓		✓
26	**Compliance Officer**	1.0	✓	✓		✓
27	**Information Technology (IT) Director** or **Chief Information Officer** (CIO)	0.5 to 1.0		✓	✓	✓
28	**Data Analytics Officer**	0.5 to 1.0		✓		✓
29	**IT Hawaii Manager**		✓	✓		✓
30	**IT Staff**	Adequate to meet Contract requirements				

B) *Full-time Employment (FTE) Requirements*

1. Some positions have an FTE requirement. An FTE shall be defined as employment for at least 35 hours per week. The FTE indicates the amount of full-time work that must be dedicated, and

performed by one person, to satisfy the requirements of a position in order to meet the staffing requirement for purposes of this RFP.

2. Except as otherwise noted, a specific FTE or number of positions is/are not required. For each position having an FTE requirement, the Health Plan must submit to DHS, the FTE that each individual serving in said position, is assigned to perform work only toward that position as it relates to the QI program. This information shall be included in the Staffing Plan (discussed below), and in staffing change notifications (discussed below) submitted to DHS.

3. The Health Plan shall ensure that adequate staff is available and assigned to appropriate areas to fulfill the required functions specified in this contract. The Health Plan shall increase staffing in specific areas if determined by DHS that contractual requirements are not being met.

C) *State of Hawaii – Location of Residence and Work*

1. Positions with a checkmark in the "HI" column, must be filled by individuals residing and working in the State of Hawaii. The Health Plan shall submit to DHS, whether each individual serving in any such position, resides and works in the State of Hawaii. This information shall be included in the Staffing Plan (discussed below), and in staffing change notifications (discussed below) submitted to DHS.

2. There are two exceptions:

a) The Claims Administrator/Manager should be located in Hawaii. If this is not feasible, a manager residing and working in Hawaii must be able to address issues regarding claims during Hawaii business hours (ex., a Provider Services Manager). The Health Plan must have a Claims Administrator/Manager.

b) The requirement to have an IT Hawaii Manager is contingent upon the residence and work location of the IT Director/CIO. The IT Director/CIO does not need to reside in Hawaii. However, if the IT Director/CIO does not reside in Hawaii, the Health Plan must have an IT Hawaii Manager who resides and works in Hawaii. The Health Plan does not need to have an IT Hawaii Manager if the IT Director/CIO does reside in Hawaii.

D) ***Resumes***

1. For positions with a checkmark in the "Resume" column, the Health Plan shall submit to DHS, a current resume of each individual serving in any such position. Resumes shall be submitted to DHS as part of the Staffing Plan (discussed below), and with staffing change notifications (discussed below).

E) ***Professional References***

1. For positions with a checkmark in the "References" column, the Health Plan shall submit to DHS three (3) professional references. Such references shall be from previous employers and current Health Plan leadership, if needed. References shall be submitted to DHS as

part of the Staffing Plan (discussed below), and with staffing change notification (discussed below).

F) *Staffing Change Notification*

1. For positions with a checkmark in the "Change Notification" column, the Health Plan shall notify DHS in writing, within seven (7) days of learning of a change in the status of such positions. The submission to DHS of a completed Staffing Change Notification Form with all required attachments, will serve as written notification to DHS. If a position remains vacant at the time the written notification is submitted to DHS, the Health Plan shall provide the name, position title, and contact information of the interim employee within the written notification. As soon as the vacancy is filled, the Health Plan shall provide written notification to DHS of such staffing change, including the name of the individual filling the vacancy and other related information. Upon DHS request, the Health Plan shall provide a written plan for filling the vacant position, including expected timelines.
2. The Staffing Change Notification Form, the Staffing Change Notification Form Instructions, and the Staffing Change Notification Form Sample, are included as part of this RFP as Appendix T, respectively.
3. The Health Plan shall also submit an electronic staff directory with contact information to DHS. It must be updated monthly, or when staffing changes occur.

G) *Job Descriptions*

For each position listed in the QI Staffing Table, the Health Plan shall submit a job description to DHS for review and approval. The job description shall include the function, duties, and responsibilities of the position. The job description shall also include the minimum education, experience, and other position qualifications required. Job descriptions shall be submitted as part of the Staffing Plan (discussed below), and updated with DHS as significant changes to a job description occur.

H) *Staffing Plan and Training Plan*

1) Overview

a) The Health Plan shall ensure that all staff have the necessary qualifications (i.e., education, skills, experience, and licenses) to fulfill position requirements and duties. The Health Plan shall conduct initial and ongoing training of its staff to ensure the staff is knowledgeable, capable, and prepared to perform work to quality standards, and fulfill the obligations of this contract.

2) Staffing Plan

a) The Staffing Plan shall provide the Health Plan's staffing for the QI line of business, and all other staffing information necessary to demonstrate compliance with Section 11 and Section 12. It shall include a table that matches each required QI RFP position to the corresponding Health Plan position which meets the QI RFP

staffing requirement. The table shall provide: the names and titles of all individuals serving in each required position or staff category; the FTE each individual will serve in the position held (if applicable); and whether each individual resides and works in the State of Hawaii (if applicable).

b) Additionally, all resumes (if applicable) and all job descriptions shall be submitted as part of the Staffing Plan. However, the resumes and job descriptions may be provided as attachments to the Staffing Plan table described above.

3) Training Plan

a) The Training Plan shall include a description of the Health Plan's systems and procedures to ensure employees are appropriately trained and informed to perform job duties, and the processes in place that will assure rapid responsiveness to effect change for contract compliance.

11.3 Position Descriptions

Administrator/CEO/COO/Executive Director:
The Health Plan shall have at least one dedicated employee (e.g., Administrator, Chief Executive Officer, Chief Operating Officer, Executive Director, etc.) who has clear authority over the general administration and day-to-day business activities of this RFP.

LTSS Director:

The Health Plan shall have one dedicated employee responsible for long term services and supports (both institutional and non-institutional LOC).

Medical Director:

The Health Plan shall have on staff a Medical Director licensed to practice medicine in the State of Hawaii. The Medical Director shall oversee the quality of care furnished by the Health Plan and ensure care is provided by qualified medical personnel. The Medical Director shall address any potential quality of care problems and direct QAPI activities. The Medical Director shall work closely with the MQD Medical Director and participate in DHS Medical Director meetings, Provider Advisory Board meetings and any committee meetings relating to the programs when requested by DHS.

Financial Officer/CFO:

The Health Plan shall have a Financial Officer/CFO who is responsible for all accounting and finance operations, including all audits related to Fraud, Waste and Abuse, and value-based payment arrangements.

Quality Management Coordinator:

The Health Plan shall have a Quality Management Coordinator or Quality Management Director who is responsible for all quality improvement activities. This person shall be a physician or registered nurse licensed in the State of Hawaii.

Behavioral Health Coordinator:

The Behavioral Health Coordinator shall be responsible for all behavioral health services, including all the requirements described in the Stepped

Care for Behavioral Health section (Section 3.6) supporting the CSC system, and all other behavioral health requirements described in Sections 3 and 4. This person shall be a physician, psychologist, registered nurse (may have additional training, e.g., advanced practice nurse practitioner), or licensed clinical social worker licensed in the State of Hawaii with experience related to the behavioral health population.

Pharmacy Coordinator/Director/Manager:

The Health Plan shall have an employed or contracted Pharmacy Coordinator/Director/Manager. This person shall be a licensed pharmacist in the State of Hawaii and shall serve as a contact for the Health Plan's providers, pharmacists, and beneficiaries.

Prior Authorization/Utilization Management/Medical Management Director:

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, to include UM line personnel. In addition, this person shall be responsible for overseeing the training and work of all line personnel performing these functions.

EPSDT Coordinator:

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.

Member Services Director:

The Health Plan shall have a Member Services Director who is responsible for all member service activities including, but not limited to, call center staffing, member handbook updates, and translation activities. In addition, this person shall oversee the training and work of all line personnel performing member service functions.

SHCN Director:

The Health Plan shall have an SHCN Director who is responsible for overseeing all Care Coordination activities. This person shall serve as the liaison to the State of Hawaii for these activities. The SHCN Director shall oversee the training and work of all staff performing Care Coordination functions and oversee all delegated Care Coordination activities. The Director should be either a registered nurse, licensed social worker, or experienced with serving SHCN and SHCN+ beneficiaries.

CIS Coordinator:

The health plan will have a coordinator for CIS.

Service Coordinator Director:

The Health Plan shall have a Service Coordinator Director who is responsible for overseeing all Service Coordination activities. The person shall serve as the liaison to the State of Hawaii for these activities. The Service Coordination Director shall oversee the training and work of all staff performing Service Coordination functions and oversee all delegated Service Coordination activities. The Director should be either a registered nurse, licensed social worker, or experienced with serving individuals who receive Service Coordination.

Provider Services/Contract Manager:

The Health Plan shall have a Provider Services/Contract Manager who is responsible for the provider network activities and provider education. This person shall oversee the training and work of all line personnel performing provider service functions.

Member Grievance Coordinator:

The Health Plan shall have a Member Grievance Coordinator who is responsible for, and oversees, all member grievance system activities.

Provider Grievance Coordinator:

The Health Plan shall have a Provider Grievance Coordinator who is responsible for, and oversees, the provider grievance and appeals system.

Compliance Officer:

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.

Information Technology (IT) Director/Chief Information Officer (CIO):

The Health Plan shall have an Information Technology (IT) Director/Chief Information Officer (CIO) who is responsible for all IT activities.

Data Analytics Officer:

The Health Plan shall have a Data Analytics Officer to support and oversee all data analytics activities of the contract including but not

limited to the implementation of sophisticated predictive analytic tools to identify target populations for various programs, conducting disparities and trend analyses, informing the incorporation and use of SDOH data into clinical and administrative data, operationalizing non-standard performance and quality metrics, and supporting the reporting and evaluation needs of the Contract.

IT Hawaii Manager:

As stated above in the QI Staffing Table, if the IT Director/CIO does not reside in the State of Hawaii, the Health Plan must have an IT Hawaii Manager who resides and works in the State of Hawaii.

SECTION 12 – Program Integrity

12.1 Procedures and Requirements to Detect and Prevent Fraud, Waste, and Abuse

A) *General Administrative and Management Compliance Program Requirements*

1. Pursuant to 42 CFR Part 455 (Program Integrity: Medicaid) and 42 CFR 438 Subpart H (Additional Program Integrity Safeguards), the Health Plan and subcontractors, to the extent that the subcontractor can be delegated responsibilities, shall have a compliance program and internal controls and policies, procedures and practices in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities. This should include a description of the specific controls in place for prevention and detection from potential or suspected fraud and abuse, such as: claims edits, post-processing review of claims, prior authorization, written provider and member material regarding fraud and abuse referrals.

2. The Health Plan shall have a Compliance Officer, who is responsible for the compliance program required under 42 CFR 438.608. This includes compliance with sufficient staffing in accordance with Section 11 and resources to identify and investigate unusual incidents and develop and implement corrective action plans to assist the Health Plan in preventing and detecting potential fraud and abuse activities. The Health Plan shall describe its organizational structure, identifying personnel roles and responsibilities for preliminary investigation(s) of provider fraud and abuse. The Health Plan's fraud

and abuse activities shall comply with the program integrity requirements outlined in 42 CFR 438.608.

3. The Health Plan and all subcontractors shall cooperate fully with Federal and State agencies, to include but not be limited to DHS and the Secretary of DHHS, in investigations and subsequent legal actions. Such cooperation shall include providing, upon request, information, access to records, access to claims, and access to Health Plan employees and consultants for interviews including but not limited to: those with expertise in the administration of the program and/or medical or pharmaceutical matters, or those who are in any matter related to an investigation.

B) ***Investigating Suspected Fraud, Waste and Abuse***

1. All suspected fraud and abuse committed by a member should be reported to the appropriate entity. The Health Plan shall report eligibility fraud affecting medical assistance to the Investigations Office (INVO) of DHS. The reporting shall be done either through written notification or a telephone call to the INVO Hotline.

2. The Health Plan shall report member fraud for circumstances such as fraudulently obtaining controlled substances, other medical services, or collusion between provider and member to obtain services, to DHS after a preliminary investigation is complete.

3. If the Health Plan becomes aware of suspected fraud, waste or abuse from any source or identifies any questionable practices, it shall conduct a preliminary investigation. Criminal intent to commit fraud is not determined by either DHS or the Health Plan. Based on all the

evidence gathered, DHS or the Health Plan only determines that an identified activity has the potential to be fraudulent and is likely not the result of an unintentional error. Health Plans are required to report all plausible incidences of suspected fraud or abuse to DHS within fourteen (14) calendar days of making such a determination. It is possible the Health Plan may need to report the suspected activity immediately, such as when patient safety is at risk, evidence is being destroyed, or there is ongoing significant monetary loss.

4. The Health Plan shall use the report form provided by DHS to report or refer suspected cases of Medicaid fraud or abuse. At a minimum, this form shall require the following information for each case:

    a) Subject (Name and ID number);

    b) Source of complaint;

    c) Type of provider;

    d) Health Plan contact;

    e) Contact information for Health Plan staff with practical knowledge of the workings of the relevant programs;

    f) Date reported to state;

    g) Description of suspected intentional misconduct, with specific details:

        1. Category of service.

        2. Factual explanation of the allegation. (The Health Plan should provide as much detail as possible concerning the names, positions and contact information of all relevant persons; a complete description of the alleged scheme as

it is understood by the HP, including, when possible, one or more examples of specific claims that are believed to be fraudulent; the manner in which the HP came to learn of the conduct; and the actions taken by the HP to investigate the allegations.)

3. Date(s) of conduct. (When exact dates are unknown, the HP should provide its best estimate.)

h) Specific statutes, rules, regulations, or policies violated includes all applicable Federal/Medicaid violations as well as Health Plan policy violations;

i) Amount paid to the provider during the past 3 years or during the period of the alleged misconduct, whichever is greater;

j) Sample/exposed dollar amount when available;

k) Legal and administrative disposition of the case; and

l) Copies of any and all communications between the Health Plan and the provider concerning the conduct at issue (including, provider enrollment documentation, and any education given to the provider as a result of past problems; as well as advisory bulletins, policy updates, or any other general communication to the provider community regarding questionable behavior. Letters, emails, faxes, memos, and phone logs are all sources of communication).

5. In addition to the information required on the form, this report shall include any and all evidence obtained in the preliminary investigation including but not limited to, copies of claims and medical records reviewed, summary of interviews conducted, and copies of audit results or review board determinations.

6. Once the Health Plan has determined the activity has the potential to be fraudulent, it shall not contact the provider who is the subject of the investigation about any matters related to the investigation, enter in an attempt to negotiate any settlement or agreement, or accept any item of monetary value or otherwise offered by the provider who is the subject of the investigation in connection with the incident.

C) ***Prompt Reporting of Overpayments to Providers and Recoveries made by Health Plans and***

1. The Health Plan shall recover or report all overpayments. "Overpayment" as used in this section is defined in 42 CFR 438.2. All overpayments identified by the Health Plan shall be reported to DHS in accordance with Section 6.3. The overpayment shall be reported in the reporting period in which the overpayment is identified. It is understood the Health Plan may not be able to complete recovery of overpayment until after the reporting period. The Health Plan must report to DHS the full overpayment identified.

