Department of Human Services
Med-QUEST Division

QI HEALTH PLAN MANUAL

Part II: Operational Guidance

TABLE OF CONTENTS

Part II: Operational Guidance 1

CHAPTER 1: Care Delivery and Health Coordination 6

1.1 Approach to Care Delivery 6

1.2 Care Delivery and Health Coordination Policies and Procedures 6

1.3 Advancing Primary Care 6

1.4 Project ECHO® 8

1.5 Description of Health Coordination Services 9

1.6 Continuum of HCS 10

1.7 Health Coordination Services Program Staff and Training 11

1.8 Person-Centered Practice Core Standards and Training 13

1.9 Health Coordination Collaboration with DOH Behavioral Servicesand Other State Partners 17

CHAPTER 2: Eligible Health Coordination Services Populations 19

2.1 Health Coordination Services (HCS) 19

2.2 Identification of Populations Eligible for HCS 19

CHAPTER 3: Screening and Assessment 21

3.1 Initial Screening for New Members 21

3.2 Screening of Existing Members for Health Coordination Services 21

3.3 Health and Functional Assessment (HFA) 22

3.4 Reassessments 25

CHAPTER 4: Health Action Plan 28

4.1 Description of a Health Action Plan (HAP) 28

4.2 Health Action Plan 29

4.3 Implementing the HAP 32

CHAPTER 5: Special Health Care Needs and Expanded Health CareNeeds 34

5.1 Description of SHCN and EHCN 34

5.2 Eligible Populations with SHCN 34

5.3 Eligible Populations with EHCN 37

5.4 Eligibility Determination for SHCN and EHCN 39

CHAPTER 6: Long-Term Services and Supports 41

6.1 Description of LTSS 41
6.2 Eligible Population 41
6.3 Eligibility Determination 43
6.4 Choice of HCBS or Institutional Services 46
6.5 Enrollment in HCBS or a Nursing Facility 46
6.6 Description of LTSS Benefits 47
6.7 HCBS Service Codes Grid 47
6.8 LTSS Service Provision 47
6.9 LTSS Service Authorization Reviews 48
6.10 Electronic Visit Verification (EVV) 52
6.11 LTSS Planning for Institutional Relocation Services 54
6.12 Waiting List for Members Receiving HCBS and At-Risk Services 54
6.13 Self-Direction 55
6.14 Home and Community-Based Services Settings Final RuleImplementation 67
6.15 Bed-Hold Requirements for Long Term Care 74
CHAPTER 7: Going Home Plus and Institution Relocation Services 76
7.1 Description of Going Home Plus and Institution RelocationServices 76
7.2 Eligible Population 77
7.3 Eligibility Determination 77
7.4 Institution Relocation Services/Transitions 77
CHAPTER 8: Community Integration Services 81
8.1 Description of Community Integration Services (CIS) 81
8.2 Eligible Population 81
8.3 CIS Identification and Referral of Potential CIS Members 83
8.4 Description of CIS Benefits 85
8.5 Rules Surrounding CIS Provision 88
CHAPTER 9: Behavioral Health Services Guidance 92
9.1 Overview 92
9.2 Stepped Approach to Behavioral Health Services Overview 92
9.3 Coverage for Standard or Specialized Behavioral HealthServices 93
9.4 CAMHD Specialized Behavior Services for SEBD 95
9.5 CCS Specialized Behavioral Services for SMI/SPMI 99
9.6 DOH-ADAD and Hawai'i CARES Overview 106
9.7 Hawai'i Coordinated Access Resource Entry System (CARES) 112
9.8 Screening, Brief Intervention and Referral to Treatment (SBIRT) 118
CHAPTER 10: Reproductive Health Services 120
10.1 Family Planning Services 120

10.2 Pregnancy-Related Services for Pregnant Women andExpectant Parents 120
10.3 Sterilizations and Hysterectomies 121
CHAPTER 11: Early Periodic Screening, Diagnostic, and Treatment(EPSDT) 122
11.1 Early Periodic Screening, Diagnosis, and Treatment Plan 122
11.2 Member Outreach and Education for EPSDT 123
11.3 Health Plan Requirements for Providers 124
11.4 EPSDT Screens..... 125
11.5 Coverage Requirements..... 127
CHAPTER 12: Developmental Disability Division (DDD) 128
12.1 Coordination between Health Plan and DDD 128
12.2 Coordination for Members Under the Age of 21 130
12.3 HCBS I/DD Waiver Services for Members..... 131
CHAPTER 13: DOH Family Health Services – Children with SpecialNeeds Branch 133
13.1 Description of Children with Special Needs Branch (CSHNB)..... 133
13.2 Early Intervention Services (EIS) Description 133
13.3 Description of Children with Special Needs Program (CSHNP)..... 134
13.4 DOH Women Infant and Children (WIC)..... 134
CHAPTER 14: Foster Care/Child Welfare Services 136
14.1 Description of Child Welfare Services (CWS) 136
14.2 Health Plan Responsibilities 137
CHAPTER 15: State of Hawai'i Organ and Tissue TransplantProgram..... 139
15.1 General Description 139
15.2 State of Hawai'i Organ and Tissue Transplant Program..... 139
15.3 Authorization and Determination Process 139
15.4 Transplant Facility Accepts Patient..... 147
15.5 One-Year Anniversary – After Successful Transplant 147
CHAPTER 16: Cognitive Rehabilitation Services..... 149
16.1 Cognitive Rehabilitation Services..... 149
CHAPTER 17: Provider 152
17.1 Provider Manual Requirements..... 152
17.2 Provider Contract Requirements..... 152
17.3 Medical Record Standards 152
17.4 Non-Emergency Medical Transportation (NEMT) Provider Eligibility 152
CHAPTER 18: Member 155
18.1 Member Enrollment..... 155
18.2 Member Handbook Requirements 155
CHAPTER 19: Coordination with Other State Programs..... 156

19.1 Medical Services Related to Dental Needs 156
19.2 Intentional Termination of Pregnancy (ITOPs) 156
CHAPTER 20: Healthcare-Acquired Conditions 157
20.1 Provider Preventable Conditions 157
CHAPTER 21: Non-Emergency Medical Transportation 159
21.1 Non-Emergency Medical Transportation Policy 159
CHAPTER 22: Encounters for Health Plan Staff Delivered Services 162
22.1 Encounters for Health Plan 162
CHAPTER 23: Staffing Notification 163
23.1 Staffing Change Notification 163
Glossary 167

CHAPTER 1: Care Delivery and Health Coordination

1.1 Approach to Care Delivery

A) Refer to the "Approach to Care Delivery" appendix in the "Health Plan Manual - Appendices" document.

1.2 Care Delivery and Health Coordination Policies and Procedures

A) The Health Plan will develop and maintain policies and procedures that comply with all requirements in Section 3, Section 11, 42 CFR §438.208, and the Health Plan Manual. The policies and procedures will be available during readiness review or upon request. Policies and procedures will be developed for the following:

1. Advancing primary care;
2. Prevention, health promotion, and disease management;
3. Stepped approach to behavioral health; and
4. Health coordination program.

B) Any changes to the policy and procedure will be submitted to DHS thirty (30) days prior to implementation of proposed change(s). Changes will be approved by DHS prior to implementation.

See RFP-MQD-2021-008 §3.1.

1.3 Advancing Primary Care

A) The Health Plan will support practices interested in:

1. Implementing advanced primary care models.
2. Integrating primary care and behavioral health services.
3. Increasing capacity to provide care coordination services.

4. The Health Plan will develop a process on how they plan to subcontract health coordination services (HCS) to primary care providers (PCP) and other providers to increase care coordination services in all settings and submit to the State for review and approval. This plan will be submitted to the State during readiness upon request for review and approval.
5. Enhancing primary care health homes, and the delivery of team-based care by leveraging all staff by incorporating community health workers, peer supports, and other lay health workers into the practice.
6. Building infrastructure to improve access or for delivery system reform.

B) The support may include, but is not limited to, general information and administrative support; training; data systems and technology support; practice transformation technical assistance; and other support. To decrease costs and increase standardization, DHS may require Health Plans to collaborate to provide these services in a standardized and centralized manner.

C) See also RFP-MQD-2021-008 §§ 7.2.D and 7.2.E.3.3 Health Plan Requirements for Prevention, Health Promotion, and Disease Management (PHPDM).

1. The Health Plan will identify at least two (2) PHPDM programs at the start of the Contract. The Health Plan will add at least one (1) additional PHPDM program by July 1st each year until the Health Plan has at least five (5) PHPDM programs. The programs will include the following conditions: pre-diabetes,

diabetes, asthma, heart disease, hypertension, high-risk pregnancy, or obesity. The Health Plan may submit a written request for approval from DHS to change one (1) program to address a different health condition based upon Member needs.

2. The PHPDM will be reviewed annually and revised as necessary based upon new treatments and innovations in the standard of care.
3. The PHPDM reports will be submitted to DHS annually.

D) Refer to the "Advancing Primary Care" report in the "Part III: Reporting Guide" document.

1.4 Project ECHO®

A) ECHO Hawai'i is a replicating partner of Project ECHO® (Extension for Community Healthcare Outcomes) - a successful, innovative medical education and mentoring program that builds PCP skills and improves access to and capacity for specialty care. Project ECHO® uses existing technologies to nurture sustainable learning collaboratives, connecting an interdisciplinary team of experts with primary care providers and paraprofessionals in rural and underserved communities.

B) Specialists help mentor participants in a "guided practice" model, with primary providers continuing their management and responsibility for patient care. Over time, clinicians develop comprehensive skills to treat specific, complex health conditions within their own practice. (https://www.Hawaiiecho.info/the-program#echo).

C) The Health Plan will:

1. Work collaboratively with Project ECHO® programs;
2. Promote Project ECHO® to providers; and
3. Support the evaluation of Project ECHO® programs.

Refer to 3.4 Project ECHO®, RFP-MQD-2021-008.

1.5 Description of Health Coordination Services

A) Health Coordination services will consist of six different categories: Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support, and Referral to Community/Social Support.

B) Health coordination (i.e., care or service coordination) can improve the safety, efficiency, and overall effectiveness of the health care delivery system. A well-designed health coordination program 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 program can address the multifaceted needs of populations with complex medical, behavioral, and social conditions.

C) The Health Plan will have an HCS program that complies with the requirements in 42 CFR §438.208, RFP-MQD-2021-008 Sections 3 and 11, and the Health Plan Manual.

D) The Health Coordination Team described in RFP-MQD-2021-008 Section 11.2.H will encourage Members with chronic or complex care needs to actively engage in comprehensive treatment and services to address physical and behavioral health (that includes

substance use disorders and mental health disorders), considering Member's preferences and personal health goals. The Health Coordination Team will also connect Members as needed to community resources and social support services assistance with problems such as food insecurity and housing instability.

E) The Health Coordination Team will conduct the Health and Functional Assessment (HFA). The Health Action Plan (HAP) is created in conjunction with the Member based on the HFA findings. The HAP identifies the Members' goals, needs, and services in collaboration with the Member and/or their authorized representative.

1.6 Continuum of HCS

A) The Health Plan will have an HCS system in place that allows Members to move seamlessly along the continuum of HCS.

B) The HCS continuum includes special health care needs (SHCN), expanded health care needs (EHCN) and long-term services and supports (LTSS) that facilitate a stepped approach to person-centered HCS with:

1. Service intensity that is matched to Member need.
2. Flexibility to adapt to change. The continuum of HCS recognizes that Members' needs can change over time. Members can move with ease between levels of HCS, enabling HCS the flexibility to cater to Members changing needs.
3. Member focused goals and decisions.

C) Coordination of Member services and supports is not only focused on the Members' healthcare, behavioral health, and social supports,

but also, the inclusion of family, informal supports, community health workers, peer specialists, primary care, specialist supports, and hospitals.

D) Crisis pathways in HCS, Health Plan will:

1. Have a process available for Members with high or urgent needs to readily access services.
2. Develop policies to address how access to these services will be implemented.

1.7 Health Coordination Services Program Staff and Training

A) The Health Plan will comply with staffing requirements in RFP-MQD-2021-008 Section 11. The Health Plan will have staffing sufficient to meet the requirements in RFP-MQD-2021-008 Section 3 and the Health Plan Manual.

B) Training:

1. At a minimum but not limited to, the training areas listed below will be provided for all Health Coordinators and paraprofessionals.

Abuse, Neglect, and Exploitation - Prevention and Reporting
Adult SBIRT
Adverse Event Reporting (AER)
Basic vital signs taking and recording
Blood-Borne Pathogen borne pathogen training
Civil Rights awareness
Collaborative care model
Consumer-directed services

Cultural competency
Documentation
First aid training
Health Action Plan
Health and Functional Assessment
HIPPA and mandated reporting requirements
Home & Community-Based Services (HCBS) Final Rule (79 FR 2947)
Level of Care and At-Risk Evaluation
Medication Assisted Treatment (MAT)
Member care training
Member training
Members/surrogate training programs including the EVV
Motivational interviewing
Paraprofessional training
Person-centered practices
Prenatal SBIRT (Screening, Brief Intervention, Referral to Treatment)
Self-direction provider training
Self-management assessment and reporting guidelines
Self-management skills
Service coordination
Signs of medical decline
Social risk factors (SRF)
Topics, goals, and frequency of Member/surrogate training programs
Trauma-informed care

Understanding and addressing unmet health-related resource and social needs
Validating active cardiopulmonary resuscitation (CPR)
Vision and Hearing a. Orthoptic training b. Visual training

2. Health Plans will develop a training schedule for training subjects listed above. Training curriculum will be available upon request to the State.

1.8 Person-Centered Practice Core Standards and Training

A) The Health Plan will collaborate with other Health Plans and stakeholders under DHS' supervision to develop ongoing training and person-centered practices. DHS will approve the Health Plan's person-centered policies and procedures and standards. At a minimum, the development of such policies and standards should align with the recommendations provided in the National Quality Forum (NQF) Final Report on Person-Centered Planning and Practices published on July 31, 2020, or any other resource approved by DHS.

1. Person-Centered Organization
    a. The Health Plan will ensure a person-centered organization to support person-centered practices facilitation. An initial self-assessment of the organization should be completed focusing in following core areas 1) leadership; 2) person-centered culture; 3) eligibility and service access; 4) person-centered

service planning and monitoring; 5) finance; 6) workforce capacity capabilities; 7) collaboration and partnership; and 8) quality and innovation. The self-assessment of the organization will be reviewed and reevaluated annually, at a minimum. To move towards a person-centered organization, the Health Plan will need to develop or amend their person-centered policies, procedures, and standards.

2. Person-Centered Practice Policies and Procedures

   a. To ensure a person-centered organization, the Health Plan policies must include but will not be limited to the following:

      1) Leadership

         a) Person-centered vision and strategy.

         b) Person-centered training plan.

      2) Person-Centered Culture

         a) Strategy for person-centered culture from leadership to line staff.

      3) Eligibility and Service Access

         a) Process for determining appropriate eligibility and referrals based on needs and goals.

      4) Person-Centered Planning and Monitoring

a) Process for ensuring the HAP aligns with Member needs, goals, strengths, and interests.

b) Process for ensuring the services and supports align with the Member's needs and desires.

5) Workforce Capacity and Capabilities

a) Process to ensure an adequate provider network for LTSS services.

b) Process to ensure that providers are qualified to deliver services.

6) Collaboration and Partnership

a) Process to ensure engagement with Members, advocacy organizations, and the larger community.

b) Process to ensure engagement of other systems including acute, primary, and chronic care; housing; education; transportation, etc.

7) Quality and Innovation

a) Process to ensure, at a minimum, quarterly evaluation of person-centered practice implementation, performance, and accountability for LTSS measures.

b) Develop a process to evaluate and improve on unmet needs.

8) Member Stakeholder Engagement

a) Policy advisory councils and ensure adequate representation of Members.

b) Process for Members to review policy changes.

B) The Health Plan will ensure organization employees and staff of subcontracted entities involved in health coordination in the HCS participate in ongoing training on person-centered practices and standards. The Health Plan will collaborate with other Health Plans and stakeholders under DHS' supervision to develop a training curriculum and core standards. DHS will approve the Health Plan's training protocols and core standards for person-centered practices. The development of training protocols and core standards must take into consideration the unique situations that may occur in LTSS and the transitions between in-home care, provider operated residential care, and long-term care facility settings. This includes but not limited to:

1. Person-centered planning purpose and definition;
2. Person-centered facilitator role and core competencies for staff performing planning process which include but not limited to:
    a. Foundational skills: understanding and empowering the individual;
    b. Relational and communication skills: motivational interviewing and active listening;
    c. Philosophy knowledge: culture competency and advocacy;
    d. Resources knowledge: navigating service systems and community supports;

e. Program policies and regulations knowledge: state and federal; and

f. Personal attributes awareness.

C) The Health Plans will ensure that organization employees and sub-contracted entity staff complete person-centered training within the first year of the executed Contract for existing Health Plan employees and within the first year of hire for new Health Plan employees and subcontracted entity staff. A refresher training and review of competencies is required at least annually. The trainings may be conducted in person or online and will be documented in the Health Plan personnel files.

D) DHS will provide additional guidance on the person-centered practices and implementation during the Contract period.

1.9 Health Coordination Collaboration with DOH Behavioral Services and Other State Partners

A) 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 (3) phases:

1. Phase I: Identification of and Access to Data on shared Members;
2. Phase II: Development of Joint Health Coordination Standards and Processes; and

3. Phase III: Implementation of Joint Health Coordination Processes.

B) Training or education will be provided by the state on best practices.

C) This process is expected to be expanded to all Members enrolled in Health Coordination Services in subsequent Contract years.

D) Health Plans will be required to establish a standardized agreement that operationally defines these processes, including:

1. Exchange of information;
2. Referral processes and procedures; and
3. Participation in coordinated, integrated, and individualized person-centered planning.

CHAPTER 2: Eligible Health Coordination Services Populations

2.1 Health Coordination Services (HCS)

A) For each category that the Member is in, refer to the specific Chapters for additional information. Also refer to RFP-MQD-2021-008 Sections 2.6 and 3.

1. Special Health Care Needs (SHCN) and Expanded Health Care Needs (EHCN)
2. Long-term Services and Supports (LTSS)
3. Going Home Plus (GHP)
4. Community Integration Services (CIS)
5. Community Care Services (CCS)

2.2 Identification of Populations Eligible for HCS

A) Health Plans must have multiple methods to identify targeted populations that would benefit from HCS, in addition to methods identified in RFP-MQD-2021-008, Section 9.2.B., that minimally include:

1. Methods to identify Members that meet HCS criteria. The analytic methodology must consider, 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. HCS screening and assessment tools;

d. SRF tools that are approved by DHS. SRFs refer to a Member's social and economic barriers to health, such as housing instability or food insecurity; and

e. Lab results.

B) Entities may contact the Health Plan Customer Service Department directly to refer Members for Health Coordination Services. Referral sources may include:

1. Providers;
2. Hospitals and nursing facilities;
3. Community-based organizations;
4. DHS, DOH, and other State agencies and programs (i.e., Child Welfare Services, Child and Adolescent Mental Health Division (CAMHD), Alcohol and Drug Abuse Division, etc.); and
5. Members, families, and their authorized representatives.

C) Health Plans will have a process to do outreach, screen, and assess referrals for appropriateness and willingness to participate as a part of the Health Coordination policy and procedure.

D) DHS may allow or require the Health Plans to conduct standardized screening to obtain additional information when needed from the Member, the Member's PCP, or other sources to determine if the Member meets the target population criteria.

E) Dual Members must be included in these identification processes.

CHAPTER 3: Screening and Assessment

3.1 Initial Screening for New Members

A. The Health Plan will conduct a new Member welcome call and new Member survey as described in RFP-MQD-2021-008 Section §9.2.B. The 834 file informs the Health Plan of a new Member assigned to their plan. Upon receipt, the Health Plan will complete the following within ten (10) days:

1. Conduct a new Member welcome call that includes identification of potential health problems and SRF. The screening for SRF will include DHS-approved SRF screening questions. See RFP-MQD-2021-008 Section 3.7.D.3.
2. If there is a positive indicator that a Member is potentially eligible for HCS, the Health Plan will refer the Member to a Health Coordination Team to schedule the HFA. (Refer to HFA for additional details.)

3.2 Screening of Existing Members for Health Coordination Services

A. The Health Coordination Team will conduct a screening call to Members that are identified through the eligibility determination process. The screening call includes the identification of potential health problems and SRF (see RFP-MQD-2021-008 Section 3.7.D.3). The SRF screening tool will include DHS-approved SRF screening questions.

B. If indicated, Members potentially eligible for HCS will be scheduled for an HFA as it relates to the Member's identified needs for SHCN, EHCN, and LTSS (Refer to the "HFA" appendix in the "Health Plan

Manual - Appendices" document) within fifteen (15) days of identifying the Member's need for health coordination. The HFA will be scheduled at a time and location agreed upon that meets the Member's needs.

C. If the screening does not indicate the need for HCS, or the Member declines HCS, the Health Plan will document the reason for not receiving HCS in the Member's file.

D. Members will be re-evaluated at any time if they are determined to be potentially eligible for HCS.

E. Re-evaluation is necessary to determine the appropriate type of HCS that the Member is eligible for.

F. The Health Plan will use evidence-based screening tools approved by DHS that are appropriate to the age of the Member.

3.3 Health and Functional Assessment (HFA)

A. The HFA serves as a starting point in the development of the HAP. This process requires input from all primary participants in the Member's Health Coordination Team (HCT). The Health Plan is encouraged to prepopulate as much data from records (i.e., claims, prior assessments, etc.) or other providers prior to the face-to-face meeting with the Member.

B. The HFA is composed of two different sections: Non-Clinical Information, and Health Status Assessment. The non-clinical portion may be completed by any member of the HCT. The Health Status Assessment portion must be completed by a licensed member of the HCT.

C. Pre-populated information will then be validated with the Member and any additional information obtained directly from the Member. For example, comparing the pre-populated Health Plan and PCP records with medications the Member is currently taking. Through this validation of data, and the process of completing the HFA, Health Plans can help increase accurate medication management.

D. The HFA is a comprehensive assessment. Sections will be completed as they relate to the target population (e.g., SHCN, EHCN, LTSS). Sections that apply to the Member's health conditions will be completed. Not all sections will apply to every Member.

E. The initial HFA is conducted

1. Within fifteen (15) days of Member identification; or
2. Prior to admission to the home for LTSS Members living in a residential setting such as a CCFFH, E-ARCH or ALF; or
3. Within seven (7)calendar days of initial enrollment for Members whose Medicaid eligibility is based upon receipt of HCBS. DHS will inform the Health Plan of these Members on the 834 file. See HPM 6.5 for additional information.

F. The HFA will be conducted face-to-face (or through other State-approved methods) and scheduled at a time and location that is agreed upon.

G. The one-page profile is the person-centered planning tool thatwill be completed with the HFA. The one-page profile is a summary of what is important to the Member and how they want tobe supported. The one-page profile is used to guide the HFA process, HAP development, and HAP implementation for all Members.

H. The Health Coordination Team will use a person-centered approach to assess the Member and take into consideration the Member's goals and their health status that includes but is not limited to a review of the Member's:

1. Physical condition;
2. Cognitive state;
3. Bodily systems including vital signs and blood pressure (if necessary);
4. Daily functioning in activities of daily living;
5. Instrumental activities of daily living;
6. Delegation of nursing tasks, if applicable;
7. Medications;
8. Treatments;
9. Risk for falls;
10. History of emergency department visits;
11. Environment;
12. Available supports (availability of school, family/natural, and personal care/caregiver supports);
13. Medical history;
14. Social needs (including day program and community integration options); and
15. Social history.

I. The HFA will identify ongoing need for HCS and the need for clinical and non-clinical services, including referrals to specialists and community resources to be included in the Health Action Plan (HAP).

J. The Health Plan will use a state-approved standardized HFA with

the personal assistance and/or nursing (PANS) tools and follow, as stated within this Manual, the process for conducting and completing the HFA. By using the LTSS PANS tools, authorized PANS hours should be assigned objectively while considering the member needs. The Health Plan will collaborate with DHS on future revisions of the HFA.

K. The Health Plan may request to use more comprehensive assessment forms approved by DHS for the SHCN, EHCN, and LTSS populations.

L. The Health Plan is responsible for ensuring that the Member's assessments are shared fully with the Member's PCP and other providers, as needed, to enhance communication and collaboration of services.

M. The Health Plan will maintain the Member's HFA within the Member's file.

3.4 Reassessments

A. The Health Plan will conduct reassessments for Members using the applicable sections of the HFA.

B. The reassessment allows the Health Coordinator to prioritize or re-prioritize goals identified by the Member, identify any new or additional services, identify changes in the Member's health status, and monitor the efficacy of the HAP.

C. The one-page profile tool will be updated during the reassessment or earlier when the Member's goals and preferences change.

D. A comprehensive reassessment will occur through a face-to-face visit or through a communication method preferred by the Member unless contraindicated (e.g., telephone, text, email, video chat,

etc.):

1. At least every twelve (12) months for SHCN, EHCN, HCBS and Institutional members; or

2. At least every six (6) months for Members living in a residential setting such as a CCFFH, E-ARCH or ALF; and

3. Within ten (10) days of when the Member's circumstances or needs have changed significantly including but not limited to:

    a. The death of a caregiver;

    b. Significant change in health status;

    c. Change in living arrangement;

    d. Institutionalization;

    e. Change in provider (if the provider change affects the HAP); or

    f. Request by Member or authorized representative when Member is experiencing any changes in situation or condition.

4. HFA reassessments for Community Integration Services (CIS) Members who opt for health coordination will occur at a minimum annually.

5. A face-to-face monitoring visit will be conducted at least once a month for Members living in a residential setting such as a CCFFH, E-ARCH or ALF, with more frequent contacts as necessary depending on the Member's condition and caregiver's capability.