2. The Health Plan may negotiate and retain a lesser repayment amount with the provider; however, the full overpayment amount will be used when setting capitation rates for the Health Plan. The Health Plan shall have in place a process for providers to report to the Health Plan when it has received an overpayment, and a process for the provider to return the overpayment to the Health Plan within 60 calendar days after the date on which the overpayment was identified. The Health Plan shall require the provider to notify the Health Plan in writing of the reason for the overpayment. DHS, or its contractor, may recover

any overpayments made to the Health Plan, and the method of recovery shall be determined by DHS.

3. The Health Plan shall also report annually to DHS on all recoveries as described in Section 6.2(F) and 6.3(B). This report shall specify overpayments identified as fraud, waste, and abuse. The Health Plan shall check the reporting of overpayments recoveries for accuracy and shall provide such accuracy reports to DHS upon request. The Health Plan shall certify that the report contains all overpayments and those overpayments are reflected in encounter data submitted to DHS as described in Section 6.5, and list these overpayments as itemized recoveries in reports submitted to DHS.

4. The Health Plan is prohibited from recovering overpayments that are being investigated by the State, are the subject of pending Federal or State litigation or investigation, or are being audited by the Hawaii Recovery Audit Contractor (RAC) or other State contracted auditor. Once the Health Plan receives notice from DHS or other State or Federal agency of such action, the Health Plan shall cease any ongoing recovery efforts and coordinate with the notifying agency.

5. If DHS determines there is a credible allegation of fraud against a provider, payments to the provider must be suspended absent a good cause exception. DHS will be responsible for the determination of a credible allegation of fraud and any good cause exception. DHS will notify the Health Plan in writing if payments to a provider are to be suspended and the effective date of the payment suspension. The Health Plan shall have in place policies and controls to prevent payments to providers under payment suspension. DHS will notify the Health Plan in writing if the payment suspension may be terminated. If the Health Plan fails to suspend payments to a provider

after being notified in accordance with this section, any payments made to the provider during the effective suspension may be recovered from the Health Plan, and sanctions may be imposed in accordance with Section 14.20.

6. DHS will conduct meetings regarding program integrity, fraud, waste and abuse. The Health Plan shall participate in meetings with state Program Integrity, Investigations or Fraud Control personnel and with other Health Plan compliance staff.

D) *Compliance Program integrity requirements set forth at 438.608*

1. The Health Plan shall have a written fraud and abuse compliance plan that shall include program goals and objectives, program scope, and 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.

2. At a minimum, the Health Plan's fraud and abuse compliance plan shall:

    a) Require the reporting of suspected and/or confirmed fraud and abuse be done as required in Section 6.2(B);

    b) Submit timely Health Plan disclosures in accordance with Section 6.2(F);

c) 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;

d) Have processes in place to monitor all providers and their officers/directors/agents/managing employees as described in Sections 8.1(A) and 8.2;

e) Require the designation of a Compliance Officer and a compliance committee that are accountable to senior management;

f) Ensure and describe effective training and education for the Compliance Officer and the organization's employees;

g) Ensure that providers and members are educated about fraud and abuse identification and reporting, and include information in the provider and member material;

h) Ensure effective lines of communication between the compliance officer and the organization's employees;

i) Ensure the enforcement of standards through well-publicized disciplinary guidelines;

j) 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;

k) Possess written policies, procedures and standards of conduct that articulate the organization's commitment to comply with all Federal and State standards related to Medicaid managed care organizations;

l) Ensure that no individual who reports Health Plan violations or suspected fraud and abuse is retaliated against;

m) 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:

1. Monitoring the billings of its providers to ensure members receive services for which the Health Plan is billed;

2. Requiring the investigation of all reports of suspected fraud and over billings (upcoding, unbundling, billing for services furnished by others, and other overbilling practices);

3. Reviewing providers for over-utilization or under-utilization;

4. Verifying with members the delivery of services as claimed; and

5. Reviewing and developing mechanisms to track consumer complaints on providers;

n) Ensure that all suspected instances of internal and external fraud and abuse relating to the provision of, and payment for, Medicaid services including, but not limited to, Health Plan employees/management, providers, subcontractors, vendors, be reported to DHS. Additionally, any final resolution reached by the Health Plan shall include a written statement that provides notice to the provider that the resolution in no way binds the State of Hawaii or the Federal government nor precludes the State of Hawaii or the Federal government from

taking further action for the circumstances that brought rise to the matter; and

o) Ensure that the Health Plan shall cooperate fully in any investigation by federal and state oversight agencies and Federal and State law enforcement agencies and any subsequent legal action that may result from such an investigation.

3. The Health Plan shall submit its Compliance plan for DHS review in accordance with Section 13.3(B), Readiness Review.

E) *Employee Education About False Claims Recovery*

1. The Health Plan shall comply with all provisions of Section 1902(a)(68) of the Social Security Act as it relates to establishing written policies for all employees (including management), and for any subcontractor or designee of the Health Plan, that includes the information required by Section 1902(a)(68) of the Social Security Act.

F) *Child and Adult Abuse Reporting Requirements*

1. The Health Plan shall report all cases of suspected child abuse to the Child Welfare Services Branch of the Social Services Division of DHS, and all suspected dependent adult abuse to the Adult Protective and Community Services Branch of the Social Services Division of DHS as required by State and Federal statutes.

2. The Health Plan shall ensure that its network providers report all cases of suspected child abuse to the Child Welfare Services Branch

of the Social Services Division of DHS, and all suspected dependent adult abuse to the Adult Protective and Community Services Branch of DHS as required by State and Federal statutes.

12.2 Verification of Services (VOS) and Electronic Visit Verification (EVV)

A) *Verification of Services (VOS)*

1. Verification of Services (VOS) billed by providers and actually received by beneficiaries is required by 42 CFR 455.20. The VOS shall include a summary of the claim(s) or explanation of benefits for the month prior to mailing.

2. The Health Plan shall include in each VOS a cover letter explaining the document, providing a telephone number for the member to call if they did not receive the services. All written communication shall comply with Section 9.4(D).

3. Whether the method of verification is by explanation of benefits or a summary of the claim(s), the verification shall include the service furnished, name of the provider furnishing the service, date on which service was furnished and amount of payment made to the provider for the service. The Health Plan shall encourage members to respond to the VOS by calling the Health Plan if the billing information is not correct.

4. The Health Plan shall send by mail VOS each month to at least twenty-five percent (25%) of their members who received services. The Health Plan shall randomly select members who received inpatient, outpatient, HCBS, prescription drugs, and institutional services (i.e., nursing facility) at least forty-five (45) days after the claim(s) was submitted.

5. If a member responds that the service was not received or provided, the Health Plan shall report this finding to their fraud and abuse staff. Once received by the fraud and abuse staff, steps should be initiated by the Health Plan to investigate accuracy of information provided by the member. The Health Plan shall report information on their VOS program as part of their fraud and abuse program in a format to be described in Section 6.2(F)

B) ***Electronic Visit Verification (EVV)***

1. The 21st Century Cures Act (Section 12006(a)(1)(A)), passed by Congress in December 2016, requires states to implement Electronic Visit Verification (EVV). This new law requires states to have an EVV system to electronically capture point of service information for personal care services (PCS) and home health care services (HHCS).

2. At a minimum, the EVV system must be able to electronically capture these six (6) data points:
    a) Type of service performed
    b) Individual receiving the services
    c) Date of service
    d) Location of service delivery at beginning and end

e) Individual providing the service
f) Time the service begins and ends

3. MQD plans to deploy an Open Vendor Model in the state of Hawaii. This model has the following characteristics:

a) MQD will contract statewide with a single EVV vendor for both the EVV data capture services (for PCS and HHCS) and a mandated data aggregator;
b) This statewide EVV vendor will be an option available for use by providers and Health Plans in Hawaii. This EVV vendor will offer a data capture system;
c) Providers and Health Plans may choose to use an alternate EVV vendor. Providers and Health Plans choosing to use an alternate system will incur any and all related costs, including costs related to system requirements necessary to transmit data to/from the statewide EVV vendor data aggregator;
d) Med-QUEST will fund the development, maintenance, and operation of the statewide EVV vendor;
e) Health Plans will be required to submit PCS and HHCS prior authorization information to the statewide EVV vendor. Health Plans will be required to validate, with the statewide EVV vendor data aggregate, that the six (6) EVV data points have been captured as a pre-payment edit prior to PCS and HHCS claim payment; and
f) There will be minimal functional requirements for alternate EVV vendors.

SECTION 13 – Readiness Review and Contract Implementation Activities

13.1 Overview

DHS is committed to ensuring the Health Plan is prepared and able to serve as a good administrator of the Medicaid managed care program. DHS and the Health Plan will engage in detailed Readiness Review and contract implementation activities beginning immediately after contract award through Date of Commencement of Services to Members, or a different period as determined by DHS. The readiness review may be conducted in phases at the discretion of DHS. The readiness review shall include all areas identified in 42 C.F.R. 438.66 and others to be identified by DHS.

13.2 DHS Responsibilities

Prior to the Date of Commencement of Services to Members as described in Section 1.5, DHS or its agent shall conduct a readiness review of the Health Plan in accordance with 42 CFR 438.66 in order to provide assurances that the Health Plan is able and prepared to perform all administrative functions required by this contract and to provide high quality service to members.

Based on the results of the review activities, DHS shall provide the Health Plan with a summary of findings including the identification of areas requiring corrective action before DHS shall enroll Members in the Health Plan.

If the Health Plan is unable to demonstrate its ability to meet the requirements of the contract, as determined by DHS, within the time frames specified by DHS, DHS may postpone availability for enrollment or terminate the contract.

A Health Plan's failure to pass the readiness review thirty (30) calendar days prior to the beginning of service delivery may result in the assessment of financial penalties against the Health Plan, delayed operations and/or immediate Contract termination.

13.3 Health Plan Responsibilities

A) *Overview and Scope of Readiness Review*

The Health Plan shall comply with all readiness review activities at the Health Plan or Subcontractor facilities required by DHS. As requested by DHS, the Health Plan shall require participation of Subcontractors in readiness review activities. The scope of the desk and onsite readiness review activities conducted by DHS will include, but will not be limited to, review and/or verification of the Health Plan's progress on the following:

1) Submission of all required review documents;
2) A walk-thru of the Health Plan's operations/administration;
3) A walk-thru of the Health Plan's Subcontractors' operations;
4) Operational readiness of subcontractors, including system readiness and demonstrations;
5) Health Plan Information Systems readiness and demonstrations;

6) Interviews with Health Plan and Subcontractor staff;
7) Statewide provider network composition and access;
8) Staffing plan and hiring and training of staff;
9) Transition of care plan;
10) Continuum of service providers;
11) Readiness of call centers;
12) Member education and outreach;
13) Provider education and outreach;
14) Policies and procedures required under the terms of the Contract, including grievance and appeals;
15) Care Coordination system;
16) Provision of services to all populations, including LTSS;
17) Quality Assessment and Performance Improvement (QAPI) program standards;
18) Utilization Management program; and
19) Submission of updates on implementation activities.

B) ***Readiness Review***

The Health Plan shall submit all required review documents identified in the table below by the required due date. The DHS reserves the right to request additional documents for review and approval during readiness review. DHS will provide due dates for additional documents at the time of the request.

Document	RFP Reference Section	Due Date
Selection and retention of providers policies and procedures	8.1(A)(13)	30 days after contract effective date
Availability of providers policies and procedures	8.1(C)(4)	30 days after contract effective date
PCP policies and procedures	8.1(E)(11)	30 days after contract effective date
Credentialing, re-credentialing and other certification policies and procedures	8.2(A)(10)	60 days after contract effective date
Model for each type of provider contract	8.3(A)(4)	10 days after contract effective date
The signature page of all finalized and executed contracts that have not been previously submitted	8.3(A)(5)	The last day of every month from contract effective date to 60-days prior to Date of Commencement of Services to Members
Provider education materials	8.4(A)(5)	At least 60 days prior to use of materials
Provider grievance and appeals system policies and procedures	8.4(B)(4)	75 days after contract effective date
Provider manual	8.4(C)(4)	30 days after contract effective date
Provider call center policies and procedures	8.4(D)(7)	60 days after contract effective date
Provider web-site screen shots	8.4(E)(4)	60 days after contract effective date
Access to provider web-site	8.4(E)(4)	60 days after contract effective date

Document	RFP Reference Section	Due Date
Web-site (member and provider portals) update policies and procedures	8.4(E)(3)	60 days after contract effective date
Self-Direction policies and procedures	3.7(M)(29)	60 days after contract effective date
CSC System Requirements	3.7	Guidance forthcoming
Stepped Care Approach	3.6	Guidance forthcoming
Assessment process	3.7	Guidance forthcoming
EPSDT plan	4.3(A)(3)	60 days after contract effective date
Cultural competency plan	4.9(A)(3)	60 days after contract effective date
Prevention and Health Promotion program policies and procedures	3.5(F)	90 days after contract effective date
Transition of care policies and procedures	9.3(C)(1)	60 days after contract effective date
Member Survey	9.2(B)(3)	30 days after contract effective date
Member Services policies and procedures	9.4(A)(7)	30 days after contract effective date
Member education materials, including the training plans and curricula	9.4(B)(4)	90 days after contract effective date
Translation Certification	9.4(C)(5)	Within 60 days of DHS approval of English versions of documents
Oral Interpretation and Translation of Materials policies and procedures	9.4(D)(7)	60 days after contract effective date

Document	RFP Reference Section	Due Date
Member handbook	9.4(E)(5)	30 days after contract effective date
Sample member ID card	9.4(H)(3)	30 days after contract effective date
Member Call Center policies and procedures	9.4(I)(10)	60 days after contract effective date
Member web-site screen shots	9.4(J)(10)	60 days after contract effective date
Access to member web-site	9.4(J)(10)	60 days after contract effective date
Marketing materials	9.6(C)-(D)	60 days after contract effective date
QAPI Plan (including SDOH and HIT Work Plan)	5.1(B)	60 days after contract effective date
Request for delegation of QAPI Program functions or activities (if applicable)	5.1(B)(7)	90 days after contract effective date
Medical records standards	5.3(A)(6)	60 days after the Date of Commencement of Services to Members
Practice guidelines policies and procedures, and a list of all current practice guidelines	5.1(B)(6)	60 days after the Date of Commencement of Services to Members
UMP description, corresponding workplan, and UMP policies and procedures	5.2(A)(3)	60 days after the Date of Commencement of Services to Members
Prior authorization/pre-certification policies and procedures	5.2(B)(1)	60 days after the Date of Commencement of Services to Members

Document	RFP Reference Section	Due Date
Grievance and appeals system policies and procedures	9.5(A)	60 days after the Date of Commencement of Services to Members
Documentation describing Health Plan disaster planning and recovery operations	10.2(H)(2)	90 days after the Date of Commencement of Services to Members
Compliance plan	12.1(D)(3)	60 days after the Date of Commencement of Services to Members
Updated Staffing and Training Plan	11.1(H)	30 days after the Date of Commencement of Services to Members
A GIS (or comparable program) report	6.3(D)(2)	30 days after contract effective date and every day thereafter until sixty (60) days prior to the Date of Commencement of Services to Members
Subcontractor agreements	14.4	30 days after the Date of Commencement of Services to Members
Contract termination procedures	14.15(D)	120 days after the Date of Commencement of Services to Members

13.4 RFP Implementation Timeframes

The Health Plan and DHS have timelines for implementation of processes prior to and after commencement of services to members. This section is a central location that compiles these processes for ease of implementation.

Document/Requirement	Due Date	Responsible Party
Prior to commencement of services to members		
"At risk" criteria	30-days	DHS
CSC template plan format	30-days	DHS
Grievance system templates	30-days	DHS
QI memoranda	30-days	DHS
"At risk" limits	30-days	DHS
Expedited appeal procedures	30-days	DHS
Appeal procedures for sanctions	30-days	DHS
Submission of marketing materials	30-days	Health Plan
Enrollment limit for auto-assignment	30-days	Health Plan
Enrollment cap for auto-assignment	30-days	DHS
DHS remotely monitor member call center	30-days	DHS/ Health Plan
After commencement of services to members – one time		
Quality-based component of auto-assignment		DHS
After commencement of services to members -annual		
Update certificate of insurance	Within 30 days of contract execution	Health Plan
Enrollment limit for auto-assignment	90-days prior to APC	Health Plan
Enrollment cap for auto-assignment	90-days prior to APC	DHS
Submission of marketing materials	45-days prior to APC	Health Plan
Update performance bond	60 days after start of new benefit period	Health Plan

SECTION 14 – Special Terms and Conditions

14.1 Overview

The following documents form an integral part of the written contract between the Health Plan and DHS (hereafter collectively referred to as "the Contract"):

1. Contract for Health and Human Services: Competitive Purchase of Service (AG Form 103F1 (10/08)) (see Appendix S), including General Conditions for Health & Human Services Contracts (AG Form 103F (10/08) (see Appendix S), any Special Conditions, attachments, and addenda;
2. this RFP, appendices, attachments, and addenda, which shall be incorporated by reference; and
3. the Health Plan's technical proposal submitted in response to this RFP form, which shall be incorporated by reference.

References to "General Conditions" in this Section 14 are to the General Conditions for Health & Human Services Contracts attached as Appendix S.

14.2 Conflict between Contract Documents, Statutes, and Rules

Replace General Condition 7.5, Conflict between General Conditions and Procurement Rules, with the following:

1. Contract Documents: In the event of a conflict among the Contract documents, the controlling order of precedence shall be

as follows: (1) Contract for Health and Human Services: Competitive Purchase of Service (AG Form 103F1), including all general conditions, special conditions, attachments, and addenda; (2) the RFP, including all attachments and addenda, as amended; and (3) applicant's proposal. In the event of a conflict between the General Conditions and the Special Conditions, the Special Conditions shall control.

2. Contract and Statutes: In the event of a conflict between the language of the Contract, and applicable statutes, the statute shall prevail.
3. Contract and Procurement Rules/Directives: In the event of a conflict between the Contract and the Procurement Rules or a Procurement Directive, the Procurement Rules or any Procurement Directive in effect on the date this Contract became effective shall control and are hereby incorporated by reference.
4. The sections of the rules and regulations cited in this RFP may change as the rules and regulations are amended for 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.

14.3 Licensing and Accreditation

General Condition 1.2.2, Licensing and Accreditation, is amended to read as follows:

At the time of submission of the applicant's proposal, the Health Plan shall be properly licensed as a Health Plan in the State of Hawaii as

described in chapters 431, 432, or 432D, HRS, and any other licenses and accreditations required under applicable federal, state, and county laws, ordinances, codes, rules, and regulations to provide the services under the Contract. The Health Plan shall comply with all applicable requirements set forth in the above mentioned statutes, and shall include with its proposal proof of licensure and a certificate of good standing from the DCCA Insurance Division dated within 30 days of the date of the proposal (see Section 15). In the event of any conflict between the requirements of the contract and the requirements of any these licensure statutes, the statute shall prevail and the Health Plan shall not be deemed to be in default of compliance with any mandatory statutory requirement.

14.4 Subcontractor Agreements

Replace General Condition 3.2, Subcontracts and Assignments, with the following:

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 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 in accordance with Section 13.3(B), Readiness Review. In addition, DHS reserves the

right to inspect all subcontractor agreements at any time during the Contract period.

The Health Plan shall notify DHS in writing at least ninety (90) days prior to adding or deleting subcontractor agreements or making any change to any subcontractor agreements which may materially affect the Health Plan's ability to fulfill the terms of the Contract.

The Health Plan shall provide DHS with immediate notice in writing by registered or certified mail of any action or suit filed against it by any subcontractor, and provide prompt notice of any claim made against the Health Plan by any subcontractor that, in the opinion of the Health Plan, may result in litigation related to, or otherwise impact in any way, the Contract the Health Plan has with the State of Hawaii.

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.

All subcontractor agreements must include all provisions that comply with 42 CFR §438.230, and:

1. Describe the activities, including reporting responsibilities, to be performed by the subcontractor and require that the subcontractor meet all established criteria prescribed and provide services in a manner consistent with the minimum standards specified in the Health Plan's Contract with the State;

2. Require that the subcontractor fulfill the requirements of 42 CFR 438.6 that are appropriate to the service delegated under the subcontract;
3. Provide information regarding member rights and processes regarding the Member Grievance System found in Section 9.5, if applicable;

4. Include a provision that allows the Health Plan to:
    a) Evaluate the subcontractor's ability to perform the activities to be delegated;
    b) Monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule (the frequency shall be stated in the agreement) established by DHS and consistent with industry standards or State laws and regulations;
    c) Identify the subcontractor's deficiencies or areas for improvement; and
    d) Take corrective action or impose other sanctions including, but not limited to, revoking delegation, if the subcontractor's performance is inadequate.
5. Require that the subcontractor submits to the Health Plan a tax clearance certificate from the Director of the DOTAX, State of Hawaii, showing that all delinquent taxes, if any, levied or accrued under State law against the subcontractor have been paid;
6. Include a provision that the Health Plan shall designate itself as the sole point of recovery for any subcontractor;

7. Include a provision that neither the State nor the Health Plan members shall bear any liability of the Health Plan's failure or refusal to pay valid claims of subcontractors;
8. Require that the subcontractor track and report complaints against itself to the Health Plan;
9. 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;
10. Require that the subcontractor follow all audit requirements as outlined in Section 14.17. The actual requirements shall be detailed in the agreement;
11. Require that the medical records be retained in compliance with Section 14.5. The actual requirements shall be detailed in the agreement;
12. Require that the subcontractor comply with all requirements related to confidentiality of information as outlined in Section 14.16. The actual requirements found in this section shall be detailed in the agreement.
13. 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 shall be within two (2) business days of discovery of the breach and a written report of the investigation and resultant mitigation of the breach shall be provided to the State within thirty (30) calendar days of the discovery of the breach.
14. Require that the subcontractor allow the state and federal government full access to audit, evaluate, and inspect any books, records, contracts, documents,

computer or other electronic system that pertain to any aspect of services and activities performed, or determination of amounts payable under the Health Plan's contract with DHS.

15. Require that the subcontractor make available its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Medicaid enrollees for the purposes of an audit, evaluation, or inspection by the state or federal government.
16. Require that the subcontractor comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions.
17. Submit data in standard claims submission formats on all services provided, and be subject to accuracy, completeness, timeliness, and other requirements described in Section 6.5.

14.5 Retention of Medical Records

The following is added to the end of General Condition 2.3, Records Retention:

The Health Plan and its providers shall retain all medical records, in accordance with 42 CFR 438.3(h), for a minimum of ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later. For minors, the Health Plan shall retain all medical records during the period of minority plus a minimum of ten (10) years after the age of majority.

The Health Plan shall include in its subcontracts and provider agreements record retention requirements that are at least equivalent to those stated in this section.

During the period that records are retained under this section, the Health Plan and any subcontractor or provider shall allow the state and federal government full access to inspect and audit any records or documents, and inspect the premises physical facilities, and equipment where Medicaid-related activities or work is conducted, to the extent allowed by law.

14.6 Responsibility for Taxes

In addition to the requirements of General Condition 3.4.4, PROVIDER's Responsibilities, subject to its corporate structure, licensure status, or other statutory exemptions, Health Plans may be liable for, or exempt from, other federal, state, and/or local taxes including, but not limited to, the insurance premium tax (chapter 431, Article 7, Part II, HRS). Each Health Plan is responsible for determining whether it is subject to, or exempt from, any such federal, state, or local taxes. DHS makes no representations whatsoever as to the liability or exemption from liability of the Health Plan to any tax imposed by any governmental entity.

14.7 Full Disclosure

A) *Business Relationships*

The Health Plan warrants that it has fully disclosed all business relationships, joint ventures, subsidiaries, holding companies, or any

other related entity in its proposal and that any new relationships shall be brought to the attention of DHS as soon as such a relationship is consummated. The terms and conditions of CMS require full disclosure on the part of all contracting Health Plans and providers.

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 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.

B) ***Litigation***

The Health Plan shall disclose any pending litigation both in and out of Hawaii to which they are a party, including the disclosure of any outstanding judgment.

14.8 Conflict of Interest

The following is added to the end of General Condition 1.7, Conflicts of Interest:

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 Chapter 84, HRS, Standards of Conduct.

The Health Plan shall not contract with the State of Hawaii unless the conflict of interest safeguards described in 42 CFR §438.58 and in Section 27 of the Office of Federal Procurement Policy Act (41 U.S.C § 423) are in place and complies with the requirement described in Section 1902 (a)(4)(c) of the Social Security Act, applicable to contracting officers, employees, or independent contractors.

14.9 Employment of State Personnel

The Health Plan shall not knowingly engage any persons who are or have been employed within the past twelve (12) months by the State of Hawaii to assist or represent the Health Plan for consideration in matters which he/she participated as an employee or on matters involving official action by the State agency or subdivision, thereof, where the employee had served.

14.10 Fiscal Integrity

A) *Warranty of Fiscal Integrity*

The Health Plan warrants that it is of sufficient financial solvency to assure DHS of its ability to perform the requirements of the Contract. The Health Plan shall comply with the solvency standards established by the State Insurance Commissioner for private health maintenance organizations or Health Plans licensed in the State of Hawaii, and shall, upon request by DHS, provide financial data and information to prove its financial solvency.

B) *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 the same to DHS prior to or at the time of the execution of the Contract. The performance bond shall be liable to forfeit by the Health Plan in the event the Health Plan is unable to properly, promptly and efficiently perform the contract terms and conditions or the Contract is terminated by default or bankruptcy of the Health Plan.

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 shall update their performance bond annually. The Health Plans shall submit to DHS a

revised performance bond no later than sixty (60) days after the start of the benefit period. The revised capitation payment shall be based upon the last capitation payment for the previous benefit period.

The Health Plan may, in place of the performance bond, provide the following in the same amount as the performance bond:

a) Certificate of deposit, share certificate, or cashier's, treasurer's, teller's or official check, or a certified check made payable to 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.
b) 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 DHS shall have the authority to, retain funds for additional costs including, but not limited to:

a) Any costs for a special plan change period necessitated by the termination of the Contract;

b) Any costs for services provided prior to the date of termination that are paid by MQD;
c) Any additional costs incurred by the State due to the termination; and
d) Any sanctions or penalties owed to DHS.

14.11 Term of the Contract

This is a multi-term contract solicitation that has been deemed to be in the best interest of the State by the Director of DHS in accordance with Section 3-149-302(c), HAR. The Contract is for the initial term from the date of commencement of services to members as specified in Section 1.5 to December 31, 2025. Unless terminated, the Contract may be extended without the necessity of re-bidding, for not more than four (4) additional twelve (12) month periods or parts thereof, only upon mutual agreement of the parties in writing. The Health Plan shall not contract with the State of Hawaii unless safeguards at least equal to Federal safeguards (41 USC 423) are in place.

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 shall 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, as allowed by law.

14.12 Liability Insurance Requirements

A) *Liability Insurance Requirements Generally*

The Health Plan shall maintain insurance acceptable to DHS in full force and effect throughout the term of this Contract, until DHS certifies that the Health Plan's work has been completed satisfactorily.

Prior to or upon execution of the Contract and any supplemental contracts, the Health Plan shall provide to DHS certificate(s) of insurance, including any referenced endorsements, dated within thirty (30) days of the effective date of the Contract necessary to satisfy DHS that the insurance provisions of this Contract have been complied with. Upon request by DHS, Health Plan shall furnish a copy of the policy(ies) and/or updated Certificate of Liability Insurance including referenced

endorsement(s) necessary for DHS to verify the coverages required by this section.

The policy or policies of insurance maintained by the Health Plan shall be written by insurance companies licensed to do business in the State of Hawaii or meet the requirements of Section 431:8-301, et seq., HRS, if utilizing an insurance company not licensed by the State of Hawaii.

The policy(ies) shall provide at least the following limit(s) and coverage:

Coverage	Limits
Commercial General Liability	Per occurrence, not claims made • $1 million per occurrence • $2 million in the aggregate
Automobile	May be combined single limit: • Bodily Injury: $1 million per person, $1 million per accident • Property Damage: $1 million per accident
Workers Compensation / Employers Liability (E.L.)	• Workers Comp: Statutory Limits • E.L. each accident: $1,000,000 • E.L. disease: $1,000,000 per employee, $1,000,000 policy limit • E.L. $1 million aggregate
Professional Liability, if applicable	May be claims made: • $1 million per claim • $2 million annual aggregate

Each insurance policy required by this Contract shall contain the following clauses, which shall also be reflected on the certificate of Insurance:

1. "The State of Hawaii is an additional insured with respect to operations performed for the State of Hawaii."
2. "Any insurance maintained by the State of Hawaii shall apply in excess of, and not contribute with, insurance provided by this policy."

Automobile liability insurance shall include excess coverage for the Health Plan's employees who use their own vehicles in the course of their employment.

The Health Plan shall immediately provide written notice to DHS should any of the insurance policies required under the Contract be cancelled, limited in scope, or not be renewed upon expiration.

Failure of the Health Plan to provide and keep in force the insurance required under this section shall be regarded as a material default under this Contract, entitling DHS to exercise any or all of the remedies provided in this Contract for a default of the Health Plan.

The procuring of such required policy or policies of insurance shall not be construed to limit the Health Plan's liability hereunder nor to fulfill the indemnification provisions and requirements of this Contract. Notwithstanding said policy or policies of insurance, the Health Plan shall be liable for the full and total amount of any damage, injury, or loss caused by the Health Plan in connection with this Contract.

If the Health Plan is authorized by DHS to subcontract, subcontractors are not excused from the indemnification and/or insurance provisions of this Contract. In order to indemnify the State of Hawaii, the Health Plan agrees to require its subcontractors to obtain insurance in accordance with this section.

B) ***Waiver of Subrogation***

Health Plan shall agree by entering into a contract with DHS to provide a Waiver of Subrogation for the Commercial General Liability, Automobile Liability, and Workers Compensation policies. When required by the insurer, or should a policy condition not permit the Health Plan to enter into a pre-loss agreement to waive subrogation without an endorsement, the Health Plan shall agree to notify the insurer and request the policy be endorsed with a Waiver of Subrogation in favor of DHS. This Waiver of Subrogation requirement shall not apply to any policy, which includes a condition specifically prohibiting such an endorsement, or voids coverage should Health Plan enter into such an agreement on a pre-loss basis.