E. During public health emergencies, alternative methods of

conducting a reassessment and obtaining signatures will be utilized as approved by DHS.

CHAPTER 4: Health Action Plan

The current Service Plan template will continue to be used until the HAP is issued. The Health Plan will collaborate with DHS and the other Health Plans to develop a state-approved HAP template. DHS anticipates the HAP template to be issued by the end of the second year of the contract.

4.1 Description of a Health Action Plan (HAP)

A) A HAP is a person-centered plan that is based on the HFA and developed with the Member and/or authorized representative.

B) The HAP will identify the Members' goals; describe the medical, behavioral, and social needs of Members; and identify all services to be utilized to include but not limited to the frequency, quantity, and provider furnishing the services.

C) The Health Plan will develop a process on how to complete the standardized HAP. This process will be submitted to DHS upon request for review and approval.

D) The person-centered HAP for LTSS Members will be based on the HFA and be developed consistent with 42 CFR §441.301(c).

1. In developing the LTSS HAP, and working with the PCP and other providers, the Health Plan will consider the appropriate type, amount, and frequency 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.

4.2 Health Action Plan

A) A HAP will be developed for each Member receiving health coordination:

1. Within thirty (30) calendar days of assessment for SHCN, EHCN, and LTSSMembers; or
2. Prior to admission to the home for LTSS Members living in a residential setting such as a CCFFH, E-ARCH or ALF.

B) A person-centered team-based approach will be used to create the HAP. It will involve the Care Team as defined in RFP MQD 2021-008 Section 2.3, Member, Member's family, significant others, caregivers, and/or Member's authorized representative. It will be reviewed and updated as needed following each quarterly review and reassessment .

C) The person-centered HAP process must use plain language and include cultural considerations, strategies for solving disagreement within the planning process, choice regarding services and providers, a process for Members to request service updates, identified risk factors, and risk mitigation strategies.

D) The HAP will include the following:

1. Member's preferences, strengths and needs;
2. Identified goals, problems, and interventions;
3. Authorized start and end dates for services;
4. Amount, type, frequency and duration of services which is the number of units authorized over a specified period of time, e.g., 10 hours/week for Personal Assistance and Nursing Services (PANS);
5. Provider of service which is the name of the provider(s) who

will be or are already servicing the Member (this may be left blank if the provider(s) are not known or not readily available at the time the service is authorized);

6. Name of lead coordinator;
7. Clinically appropriate care;
8. Gaps in care, including appropriate use of culturally appropriate, evidence- or research-based practices;
9. Modifications to treatment plans to address unmetservice needs that limit progress;
10. Opportunities for full integration in community life andcontrol personal resources;
11. Interventions to assist a Member during a medical or behavioral health crisis;
12. Medication regimen;
13. Back-up plan for situations when regularly scheduled providers are unavailable. Back-up plans may involvethe use of non-paid caregivers and/or paid caregivers;
14. Advance care plan; and
15. Disaster plan.

E) Additional elements in the HAP may include:

1. Any behavioral health and other underlying conditions;
2. Linking and integrating care with services such as: Collaborative Care Model services, Hawai'i Coordinated Access Resource Entry System (CARES), and other behavioral health resources;
3. Addressing needed actions to mitigate identified SRF;
4. Applying the Stepped Care Approach concept to Members with behavioral health needs; and

5. Prevention and health promotion interventions.

F) The HAP process will document the coordination and verification of assessments and evaluations with mental health, substance use disorder (SUD), and other providers.

G) The HAP will be written in accordance with the requirements described in this chapter. At a minimum, the HAP must be:

1. Signed and dated by the Health Coordinator and the Member; the Member's authorized representative or surrogate may sign for the Member;
    a. The signature can be an electronic signature;
2. A copy of the HAP will be made available to the Member and/or authorized representative, thePCP and the Care Team; and
3. Documented, in the Member records or progress notes and shall include the date the signed final HAP was reviewed and discussed, Member's response, the date the copy of the HAP was given to the Member and/or authorized representative and Member's PCP, and any actions, delays or exceptions to obtaining Member or authorized representative signatures on the HAP.

H) Refer to the Reassessments section for additional information and frequency.

I) Any authorization or denial of QI covered services, identified in the HAP, must be a collaborative dialogue with the member and his/her family. If the Health Coordinator cannot reach an agreement with the family, the QI health plan shall follow their contract for denial of services (QI RFP Section 9.5). If the health plan authorizes the termination, suspension or reduction of the

member's LTSS, the Health Coordinator shall:

1. Update the HAP with the authorized change(s) to the start date, provider, frequency/amount and duration of the LTSS;
2. Review and discuss the updated HAP with the member prior to the member receiving the Notice of Adverse Benefit Determination;
3. Send a Notice of Adverse Benefit Determination (NABD) with appeal rights to the member within the specified timeframe in accordance with Section 9.5.G of the QI RFP; and
4. Ensure that steps in 4.3.G are followed when HAP updates include service changes that result in NABD.

4.3 Implementing the HAP

A) The Health Coordination Team

1. Will implement the HAP as written in collaboration with the Member and Member's family, if appropriate;
2. Will arrange for and ensure that Member receives the services indicated in the most current HFA and documented in the HAP;
3. Is responsible for monitoring and documenting the Members' progress. This includes documenting office visits attended, preventive services received, etc.; and
4. May utilize Community Health Workers to outreach and assist Members needing access to services and information relevant to their special condition or circumstance;

B) The Health Coordination Team will have at least one (1) face-to-face visit with the Member to review the HAP implementation, at a minimum, every ninety (90) days for SHCN, EHCN, or HCBS and every six (6) months for Members living in a residential setting such

as CCFFH, E-ARCH, ALF, or NF. This may be face-to-face in person, virtually, or through alternative communication methods (e.g., telephone, text, email, etc.).

C) The Health Coordination Team will conduct a comprehensive update to the HAP after each reassessment. Refer to the Reassessments section 3.4.D for additional information and frequency.

CHAPTER 5: Special Health Care Needs and Expanded Health Care Needs

5.1 Description of SHCN and EHCN

A) SHCN services are provided to Members who have a chronic physical, behavioral, developmental, or emotional condition that requires health-related services of a type or amount that is beyond what is required for someone of their general age.

B) EHCN services are provided to Members who have complex healthcare needs and conditions, or who is at risk of developing these conditions is imminent. The Members that meet EHCN criteria are considered highly impactable and likely to benefit from health coordination services. EHCN-eligible Members will have access to a future service called Hale Ola where they reside and consent to enroll with the Hale Ola (see RFP MQD 2021-008 Section 3.7).

C) Refer to the "Special Health Care Needs" report in the "Part III: Reporting Guide" document.

5.2 Eligible Populations with SHCN

A) SHCN – Children

1. A child with SHCN is a Member under twenty-one (21) years of age who qualifies due to having met one or more of the following conditions:

    a. Pregnant;

    b. Has at least one chronic condition;

c. Has cancer, Hepatitis B, Hepatitis C, HIV/AIDS, or tuberculosis;

d. Takes medications for any serious behavioral/medical conditions that has lasted, or is expected to last, at least (12) months (excludes vitamins and fluoride);

e. Has limited 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 activities of daily living(ADL));

f. Needs or receives treatment or counseling for an emotional, developmental, or behavioral problem that has lasted or is expected to last at least twelve (12) months;

g. Needs or receives 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;

h. Experiences social conditions such as homelessness or have multiple adverse childhood events (ACE);

i. Discharged from an acute care setting when the length of stay is greater than ten (10) days;

j. Has multiple hospital and emergency department visits during a six (6) month period;

k. Has a hospital readmission within thirty (30) days of the previous admission; and/or

l. Has any combination of chronic conditions that have a moderate to high level of severity, and those conditions are not included in the EHCN target group populations.

B) SHCN – Adults

1. An adult with SHCN is a Member who is twenty-one (21) years of age or older who qualifies due to having met one or more of the following conditions:

    a. High-risk pregnancies;

    b. Untreated or unmanaged chronic medical condition;

    c. Untreated or unmanaged behavioral health conditions, including substance use;

    d. Social conditions such as homelessness, food insecurity, lack of financial benefits, and limited English proficiency to negotiate the healthcare system;

    e. 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;

    f. Has cancer, chronic Hepatitis B, chronic Hepatitis C, late stage HIV/AIDS, or active tuberculosis;

g. Discharged from an acute care setting with a length of stay of ten (10) days or longer;

h. Multiple hospital or emergency department admissions during a six (6) month period;

i. Hospital readmission within thirty (30) days of the previous admission; and/or

j. Has any combination of chronic conditions that have a moderate to high level of severity, and those conditions are not included in the EHCN target population groups.

k. For SHCN Members who also receive outside HCS from DHS, DOH, Department of Education (DOE) or Community Care Services (CCS), the QI (QUEST Integration) HCS will:

1) Facilitate access and authorizations to State Plan provider services including medical transportation;
2) Coordinate and/or collaborate on person-centered team meetings with outside HCS to impact the Member's health and social outcomes; and
3) Not duplicate other services the Member is receiving.

5.3 Eligible Populations with EHCN

A) EHCN services are provided to adults and children that meet the qualifications of the EHCN population due to the Member having met one or more of these medical conditions:

1. A serious mental illness (SMI):

a. Members, who are not enrolled in CCS;

b. One or more serious and persistent behavioral health conditions; or

c. Including a diagnosable mental, behavioral, or emotional disorder which results in serious functional impairment and substantially interferes with or limits one or more major life activities.

2. SUD – Members with SUD which include:

a. Recurrent use of alcohol and/or drugs that causes clinically significant impairment;

b. Health problems;

c. Disability; and

d. Failure to meet major responsibilities at work, school or home.

3. Two or more of the following chronic conditions:

a. Asthma;

b. Chronic obstructive pulmonary disease (COPD);

c. Coronary artery disease (CAD);

d. Congestive heart failure (CHF);

e. Diabetes;

f. Obesity;

g. Chronic renal disease;

h. Chronic liver disease; and

i. Members receiving palliative care.

4. One of the identified chronic health conditions listed above and one impairment in an ADL.
5. Any of the identified chronic health conditions listed above and have identified SRF needs and/or high utilization of health services, including emergency department utilization.
6. For Members who have access to another form of health coordination or other service, the following criteria must be met by the contracted provider:
    a. Provider will deliver additional services that otherwise are not available;
    b. Provider services are likely to have an impact on the Member's health outcomes; and
    c. Provider services are not duplicative of the other services the Member is receiving.
7. The EHCN population does not include Members who meet the above EHCN criteria and meet one of the criteria listed below:
    a. Members in a long-term nursing facility for more than ninety (90) days;
    b. Members receiving hospice care;
    c. Members in the transplant program; and/or
    d. Fee-for-service Members.

5.4 Eligibility Determination for SHCN and EHCN

A) The Health Plan will complete the HFA to determine needs of the Member and identify if Member would benefit from SHCN and/or EHCN services.

CHAPTER 6: Long-Term Services and Supports

6.1 Description of LTSS

A) The Health Plan will provide LTSS services to Members who meet At Risk or NF Level of Care (LOC) on the DHS 1147 form (refer to the "Level of Care and At-Risk Evaluation" Appendix G in the "Health Plan Manual - Appendices" document). Members' LOC must be re-evaluated annually, at a minimum. Each LTSS group receives a distinct package of Home and Community-Based Services (HCBS) or Institutional services as described in HAR §17-1720-18 – HCBS or HAR §17-1720-22 – Institutional care.

B) LTSS Members are eligible to receive HCS for the entire duration the Member is receiving LTSS benefits.

C) Refer to the "LTSS" report in the "Part III: Reporting Guide" document.

6.2 Eligible Population

A) In general, Members eligible to receive LTSS benefits are segmented into three groups that are determined by using the DHS 1147 Level of Care and At-Risk Evaluation Form. Each LTSS group receives a distinct package of HCBS or institutional services.

1. "At Risk:" HCBS Member is at risk of deteriorating to the nursing facility level of care.
    a. Member meets "At Risk" level of care using the points on the DHS 1147 form.
    b. Member lives in the community, is eligible for a limited HCBS benefit package, and cannot be residing in a care

home, foster home, hospital, nursing facility, hospice facility, or ICF/ID facility.

c. The three (3) levels of "At Risk" HCBS benefits are:

1) 5-7 points: Home delivered meals and personal emergency response system (PERS);
2) 8-10 points: Home delivered meals, PERS and personal assistance (Level 1);
3) More than 10 points: Home delivered meals, PERS, personal assistance (both Level 1 and 2), adult day care, adult day health and private duty nursing.

2. Community HCBS

a. Member meets nursing facility level of care using the DHS 1147 and chooses to receive HCBS;

b. Member lives in the community; and

c. Member is eligible for the comprehensive HCBS benefit package (refer to the "Long-Term Services and Supports Benefits" appendix in the "Health Plan Manual - Appendices" document) based on the HFA.