14.13 Modification of Contract

The following is added as General Condition 4.1.4:

All modifications of the Contract may be negotiated and accompanying capitated rates established. Such modifications shall result in a supplemental agreement document produced by DHS and delivered to the Health Plan. If the parties are in agreement, the supplemental agreement document shall be signed by the Director of DHS and an authorized representative of the Health Plan. If the parties are unable to reach an agreement within thirty (30) calendar days of the Health Plan's receipt of the supplemental agreement document, the provisions of such Contract change will be deemed to have been accepted on the thirty-first (31st) calendar day after the Health Plan received the supplemental agreement document, even if the Contract change has not been signed by the Health Plan, unless within the thirty (30) calendar days after the Health Plan received the supplemental agreement

document, the Health Plan notifies DHS in writing that it refuses to sign the amendment. If the Health Plan provides such notification, DHS will initiate termination proceedings.

14.14 Conformance with Federal Regulations

Any provision of the Contract which is in conflict with Federal Medicaid statutes, regulations, or CMS policy guidance, is superseded to conform to the provisions of those laws, regulations, and federal policy. Changes shall be effective on the effective date of the statutes or regulations necessitating it, and shall be binding on the parties even though an amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

14.15 Termination of 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 S:

A. Termination for Default;
B. Termination for Expiration or Modification of the Programs by CMS; or
C. Termination for Bankruptcy or Insolvency

A) *Termination for Default*

The failure of the Health Plan to comply with any term, condition, or provision of the Contract or applicable requirements in Sections 1932,

1903(m) and 1905(t) of the Social Security Act shall constitute default by the Health Plan. In the event of default, DHS shall notify the Health Plan by certified or registered mail, with return receipt requested, as well as regular mail, of the specific act or omission of the Health Plan, which constitutes default. The Health Plan shall have fifteen (15) days from the date of receipt of such notification to cure such default. Regular mail is deemed received two days after mailing. In the event of default, and during the above-specified grace period, performance under the Contract shall continue as though the default had never occurred. In the event the default is not cured within fifteen (15) days, DHS may, at its sole option, terminate the Contract for default. Such termination shall be accomplished by written notice of termination forwarded to the Health Plan by certified or registered mail and shall be effective as of the date specified in the notice. 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 S.

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.

B) ***Termination for Expiration or Modification of the Programs by CMS***

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

DHS, DHS shall so notify the Health Plan by certified or registered mail, return receipt requested, as well as regular mail. Regular mail is deemed received two days after mailing. The termination shall be effective as of the date specified in the notice.

C) ***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, DHS may, at its option, terminate the Contract. In the event DHS elects to terminate the Contract under this provision it shall do so by sending notice of termination to the Health Plan by registered or certified mail, return receipt requested, as well as regular mail. Regular mail is deemed received two days after mailing. 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.

D) ***Procedure for Termination***

In the event the State decides to terminate the Contract, it shall provide the Health Plan with a pre-termination hearing. The State shall:

a) 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
b) 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 shall provide written notice to the Health Plan of the termination decision affirming or reversing the proposed termination. If the State decides to terminate the Contract, the notice shall include the effective date of termination. In addition, if the Contract is to be terminated, the State shall notify the Health Plan's members in writing of their options for receiving Medicaid services following the effective date of termination.

In the event of any termination, the Health Plan shall:

a) Stop work under the Contract on the date and to the extent specified in the notice of termination;
b) Complete the performance of such part of the work as shall not have been terminated by the notice of the termination;
c) Notify the members of the termination and arrange for the orderly transition to the new Health Plan(s), including timely provision of any and all records to DHS that are necessary to transition the Health Plan's members to another Health Plan;

d) Promptly supply all information necessary for the reimbursement of any outstanding claims;
e) Place no further orders or enter into subcontracts for materials, services, or facilities, except as may be necessary for completion of the work under the portion of the Contract that is not terminated;
f) Terminate all orders and subcontracts to the extent that they relate to the performance of work terminated by the notice of termination;
g) Assign to DHS in the manner and to the extent directed by the MQD Administrator the right, title, and interest of the Health Plan under the orders or subcontracts so terminated, in which case DHS shall have the right, in its discretion, to settle or pay any or all claims arising out of the termination of such orders and subcontracts;
h) With the approval of the MQD Administrator, settle all outstanding liabilities and all claims arising out of such termination of orders and subcontracts, the cost of which would be reimbursable, in whole or in part, in accordance with the provisions of the Contract;
i) Take such action as may be necessary, or as the MQD Administrator may direct, for the protection and preservation of any and all property or information related to the contract which is in the possession of the Health Plan and in which DHS has or may acquire an interest; and
j) Within thirty (30) business days from the effective date of the termination, deliver to DHS copies of all current data files, program documentation, and other documentation and procedures used in the performance of the Contract at no cost

to DHS. The Health Plan agrees that DHS or its designee shall have a non-exclusive, royalty-free right to the use of any such documentation.

k) Submit 100% of encounter data no later than 15 months following the end of the Contract term.

The Health Plan shall create written procedures for the orderly termination of services to any members receiving the required services under the Contract, and for the transition to services supplied by another Health Plan upon termination of the Contract, regardless of the circumstances of such termination. These procedures shall include, at the minimum, timely notice to the Health Plan's members of the termination of the Contract, and appropriate counseling. The Health Plan shall submit these procedures to DHS for review and approval in accordance with Section 13.3(B), Readiness Review.

E) *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:

a) At the Contract price(s) for the number of members enrolled in the Health Plan at the time of termination; and
b) At a price mutually agreed to by the Health Plan and DHS.

In the event the Health Plan and DHS fail to agree, in whole or in part, on the amount of costs to be paid to the Health Plan in connection with the total or partial termination of work pursuant to this section, the MQD Administrator shall determine, on the basis of information available to DHS, the amount, if any, due to the Health Plan by reason of the termination and shall pay to the Health Plan the amount so determined.

The Health Plan shall have the right to appeal any such determination made by the MQD Administrator as stated in Section 14.19.

14.16 Confidentiality of Information

In addition to the requirements of General Condition 8, the Health Plan understands that the use and disclosure of information concerning applicants, beneficiaries 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, beneficiary'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:

a) 42 CFR Part 431, Subpart F;
b) The Administrative Simplification provisions of HIPAA and the regulations promulgated thereunder, including but not limited to the Security and Privacy requirements set forth in 45 CFR Parts 160 and 164;Section 346-10, HRS; and
c) All other applicable federal and State statutes and administrative rules, including but not limited to:
    1. Section 325-101, HRS, relating to persons with HIV/AIDS;
    2. Section 334-5, HRS, relating to persons receiving mental health services;
    3. Chapter 577A, HRS relating to emergency and family planning services for minor females;
    4. 42 CFR Part 2 relating to persons receiving substance abuse services;
    5. Chapter 487J, HRS, relating to social security numbers; and
    6. Chapter 487N, HRS, relating to personal information.
    7. Session Laws of Hawaii, Act 139(16), relating to insurance.

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 U.S. Department of Health and Human Services (HHS), the Secretary, DHS and other individuals or entities as may be required by DHS. (See 42 CFR 431.300, et seq. and 45 CFR Parts 160 and 164.)

Any other party shall be granted access to confidential information only after complying with the requirements of state and federal laws, including but not limited to HIPAA, and regulations pertaining to such access. The Health Plan is responsible for knowing and understanding

the confidentiality laws listed above as well as any other applicable laws. The Health Plan, if it reports services to its members, shall comply with all applicable confidentiality laws. Nothing herein shall prohibit the disclosure of information in summary, statistical or other form that does not identify particular individuals, provided that de-identification of protected health information is performed in compliance with the HIPAA Privacy Rule.

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 Chapter 17-1702, HAR, 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.

Health Plans are business associates of DHS as defined in 45 CFR §160.103, and agree to the terms of the Business Associate Agreement (BAA) found in Appendix U.

14.17 Audit Requirements

The state and federal standards for audits of DHS designees, contractors and programs conducted under contract are applicable to this subsection and are incorporated by reference into the Contract. DHS, the HHS, the Secretary, CMS, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any records, inspect the premises, physical facilities, and equipment of the

Health Plan and its subcontractors, subcontractor's contractors, or providers where Medicaid-related activities or work is conducted. There shall be no restrictions on the right of the State or Federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services and reasonableness of their costs. The right to audit shall exist for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later.

A) *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. The Health Plan shall submit audited financial reports specific to this Contract to the DHS annually. The audit must be conducted in accordance w/ generally accepted accounting principles and generally accepted auditing standards.

B) *Inclusion of Audit Requirements in Subcontracts*

The provisions of Section 14.17 and its associated subsections shall be incorporated in every subcontract/provider agreement.

14.18 Ongoing Inspection of Work Performed

DHS, the State Auditor of Hawaii, the Secretary, the U.S. Department of Health and Human Services (HHS), CMS, 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, State of Hawaii, or their authorized representatives shall have the right to enter into the premises of the Health Plan, all subcontractors and providers, or such other places where duties under the Contract are being performed, to inspect, monitor, or otherwise evaluate the work being performed and have access to all records. All inspections and evaluations shall be performed in such a manner to not unduly delay work. This includes timely and reasonable access to the personnel for the purpose of interview and discussion related to the records. All records and files pertaining to the Health Plan shall be located in the State of Hawaii at the Health Plan's principal place of business or at a storage facility on Oahu that is accessible to the foregoing identified parties.

14.19 Disputes

The parties shall first attempt to resolve all disputes arising under this Contract by informal resolution. Where informal resolution cannot be reached, the Health Plan shall submit a written request for dispute resolution (by certified mail, return receipt requested) to the Director of

DHS or the Director's duly authorized representative. The Health Plan shall be afforded the opportunity to be heard and to present evidence in support of its position in the dispute. The Director of DHS or the Director's authorized representative shall issue a written decision within ninety (90) days of the Health Plan's written request. The decision of the Director of DHS or the Director's authorized representative shall be final and binding and may only be set aside by a State court of competent jurisdiction where the decision was fraudulent, capricious, arbitrary, or grossly erroneous as to imply bad faith.

Pending any subsequent legal proceedings regarding the final decision, including all appeals, the Health Plan shall proceed diligently in the performance of the Contract in accordance with the Director's final decision.

Any legal proceedings against the State of Hawaii regarding this RFP or any resultant contract shall be brought in a State court of competent jurisdiction in the City and County of Honolulu, State of Hawaii.

This dispute resolution section does not apply to the appeals of sanctions imposed under Section 14.20(B).

14.20 Liquidated Damages, Sanctions and Financial Penalties

A) *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.

DHS may withhold amounts for liquidated damages from payments to the Health Plan until such damages are paid in full.

B) *Sanctions*

DHS may impose sanctions for non-performance or violations of Contract requirements if DHS determines that a Health Plan acts or fails to act as follows:

a) Fails substantially to provide medically necessary services that the Health Plan is required to provide, under law or under its contract with the State, to an enrollee covered under the contract.

b) Imposes on enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.

c) Acts to discriminate among enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services.

d) Misrepresents or falsifies information that it furnishes to CMS or to the State.

e) Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider.

f) Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in §§ 422.208 and 422.210 of this chapter.

g) Has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information.

h) Has violated any of the other requirements of sections 1903(m) or 1932 of the Act, or any implementing regulations.

Sanctions shall be determined by the State and may include:

a) Imposing civil monetary penalties (as described below);
b) Suspending enrollment of new members with the Health Plan;
c) Suspending payment;
d) Notifying and allowing members to change plans without cause;
e) Appointment of temporary management (as described in Section 14.20(C)); or
f) Terminating the Contract (as described in Section 14.15).

The State shall give the Health Plan timely written notice that explains the basis and nature of the sanction as outlined in 42 CFR Part 438, Subpart I. The Health Plan may follow DHS appeal procedures to contest the penalties or sanctions.

The civil or administrative monetary penalties imposed by DHS on the Health Plan shall not exceed the maximum amount established by federal statutes and regulations.

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 furnished to the CMS or the State	A maximum of one hundred thousand dollars ($100,000) for each determination
2	Acts to discriminate among members on the basis of their health status or need for healthcare services	A maximum of one hundred thousand dollars ($100,000) for each determination
3	Failure to implement requirements stated in the Health Plan's proposal, the RFP or the contract, or other material failures in the Health Plan's duties, including but not limited to failing to meet readiness review or performance standards	A maximum of fifty thousand dollars ($50,000) for each determination
4	Substantial failure to provide medically necessary services that are required under law or under contract, to an enrolled member	A maximum of twenty-five thousand dollars ($25,000) for each determination
5	Imposition upon members' premiums and charges that are in excess of the premiums or charges permitted under the 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

Number	Activity	Penalty
8	Failure to comply with the requirements for physician incentive plans, as set forth in 42 CFR 422.208 and 422.210	A maximum of twenty-five thousand dollars ($25,000) for each determination
9	Distribution, directly or indirectly through any agent or independent contractor, of marketing materials that have not been approved by the State in form in which distributed or that contain false or materially misleading information	A maximum of twenty-five thousand dollars ($25,000) for each determination
10	Failure to use DHS approved materials for marketing during APC	Loss of all auto-assignment for contract year for that Initial Enrollment or APC
11	Not enrolling a member because of a discriminatory practice	A maximum of fifteen thousand dollars ($15,000) for each member the State determines was not enrolled because of a discriminatory practice
12	Failure to resolve member appeals and grievances within the time frames specified in Section 9.5.	A maximum of ten thousand dollars ($10,000) for each determination of failure
13	Failure to comply with the claims processing standard required in Section 7.2(A).	A maximum of five thousand dollars ($5,000) for each determination of failure
14	Failure to meet minimum compliance of provision of periodic screens to EPSDT eligible members as described in Section 4.3	A maximum of five thousand dollars ($5,000) for each determination of failure
15	Failure to conduct an assessment or develop a service plan within the timeframe required in Section 3.	A maximum of five thousand dollars ($5,000) for each determination of failure
16	Failure to comply with staffing requirements as outlined in Section 11.	A maximum of five thousand dollars ($5,000) for each determination of failure
17	Failure to provide accurate information, data, reports and medical records, including behavioral health and substance abuse records to DHS under the Contract.	Two hundred dollars ($200) per day until all required information, data, reports and medical records are received
18	Failure to report confidentiality breaches relating to Medicaid applicants and recipients to DHS by the specific deadlines provided in Section 14.16.	One hundred dollars ($100) per day per applicant/recipient. A maximum of twenty-five thousand dollars ($25,000) until the reports are received

Payments provided for under the Contract shall be denied for new members when, and for so long as, payment for those members is denied by CMS in accordance with the requirements in 42 CFR 438.730.

C) *Special Rules for Temporary Management*

The sanction of temporary management may be imposed by the State, as allowed or required by 42 CFR 438.706, if it finds that:

a) There is continued egregious behavior by the Health Plan, including, but not limited to, behavior that is described in 42 CFR 438.700, or that is contrary to any requirements of Sections 1903(m) and 1932 of the Social Security Act;
b) There is substantial risk to the member's health; or
c) The sanction is necessary to ensure the health of the Health Plan's members while improvements are made to remedy violations under 42 CFR 438.700 or until there is an orderly termination or reorganization of the Health Plan.

The State shall impose temporary management if it finds that the Health Plan has repeatedly failed to meet the substantive requirements in Sections 1903(m) and 1932 of the Social Security Act. The State may not delay imposition of temporary management to provide a hearing before imposing this sanction.

The State may not terminate temporary management until it determines that the Health Plan can ensure that the sanctioned behavior will not recur.

In the event the State imposes the sanction of temporary management, members shall be allowed to disenroll from the Health Plan without cause.

14.21 Compliance with Laws

In addition to the requirements of General Condition 1.3, Compliance with Laws, the Health Plan shall comply with the following:

A) *Wages, Hours and Working Conditions of Employees Providing Services*

Pursuant to Section 103-55, HRS, services to be performed by the Health Plan and its subcontractors or providers shall be performed by employees paid at wages or salaries not less than the wages paid to public officers and employees for similar work. Additionally, the Health Plan shall comply with all applicable Federal and State laws relative to workers compensation, unemployment compensation, payment of wages, prepaid healthcare, and safety standards. Failure to comply with these requirements during the Contract period shall result in cancellation of the Contract unless such noncompliance is corrected within a reasonable period as determined by DHS. Final payment under the Contract shall not be made unless DHS has determined that the noncompliance has been corrected. The Health Plan shall complete and submit the Wage Certification provided in Appendix D.

B) ***Compliance with other Federal and State Laws***

The Health Plan shall agree to conform to the following federal and state laws as affect the delivery of services under the Contract including, but not limited to:

a) Titles VI, VII, XIX, and XXI of the Social Security Act;
b) Title VI of the Civil Rights Act of 1964;
c) Title IX of the Education Amendments of 1972 (regarding education programs and activities);
d) The Age Discrimination Act of 1975;
e) The Rehabilitation Act of 1973;
f) The Americans with Disability Act of 1990 as amended;
g) The Patient Protection and Affordable Care Act of 2010, including section 1557;
h) Chapter 489, HRS (Discrimination in Public Accommodations);
i) Education Amendments of 1972 (regarding education programs and activities);
j) Copeland Anti-Kickback Act;
k) Davis-Bacon Act;
l) Debarment and Suspension;
m) All applicable standards, orders or regulations issued under section 306 of the Clean Air Act, as amended (42 USC 1857 (h)), section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR part 15) and the Federal Water Pollution Control Act, as amended (33 U.S.C. Section 1251, et seq.);
n) The Byrd Anti-Lobbying Amendment (31 USC Section 1352); and

o) E.O. 11246, "Equal Employment Opportunity," as amended by E.O. 11375 "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor".

The Health Plan shall comply with any and all applicable Federal and state laws that pertain to member rights and ensure that its employees and contracted providers observe and protect those rights.

The Health Plan shall recognize mandatory standards and policies relating to energy efficiency that are contained in any State energy conservation plan developed by the State in accordance with the Energy Policy and Conservation Act (Pub. L. 94-163, Title III, Part A).

The Health Plan shall include notice of grantor agency requirements and regulations pertaining to reporting and patient rights under any contracts involving research, developmental, experimental or demonstration work with respect to any discovery or invention which arises or is developed in the course of or under such contract, and of grantor agency requirements and regulations pertaining to copyrights and rights in data.

14.22 Miscellaneous Special Conditions

A) *Use of Funds*

The Health Plan shall not use any public funds for purposes of entertainment or perquisites and shall comply with any and all conditions applicable to the public funds to be paid under the Contract, including those provisions of appropriate acts of the Hawaii State Legislature or by administrative rules adopted pursuant to law.

B) *Prohibition of Gratuities*

Neither the Health Plan nor any person, firm or corporation employed by the Health Plan in the performance of the contract shall offer or give, directly or indirectly, to any employee or designee of the State of Hawaii, any gift, money or anything of value, or any promise, obligation, or contract for future reward or compensation at any time during the term of the Contract.

C) *Publicity*

General Condition 6.1 is amended to read as follows: Acknowledgment of State Support. The Health Plan shall not use the State's, DHS's, MQD's name, logo or other identifying marks on any materials produced or issued without the prior written consent of DHS. The Health Plan also agrees not to represent that it was supported by or affiliated with the State of Hawaii without the prior written consent of DHS.

D) *Force Majeure*

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 DHS from terminating the Contract for reasons other than default during the period of events set forth above, or for default if such default occurred prior to such event.

E) *Attorney's Fees*

In addition to costs of litigation provided for under General Condition 5.2, in the event that DHS shall prevail in any legal action arising out of the performance or non-performance of the Contract, or in any legal action challenging a final decision under Section 14.19, the Health Plan shall pay, in addition to any damages, all of DHS' expenses of such action including reasonable attorney's fees and costs. The term "legal action" shall be deemed to include administrative proceedings of all kinds, as well as all actions at law or in equity.

F) ***Time is of the Essence***

Time is of the essence in the Contract. As such, any reference to "days" shall be deemed calendar days unless otherwise specifically stated.

G) ***Health Plan request for waiver of contract requirements***

Health Plans may request a waiver of operational contract requirements from DHS that are described in the RFP. Health Plans may submit this request in a format provided by DHS. DHS shall only approve a Health Plan's request for waiver of a contract requirement that does not adversely affect the outcome of services that its members receive, is consistent with State law and policy, and is allowable under federal and State authority. DHS reserves the right to revoke these waivers at any time upon written notice to the affected Health Plans. Whenever possible, DHS shall provide reasonable advance notice of any such revocation to allow the affected Health Plan(s) to make any necessary operational changes.

14.23 Transition Plan for Mergers

The Health Plan shall not assign or transfer any right or interest in this Contract to any successor entity or other entity that results from a merger of the Health Plan and another entity, without the prior written consent of DHS. The Health Plan shall include in such request for approval a detailed transition plan for DHS to review. The purpose of the transition plan review is to:

A) ensure services to Members are not interrupted or diminished;

B) evaluate the new entity's staffing plan;

C) evaluate the new entity's plan to support the Health Plan's provider network;

D) ensure that the new entity can pass a readiness review; and

E) ensure that DHS is not adversely affected by the assignment or transfer of this Contract.

SECTION 15 – Mandatory and Technical Proposal

15.1 Overview

A. The Health Plan shall comply with all content and format requirements for the technical proposal. The proposal shall be on standard 8 ½" by 11" paper, one and a half (1½) spaced, singled sided and with text no smaller than 11-point Calibri font. For graphics and diagrams, text must be no smaller than 10-point Calibri font. The pages must have at least one-inch margins. All proposal pages must be numbered and identified with the Health Plan's name.

B. The Health Plan shall answer all questions as part of the narrative in the order that they appear in each sub-section. The question shall be restated above the response. The maximum page numbers includes restating the question. The question may be stated single spaced with text no smaller than 11-point Calibri font. The questions related to any attachment do not need to be restated as long as it is clear from the heading of 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.

C. Responses in excess of the maximum page limits and any documentation not specifically requested shall not be reviewed. Likewise, providing actual policies and procedures in lieu of a narrative may result in the Health Plan receiving a non-responsive score for that question.

D. The following sections describe the required content and format for the mandatory and technical proposals. These sections are designed to ensure submission of information essential to understanding and evaluating the proposal.

E. The Health Plan must submit a proposal that addresses all the provisions in this RFP for Oahu and all the Neighbor Islands.

15.2 Mandatory Requirements

A) *Transmittal Letter*

1. The transmittal letter shall be on official business letterhead and shall be signed by an individual authorized to legally bind the Health Plan. It shall include:

    a) A statement indicating that the Health Plan is a corporation or other legal entity and is a properly licensed health plan in the State of Hawaii at the time of proposal submission. All Subcontractors shall be identified and a statement included indicating the percentage of work to be performed by the prime Health Plan and each subcontractor;

    b) A statement that the Health Plan has an established provider network to serve Medicaid beneficiaries in the State of Hawaii or will have a provider network to serve Medicaid beneficiaries in the State of Hawaii before the Commencement of Services;

    c) A statement that the Health Plan is registered to do business in Hawaii and has 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 1.5);

d) The Health Plan's Hawaii General Excise tax number (if applicable);

e) A statement to acknowledge that this proposal includes all amendments and addenda to this RFP issued by the issuing office. If no amendments or addenda have been issued, a statement to that effect shall be included;

f) A statement of affirmative action that the Health Plan does not discriminate in its employment practices with regard to race, color, creed, ancestry, age, marital status, arrest and court records, sex, including gender identity or expression, sexual orientation, religion, national origin or mental or physical handicap, except as provided by law;

g) A statement that no attempt has been made or will be made by the Health Plan to induce any other party to submit or refrain from submitting a proposal;

h) A statement that the Health Plan has read, understands and agrees to all provisions of this RFP;

i) A statement that it is understood that if awarded the contract, the Health Plan's organization shall deliver the goods and services meeting or exceeding the specifications in the RFP and amendments;

j) A statement that the person signing this proposal certifies that he/she is the person in the Health Plan's organization responsible for, or authorized to make, the offer firm and

binding, and that he/she has not participated and shall not participate in any action contrary to the above conditions; and

k) A statement that the Health Plan understands that it must submit a proposal that addresses the provisions of this Contract statewide. All four (4) contracted Health Plans will provide Covered Services on Oahu and two (2) of those four (4) Health Plans will also be selected to provide Covered Services on the neighbor islands.

2. If any page is marked "Confidential" or "Proprietary" in the Health Plan's proposal, an explanation to DHS of how substantial competitive harm would occur if the information is release.

B) ***Company Background Narrative***

1. The Health Plan shall provide the following information:
2. The legal name and any names under which the Health Plan has done business. Indicate the Health Plan's form of business (e.g., corporation, non-profit corporation, partnership, etc.).
3. Federal and State Tax Identification Numbers.
4. Address, telephone number and e-mail address of the Health Plan's headquarter office.
5. Date the company was established and then began operations.
6. Relationship to parent, affiliated and/or business entities and copies of management agreements with parent organizations.
7. Organization chart of parent company and all Subcontractors.

8. Names, addresses and contact information for all officers, directors and partners.

9. Provide copies of the Health Plan's articles of incorporation, bylaws, partnership agreements, or similar business entity documents, including any legal entity have an ownership interest of five percent (5%) or more.

10. The size and resources, including the gross revenues both in Hawaii and nationally, if applicable.

11. Total current number of employees both in Hawaii and nationally, if applicable.

12. Provide a statement of whether there is any pending or recent (within the past five (5) years) litigation against the Health Plan both in and out of Hawaii or sanctions, including but not limited to the following:

    a) Litigation involving the Health Plan's failure to provide timely, adequate, or quality Covered Services. If any litigation listed, include damages sought or awarded or the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Include an opinion of counsel as to the degree of risk presented by any pending litigation and whether the pending or recent litigation will impair your organization's performance in a Hawaii Medicaid managed care Contract.

    b) Sanctions for deficiencies in performance of contractual requirements related to an agreement with any federal or state regulatory entity. Include monetary sanctions the Health Plan has incurred pursuant to contract enforcement from any state,

federal, or private entity, including the date, amount of sanction, and a brief description of such enforcement, corrective action, and resolution.

c) Any Securities Exchange Commission (SEC) filings discussing any pending or recent litigation.

d) The Health Plan may exclude workers' compensation cases.

13. For the Health Plan list and describe any Protected Health Information (PHI) breaches both in and out of Hawaii that have occurred and the response. Do not include items excluded per 42 CFR 164.402.

14. Has the Health Plan ever had its accreditation status (e.g., NCQA, URAC, or Accreditation Association for Ambulatory Health Care (AAAHC)) in any state for any product line adjusted down, suspended, or revoked? If so, identify the state and product line and provide an explanation. Include the same information for the Health Plan's parent company and subsidiaries.

15. Provide a listing of Medicaid managed care contracts both in and out of Hawaii held in the past (5) years for which the Health Plan has:

a) Voluntarily terminated all or part of the contract under which it provided healthcare services as the licensed entity.

b) Had such a contract partially or fully terminated before the contract end date (with or without cause).

c) Had a contract that was not renewed.

d) Had a reduction of enrollment levels imposed by the client.

e) The Health Plan's response shall include information for the Health Plan as well as subsidiaries, and Subcontractors. For

each contract identified, provide a description of the reason for the change in contracting.

16. A description of any services the Health Plan objects to based on moral or religious grounds as described in Section 8.5 including a description of the grounds for the objection and information on how it will provide the required services. The description must include a listing of the codes impacted including but not limited to CPT codes, HCPCS codes, diagnosis codes, revenue codes, modifier codes, etc. If there are no services to which it objects, the Health Plan shall so state.

C) *Other Documentation*

1. The Health Plan shall attach, in the following order, completed forms provided in Appendix D:

    a) The Proposal Application Identification form (Form SPO-H-200);

    b) The State of Hawaii DHS Proposal Letter*;*

    c) The Certification for Contracts, Grants, Loans and Cooperative Agreements form;

    d) The Disclosure Statement (CMS required) form;

    e) Disclosure Statement;

    f) The Disclosure Statement (Ownership) form;

    g) The Organization Structure and Financial Planning form;

    h) The Financial Planning form;

    i) The Controlling Interest form;

j) The Background Check Information form;

k) The Operational Certification Submission form;

l) The Grievance System form;

m) Health Plan's Proof of Insurance;

n) The Wage Certification form;

o) The Standards of Conduct Declaration form;

p) The State and Federal Tax Clearance certificates from the prime Health Plan and, upon request from subcontractors, as assurance that all federal and state tax liabilities have been paid and that there are no significant outstanding balances owed (a statement shall be included if certificates are not available at time of submission of proposal that the certificates will be submitted in compliance with Section 1.11);

q) Proof of its current license to serve as a Health Plan in the State of Hawaii. A letter from the Insurance Division notifying the Health Plan of its license shall be acceptable "proof" for DHS; and

r) Certificate of Compliance from the State of Hawaii, Department of Commerce and Consumer Affairs, Insurance Division that validates financial solvency.

D) *Risk-Based Capital*

1. The Health Plan shall provide the most recent completed risk based capital (RBC) amount. Where applicable, the Health Plan shall submit separate RBC amounts for all affiliated companies and companies with the same parent company as the Health Plan.

15.3 Technical Proposal

The Health Plan should submit all materials as specified in this section in the order in which the information is requested. DHS assumes no responsibility for knowledge of any material that is not presented in accordance with DHS instructions. Unless requested in the technical proposal question, self-promotional materials will not be reviewed or evaluated.

The Health Plan's responses to the technical proposal questions in this section must address Oahu and the neighbor islands so that DHS is able to evaluate all responses on a statewide basis.

DHS shall evaluate the proposals by assigning scores as indicated in Section 16, Evaluation and Selection.

A) *Evaluation Category 1 - Executive Summary*

Page limit for Section 15.3(A): Ten (10) pages.