3. Institutional Services

a. Member meets nursing facility level of care using the DHS 1147 and chooses to receive institutional care in a nursing facility.

6.3 Eligibility Determination

A) In general, Members must be determined to be aged or disabled prior to receipt of LTSS services. The following assessments must occur before LTSS services can be provided:

1. HFA: The Health Plan or subcontracted entity will perform an individual assessment 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 will be based upon the individual assessment, medical necessity, and person-centered Health Action Plan. Refer to Screening and Assessment.
2. The Health Coordination Team will conduct an HFA within fifteen (15) calendar days of the identification of LTSS service needs.
3. LOC Determination: Members who will receive HCBS or Institutional services need an approved LOC determination completed on the DHS 1147 form (refer to the "Level of Care and At-Risk Evaluation" appendix in the "Health Plan Manual - Appendices" document).
4. ADRC Disability Determination: Members who want HCBS but are not 65 years old and have not yet been determined disabled require a disability determination:
    a. The DHS 1127, DHS 1128, and DHS 1180 forms (refer to the "Aid to Disabled Review Committee" appendix in the "Health Plan Manual - Appendices" document) Disability Report packet must be completed and

submitted to the Health Plan Medical Director then to the DHS Medical Director for final approval.

b. An approved DHS 1147 form that indicates a permanent disability may be submitted in lieu of the DHS 1128 Physician Disability Report.

5. LTSS Eligibility Determination: In general, Members who meet nursing facility LOC on the DHS 1147 form and want to receive HCBS or Institutional services, will be subject to an asset test and are required to submit an additional LTSS application packet to the DHS eligibility worker (EW) for LTSS eligibility approval.

    a. LTSS services are to be provided according to the established Level of Care from the date of the clinician signature on the DHS 1147 until a reassessment is completed according to RFP-MQD-2021-008 §3.7.D.6.

B) LOC Determination

1. If the HFA identifies that the Member will need "At Risk" or Institutional LOC services, the Health Plan will be responsible for assessing Members using the State's LOC and At-Risk Evaluation form (DHS 1147 form). The Health Plan may subcontract this responsibility to a qualified provider or subcontracted entity. The State's LOC and At-Risk Evaluation form is the form used to determine institutional LOC. Once the LOC assessment is completed, the Health Plan or the delegated providers will forward the completed form to DHS, or its designee, for LOC determination. DHS, or its designee, will make the LOC determination. The State's LOC evaluation form

and instructions may be found in the "Level of Care and At-Risk Evaluation" appendix in the "Health Plan Manual - Appendices" document.

2. LOC must be annually renewed prior to expiration using the DHS 1147 Form. LOC renewal should occur at any time if the Member's status improves or deteriorates to necessitate a change to "At Risk", NF LOC or termination if no longer LOC eligible.

6.4 Choice of HCBS or Institutional Services

A) For Members who meet institutional LOC on the DHS 1147 form, the Health Plan will offer and document, in the Member's record, the Member's choice of institutional services or HCBS.

6.5 Enrollment in HCBS or a Nursing Facility

A) When the Health Plan identifies that the Member will be receiving LTSS, the Health Plan will submit a MEDICAID ELIGIBILITY FOR LONG-TERM CARE (LTC) SERVICES form (DHS 1148) to the DHS Eligibility Branch (EB) for long-term care eligibility determination. The DHS 1148 form and instructions may be found in the "Medicaid Eligibility for Long-Term Care Services" appendix in the "Health Plan Manual - Appendices" document.

B) Submission of the DHS 1148 form to EB is not required to provide "At Risk" services for Members. Refer to the "Level of Care and At-Risk Evaluation" appendix in the "Health Plan Manual - Appendices" document for service coverage.

C) The 834 File:

1. The Health Plan receives an 834 file via the DHS SFTP service daily. The 834 file is one mechanism for the Health Plan to confirm Member Medicaid eligibility, LTSS eligibility, enrollment in LTSS, and DHS 1147 authorization dates.

2. For new Members, the 834 file may convey decisions related to whether or not a new Member is determined to be eligible for LTSS. 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 or if the Member's eligibility is based upon receipt of HCBS or nursing facility services, the Health Plan will conduct an HFA within seven (7) calendar days of initial enrollment.

6.6 Description of LTSS Benefits

A) The Health Plan will provide coverage of the following LTSS services: See RFP MQD 2021-008 Section 4.8.B and the "Long-TermServices and Supports Benefits" appendix in the "Health Plan Manual - Appendices" document for Personal Assistance Services.

6.7 HCBS Service Codes Grid

A) Refer to the "Home and Community-Based Service Codes" appendix in the "Health Plan Manual - Appendices" document for the list of HCBS procedure codes.

6.8 LTSS Service Provision

A) The Health Plan may start providing LTSS while the eligibility process is being conducted.

B) The Health Plan will document its good faith efforts to establish cost-neutral HAPs in the community (refer to HAP). The Health Plan must receive prior approval from DHS or its designee prior to disapproving a request for HCBS.

C) The Health Plan will contract with Community Care Case Management Agencies (CCMA) to provide services for Members living in community care foster family homes (CCFFH), expanded adult residential care homes (E-ARCH) and assisted living facilities (ALF). This includes completion of all LOC assessments, HFAs, HAPs, monitoring, and reassessments for this LTSS population.

D) 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 ninety (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.

6.9 LTSS Service Authorization Reviews

HCBS levels assure oversight of authorizations and changes enacted by the Health Coordinator (HC) and Health Plan (HP). The MQD role is not a decision-making role for changes in HCBS, but to provide guidance and oversight. The total number of PANS hours per week is a combination of Personal Assistance Level I (PA I), Personal Assistance Level II (PA II), and Private Duty Nursing. See RFP MQD 2021-008 Section 4.8.C and Health Plan Manual Appendix I for all HCBS service descriptions.

A) Service Authorization and Limitations

1. PA I services may be provided up to 10 hours per week for members who do not meet the nursing facility level of care criteria and are determined "At Risk". However, additional PA I

hours may be authorized for "At Risk" if medically necessary

2. PANS may be provided more than 10 hours per week for members who meet the nursing facility level of care criteria and based on the members' assessed needs.

B) Service Authorization Reviews and Oversight Authority

1. The different levels in the table below illustrates the oversight authority for service authorization reviews and approvals. All Level 3 cases must be submitted to MQD for secondary review and approval when the HP Medical Director has made an initial decision to approve or deny services.

Members under 21 years old				
Level	Hrs/wk	Initial HCBS admission	Increase in service hours	Decrease in service hours
1	<56	HC or HC supervisor	HC or HC supervisor	HC Supervisor or UR Committee
2	57-84	HP Medical Director	HP Medical Director	HP Medical Director or UR Committee
3	>84	HP Medical Director and MQD	HP Medical Director and MQD	HP Medical Director and MQD
Members 21 years and older				
Level	Hrs/wk	Initial HCBS admission	Increase in service hours	Decrease in service hours
1	<70	HC or HC supervisor <21hrs/wk HC only	HC or HC supervisor <21hrs/wk HC only	HC Supervisor or UR Committee
2	71-98	HP Medical Director	HP Medical Director	HP Medical Director or UR Committee
3	>98	HP Medical Director and MQD	HP Medical Director and MQD	HP Medical Director and MQD

2. When submitting information to MQD for service authorization reviews, please submit **all** of the following information to MQD

via your FTP site:

a. Long Term Services and Supports Health and Functional Assessment (LTSS HFA)
    1) Provide the last LTSS HFA and PANS tool(s) (if applicable).
    2) If the services and hours which the Member is currently receiving are not reflected in the last LTSS HFA and PANS tools, provide these in addition.
b. Current Health Action Plan.
c. Progress Notes as it relates to the proposed change in services.
d. Member profile: Member identification, age, diagnosis and brief summary of Member's current condition.
e. Primary Caregiver and support system: Describe who is responsible for Member's care and others who are assisting with care (e.g., family, friends).
f. Psych-social issues (if applicable): Describe how these are being addressed.
g. Summary of current services by service type: Include the length of time that Member has been receiving this level of services (i.e., Member has had 10 hours of PA I and 15 hours of PA II since February 2021).
h. 24/7 Color Coded Daily Activity Schedule.
i. Summary of proposed increase, or reduction of services by service type and justification: Include results of secondary review process and specify proposed hours for each task (e.g., bathing, dressing, grooming, etc.).
j. Explanation of what has changed:
    1) Has a new support structure been identified to replace services being reduced?

2) Has Member's condition improved?
3) Was a previous assessment incomplete or has new information been identified?
4) Are current services authorized not being utilized as indicated (i.e., is there waste in the current plan)?
5) Has Member's informal support and/or caregiver capabilities changed?
6) Member choice (moving to facility placement)?
7) How many hospitalizations has member had in the past 12 months? (if available)

3. Documentation in the Progress Notes that member is aware of the recommended increase or reduction in services being recommended by Health Coordinator.
4. Documentation in the Progress Notes whether Member agrees/disagrees with the proposed change to increase or decrease services.

C) Transition Plan for Reduction of Services

1. The goal of transition planning is a collaborative process that allows members to gradually decrease the number of PANS hours while ensuring that the reduction does not adversely affect the Member's health and safety.
2. Health plans shall develop a transition plan for reductions of over 7 hours a week. If a Member does not agree to the transition plan, the health plan shall document any denial of a transition plan in writing and include the Member's signature or indicate the Member's refusal to sign.
3. Health Coordinators should arrange follow-up phone calls and visits during the transition time to assess the impact of the reduction in service hours on the Member and the Member's

family.

D) Fraud, Waste, and Abuse

1. The health plan, its employees and delegates [e.g. Community Care Foster Family Homes (CCFFH)] must be aware of the potential for fraud, waste and abuse in the approval, provision and monitoring of LTSS. Health plans shall report any suspected fraud, waste or abuse and corrective action taken in accordance with the QI Contract, State and Federal regulations and requirements.

6.10 Electronic Visit Verification (EVV)

A) Pursuant to Subsection (l) of Section 1903 of the Social Security Act (SSA) (42 U.S.C. 1396b), all states must implement EVV for Medicaid-funded home health and HCBS home care services.

B) Electronic Visit Verification (EVV) electronically verifies that authorized in-home service visits occur.

1. EVV solutions must verify: Type of service performed; Individual receiving the service; Date of the service; Location of service delivery; Individual providing the services; and Time the service begins and ends.

2. EVV services are paid for by the State though the Health Plan.

C) Effective January 1, 2020, Hawai'i, Hawaii implemented an EVV system for home health services, home care services, and self-direct services, EVV services include:

1. Home Health Agency Services

2. Home Care Agency Services:

    a. Personal assistance services: Level I and II;

    b. Attendant care services;

    c. Respite services; or

    d. Private duty nursing services.

3. Self-directed services include:

    a. Personal assistance services: Level I and II;

    b. Personal assistance level – delegated nursing services; and

    c. Attendant care and respite are reported as personal assistance.

D) Health plans are responsible to submit or upload timely authorizations to provider agencies through the EVV vendor before service delivery

1. Reauthorizations, authorization edits and terminations, should also be delivered, prior to service delivery, to the EVV vendor.

E) The EVV System requires workers to check in and check out of each Member service in the home and electronically record the time and units of services provided.

F) At the completion of each visit, Members are required to confirm that their services were provided as authorized.

G) Hawaii requires live-in caregivers to participate in EVV self-direct services.

H) All claims and encounters for home health and home

care services are subjected to EVV requirements for dates of service on or after October 1, 2021, and must have a corresponding electronic visit or claims payment will be denied.

6.11 LTSS Planning for Institutional Relocation Services

A) For institutionalized Members who are preparing for discharge to the community, the Health Coordination Team will complete the HFA prior to the date of discharge. The Health Plan will complete Members' discharge planning prior to the Member leaving the institution and ensure all the necessary durable medical equipment (DME) or related supplies are available to the Member upon return. Refer to Relocation Services.

6.12 Waiting List for Members Receiving HCBS and At-Risk Services

A) 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 will 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.

B) The Health Plan will provide all other medically necessary primary and acute care services to Members on the HCBS waiting list.

C) DHS will regularly monitor the Health Plan's management of its HCBS waiting list. As a part of these monitoring activities, monthly, the Health Plan will submit to DHS the following information relevant to its HCBS 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.

D) DHS will meet with the Health Plans on a quarterly basis to discuss issues associated with management of the waiting list. DHS will review the following at these quarterly meetings:

1. Health Plan's progress towards meeting annual thresholds; and
2. Any challenges with meeting the needs of the specific Members on the waiting list.

E) Members who are on a Health Plan's waiting list may change to another Health Plan that does not have a waiting list.

6.13 Self-Direction

6.13.1 Description of Self-Direction

A) Members assessed to need personal assistance services or respite care services may choose to receive these services through an agency, by self-direction, or by both at the same time. Members choosing agency services may choose to use self-direction at any time.

B) Members will have the ability to hire family members (including spouses and parents of minors), neighbors, friends, etc. as service providers.