1. Provide an Executive Summary that summarizes the Health Plan's proposed staffing and organizational structure and approach to provide the full scope of work in an integrated manner for all Members covered under the Contract.
2. The Health Plan's response must address the following, at a minimum:
    a) The Health Plan's statement of understanding of the healthcare environment and challenges in Hawaii, the DHS Medicaid program, and needs of Medicaid Members. This

understanding must address healthcare and geographic disparities in Hawaii.

b) An overview of the Health Plan's proposed organization to provide services on a statewide basis under the Contract.
c) A description of the Health Plan's understanding, strategy and approach for implementing care delivery and service coordination and quality initiatives, utilizing community resources, identifying and addressing SDOH, and integrating care and services across all initiatives defined in this RFP.
d) The approach for implementing VBP and value-driven healthcare requirements, and supporting and incentivizing providers.
e) A summary of the Health Plan's strategy and approach for establishing and sustaining a comprehensive provider network to meet the needs of Members on a statewide basis.
f) A summary of innovations, technology and initiatives the Health Plan proposes to implement to achieve improved health outcomes for Members in a cost effective manner.
g) Include a discussion of challenges the Health Plan anticipates, how the Health Plan will work to address such challenges, and the Health Plan's approach to collaborating with DHS and other Health Plans in overcoming these challenges.

B) *Evaluation Category 2 - Company Background*

Page limit for Section 15.3(B): Fifteen (15) pages, excluding attachments referenced below.

1. Corporate Experience

    a) Describe the Health Plan's experience in the provision of managed care services to the populations specified in this Contract. In addition, include the following information in the response:

        1. Experience in implementation of population health management programs and initiatives.

        2. Experience with the Native Hawaiian population and related healthcare disparities, experience with rural populations and disparities caused by geographic barriers, as well as any other disparities affecting health care delivery and outcomes. If the Health Plan does not have such experience, the narrative must address similar experience with other native populations and how the Health Plan will use this experience to conduct outreach and build an understanding of the Native Hawaiian population.

        3. The Health Plan shall indicate if it has NCQA accreditation for the Hawaii Medicaid market, and if not, the proposed timeline for achieving accreditation.

        4. Three (3) examples of innovations or initiatives the Health Plan has implemented for Medicaid managed care programs not described elsewhere in the Health Plan's proposal that have supported improved health outcomes for beneficiaries, enhanced investment in primary care, improved service delivery and coordination, or supported behavioral health integration. Describe whether such

innovations and/or initiatives were cost effective and resulted in sustained change.

5. A summary of lessons learned from the Health Plan's experience providing similar managed care services to similar populations as defined in the RFP.

6. How the Health Plan will apply such lessons learned to the QI Medicaid managed care program.

b) Describe the Health Plan's experience in operating a D-SNP including a description of the Health Plan's experience aligning administrative processes across Medicare and Medicaid to create a seamless system for dual eligible members. Describe the Health Plan's experience using Medicare and Medicaid data to coordinate, track, and report on care provided across programs.

c) Provide a listing, in table format, of the Health Plan's prior and existing full risk Medicaid managed care contracts for the previous five (5) years. The Health Plan may include experience of an affiliated company, a company with the same parent company as the Health Plan, and any subcontractors who will be providing direct services and that the Health Plan intends to use in the QI program. Include the following information:

1. State name, including agency name.

2. Name, title, address, telephone number, and email address of the client and/or contract manager.

3. Contract start and end dates.

4. Number and description of covered lives.

5. Status of NCQA accreditation for each of these state contracts.

2. Client References

a) Provide three (3) client references for current and active Medicaid managed care contracts where the Health Plan is the prime contractor. The Health Plan may consider the experience of subsidiaries of the Health Plan's parent company when submitting client references. References from proposed Subcontractors may not be submitted to meet this requirement. DHS cannot serve as a reference to meet this requirement.

b) If the Health Plan has had a managed care contract in Hawaii and/or does not have contractual history with three (3) state Medicaid programs, the Health Plan may submit references from member advocacy groups or provider entities or organizations in the State that have a prior work history with the Health Plan. The Health Plan shall not submit references from any individual or organization with a financial conflict of interest, including board directors, officers, or other board members.

c) For each reference, complete the client reference template provided by DHS and submit as an attachment to the proposal (Appendix W).

d) DHS is not requesting letters of recommendation. Any such letters submitted will not be considered for evaluation purposes.

C) *Evaluation Category 3 - Approach to Care Delivery and Coordination*

Total Page Limit for Section 15.3(C): Sixty-five (65) pages.

1. Describe the Health Plan's approach to meeting the Care and Service Delivery System requirements of this procurement. Specifically, the proposal should:

    a) Describe the process, tools and data/information the Health Plan will use to identify the SHCN and SHCN+ population. Include the availability of/ability to incorporate SDOH into effective identification.

    b) Describe how the Health Plan will delegate Care and Service Coordination (CSC) services as described in Section 3.5.B. Optional: The Health Plan may provide up to five (5) pages of graphics that do not count toward the page limit of this section if desired. The font size of the graphics must be ten (10) point or higher.

        1. Describe the process to notify the delegated entities of newly identified CSC members. Also describe how the Health Plan will support delegated entities by sharing information such as claims history, pharmacy data, previous assessments and care/service plans, information on recent significant events such as hospitalizations, etc., that are needed for the provision of care.

        2. Describe how the Health Plan will provide oversight and management of the CSC services to ensure quality services are provided by the appropriate staff, duplication of services is avoided, and optimal results are achieved.

c) Describe the Health Plan's staffing model for providing CSC and Community Integration Services (CIS) that are not delegated to external entities. Include a brief description of the positions, the qualifications, and the responsibilities. Also describe how the Health Plan will ensure that quality services are provided by the appropriate staff, and that all care and service coordination requirements will be met. Optional: The Health Plan may provide up to five (5) pages of graphics that do not count toward the page limit of this section if desired. The font size of the graphics must be ten (10) point or higher.

Page limit: Twenty-five (25) pages, excluding graphics.

2. Describe how will the Health Plan will ensure and monitor that the full continuum of care for behavioral health services will be available for individuals with behavioral health conditions, including describing how they will be working with both their behavioral and physical health providers, regional enhanced referral networks, and direct and/or delegated care coordinators to optimize their overall health. How will Members be able to move up or down the continuum as needed so that the plan is achieving DHS' vision of the Stepped Care approach?

   Page limit: Fifteen (15) pages.

3. Describe how will the Health Plan ensure, promote, and monitor a person-centered approach to HCBS that empowers individual initiative, autonomy, and independence in making life choices and facilitates individual choice in designing and receiving HCBS. How will

the Health Plan support and further the goals of providing LTSS in the member's home and community whenever possible and ensuring that LTSS in all settings is offered in a way that supports whole person care? How will the Health Plan support full access of Members to their greater community, including opportunities to seek employment and work, engage in community life, and manage their own resources?

Page limit: Fifteen (15) pages, excluding graphics.

4. Use Case 1

   The Health Plan should provide its approach to serving Members through its response to this use case scenario. As part of its response to this use case, the Health Plan must describe how it will ensure access to appropriate Health Plan-covered services, referral to other needed services and provide support to Members through care and/or service coordination, as well as coordination with other systems responsible for serving Members with Special Health Care Needs (Hale Ola, CAMHD, CCS, LTSS, etc.). In addition, the Health Plan should provide details on the resources and infrastructure that it will bring to serve these individuals.

   The Health Plan has a Member who is a 62-year-old female with a history of schizoaffective disorder, bi-polar sub-type. She has a history of medication non-compliance, suicide attempts, and multiple psychiatric hospitalizations with the last occurring several months ago. The Member has high blood pressure and suffers from chronic pain and weakness due to unspecified neuropathy. Though her chronic pain and subsequent weakness is limiting her ability to

ambulate independently, the majority of her functional deficits are due to anxiety in performing tasks and/or not having proficiency in completing tasks independently. The Member is currently residing in a nursing home, though a recent evaluation of functioning indicates she no longer meets eligibility for this level of care. Additionally, assessment indicates the nursing home is not the least restrictive setting. She is estranged from her family and was evicted from her apartment during her nursing facility stay but expressed her preference to return to her previous apartment or another apartment. She has a history of frequent emergency department visits prior to her nursing facility stay for both physical health and behavioral health causes.

Describe how the Health Plan will manage care to transition her into the community and achieve the best health and behavioral health outcomes for the Member.

Response should include, at a minimum:

a) Care Coordination, including coordinated management of physical and behavioral health conditions;

b) Management of psychotropic medications;

c) HCBS service assessment/service coordination planning;

d) Social Determinants of Health; and

e) Community resources.

Page limit: Five (5) pages.

5. Use Case 2

The Health Plan should provide its approach to serving Members through its response to this use case scenario. As part of its response to this use case, the Health Plan must describe how it will ensure access to appropriate Health Plan-covered services, referral to other needed services and provide support to Members through care and/or service coordination, as well as coordination with other systems responsible for serving Members with Special Health Care Needs (Hale Ola, CAMHD, CCS, LTSS, etc.). In addition, the Health Plan should provide details on the resources and infrastructure that it will bring to serve these individuals.

The Health Plan has a Member who is a 17-year-old male with a history of violence, aggression, and destructive behavior. Both parents live in the home and the Member has five siblings, ages two – nine years. He has a history of harming his parents and siblings. When in middle school the Member started fires at school and physically bullied younger students. Once in high school, he began experimenting with drugs and alcohol, and was suspended twice for bullying students and destruction of school property. After physically attacking a teacher, the Member was arrested and placed in a juvenile detention center. The charges were later dropped so that he could receive treatment.

The Member's parents refused his request to return home and the Hawaii Department of Human Services, Social Services Division coordinated his placement in foster care and a group home. Despite repeated requests from the Member, there has been no contact between him and his family since he entered foster care.

The Member has been prescribed two (2) psychotropic medications at the higher end of the dosage range but hasn't been evaluated by his PCP or behavioral health provider in approximately a year. In addition to his ongoing behavioral issues, the Member has moderate persistent asthma and has a history of several ED visits and one hospitalization related to his asthma over the past two years. His BMI is 25.

With his case worker, the Member discussed his loneliness, desire to return home, and regrets over hurting his family. He expressed his frustration over not being able to talk with his family to discuss how they "can be a family again."

The Member is ambivalent about remaining in foster care once he reaches his 18th birthday. He sometimes expresses a desire to leave foster care and, at other times, he states his understanding of the support needed to transition into the community and possibly reconcile with his family.

The Health Plan must describe how it would address the Member's situation and coordination with the Social Services Division staff, group home, physical and behavioral health providers, and his family. At minimum, the Health Plan shall address the following programs and services in its response:

a) Care Coordination, including coordinated management of physical and behavioral health conditions;

b) Management of psychotropic medications;

c) Evidence based psychotherapeutic interventions;

d) Social Determinants of Health;

e) Community resources;

f) Education; and

g) Aging out of foster care.

Page limit: Five (5) pages.

D) *Evaluation Category 4 - Covered Benefits and Services*

Total Page Limit for Section 15.3(D): Fifty (50) pages.

1. Experience. The Health Plan shall describe its experience providing covered services, as described in Section 4, Covered Benefits and Services, under risk-based contracts for state Medicaid managed care programs. This description shall indicate:

    a) The extent to which this experience is for populations comparable to Hawaii's membership, as well as experience in providing services to Members with special health care needs;

    b) The Health Plan's competency serving the cultures in Hawaii and understanding the population served by the State's Medical Assistance program.

    c) Subcontracting arrangements through which subcontractors will be responsible for provision of covered benefits and services.

    Page limit: Twenty (20) pages

2. Approach. Describe the Health Plan's comprehensive approach to providing covered services, including the following:

    a) Approach to and operations the Health Plan will have in place to support integrated service delivery across services, and that address social determinants of health.

    b) Technological solutions the Health Plan will implement to support the provision of covered services.

    c) Approach to lifestyle change/disease prevention classes, self-management education classes, and smoking cessation services, including information about successful strategies the Health Plan has previously implemented and that the Health Plan will use as models in Hawaii.

    d) Approach to provision of EPSDT services, including detailed information about the Health Plan's outreach methods to members and providers about the EPSDT benefit.

    e) Approach to provision of behavioral health services, including coordination as required with DOH and DHS regarding specialized behavioral health benefits.

    f) Approach to administration of pharmacy benefits and related services.

    g) Approach to provision of Community Integration Services, including coordination with homeless service providers in the community.

    h) The Health Plan shall provide its proposed approach for delivery of LTSS, including approaches to the following:

1. Assessment of an individual's LTSS needs and determining the appropriate HCBS for an individual;
2. Assurance of provision of choice when a member requires LTSS;
3. Methods for minimizing and decreasing the Health Plan's acute waitlisted ICF/SNF members; and
4. Ensuring that services are provided in a manner that facilitates maximum community placement for members who require LTSS.

i) For any covered services for which the Health Plan proposes to subcontract, the Health Plan shall describe its approach to collaboration and coordination to ensure integrated service delivery.

j) Describe the Health Plan's approach to use of data analytics to monitor outcomes and trends in provision of Covered Services and to inform areas for additional focus and improvement. Describe how the Health Plan uses findings in monitoring of and feedback to Subcontractors that administer Covered Services.

Page limit: Twenty (20) pages.

3. Value-Added Services

a) The Health Plan may propose to offer Value-added Services. Health Plans may include services that address SDOH. For each service proposed, provide the following:

b) Describe proposed Value-added Services that best serve the Medicaid population. The Health Plan should justify its selection of the proposed value-added services through research demonstrating the intended long-term impact.

c) Include analysis that demonstrates the impact in terms of cost savings, and perceived qualitative value of each service for the targeted population. The Health Plan may use the "Value Added Services Proposal" template provided in Appendix V to project cost savings. The methodology must also include information on how initial medical costs, savings assumption(s), costs of operating the program, and the viability and outcomes of the proposal were calculated.

d) Identify the category or group of Members eligible to receive proposed Value-added Services, with explanation as to why the service is targeted for these Members. The Health Plan should describe its methodology in determining the number and type of members enrolled in each year, and the retention of members targeted each year.

e) Limitations or restrictions that apply to the Value-added Services.

f) Identify the Providers or entities responsible for providing the Value-added Services, including any limitations on Provider capacity, if applicable.

g) Methods and timing for notifying Providers and Members about the availability of the Value-added Services; as well as the Health Plan's proposed method(s) of outreach.

h) A description of the process by which a Member may obtain or access the Value-added Services, including any action required by the Member, as appropriate.

i) A description of how the Health Plan will identify the Value-added Services in administrative data (e.g., encounter data), if applicable.

Page Limit: Ten (10) Pages

E) *Evaluation Category 5 - Quality, Utilization Management and Administrative Requirements*

Total Page Limit for Section 15.3(E): Sixty (60) pages, excluding attachments referenced below.