C) 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

services must meet all of the following authorization criteria and monitoring provisions. The services must:

1. Meet the definition of service as defined in the "Long-Term Services and Supports Benefits" appendix in the "Health Plan Manual - Appendices" document;
2. For personal assistance services Level II and respite services, be necessary to avoid institutionalization;
3. Be a service that is specified in the HAP;
4. 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;
5. Be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service; and
6. 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 considerthe extent to which a Member who is the same age without disability would need the requested level of service or assistance as the Member with a disability.

D) The family member and other self-directed providers will comply with the following:

1. 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;
2. The family member must participate in the EVV program which may also require the Member to maintain and submit all required documentation, such as time sheets for hours

worked; and

3. Married Members must be offered a choice of providers. If the Member chooses a spouse as the Member's provider, it must be documented in the Health Action Plan.

E) The Health Plan will be required to conduct the following additional monitoring activities when Members elect to use a spouse or parents as paid providers:

1. At least quarterly reviews of expenditures and the health, safety, and welfare status of the Member;

2. Face-to-face visits with the Member on at least a quarterly basis; and
3. Monthly reviews of hours billed for family-provided services and the total amounts billed for all goods and services during the month.

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

6.13.2 Role of the Health Plan for Self-Direction

A) The Health Plan will provide all Members assessed to need personal assistance services [as defined in the "Long-Term Services and Supports Benefits" appendix in the "Health Plan Manual - Appendices" document and respite services as defined in RFP MQD 2021-008 Section 4.8(C)(1)(o)] the opportunity to have choice andcontrol over their providers (referred to as self-direction). A Member choosing self-direction will be responsible for fulfilling the following functions:

1. Recruiting/selecting Medicaid providers;

2. Determining provider duties;
3. Determining a rate of pay that is at least the Federal or
4. State minimum wage, whichever is higher;
5. Scheduling providers;
6. Instructing and training providers in preferred duties;
7. Supervising providers;
8. Evaluating providers;
9. Verifying time worked by provider and approving time sheets; and
10. Discharging providers.

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

C) The Health Plan will perform the administrative functions associated with employing self-direction providers for the Member, who is the employer of record, including:

1. Paying providers;
2. Monitoring the EVV portal for completed visits including completion of time sheets when needed;
3. Assuring tuberculosis (TB) test is completed;
4. Validating active cardiopulmonary resuscitation (CPR) and first aid training;
5. Blood-borne pathogen training;
6. Reviewing and verifying results of the status of criminal history

record checks of providers per State requirements (the Members will pay for the cost of background checks out of their budget);

7. Reviewing and approving payment for allowable services; and
8. Withholding, filing, and paying applicable federal, state and employment taxes.

D) Members choosing to hire their friend or family member may elect to forego subchapter 6.12.2. bullets C.3, C.4., C.5., and C.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.

E) The Health Plan will require that all Members and/or surrogates participate in a training program prior to assuming self-direction.At a minimum, self-direction training programs will address the following:

1. Understanding the role of Members/surrogates in self-direction;
2. Selecting and terminating providers;
3. Being an employer and managing employees;
4. Conducting administrative tasks such as staff evaluations and approving time sheets when applicable;
5. How to use the EVV system including why and how to approve every service visit using the EVV device; and
6. Scheduling providers and back-up planning.

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

1. Understanding the role of Members/surrogates in self-direction;

2. Understanding the role of the provider in self-direction, including criteria for job termination;
3. Understanding the tasks that they are being compensated for (i.e., personal assistance or respite);
4. How to use the EVV system including how to check in and out of all service visits; document completion of tasks; and complete timesheets as needed;
5. Payment schedules;
6. Process for notifying Member if unable to perform assigned duties; and
7. Skills competency to perform PA II and delegated tasks, if applicable.

G) 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 Health Coordination Team. The Health Plan may develop these programs internally or contract for this service. Additional and ongoing self-direction programs will be made available at the request of the Member, surrogate, or Health Coordination Team. All new training programs and materials and any changes to programs and materials will be submitted to DHS for approval thirty (30) days prior to implementation.

H) The Health Plan will establish and maintain self-direction policies and procedures that include forms utilized and will submit these to DHS for review and approval in accordance with the Readiness

Review. The policies and procedures will include, at minimum:

1. Process to document choice of self-direction when Member is assessed to need personal care or respite care services;
2. Process to assess Member's ability to implement self-direction, including a copy of the self-assessment form;
3. Process to document Member agreement to self-direct their service;
4. Process for establishing and monitoring nurse delegation for required personal assistance services - Level II;
5. Sample agreement between provider and Health Plan;
6. Process for paying providers (including verifying hours worked using the EVV system);
7. Topics, goals, and frequency of Members/surrogate training programs including the EVV;
8. Topics, goals, and frequency of self-directed provider training programs including the EVV; and
9. Process for Member termination from self-direction.

I) Changes to these policies and procedures or forms will 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.

J) The Health Plan will 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.

K) This term and condition will be specified in the agreement between the provider and the Health Plan. A Member's release of their self-direction provider will be documented in the Health Action Plan.

L) The Health Plan may delegate these functions to another entity through a subcontract. The subcontractor agreement will complywith all requirements outlined in RFP-MQD-2021-008, Section 14.4.

6.13.3 Role of the Health Coordination Team for Self-Direction

A) The Health Coordination Team will assist the Member in facilitating self-direction and in accessing available resources and supports. The Health Coordination Team will also be responsible for monitoring the Health Action Plan to ensure that assessed needs are addressed and to ensure Members' overall well-being.

B) The Health Coordination Team will document the Member's decision to self-direct their service and the appointment of a surrogate (including the surrogate's name and relationship to the Member) in the HAP.

C) The Health Coordination Team will develop a budget for each Member electing self-direction. The budget will 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 will constitute the Member's budget for self-direction and will be discussed and sharedwith the Member by the Health Coordination Team. The Health Coordination Team will educate the Member on choosing the rate of

pay based upon Member's budget that meets state and federal minimum wage requirements.

D) The Health Coordination Team will closely monitor the adequacy and appropriateness of the services provided to determine the extent to which adjustments to the Health Action Plan will necessitate adjustments to the budget.

6.13.4 Role of the Member for Self-Direction

A) As a part of the HAP process, Members assessed to need personal assistance services or respite service, will be informed by the Health Coordination Team of the self-direction option. Members expressing an interest in self-direction will be required to completethe Health Plan's self-assessment form. The form is intended to determine a Member's:

1. Ability to make decisions regarding their 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 their service, but the Member is still interested inelecting the option, the Member will be required to appoint a surrogate to assume the self-direction responsibilities on theirbehalf.

B) Member may choose to designate one (1) Member to act as a surrogate on their 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.

C) 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.

D) A Member can change a surrogate at any time. Changes in a surrogate will be reported to the Health Plan within five (5) days. The Health Coordination Team may recommend that a Member change surrogates if the Member can document that the surrogateis not appropriately fulfilling their obligations. If, however, the Member chooses to continue using the surrogate, the documentedincident(s), the Health Coordination Team's recommendation, andthe Member's decision will be noted in the Health Action Plan.

E) The budget for each Member electing self-direction will 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 their providers.

F) As part of the interview and hiring process, and with the aid of the Health Coordination Team, Members will:

1. Develop interview questions;
2. Screen and interview applicants; and
3. Include in the service agreement between the Health Plan and the provider, the roles and responsibilities of both the Member and the provider.

G) Members choosing to hire their family member may elect to forego bullets F.1. and F.2. above. However, a service agreement delineating the roles and responsibilities of both the Member and the provider is still required.

H) A Member may terminate their self-direction provider for violating the terms of the service agreement.

I) 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 Health Coordination Team will assist the Member in accessing available network providers for personal assistance or respite care services. Members may utilize self-direction and other services simultaneously.

6.13.5 Role of the Provider for Self-Direction

A) 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 will enter into an agreement with each self-direction provider. The agreement will specify the roles and responsibilities of both parties.

B) Self-directed providers will receive overtime pay for authorized time-worked that exceeds forty (40) hours per week. The Health Plan will 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 Health Coordination Team, will decrease the hours of service that they may receive in subsequent weeks. The Health Plan will 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.

6.13.6 The Self-Direction Internal Processes

A) The Health Plan will have a process that details how they will provide a self-direction program for personal assistance and respite services that:

1. Permits Members to hire, fire, supervise, and manage the individuals providing such services;
2. Offers voluntary Member participation and Members are informed of feasible alternatives that include agency-providedservices;
3. Provides Member and provider training, and ensures fiscal accountability and risk management safeguards to protect Member health and welfare; and
4. Monitors self-direction activities and Member outcomes.

B) The Health Plan will provide self-direction program operational documentation, including but not limited to, program policies; procedures; Member and provider training; use of family, household members, and surrogates; provider payment; service monitoring; and Member outcomes to DHS upon request during RFP readiness review and upon DHS request thereafter.

6.14 Home and Community-Based Services Settings Final Rule Implementation

A) In January 2014, the Centers for Medicare & Medicaid Services (CMS) issued new regulations that require home and community-based services (HCBS) to be provided in community-like settings in accordance with 42 C.F.R. 441.301(c)(4). Settings that do not meet the new rules by March 17, 2023, will not be contracted or receive reimbursements by the Health Plan.

B) See Med-QUEST website My Choice My Way for the CMS-approved transition plan. The main components of the transition plan are Self-Assessment, Remediation, and Key Stakeholder Engagement and Public Comment.

C) The settings rule that applies to HCBS services under QI includes, but is not limited to, in-home personal care supports; residential living options such as assisted living, residential care, domiciliary care, and foster homes; and non-residential options such as day care and day health.

D) The purpose of the CMS rule is to ensure Members get Medicaid HCBS in settings that are integrated in the community and Members getting services have access to community resources equal to that of people who do not get HCBS. This means Members getting services should be able to:

1. Have opportunities to seek employment and work in competitive and integrated settings;
2. Engage in community life;
3. Control personal resources; and

4. Get services in the community.

E) The rule also aims to make sure Members getting HCBS have a free choice of where they live and who provides services to them, as well as ensuring that each person's rights are not restricted. While Medicaid HCBS has never been allowed in institutional settings, the new rule clarifies that HCBS will not be allowed in settings that have the qualities of an institution.

F) The Health Plan will ensure that all HCBS is provided through a person-centered planning process outlined in the final rule 42 C.F.R. 441.301(c)(1). The person-centered planning process will:

1. Be driven by the Member and includes people chosen by the Member;
2. Provide necessary information and support to the Member to ensure that the Member directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
3. Be timely and occurs at times/locations of convenience to the Member;
4. Offer informed choice regarding services and supports the Member receives and from whom;
5. Reflect cultural considerations and use plain language;
6. Include strategies for solving conflicts or disagreements within the process, including clear conflict-of-interest guidelines for all planning participants;

7. Reflect what is important to the Member to ensure delivery of services in a manner reflecting personal preferences, strengths, and ensuring health and welfare;
8. Identify strengths, preferences, needs, and desired outcomes of the Member;
9. Include goals and preferences which are related to relationships, community participation, employment, and health;
10. Include risk factors and plans to minimize them;
11. Include a method for the Member to request updates to the plan as needed;
12. Be signed by all Members and providers responsible for its implementation and a copy of the plan must be provided to the Member and their representative; and
13. Any exceptions or modifications to the settings requirements must be documented in the Health Action Plan and meet the Member'sgoals.

G) The Health Plan will ensure all Medicaid providers must be fully compliant with the HCBS final rule. The Health Plan will develop policies and procedures to prescreen HCBS providers for compliance with the Final Rule before initiating a contract. Policies and procedures will be submitted to DHS for review and approval.

H) Health Plan health coordination policies and training protocols must include, but not limited to:

1. HCBS Final Rule overview [42 CFR §441.301(c)(4)/42 CFR §441.710(a)(1)], a process that ensures that the Member
    a. receiving services and supports through Medicaid-

funded HCBS programs has full access to the benefits of community living and is able to receive services in the most integrated setting; and

b. is informed and supported to exercise their freedom of choice in selecting between institutional or home and community-based waiver services.

2. Options counseling, a decision support process that ensures that the Member
    a. understands their Member rights;
    b. has access to services in non-disability specific settings among their service options for both residential and non-residential services;
    c. is provided with options and choice of activities;
    d. is consulted in active selecting, planning, and scheduling organized activities;
    e. knows how to request a change of service provider or support staff;
    f. is treated with dignity and respect;
    g. is afforded privacy for personal activities;
    h. is engaged in community living and social activities of their preference outside of the setting at will;
    i. has choice in visitors and opportunity to schedule visits; and
    j. is involved in choice of community activities based on their choices and interests, even beyond center-based programs.
3. Person-centered thinking and planning [42 C.F.R.441.301(c)(1)-(2)], see Section 6.14.F

I) Health Plan will ensure that health coordinators, support staff assisting with coordination of HCBS services, and other contacted

coordinators/case managers are trained. Training may be delivered as an online module or in person, as needed. The health plan may use the curriculum recommended by the state or request to use an alternative. When requesting to use an alternative curriculum the health plan must submit proposal to MQD for review and approval. Factsheets and MQD trainings are available on the My Choice My Way website "Resources" tab at https://medquest.hawaii.gov/en/members-applicants/already-covered/my-choice-my- way.html

J) The Health Plan will develop policies and procedures to prescreen new HCBS providers for compliance with the Final Rule before initiating a contract. Prescreening includes, but not limited to, ensuring that the Provider has a Medicaid identification number, a completed Provider Self-Assessment Survey, and a validation check on file by MQD. A sample of a Provider Self-Assessment Survey is included as Appendix AB. Policies and procedures will be submitted to MQD for review and approval.

K) The Health Plan will develop policies and procedures for HCBS providers. The Health Plan shall continue a HCBS contract if the provider is able to demonstrate the provision of services in fully integrated community settings to continue the approval and delivery of HCBS services. This includes the submission of a provider self-assessment survey, provider attestation of ongoing compliance, and evidence tool with supporting documentation. A sample of a provider attestation and evidence tool has been provided in Appendix AC.

L) Health Plans will have a process to validate the delivery of HCBS in provider-owned and controlled settings and in private residential homes. The Health Plan shall have a quality monitoring tool used to validate the provider for ongoing compliance when attestation and evidence tool is submitted. The validation of settings compliance

may be conducted in person or virtually. See Appendix AD for a sample of the quality monitoring tool. The provider attestation and validation approval are valid for up to five (5) years based on the discretion of the Health Plan. The Health Plan shall provide technical assistance related to contracting requirements, as needed. If the provider does not demonstrate compliance, the Health Plan will temporarily suspend new admissions or services until remediated. If the provider does not demonstrate compliance within the remediation timeframe, the Health Plan shall terminate contract. The Health Plan shall also notify DHS when a provider contract is terminated.

M) The Health Plan will have a process to validate the delivery of HCBS for Members in independent living arrangements. The Health Plan may conduct a satisfaction survey that focuses on Member rights. See Appendix AE for an example of the Member satisfaction survey. If the Health Plan identifies a disregard of Member rights the Health Plan must have a intervention process.

N) The Health Plan will have a process for members to report a non-compliant provider and how to address the Member feedback. The Health Plan may use the grievance process and/or notification a health coordinator.

O) The Health Plan will ensure that any provider operating in a setting that is not in full compliance will be notified that participants receiving services in the setting will be transitioned to another setting. The Health Plan will work closely with the HCBS provider to transition participants into other compliant settings.

1) The Health Plan will coordinate a transition of care plan for participants in settings that cannot meet the HCBS requirements. The Health Plan will develop policies and procedures for transition of care. The process will include, but

not be limited to:

a. Timely notification to the Member and provider;
b. Providing informed choice of different setting options in a person-centered planning meeting;
c. Developing a transition plan with timelines;
d. Ensuring continuity of services in setting of choice;
e. Ensuring the participant needs and preferences are met; and
f. Ensuring seamless coordination between service providers.

2) Once transition has taken place, the Health Plan will update the person-centered action plan and establish ongoing monitoring aligned with onsite visit requirements.

P) The Health Plan will not contract with settings that have qualities of an institution or have the effect of isolation by service location or operational structure such as, the setting:

1. Is privately or publicly owned facility that provides inpatient treatment.
2. Is on the grounds of or adjacent to a public institution.
3. Could have the effect of isolating Members from the community.
4. Has a reverse integration or a program model that intentionally invites individuals not receiving HCBS into the setting.
5. Has multiple co-located and operationally related locations that congregate many people with disabilities and provide significant shared programming staff, such that the Members' ability to interact with the broader community is limited.
6. May isolate Members, such as:
   a. Use of interventions or restrictions that are used in

institutional settings (e.g., seclusions).

b. Multiple types of services and activities on-site, including housing, day services, medical, behavioral, and therapeutic services, and/or social recreational activities provided only to Members with disabilities.

c. Members in the setting have limited interaction with the broader community.

6.15 Bed-Hold Requirements for Long Term Care

A) A Medicaid beneficiary's bed may be reserved during a beneficiary's temporary absence from the long-term care facility if:

a. The client's beneficiary's plan of care provides for absences other than for hospitalization and is approved by the client's beneficiary's attending physician;

b. Any single episode during which a bed is reserved does not exceed a period of three consecutive days, unless a request for prior approval is submitted to the program, reviewed and approved by DHS;

c. The total number of days a beneficiary's reserves a bed does not exceed twenty-four (24) days in a calendar year (consecutive 12 months from the first day of the calendar year); and

d. A record is maintained of the beneficiary's medical chart which accounts for the number of days and specific dates for any year that a client beneficiary reserved a bed, subject to periodic review by the department's representatives.

B) Payments shall not be made for a reserved bed when the beneficiary's absence is due to acute hospitalization stays.

C) Payments for a reserved bed during a beneficiary's absence as defined in item A, shall be based on reimbursement methodology established by the Health Plan.

CHAPTER 7: Going Home Plus and Institution Relocation Services

7.1 Description of Going Home Plus and Institution Relocation Services

A) Person-centered relocation services are provided to help members in institutions (i.e., hospitals, psychiatric residential treatment facilities, prisons, nursing homes, or other long-term care facilities) who are: youth with mental illness; elderly; or have physical, intellectual, and developmental disabilities to move out and receive services to live in their own homes and communities.

B) Relocation activities include all transitions from institutions to communities, including:

1. Going Home Plus (GHP) eligible Members who meet nursing facility Level of Care and have been institutionalized for at least sixty (60) days for which an enhanced Federal Medical Assistance Percentage (FMAP) is received; and
2. CIS-eligible Members institutionalized for at least sixty (60) days.

C) The Health Plan will have a process in place that details how the Health Plan will identify and prepare institutionalized Members for successful community transition including transitions to independent living; and how they will track and report efforts to rebalance its long-term services and supports system by increasing the use of community-based services rather than institutional services.

7.2 Eligible Population

A) For each category that the member is in, refer to the specific chapters for additional information:

1. Long-term Services and Supports (LTSS)
2. Community Integration Services (CIS)
3. Community Care Services (CCS)

7.3 Eligibility Determination

A) The Health Plan or subcontracted entity will complete the HFA to determine the Member goals; health and functional capability of the Member; and the appropriate strategies and services to best meet the needs and goals. The scope, duration, and amount of HCBS and community support services should be based upon the HFA, medical necessity, and the person-centered Health Action Plan.

B) The HFA will be conducted prior to discharge from the institution and the Member will be reassessed within fifteen (15) calendar days post discharge to ensure adequate support services are in place for the Member.

7.4 Institution Relocation Services/Transitions

A) Role of the Health Plan for Relocation Services

1. The Health Plan will participate in institutional relocation services such as the GHP nursing home and hospital waitlist relocation services.
2. Health Plans must have data analytics to identify potential relocation candidates that include strategic targeting forms like the MDS Section Q responses, MDS summary reports, and

facility census reports that may be available to the Health Plan and/or the state.

3. The Health Plan must designate a point of contact, if not the Health Plan's Nursing Facility Health Coordinator, to receive referrals for institutionalized Members who:
    a. Request to return to the community and require HCBS services and or housing services; and
    b. Are referred by facility discharge planners because Member has requested, or Member is ready for discharge.
4. If needed, the Health Plan must engage housing coordination services and refer for additional community resources or supplemental funds as one-time financial assistance for rental assistance, essential household or transition expenses not covered by transition assistance services (TAS) or CIS, for all members with an identified need.
5. Prior to the discharge date, the Health Plan will ensure that the HFA, person-centered Health Action Plan, and home assessments are completed, and all necessary services and equipment, including transition assistance services items, as well as mental health or SUD treatment, are in place on the day of discharge.
6. Following discharge, the Health Plan or contracted entity will maintain additional oversight and coordination activities with members relocated from institutions, such as nursing facilities and hospital waitlist beds, for at least three months to stabilize

the transition and prevent readmission to the facility. Minimum requirements for GHP and CIS members post discharge: Month 1-weekly; Month 2-semi-monthy; Month 3-12 – monthly.

7. Upon DHS request, the Health Plan will provide their written policies, procedures, completed assessments, and action plans.

B) Role of the Health Coordination Team for Relocation Services

1. The Health Coordination Team or contracted entity must assess the Member to determine if the Member can be safely served in the community with available resources.
2. The Health Coordination Team or contracted entity must work with the Member and their family, the Member's Primary Care Provider, the nursing facility discharge planner, and other community partners, as needed, to ensure timely and coordinated access to an array of providers and other non-capitated services as necessary and appropriate, including referrals to community organizations.
3. Prior to discharge, the Health Coordination Team or contracted entity must:
    a. Assess the Member for services, equipment, and transition needs, including accessibility, mental health, and SUD services;
    b. Conduct a home assessment to identify and address any safety and accessibility barriers; and
    c. Develop and implement a transition plan with the Member and their supports.

4. If the initial review does not support a return to the community, the Health Coordination Team will conduct a second assessment ninety (90) days after the initial assessment, and quarterly thereafter, to evaluate if the Member’s condition or circumstances changed and support a return to the community.
5. The Health Coordination Team or contracted entity must be present at the relocation site on the day and time of the Member's transition.
6. Assessments and transition/Health Action Plans completed as part of institutional relocation services will be available for DHS review at any time

CHAPTER 8: Community Integration Services

8.1 Description of Community Integration Services (CIS)

A) Community Integration Services (CIS) – Supportive Housing Services are Medicaid-reimbursable pre-tenancy and housing stabilization services. The QI Health Plan will provide CIS-eligible Members with SHCN, EHCN, or LTSS health coordination services that seek to coordinate access to healthcare while addressing housing needs for vulnerable members. QI Members enrolled in the Community Care Services (CCS) behavioral health organization (BHO) will receive CIS through the CCS plan.

B) Refer to the "Community Integration Services" report in the "Part III:Reporting Guide" document.

8.2 Eligible Population

A) Members eighteen (18) years of age or older if the Member meets the criteria:

1. Expected to benefit from CIS and meets at least one of the following health needs-based criteria:
    a. Member is assessed to have a behavioral health need which is defined as one or both of the following criteria:
        1) Mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to liveindependently without support) resulting from the presence of a serious mental illness; and/or
        2) Substance use need, where an assessment using American Society of Addiction Medicine

(ASAM) criteria where the Member meets at least ASAM level 2.1 indicating, at minimum, the need for outpatient day treatment for 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).

2. Member has at least one of the following risk factors:

a. Homelessness, defined as lacking a fixed, regular, and adequate night-time residence, meaning:

1) Has a primary night-time 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

2) 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 night-time residence:

1) There is notification in writing that their

residence willbe lost within (twenty-one) 21 days of the date of application for assistance; such that:

2) No subsequent residence has been identified; and

3) The Member does not have sufficient resources or support networks (e.g., family, friends, faith-based orother 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 an institution:

1) Frequent is defined as more than one contact in thepast twelve (12) months.

2) Lengthy is defined as sixty (60) or more consecutivedays within an institutional care facility.

8.3 CIS Identification and Referral of Potential CIS Members

A) Referrals for CIS will come through different entities, depending on where the Member is engaged and/or identified as potentially eligible for CIS. QI entry points into CIS will include:

1. QI Health Plan entry points into the system for persons experiencing homelessness, or institutionalization for sixty (60) days or more with no home to return to or risk for eviction:

a. The State and QI Health Plan data analysis for Homelessness Z Code (Z59.00), demographic/addressinformation on the 834 file, or other indications of homelessness.

b. QI Health Plan screens of utilization data on Members who are homeless.

c. QI Health Plans Member matching with the homeless management information system (HMIS) data when the HMIS data-sharing agreements are available.

d. Welcome calls for new QI Members/Member surveys from QI Health Plan activities.

e. Quality improvement activities – through QI Health Plans.

f. HFA reassessments for QI Members – from HealthCoordinators at the QI Health Plans.

2. Community entry points for all others – since eligibility for CIS is broader than persons who are homeless, referrals will also come from other sources:

    a. HMIS/Coordinated Entry System (CES) by-name-list.

    b. Community Service Coordinators/Case Managers.

    c. Current homeless agencies and independent living providers, DHS and Housing and Urban Development Continuum of Care Programs, Public Housing Authority, DOH/ADAD and AMHD.

    d. Medical provider referrals: inpatient/emergency department/nursing facility/primary care physician/clinics-FQHC/nursing facilities or other institutional settings.

    e. The State Medicaid eligibility workers.

    f. Re-entry worker/system referrals: Hawai'i State

Hospital (HSH), Prisons, Drug Treatment, etc.

g. Members, friends, and family members.

8.4 Description of CIS Benefits

A) Pre-tenancy supports

1. The Health Plan will cover the following pre-tenancy support services:

    a. Conducting a housing 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); identifying needs for support to maintain community integration (including what type of setting works best for the Member); and providing assistance in budgeting for housing and living expenses.

    b. Developing an individualized housing support plan based upon the housing 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.

    c. Assisting the Member with connecting to social services to help with obtaining documents; filling out and submitting applications for entitlements such as food and income necessary for community living and establishing credit; training to understand and meet obligations of tenancy; and finding and applying for

housing and rental subsidies necessary to support the Member with meeting their medical care needs.

d. Participating in person-centered plan meetings at redetermination and/or conducting revision plan meetings, as needed.

e. Providing supports and interventions per the person-centered plan.