1. Quality Assessment and Performance Improvement Program

   a) The Health Plan shall provide its strategic approach to developing its QAPI program addressing all requirements in Section 5, Quality, Utilization Management and Administrative Requirements. Describe in detail how the Health Plan will align its program to address requirements in 5.1(B), as well as strategies the Health Plan will include in its work plans to advance goals.

   b) A description of the Health Plan's experience in each SDOH goal area as stated in Section 5.1(B)(2), including examples of current activities and the geographic/population reach for each of those examples that the Health Plan has achieved or intends to achieve for each SDOH goal area described. The Health Plan is encouraged to identify community partnerships it has forged that are

instrumental in advancing its SDOH efforts and examples of success.

c) A description of the Health Plan's experience in each HIT required element as stated in Section 5.1(B)(3). The Health Plan's response shall include examples of efforts it has undertaken in Hawaii and other states, as possible, to address the goal areas, the geographic/provider reach of its efforts, and examples of success. If examples from states other than Hawaii are used, they should be selected to help convey the Health Plan's understanding and experience in challenges similar to those faced locally in Hawaii. The Health Plan may provide examples of screen shots of tools, if needed, to support the response. Such information must be provided as attachments and will be excluded from the page limits.

Page limit: Fifteen (15) pages.

2. Provider Support, Performance Improvement, and Information Sharing

a) The Health Plan shall describe the tools, reports and feedback mechanisms that the Health Plan will utilize to garner provider support for all improvement activities and enable advancement in quality outcomes.

b) The Health Plan shall provide strategies it will use to enhance performance measurement and support improvement. Provide examples of strategies in Hawaii or other state Medicaid programs, and how the Health Plan will apply successes and lessons learned in Hawaii.

c) The Health Plan shall describe methods it will implement for sharing evaluation results of practice patterns with providers, and interventions the Health Plan will implement to increase the rate of high value care and reduce variation from evidence-based standards. The Health Plan shall describe successes it has had in implementation of such interventions with Medicaid providers. The Health Plan shall describe whether it has made available provider portal features that enable comparative peer data and provider insight relating to patient outcomes.

Page limit: Fifteen (15) pages.

3. The Health Plan shall describe its general approach to designing and implementing Performance Improvement Projects (PIPs) that address identified focus areas and target initiatives to improve quality and outcomes. Describe the following in the Health Plan's response:

   a) The approach used to clarify the aim, theory of change, primary and secondary drivers of the project, as well as methods for selecting appropriate evidence-based interventions, measurable indicators of output, process, and outcomes; and methods for accurate data collection.

   b) Health Plan's experience conducting PIPs, and how such experience will provide lessons learned, successes and problems common to PIPs for consideration when implementing PIPs.

   c) How the Health Plan reviews progress and adjusts as needed when it is determined that initiatives are not effective.

d) Describe how the health plan incorporates HEDIS performance metrics in performance improvement by outlining the processes and strategies used to increase a metric in which the health plan has relatively low scores.

Page limit: Ten (10) pages.

4. Utilization Management

a) The Health Plan shall describe its Utilization Management program, including how it will be structured to assist in objectively and systematically monitoring and evaluating the necessity, appropriateness, efficiency, timeliness and cost-effectiveness of care and services. The response shall address activities specific to pharmaceutical management. Include workflows that depict the process from the initial receipt of a request to final disposition.

b) The Health Plan shall describe strategies it will implement within its Utilization Management program and prior authorization processes to address administrative simplification for providers.

Page limit: Five (5) pages.

5. Use Case 3

The Health Plan shall submit its response to the following use case including innovative approaches to fulfill the requirements of the Contract. The use case represents hypothetical Members, providers, or entities. Responses must include, at a minimum, the program and services listed within each use case, but the Health Plan is not limited to responding only to those areas. The Health Plan should include any

limitations or exceptions to providing the programs and services listed.

The Health Plan's response may include a detailed narrative, diagrams, exhibits, or descriptive literature specifically tailored for Hawaii.

The Health Plan is implementing a two-year initiative to improve outcomes by addressing a variety of health behaviors and Social Determinants of Health. The Health Plan has enrolled several primary care and multi-specialty provider groups in the area to participate in the initiative and has developed relationships with various community agencies to support the effort. The Health Plan has identified three (3) quality measures for which providers will receive incentives for meeting targeted improvements. The quality measures emphasize physical and behavioral health integration, Social Determinants of Health, and critical community resources. The Health Plan intends to make initial incentive payments fourteen (14) months after the start of the initiative. Six (6) months into the project, a primary care and multi-specialty provider group's Administrator met with the Health Plan to discuss challenges the group is encountering with the initiative and to raise concerns about reporting. Specifically, challenges are as follows:

a) Some practitioners in the group are very engaged while others are less interested in supporting the effort, indicating it is administratively burdensome as the group is also participating with similar initiatives being implemented by the other contracted Health Plans with different measures.

b) The provider group has a new electronic health record (EHR) system and experienced numerous onboarding issues that

haven’t yet been resolved. The provider group does not receive ADT data from local hospitals.

c) The Administrator has made multiple attempts to outreach to a community housing agency that the Health Plan indicated is supporting the effort to discuss opportunities to collaborate; however, the agency has not returned calls.

d) Member compliance is lower than anticipated. Follow up and other outreach has been difficult due to Members not returning calls and incorrect Member contact information.

e) The Administrator is frustrated that the Health Plan had not provided feedback on the first set of required reports that were submitted three months after project initiation. Communication has been minimal and the Administrator is concerned about lack of support.

f) The Administrator and practice leadership are concerned with the extended timeframe for incentive payments and the ability to impact providers’ behaviors.

The Health Plan must address its approach in addressing the Provider’s concerns. At a minimum, the Health Plan shall address the following in its response:

a) Provider engagement at local, regional, and statewide levels;

b) Provider education, communications, and support;

c) Simplification of provider administrative burden;

d) Member engagement;

e) Technology; and

f) Health Plan assessment of internal operation challenges and mitigation strategies.

Page Limit: Ten (10) pages

6. Use Case 4

The Health Plan shall submit its response to the following use case including innovative approaches to fulfill the requirements of the Contract. The use case represents hypothetical Members, providers, or entities. Responses must include, at a minimum, the program and services listed within each use case, but the Health Plan is not limited to responding only to those areas. The Health Plan should include any limitations or exceptions to providing the programs and services listed.

The Health Plan's response may include a detailed narrative, diagrams, exhibits, or descriptive literature specifically tailored for Hawaii.

The Health Plan has a 38 year-old female Medicaid Member who was diagnosed with Type II diabetes six (6) years ago. She recently lost her apartment and is staying with friends. The Member does not have access to public transportation and relies on her friends for transportation support. The Member's friends are moving to the mainland soon and the she is concerned about her living arrangements and transportation. Her only exercise is walking to the nearby gas station food mart for snacks. Her diet consists primarily of fast food and soft drinks, and she consumes an average of ten (10) beers each week.

The Member sees her PCP annually and uses the emergency department (ED) for physical health concerns, such as complications of her unmanaged type II diabetes and urinary tract infections. She has been to the ED three (3) times in a sixty (60) day period.

During her last PCP visit, her BMI was 38, HbA1c 12.9% with a post-prandial blood glucose of 258 mg/dL, and her blood pressure was 166/98 mm Hg. She has been prescribed the following medications by different physicians: an antidepressant, a statin to manage elevated cholesterol levels, birth control, antihypertensive medication, insulin and glipizide, along with blood glucose testing 4 – 6 times each day and insulin on a sliding scale as needed. The Member does not regularly check her blood glucose levels with her glucometer and is often non-compliant in taking her medications regularly or timely.

The Member's PCP is concerned about her medication compliance and self-management of her diabetes, as well as unstable housing, nutrition, and transportation.

The Health Plan must describe the approach to treatment for the Member, as well as improvement of coordination and information exchange between associated provider entities. At minimum, the Health Plan shall address the intersection of the following topics in its response:

a) Risk stratification;

b) Care Coordination;

c) Referral processes;

d) Medication reconciliation;

e) Exchange of health information;

f) Admit, Discharge and Transfer (ADT) processes;

g) Social Determinants of Health;

h) Transportation;

i) Value-added Services; and

j) Quality outcome monitoring.

Page Limit: Five (5) pages

F) ***Evaluation Category 6 - Health Plan Reporting and Encounter Data***

Total Page Limit for Section 15.3(F): Ten (10) pages.

1. The Health Plan shall provide its capability to develop required reports to the extent described in Section 6, including an overview of the reporting systems and the ability to configure such systems and tools to capture data as specified by DHS. Discuss methods the Health Plan uses for reviewing accuracy and completeness of data reported. Include information about validating data and reporting from Subcontractors. The Health Plan shall also describe its analytic tools for population health, CIS supports such as tracking utilization and trends, and other analytic and reporting tools for program and performance improvement.

   Page limit: Ten (10) pages.

2. Encounter Data

The Health Plan shall confirm its adherence and describe its approach to meeting DHS' expectations and requirements outlined in Section 6.5, Encounter Data. The Health Plan's response shall include:

a) Performance management strategies to ensure complete, accurate and timely encounter data submissions are made to DHS.

b) Procedures for working with providers and internal operations to correct encounter errors.

c) Describe the Health Plan's past performance in complying with encounter submission requirements for other Medicaid managed care clients including the acceptance, completion, and accuracy rates as percentages.

Page limit: Five (5) pages.

G) *Evaluation Category 7 - DHS and Health Plan Financial Responsibilities*

Total Page Limit for Section 15.3(G): Thirty (30) pages

1. Incentive Strategies for Health Plans

The incentive strategies outlined in Section 7.1(B) are designed to impact Health Plan and provider behaviors in various technical, operational, and clinical aspects of the program. The Health Plan shall describe its understanding of DHS' expectations for each incentive strategy including the following components:

a) The processes the Health Plan will employ to ensure operational requirements are met consistently, completely, and in a timely manner.

b) The Health Plan’s approach for implementing performance measures, including the processes for collecting data and performing analytics, monitoring plan and individual providers’ performance over a performance period, sharing data and analytics with providers for purposes of improvement and correction, and other related operational or technical components the Health Plan will employ to ensure successful performance measurement and reporting as related to the incentive strategies.

Page limit: Ten (10) pages.

2. Value-based Payment

a) The Health Plan shall confirm its adherence and describe its approach to meeting the DHS’ expectations and requirements for VBP stated in Section 7.2.B, Value Based Payment, including a description of the Health Plan's approach to ensuring payments to providers are increasingly focused on population health, appropriateness of care and other measures related to value. The Health Plan’s comprehensive approach to meeting DHS’ expectations and requirements for VBP shall address the following:

1. Approach to assessing the current state of provider VBP engagement and readiness against the LAN framework.

2. Methods the Health Plan will use to address the following areas:

    a) APM design or implementation;

    b) Strategy for developing APMs that mature along the LAN continuum over the course of the Contract;

    c) Operational and process infrastructure;

    d) Data reporting, collection, and analytics;

    e) Quality measurement;

    f) Payment mechanisms;

    g) Provider engagement, technical assistance, and contracting; and

    h) Provider incentives.

b) Provide an overview of the Health Plan's infrastructure for administering and monitoring the VBP strategy and to assure all VBP contract requirements and minimum spend requirements set forth in Section 7.2(B)(3), Value-driven Healthcare Schedule, are met over the course of the Contract.

c) Describe the Health Plan's approach to using VBP to advance primary care, including through supporting PCMH, by:

    1. Developing a tiered payment structure for different PCMH levels, as well as the Health Plan's strategy for supporting aligned Health Plan recognition for Tier 1 and Tier 2 providers.

    2. Encouraging and incentivizing primary care VBP engagement, and methods the Health Plan will implement

to increase network primary care provider participation over the course of the Contract.

d) Describe the Health Plan's approach to developing hospital VBP in accordance with Section 7.2(B)(4) of the RFP. Include, at a minimum, the proposed approach to the following:

   1. Encouraging and incentivizing hospital VBP engagement, and methods the Health Plan will implement to increase network hospital participation in VBP over the course of the Contract.

   2. Addressing Hawaii-specific challenges that might hinder hospital VBP, and proposed methods for addressing such challenges.

e) Describe the Health Plan's approach to incorporating major provider types (mental health services providers, substance use disorder (SUD) services providers, LTSS providers; specialty services providers; and rural health providers) into its VBP strategy.

Page limit: Twenty (20) pages.

H) ***Evaluation Category 8 - Responsibilities and Requirements of DHS and Health Plans: Provider Networks; Provider Credentialing; Provider Contracts; and Other Functions for Providers***

Total Page Limit for Section 15.3(H): Thirty-five (35) pages.

1. The Health Plan shall describe its proposed network development strategy to meet all contract requirements and allow for timely availability and access to a continuum of physical health, behavioral health, and Long-Term Services and Support providers. In addition

to overall strategy, the response shall specifically address the following:

a) Methods to develop a provider network that sufficiently addresses the needs of individuals with mental health and/or substance abuse issues and individuals with co-morbid physical health, mental health and substance use conditions;

b) How the Health Plan will develop a provider network that sufficiently addresses Long Term Services and Supports (LTSS) including Home and Community Based Services (HCBS);

c) Innovative methods the Health Plan will implement to recruit providers in rural and underserved areas or to address provider types for which it is struggling to recruit, as well as strategies to support contracted providers in these areas to encourage continued participation.

d) Identification of covered services that subcontractors will provide, if any, and how the Health Plan will assure network development activities are coordinated and thoroughly monitored.

e) Approach to providing out-of-network care when timely access is not possible.

f) Potential challenges the Health Plan anticipates in building a network across islands and strategies the Health Plan will implement to address identified challenges, including contracting innovations and retention and recruitment efforts.

Page limit: Fifteen (15) pages.

2. The Health Plan shall describe its proposed approach to use of telehealth services to increase access and availability of services. The response shall include information about its experience in contracting for telehealth services and specifically how it will use lessons learned to inform its contracting for telehealth services in Hawaii.

   Page limit: Five (5) pages.

3. Describe the Health Plan's experience with addressing provider workforce shortages within Hawaii and other states, including the behavioral health workforce and other issues such as attrition due to retiring providers, and provide lessons learned and successes the Health Plan has experienced that it proposes to apply in Hawaii.

   Page limit: Ten (10) pages.

4. The Health Plan shall attest to and demonstrate progress on developing a provider network by providing information about signed Letters of Intent and Contracts by provider type by island for those providers listed in Section 8.1.B Provider Network, Specific Minimum Requirements, as well as any additional provider types the Health Plan proposes to designate. The Health Plan shall provide an electronic listing in Microsoft Excel format of the following information by provider:

   a) Provider type;
   b) Specialty area;

c) Name and contact information;
d) Clinic name, if applicable;
e) Island/County (for Oahu include city);
f) Medicaid Identification Number;
g) Indication of signature of Letter of Intent or Contract; and
h) Indication as to whether the provider is accepting new Medicaid patients.

Page limit: Five (5) pages, excluding attachments.

I) *Evaluation Category 9 - Responsibilities and Requirements of DHS and Health Plans: Eligibility, Enrollment, Disenrollment, Continuity of Care, and Grievance and Appeals*

Total Page Limit for Section 15.3(I): Forty (40) pages.

1. Describe the Health Plan's operation of the Member Services call center including:

    a) How the Health Plan will monitor and assure full staffing during operational hours.

    b) Examples of training and informational resources provided to call center staff, including the process for remedial training for staff failing to meet Health Plan standards. The response must address how the call center staff information is provided, updated, and monitored to ensure accuracy of information provided to Members.

    c) Approach to using back-up staff to support increased call volumes, how the Health Plan assures such staff are trained

and have the correct materials specific to the Hawaii Medicaid managed care program, and location of these staff.

d) Process for routing calls, including crisis calls and after-hours calls, to appropriate persons, including care coordinators, and the process for escalation and tracking.