B) Housing Stabilization (Tenancy Sustaining) Services

1. The Health Plan will cover the following tenancy sustaining services:

   a. Service planning support and participation in person-centered plan meetings at redetermination and/or while conducting revision plan meetings, as needed.

   b. Coordinating and linking the Member to services and service providers including primary care and health homes; SUD 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.

   c. Applying for entitlements and rental subsidies including assisting Members in obtaining documentation; navigating and monitoring applications and

reauthorization processes; and coordinating with the

entitlement agencies and rental subsidy providers.

d. Assistance in accessing supports to preserve the most independent living, such as individual and family counseling, support groups, and natural supports.

e. Providing supports to assist the Member in the development of independent living skills, such as skills coaching, financial counseling, and anger management.

f. 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.

g. Coordinating with the Member to review, update, and modify the housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.

h. 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

1. The Health Plan will cover the following community transition services:

   a. Transitional Case Management Services. Services that will assist the Member with moving into stable housing,

including assisting the Member in arranging the move, assessing the unit's and Member's readiness for move-in, assisting the Member (excluding financial assistance) in obtaining furniture and commodities.

b. 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 healthcare professional, and remediation is not covered under any other program.

c. Legal Assistance. Assisting the Member 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.

d. 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 Member during the life of the demonstration, except for State determined extraordinary circumstances such as a natural disaster.

8.5 Rules Surrounding CIS Provision

A) HFA

1. All CIS members will have an HFA.
2. The Health Coordination Team will be responsible for

conducting the HFA and reassessments to determine whether a Member is eligible for CIS services and completing a Health Action Plan.

B) CIS Housing Assessment and CIS Housing Support Plan

1. Standardized forms developed by DHS.
2. The QI Health Plan service coordinator or the contracted CIS provider will conduct the CIS housing assessment and create the housing support/crisis plan.
3. CIS housing reassessments will occur, at a minimum, every ninety (90) days through a face-to-face visit or through a communication method preferred by the Member unless contraindicated (e.g., telephone, text, email, video chat, etc.)

C) Provision of CIS Services for CCS BHO Members

1. QI Health Plan Members enrolled in CCS will receive CIS services from the CCS BHO. CCS will:
    a. Ensure eligible Members are provided the CIS services needed to secure and maintain permanent housing.
    b. Use the CIS eligibility determination criteria in Chapter 9.2 within this Manual to identify CIS-eligible Members.
    c. Be responsible for timely tracking and reporting of all CIS status changes to the State and the Members' QI Health Plan.
    d. Coordinate with the Member's QI Health Plan:
        1) Obtain needed medical care, transportation, and wrap around support HCBS services for CIS Members.
        2) Transition CIS service provision to the Member's QI Health Plan when Member is no longer CCS-eligible

e. Paying for CIS services.

D) The Health Plan will have policies and procedures to promote coordinated CIS services that vary in scope and frequency based on the Members' intensity of need and ensures:

1. Coordinated provision of CIS with the goal of providing person-centered whole person services that promote community integration, Member advocacy and self-sufficiency;
2. An active, assertive system of outreach 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; and
3. Conflict free case management that includes a broad provider network of contracted entities (e.g., homeless agencies, case managers, independent living providers) that will provide CIS services for Members.

E) The following use of CIS funds is prohibited:

1. Payment of ongoing rent or other room and board costs.
2. Payment for document recovery and housing application fees.
3. Capital costs related to the development of housing.
4. Expenses for ongoing regular utilities or other regularly occurring bills.
5. Goods or services intended for leisure or recreation.
6. Duplicative services from other State or federal programs
7. Services to individuals in a correctional institution or an

institution for mental disease (IMD), other than services that meet the exception to the IMD exclusion.

8. CIS supportive housing services do not include meals, mortgage payments, televisions, cable, telephones or telephone usage fees, recreation expenses, legal representation or payment for legal representation, furniture, and commodities.
9. Direct payment for CIS-supported housing services to the QI Member and/or their family are not permitted.
10. CIS–supported housing services must not be used to cover residential treatment facility room and board charges.

F) CIS Status Codes

1. The State database will always reflect the most current CIS program Member status: A bidirectional mechanism has been established using the State 834 report and the QI Health Plan daily, weekly or monthly CIS Status code file upload to notify

   DHS, and vice versa, about Members identified for and receiving CIS services.

CHAPTER 9: Behavioral Health Services Guidance

9.1 Overview

A) The Med-QUEST Division (MQD) is responsible for providing behavioral health services to all Members. QI provides standard behavioral health services to all beneficiaries and specialized behavioral health services to beneficiaries with SMI, serious and persistent mental illness (SPMI), or requiring support for emotional and behavioral development (SEBD).

9.2 Stepped Approach to Behavioral Health Services Overview

A) DHS is adopting the framework of a stepped approach to behavioral health (Von Korff and Tiemens, 2000) in order to achieve the Member's personalized treatment goals that are guided by the Member's response to treatment, the Member's readiness to engage in self-care, and the provision of adequate supports and follow up.

B) A stepped approach allows the Member to fluidly move up and down a continuum of care, and treatment levels and interventions will be paired with the Members' level of acuity to provide effective care without overutilization of resources.

C) Implementing the stepped approach to behavioral health, the Health Plans will work together by January 1, 2022, to:

1. Develop a standardized protocol that will be used by all plans to define how Members will move up and down the continuum of care;
2. Describe in detail, the way in which member movement happens;

3. Submit the agreed upon standardized protocols to the State upon readiness and any time prior to releasing an update; and
4. Ensure that services are utilized in the most effective and efficient manner possible through in-service training, data collection, and evaluation when feasible to implement the DHS-approved protocols.

9.3 Coverage for Standard or Specialized Behavioral Health Services

A) Coverage for all Members receiving behavioral health services

1. Regardless of the type of behavioral health service a Member receives or where the Member receives their behavioral health services, the Member continues to have access to all other services for which the member is eligible, including:
    a. Primary and acute care services from their Health Plan;
    b. Early periodic screening, diagnosis, and treatment (EPSDT) services if the Member is under the age of 21;
    c. Home and community-based services/long-term supports and services (HCBS/LTSS) under the section 1115 demonstration waiver; and
    d. Services or under the Intellectual and/or Developmental Disabilities (I/DD) 1915(c) waiver.

B) Standard coverage for behavioral health services

1. All Members have access to standard behavioral health services through the Health Plans.
    a. The standard behavioral health services include:

1) Inpatient psychiatric hospitalization;
2) Emergency department services;
3) Ambulatory services that includes crisis management and residential services;
4) Medications;
5) Medication management;
6) Diagnostic services;
7) Psychiatric and psychological evaluation and management; and
8) Medically necessary SUD treatment and methadone management.

C) Specialized behavioral health services for Members with SMI, SPMI, or SEBD

1. For children (members <21), the SEBD services are provided through the DOH Child and Adolescent Mental Health Division (CAMHD) below.
2. For adults (members >18) the SMI/SPMI services are provided through the State's behavioral health program.

D) Members who no longer meet the criteria, or Members who opt out of specialized behavioral services will receive standard behavioral health services through the Health Plan.

E) QI standard and specialized behavioral health charts:

1. Refer to the "Behavioral Health Service Delivery" appendix in the "Health Plan Manual - Appendices" document for an overview of the behavioral health services delivery systems for Members with SMI, SPMI, or SEBD; and

2. Refer to the "Details of Covered Behavioral Health Services" appendix in the "Health Plan Manual - Appendices" document for a detailed description of the services provided by CAMHD, AMHD, CCS, and the Health Plans.

9.4 CAMHD Specialized Behavior Services for SEBD

9.4.1 SEBD Coordination with CAMHD

A) CAMHD provides mental health services for eligible children and youth in Hawai'i who have severe emotional and/or behavioral challenges.

9.4.2 DHS Coordination with CAMHD for SEBD services

B) DOH-CAMHD, referred to as CAMHD, provides mental health services for eligible children and youth in Hawai'i who have severe emotional and/or behavioral challenges.

C) DHS has a Memorandum of Agreement (MOA) with CAMHD to provide SEBD services to QI Members who meet eligibility criteria.

D) CAMHD SEBD services are carved out of the QI Health Plan responsibilities.

9.4.3 Eligible Population

A) Age three (3) through twenty (20) years;

B) Falls under one of the qualifying diagnoses (refer to the "Eligibility Diagnoses for QI Specialized BHS" appendix in the "Health Plan Manual - Appendices" document) as determined by a qualified mental health professional (QMHP);

C) Child and Adolescent Functional Assessment Scale (CAFAS) score is greater than 80;

D) The CAMHD Medical Director or designated Qualified Mental Health Professional reviews and makes the determination of SEBD eligibility;

E) Members who do not meet the eligibility criteria, based on assessment by the Health Plan's medical director, but are determined to need additional services for the Member's health and safety, will be referred to CAMHD for provisional eligibility on a case-by-case basis;

F) Qualifies for special education due to emotional or behavioral needs (if referred by the Department of Education).

9.4.4 Referral and Evaluation

A) The Health Plan will:

1. Make referrals to CAMHD through use of the SEBD referral developed by CAMHD.
2. The Health Plan is notified of Members eligible to receive services from CAMHD via the 834 file. The Health Plan is responsible for coordinating with CAMHD to continue providing necessary services, including behavioral health services, even after the Member is admitted into the CAMHD program.
3. In cases where both the Health Plan and CAMHD are providing services for the Member, the Health Plan will not provide services offered by CAMHD, and CAMHD will not provide services offered by the Health Plan.

4. When a Member is no longer eligible for services through CAMHD, CAMHD will coordinate transition of care with the Member's Health Plan.

B) Referrals to CAMHD can also occur through the school, parent, Member, or the Health Plan.

1. CAMHD considers all referrals through an assessment process;
2. Even if a Member qualifies for SEBD services, parents can choose to have the Member's behavioral health services provided through the Member's Health Plan;
3. However, the Health Plans are only able to provide the standard and specialized behavioral health services identified in their contract; and
4. CAMHD provides specialized behavioral health services.

9.4.5 SEBD Services

A) Services include assessment, case management, and an array of therapeutic supports provided in the home, community, or temporary out-of-home placements that include:

1. Hospital-based residential services
2. Therapeutic living supports:
    a. Transition family homes
    b. Community-Based Residential based-residential
3. Intensive outpatient hospital services
4. Outpatient services:
    a. Intensive in-home services

b. Multi-systemic therapy

c. Functional family therapy

5. 24-hour crisis outreach:

a. Consultation

b. Mobile outreach services

c. Crisis intervention/stabilization services

6. Crisis residential services

7. Targeted case management

9.4.6 Health Plan Responsibilities for SEBD

A) The Health Plan will work with CAMHD to transition Members in and out of the SEBD programs and coordinate medically necessary services while in the program. The Health Plan must exchange existing Health Action Plan and supporting documents as requested during these transitions.

B) The DOH CAMHD program and Health Plans will exchange information using industry standard electronic data interchange formats. These may initially include secure email, and after the initial year these must use technical methods compliant under the Federal 21st Century CURES Act. This may comprise HL7 FHIR v4.0 APIs and USCDI, or equivalent technical methods and standards for interoperability in importing/exporting Member Health Action Plan, clinical, and enrollment data for the purposes of ensuring information flow required for Member Health Coordination and transitions of care. Health Plans must jointly develop policies and procedures for assuring participation in and integration of health

action planning with the Member/guardian consent according to timelines and standards established by DHS with CAMHD.

9.5 CCS Specialized Behavioral Services for SMI/SPMI

9.5.1 Community Care Services (CCS) Overview

A) CCS is the Medicaid program responsible for the delivery of behavioral health services to adult Members of QUEST Integration (QI) Health Plans who have SMI or serious and persistent mental illness (SPMI). CCS services are provided statewide and managed by a single vendor. The vendor that is contracted by DHS to provide these services is referred to as the BHO.

9.5.2 CCS Eligible Population

A) Member is 18 years and older with a SMI or SPMI;

B) Member demonstrates presence of a qualifying diagnosis (refer to the "Eligibility Diagnoses for QI Specialized BHS" appendix in the "Health Plan Manual - Appendices" document) for at least twelve (12) months or is expected to demonstrate the qualifying diagnosis for the next twelve (12) months; and

C) Member meets at least one (1) of the criteria below demonstrating instability and/or functional impairment:

1. Clinical records demonstrate that the Member is currently unstable under current treatment or plan of care. Examples include, but are not limited to:

    a. Multiple hospitalizations in the last year and currently unstable; substantial history of crises and currently unstable; 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. Member is under protective services or requires intervention by housing or law enforcement officials.

D) If Member does not meet the eligibility criteria but is determined by the DHS medical director or its designee, that additional behavioral health services are medically necessary for the Member's health and safety, the Member will be evaluated on a case-by-case basis for provisional eligibility into CCS.