Page limit: Ten (10) pages.

2. Describe the Health Plan's approach to Member outreach and education, including the following at a minimum:

a) Overall approach to educating and engaging Members about topics such as but not limited to Covered Services, accessing care, availability of the care coordination services, and improving overall health.

b) Topics the Health Plan proposes to be priority areas of focus for Member outreach and education.

c) Initiatives and education (health literacy) the Health Plan will use to drive appropriate utilization and cost-effective health care services.

d) Collaboration opportunities with other contracted Health Plans, DHS agencies, and community partners to support Member needs through joint outreach and education.

Page limit: Fifteen (15) pages.

3. Describe methods for communicating with Members as follows:

a) Describe innovative technologies (e.g., smart phone applications, internet and smart phone chat, e-mail, and other non-telephonic means of communication) the Health Plan will use to engage with members to achieve high levels of member engagement, as methods to educate members and advance their own involvement in their health care, and to communicate information specific to individual health conditions. The response should detail populations to which the technologies would apply, and the extent to which technologies previously deployed have been successful in reaching Medicaid beneficiaries.

b) Provide an overview of the Health Plan's proposed Member web site and Member portal. Include screen shots of the Member web site and examples of proposed resources, tools and materials that will be meaningful to Members.

c) Approach to identifying, developing, and distributing materials that will be of most use to Member populations, and efforts the Health Plan proposes to target distribution to specific populations as appropriate. Based on the Health Plan's experience, what are some lessons learned that can be applied to enhance effectiveness of educational materials?

d) Methods of leveraging culturally-appropriate communications to meet the diverse needs and communication preferences of Members, including but not limited to individuals with diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.

e) Describe the proposed approach to assess Member satisfaction at each point of contact (call, online and in-person), including tools, frequency and process to measure trends, and use of findings to support ongoing program improvement.

Page limit: Ten (10) pages.

4. Describe the Health Plan's proposed Member Grievances and Appeals process, including a summary of methods for the following:

   a) Compliance with State and Federal requirements.

   b) Tracking grievances and appeals received by type and trending results for use in improving operations.

   c) Reviewing overturned decisions to identify needed changes.

   Page limit: Five (5) pages.

J) *Evaluation Category 10 - Information Systems and Information Technology*

Total Page Limit for Section 15.3(J): Fifteen (15) pages

1. The Health Plan shall describe in comprehensive detail the Management Information System (MIS) it proposes to use in performance of Contract requirements. The response shall include flowcharts and diagrams to demonstrate each component of the MIS and interfacing support systems. The response shall address:

   a) Hardware and system architecture specifications for all systems the Health Plan or its subcontracts will use to support contract services (e.g., enrollment, claims processing, member

and provider service systems, utilization management/prior authorization, care coordination, reporting, and financial systems).

b) All proposed functions and required interfaces, including a description of the capacity of the Health Plan's system to interface with DHS' system, network providers and subcontractors.

c) Capability to store and use large amounts of data, to support data analyses, and to create standard and ad hoc reports.

d) Proposed resources the Health Plan will dedicate to MMIS exchanges.

e) Health Plan's data security approach and processes to comply with privacy standards.

Page limit: Fifteen (15) pages, excluding flowcharts and diagrams.

K) *Evaluation Category 11 - Health Plan Personnel*

Total Page Limit for Section 15.3(K): Forty (40) pages.

1. Describe the Health Plan's proposed approach to staffing the Contract, including the following information at a minimum:

    a) Description of how the organizational structure provides solutions for meeting programmatic goals specific to Hawaii's Medicaid program, Members, providers, and other stakeholders.

b) Description of how the organizational structure will support whole-person integrated care, population health and overall improvement in health outcomes in a cost-effective manner.

c) The Staffing Plan identified in Section 11.2(H) of the RFP, Health Plan Personnel, and as otherwise defined by the Health Plan, including:

    1. Individual staff names, titles, and qualifications.

    2. Number of proposed FTEs dedicated to the Contract, by position type and operational area, and how the Health Plan determined the appropriateness of these ratios. Office locations for staff must be provided.

    3. Whether each Mandated QI Personnel position will be filled by the Health Plan's employee or a Subcontractor.

    4. Job descriptions as addressed in Section 11.2.F.

    5. Resumes, including information such as degrees, credentials, clinical licensure as applicable, years and type of experience. Resumes are excluded from page limits.

    6. Three (3) professional references for each person identified Section 11.2(A). References are excluded from page limits.

d) Summary of recruitment timelines and activities for Mandated QI Personnel positions for which individuals have not been identified at the time of the proposal. Describe contingency plans should those positions continue to remain open after Contract Award.

e) The Training Plan identified in Section 11 of the RFP, Health Plan Personnel, including:

1. Description of the Health Plan's proposed training of staff to fulfill all requirements and responsibilities of the Contract for all operational areas.
2. Description of the Health Plan's approach to monitoring Subcontractors' progress in recruiting and training of staff to meet all requirements of Contract.
3. Retention approach for key personnel.

Page limit: Thirty (30) pages, excluding attachments.

2. Provide a detailed description of the Health Plan's organizational structure for this Contract, including an organizational chart that clearly displays the following:

a) Management structure, lines of responsibility, and authority for all operational areas of this Contract.

b) Where Subcontractors will be incorporated.

Page limit: Ten (10) pages.

L) *Evaluation Category 12 - Program Integrity*

Total page limit for Section 15.3(L): Ten (10) pages.

1. Provide a detailed summary of Health Plan's proposed Compliance plan, including a discussion of the following:

a) The Health Plan's fraud and abuse detection/prevention program activities for employees, caregivers and providers, including reporting and follow-up, continuous monitoring of compliance, identification and reporting of issues to all required parties, and ongoing training.

b) The proposed appeals process.

c) A description of the Compliance Committee.

d) Proposed innovations for analyzing and reporting data in the Program Integrity area. Provide examples of successful innovations implemented in Hawaii or other states.

SECTION 16 – Evaluation and Selection

16.1 Overview

A. DHS shall conduct a comprehensive, fair and impartial evaluation of proposals received in response to this RFP. DHS shall be the sole judge in the selection of the Health Plan(s). The evaluation of the proposals shall be conducted as follows:

1. Review of the proposals to ensure that all mandatory requirements detailed in Section 15 – Technical Proposal are met;

2. Review and evaluation of the technical proposals that meet all mandatory requirements to determine whether the Health Plan meets the minimum technical criteria and requirements detailed in Section 15, Technical Proposal; and

3. Award of the Contract to the selected Health Plans.

B. DHS reserves the right to waive minor irregularities in proposals provided such action is in the best interest of the State. Where DHS may waive minor irregularities, such waiver shall in no way modify the RFP requirements or excuse the Health Plan from full compliance with the RFP specifications and other Contract requirements if the Health Plan is awarded the contract.

16.2 Evaluation Process

A. DHS shall establish an Evaluation Committee (Committee) that shall review and evaluate each Health Plan's proposal and make award

recommendations. The Committee shall consist of members who are familiar with the programs and the minimum standards or criteria for the particular area. Additionally, DHS may, at its discretion, designate additional representatives to assist in the evaluation process. DHS reserves the right to alter the composition of the Committee or designate other staff or vendors to assist in the evaluation process. The Committee shall review and evaluate all qualified responses to the RFP and the Health Plan's onsite evaluation interview. The Committee will be responsible for the entire evaluation process and scoring will be determined by consensus.

16.3 Mandatory Proposal Evaluation

A. Each proposal shall be evaluated to determine whether the requirements as specified in this RFP have been met. The proposal shall first be evaluated against the following:
    1. The Health Plan successfully met all of the requirements set for in Section 1.16, Submission of Proposals;
    2. All information required in Section 15.2, Mandatory Requirements, has been submitted; and
    3. The proposal contains the required information in the proper order.

B. A proposal must meet all mandatory requirements prior to the technical evaluation. Any proposal that does not meet all mandatory requirements shall be rejected.

16.4 Technical Proposal Evaluation

A. DHS shall conduct a comprehensive, fair, and impartial evaluation of all Health Plan proposals. DHS may reject any proposal that is incomplete or in which there are significant inconsistencies or inaccuracies. Each Health Plan is responsible for submitting all relevant, factual and correct information with their proposal to enable the Committee to afford each Health Plan the maximum score based on the available data submitted by the Health Plan.

B. The Health Plan's responses to the technical proposal will be evaluated in how responses address program requirements for Oahu and the Neighbor Islands.

16.5 Evaluation Categories and Criteria

A. The Evaluation Categories and points are described in the table below.

Evaluation Categories	RFP Section	Maximum Points Possible
1. Executive Summary	**Section 15.3(A)**	**50**
2. Company Background	**Section 15.3(B)**	**70**
3. Approach to Care Delivery and Coordination	**Section 15.3(C)**	**150**
Approach to meeting the Care and Service Delivery System requirements	*Question 15.3(C)(1)*	*50*
Full continuum of care for behavioral health services	*Question 15.3(C)(2)*	*30*
Person-Centered HCBS Planning	*Question 15.3(C)(3)*	*30*
Use Case 1	*Question 15.3(C)(4)*	*20*
Use Case 2	*Question 15.3(C)(5)*	*20*
4.Covered Benefits and Services	**Section 15.3(D)**	**100**
Experience	*Question 15.3(D)(1)*	*40*

Evaluation Categories	RFP Section	Maximum Points Possible
Approach	*Question 15.3(D)(2)*	*50*
Value-Added Services	*Question 15.3(D)(3)*	*10*
5.Quality, Utilization Management and Administrative Requirements	**Section 15.3(E)**	**150**
QAPI Program	*Question 15.3(E)(1)*	*40*
Provider Support, Performance Improvement, and Information Sharing	*Question 15.3(E)(2)*	*30*
Approach to PIPs and Performance improvement	*Question 15.3(E)(3)*	*25*
UM Approach	*Question 15.3(E)(4)*	*15*
Use Case 3	*Question 15.3(E)(5)*	*25*
Use Case 4	*Question 15.3(E)(6)*	*15*
6.Health Plan Reporting and Encounter Data	**Section 15.3.F**	**40**
Reporting capacity	*Question 15.3(F)(1)*	*25*
Encounter Data	*Question 15.3(F)(2)*	*15*
7.DHS and Health Plan Financial Responsibilities	**Section 15.3(G)**	**75**
Incentive strategies for health plans	*Question 15.3(G)(1)*	*25*
Value Based Payment	*Question 15.3(G)(2)*	*50*
8.Requirements for Providers	**Section 15.3.H**	**115**
Network Development	*Question 15.3(H)(1)*	*40*
Approach to Telehealth	*Question 15.3(H)(2)*	*15*
Approach to Workforce Shortages	*Question 15.3(H)(3)*	*30*
Provider Attestations	*Question 15.3(H)(4)*	*30*
9.Requirements for Members	**Section 15.3(I)**	**100**
Call Center Requirements	*Question 15.3(I)(1)*	*25*
Member Outreach and Education	*Question 15.3(I)(2)*	*30*
Member Communications	*Question 15.3(I)(3)*	*30*
Member Grievances and Appeals	*Question 15.3(I)(4)*	*15*

Evaluation Categories	RFP Section	Maximum Points Possible
10.Information Systems and Information Technology	**Section 15.3(J)**	**45**
11.Health Plan Personnel	**Section 15.3(K)**	**60**
Approach to Staffing	*Question 15.3(K)(1)*	*40*
Organizational Structure	*Question 15.3(K)(2)*	*20*
12.Program Integrity	**Section 15.3(L)**	**45**
Total Possible Points		**1,000**

16.6 Scoring

A. The Evaluation Committee will score Health Plan proposals using the following rating methodology:

Rating Score	Description
5	**Excellent.** The proposal addresses all relevant aspects of the question. Reply goes beyond the requirements listed in the RFP to provide added value. In addition, the response may cover areas not originally addressed within the RFP and/or include additional information and recommendations that would prove both valuable and beneficial to the agency. The response includes a full, clear, detailed explanation of how requirement(s) are met. No errors in technical writing.
4	**Very Good.** The Proposal addresses the criterion very well, highly comprehensive. No deficiencies noted. The proposal describes how the requirements will be minimally met.
3	**Good.** The Proposal addresses the criterion well. The response meets the requirements. Demonstrates knowledge and understanding of the subject matter. The proposal contains no major deficiencies and only minor deficiencies that are easily correctible.
2	**Fair.** The Proposal broadly addresses the criterion, but there are significant weaknesses. The proposal has one major

	deficiency and/or multiple minor deficiencies that do not appear to be easily correctable.
1	**Poor.** The criterion is inadequately addressed. Health Plan's response has multiple major deficiencies that do not appear to be correctable.
0	The Proposal fails to address the criterion or cannot be assessed due to missing or incomplete information. Health Plan has not demonstrated sufficient knowledge of the subject matter or has failed to explain how requirement(s) is met.

B. The Health Plan must receive at minimum a rating score of three (3) for each Evaluation Category or the proposal will not be considered technically acceptable and shall be rejected. Health Plans must receive a minimum score of seven hundred fifty (750) points, seventy-five percent (75%) of the total available points to be considered responsive to the RFP. Proposals not meeting the total required points shall not be awarded a contract.

C. The rating score (0-5) shall represent the corresponding conversion factor used to calculate the points awarded for each Evaluation Category listed in Section 16.5, as follows:

Rating Score	Conversion Factor
5	100%
4	88%
3	75%
2	50%
1	25%
0	0%

D. The total maximum number of points available for each Evaluation Category will be multiplied by the applicable conversion factor, based on the rating score given, to determine the number of points awarded

for the Evaluation Category. The points awarded for each Evaluation Category shall by totaled to yield a final score.

E. Scoring will be based on the entire content of the proposal and the information as communicated to the Committee. The information contained in any part of the proposal may be evaluated by DHS with respect to any other scored section of the proposal. Lack of clarity and inconsistency in the proposal will impede effective communication of the content and may result in a lower score.

16.7 Selection of Health Plans

A. Upon completion of the Technical Proposal evaluations, DHS shall sum the scores from the evaluation to determine the Health Plans that shall be awarded contracts from the State. Four (4) health plans will be selected to provide Covered Services on Oahu and two (2) of the four (4) health plans will be selected to provide Covered Services Statewide. Statewide contract awards will be awarded to the two Health Plans with the highest scoring technical proposals.

16.8 Contract Award

A. Upon selection of the Health Plans that will be awarded contracts, DHS shall initiate the contracting process. The Health Plan shall be notified in writing that the RFP proposal has been accepted and that DHS intends to award a contract to the Health Plan. This letter shall serve as notification that the Health Plan should begin to develop its programs, materials, policies and procedures for the programs.

B. The contracts shall be awarded no later than the Contract Award date identified in Section 1.5. If an awarded Health Plan requests to withdraw its proposal, it must be requested in writing to the DHS before the close of business (4:30 p.m. H.S.T.) on the Contract Award date identified in Section 1.5. After that date, DHS expects to enter into a contract with the Health Plan.

C. This RFP, the Health Plan's technical proposal, and any other materials submitted by the Health Plan shall become part of the contract.