9.5.3 CCS Referral and Evaluation

A) Identification of the Members who meet the above criteria will be done by the QI Health Plan using the following:

1. Encounter data;
2. Pertinent medical information; or
3. Referrals and/or consultation with but not limited to: Health Plan staff, mental health contractors, social service agencies.

B) The QI Health Plans will send referral form 1157 (refer to the "Referral for SMI CCS Program" appendix in the "Health Plan Manual - Appendices" document) to DHS indicating that the member has been identified as meeting criteria for the CCS program (refer to RFP MQD 2021-008 Section 4.4.B.2).

C) Potential Members may be referred to DHS for eligibility determination. CCS referrals may be submitted to DHS by the following agencies:

1. QI Health Plan;
2. Hawai'i State Hospital (HSH) for individuals who are being discharged;
3. DOH: AMHD, CAMHD, or Developmental Disabilities Division (DDD);
4. Department of Public Safety for individuals who are being discharged from a correctional facility;
5. DHS for those 18 years or older who are being discharged from the Hawai'i Youth Correctional Facility; or
6. Self-referring Medicaid members directly to CCS or by referrals through crisis services.

D) The DHS psychiatrist or medical director reviews the referrals and determines CCS eligibility based on the clinical criteria in the RFP-MQD-2021-008. Once the Member has been determined to meet the criteria, the Member will be enrolled into CCS five (5) business days after the date of approval.

E) Upon enrollment, the Member can choose from the CCS-contracted, community-based case management (CBCM) agencies. Once chosen:

1. The agency will assign a case manager to conduct an assessment;
2. An Individualized Treatment Plan is developed; and

3. If an agency is not chosen, CCS will assign a CBCM agency.

F) CCS exception: AMHD and DHS have an MOA for the provision of behavioral health services for Medicaid beneficiaries over 18 years old with SMI/SPMI who are legally encumbered. General coordination of behavioral health services will be provided through AMHD.

9.5.4 CCS Services

A) The services to be provided by the BHO include:

1. All medically necessary behavioral health services for eligible members who have been determined to be SMI/SPMI or have a provisional diagnosis of SMI/SPMI;
2. The BHO is required to utilize the definition found in Section 432E-1.4, HRS defined in the State statute for medical necessity for provision of behavioral health services; and
3. The BHO is required to provide all necessary covered services to all eligible members. These necessary covered services are required to be furnished in an amount, duration, and scope to achieve the purpose for which the services are furnished.

B) The BHO is required to assure provisions of a full range of services to include, but not limited to, the following:

1. Psychiatric and SUD inpatient, outreach, treatment, and rehabilitation;
2. CIS and crisis response services needed by adults with a diagnosis of SMI/SPMI; and

3. Coordination of its services and sharing with the State, the Member's Health Plan, and Member's other providers, the results of any identification and assessment of the Member's needs to prevent duplication of services and ensure that services are appropriately provided.

C) Services may be provided or arranged in a variety of ways through:

1. Natural supports;
2. Mental health agencies;
3. General hospitals;
4. Family members;
5. Consumer help approaches; and
6. Recovering consumers as paid or volunteerstaff.

D) The BHO is required to assist and empower Members to manage their illness, develop the appropriate and necessary living skills, and acquire supports and resources they need to maximize their quality of life in the community. The BHO is required to ensure that its Members have access to medically necessary services that address prevention, diagnosis, and treatment. BHO services include, without limitation, the following services as medically-necessary:

1. Inpatient behavioral health hospital services;
2. Emergency department services;
3. Ambulatory behavioral health services and crisis management;
4. Medications and medication management;

5. Diagnostic services and treatment to include psychiatric or psychological evaluation and treatment;
6. Medically necessary SUD services;
7. Methadone management services;
8. Intensive case management;
9. Partial hospitalization or intensive outpatient hospitalization;
10. Psychosocial rehabilitation/clubhouse;
11. Therapeutic living supports;
12. CIS;
13. Representative payee;
14. Supported employment;
15. Peer specialist;
16. Behavioral health outpatient services; and
17. Other services.

E) The BHO is required to have direct access to behavioral health outpatient services as described in RFP MQD 2021-008 Section 4.4 (Coverage Provisions for Behavioral Health Services).

F) The BHO must specify what constitutes "medically-necessary services" that is no more restrictive than the state Medicaid program, including quantitative and non-quantitative treatment limits (QTL) (NQTL), as indicated in State statutes and regulations, the BHO, and other State policies and procedures.

G) The BHO is required to offer CIS to CCS Members eighteen (18) years of age or older if the Member meets the following criteria as listed in RFP MQD 2021-008 Section 14.4. and Chapter 9.2.

1. Identification of the CCS Members who meet the CIS eligibility criteria defined in Chapter 9.2 will be done by the BHO using the following:
    a. Encounter data;
    b. Consultation with social service agencies/case management agencies' assessments; and
    c. Partnerships established for Hawai'i's Homeless Management Information System Hawaii's homeless management information system (HMIS) and homeless coordinated entry systems (CES).

9.5.5 Coordination with CCS

A) The Health Plans and CCS will coordinate the medical and behavioral health needs of its Members. Collaboration between the Health Coordination System (HCS) and CCS case managers is expected.

B) Coordination with CAMHD, AMHD, and DDD is required.

1. CCS is expected to jointly develop policies and procedures assuring participation in the development of the HAP with Member/authorized representative or with a legal guardian consent according to timelines and standards established by DHS with CAMHD, AMHD, and DDD.
2. CCS is required to work with the agencies in transitioning Members in and out of the programs and for coordinating medical and behavioral health services. CCS is required to coordinate and integrate existing care plans during these

transitions. Additionally, CCS 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.

3. DHS may provide additional guidance during the Contract period.

9.6 DOH-ADAD and Hawai'i CARES Overview

A) DOH – The Alcohol and Drug Abuse Division (ADAD) is the primary, and often sole, source of public funds for substance use treatment. ADAD's treatment efforts are designed to promote a statewide culturally appropriate, comprehensive system of services to meet the treatment and recovery needs of Members and families. Treatment services have, as a requirement, priority admission for pregnant women and injection drug users.

B) Hawai'i CARES is a collaboration program between DOH and the University of Hawai'i. Hawai'i CARES is a 24/7 coordination center for support with substance use, mental health, and crisis intervention. Any resident may call Hawai'i CARES.

9.6.1 ADAD and Hawai'i Cares Description of Services

A) ADAD contracts and provides oversight for SUD Continuum of Care (SUD COC), treatment, and recovery support services accessible through Hawai'i Cares. Types of SUD services include:

1. Pre-treatment services: outreach, motivational enhancement, interim services, screening, addiction care coordination, stabilization bed.

2. Treatment services: assessment, placement determination/referral, health and wellness planning, ASAM 3.7 WM Medically-Monitored Inpatient Withdrawal Management, ASAM 3.2 WM Clinically- Managed Residential Withdrawal Management, ASAM 3.5 Clinically Managed High-Intensity Residential Services, ASAM 2.5 Partial Hospitalization Services (Day Treatment), ASAM 2.1 Intensive Outpatient, ASAM 1.0 Outpatient, Opioid Recovery Services (All ASAM Levels), child care, addiction care coordination, and stabilization bed.
3. Recovery support services: ASAM 3.1 Clinically Managed Low-Intensity Residential Services, Therapeutic Living Program, clean and sober housing, group recovery homes, continuing care services, addiction care coordination, and stabilization bed.
4. Additional services: urinalysis, urinalysis confirmatory, MAT daily dosing, toxicology screening, stabilization beds, transportation services, translation services, cultural activities, and contingency management.

9.6.2 SUD Criteria for Services

A) SUD: An adult Member, an adolescent Member, and family with an adult or adolescent Member with an SUD who meets the most current United States Clinical Modification version of the ICD of the WHO criteria for a SUD (per the ICD, a mental and behavioral disorder DUE to psychoactive substance use) alone. All Members in any level of treatment will meet the most current version of the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC) for admission, continuance, and discharge; and

B) A member that meets LOC and DSM criteria 1 or 2 of the ICD diagnosis for SUD through the completion of a substance use screening and assessment by an ADAD approved SUD provider witha minimum of a CSAC (Certified Substance Abuse Counselor) certification.

9.6.3 SUD Target Population

A) The target populations for ADAD SUD treatment services are adults, adolescents, and families with alcohol and other SUD who meet the most current United States Clinical Modification version of the ICD of the WHO criteria for:

1. SUD (per the ICD, a mental and behavioral disorder due to psychoactive substance use) alone; or in combination with a mental health disorder (per the ICD, a mental, behavioral, or neurodevelopmental disorder not due to psychoactive substance use (i.e., co-occurring disorder));
2. Families include an adult or adolescent who meet the most current United States Clinical Modification version of the ICD of the WHO criteria for: SUD (per the ICD, a mental and behavioral disorder due to psychoactive substance use) alone; or
3. In combination with a mental health disorder (per the ICD, a mental, behavioral, or neurodevelopmental disorder not due to psychoactive substance use (i.e., co-occurring disorder)).

B) A subpopulation with compromising conditions is to be given priority for services. These groups consist of:

1. Pregnant and parenting women;

2. Individuals with HIV/AIDS;
3. Individuals with TB; and
4. Individuals who use illegal injectable drugs.

9.6.4 ADAD Health Plan Role and Responsibilities

The Health Plan:

A) Is encouraged to outreach all ADAD substance use providers to become Medicaid providers and subsequently contract as participating providers with the Health Plan.

B) Will submit a report of all contracted Medicaid SUD providers to ADAD and DHS within the 1st quarter of the contract and once a year thereafter.

C) To designate at least one behavioral health point-of-contact staff to be available during normal business hours for communication and coordination between ADAD, AMHD, and Hawai'i CARES regarding Members' services/coverages as needed and assist with the following:

1. Preauthorization for treatment within 48 (prefer 24) hours;
2. Authorization for services;
3. Provide written explanation articulating justification for denial of services; and
4. This notification is to be sent to Hawai'i CARES, ADAD, and DHS point of contact within 24 hours of receiving the request for services; responses will be sent via secure email.

D) To coordinate SUD COC treatment and recovery support services for Members through Hawai'i CARES.

E) To collaborate with ADAD regarding services for opioid patient treatment in order to meet the new MAT criteria.

F) To collaborate with ADAD and send at least one representative to engage in opioid treatment initiative (OTI) meetings.

G) To communicate/disclose the requirements set by NCQA and other governing entities on licensure requirements for those qualified to conduct an assessment with ADAD and Hawai'i Cares.

H) To provide appropriate medically necessary substance use treatment services, while the Member is awaiting SUD treatment;

I) To cover all medical costs for the Member while the Member is receiving SUD treatment.

J) To coordinate with ADAD, Hawai'i CARES, and the SUD provider at a minimum of thirty (30) days prior to and following the Member's discharge from the residential treatment program to ensure a smooth transition within the COC.

K) To engage and collaborate with DHS and ADAD to provide training and implement screening, brief intervention, referral to treatment (SBIRT) to expand delivery of early intervention and treatment services for Members presenting or at risk of developing a SUD.

L) To collaborate with ADAD in the design of a workflow regarding Members who have been identified to be at risk or screened positive for SBIRT that received services.

M) To ensure Members who screen positive for SUD are referred to Hawai'i Cares for evaluation, SUD COC treatment, and recovery services.

N) Referral Process to Hawai'i CARES:

1. Through Hawai'i Web Infrastructure for Treatment Services (HI WITS): there is a referral function in HI WITS that are inputted by the providers who are sending the referrals to HI CARES via HI WITS. Part of the referral through HI WITS consist of creating a consent form that will allow the provider to share the following docs that are in their HI WITS system (profile, intake, screening, assessment (ADAD/ASI), treatment plan, ASAM). Those who are not on HI WITS would call into 832-3100 and complete the universal standardized intake and screening form with the operator. Once that is completed by the operator the Member is linked to a provider for a substance use assessment.

O) To utilize ADAD's learning management system (LMS). The LMS will contain SBIRT trainings for SBIRT certification. Training topics will include SBIRT applications for perinatal, primary, and behavioral health; and to have SBIRT-certified providers within their network to conduct SBIRT screening and services to QI Health Plan Members;

P) To ensure that if the Member is receiving SUD treatment services and undergoes a Health Plan change, services for the Member will not be interrupted or reduced. The outgoing Health Plan will collaborate with both the incoming Health Plan and ADAD SUD provider to ensure that the Member services are uninterrupted, this includes SUD services, medical and prescription medication services, behavioral health services, and, when applicable, dental services;

Q) Medication Assisted Treatment (MAT) combines use of medications with counseling and behavioral therapies to provide a "whole-patient" approach to the treatment of SUD. Medications used in MAT are approved by the Food and Drug Administration (FDA) and MAT programs are clinically driven and tailored to meet each patient's needs.

1. The Health Plan will work with ADAD, Hawai'i CARES, the pharmacist, and SUD providers to create a systematic approach that will create a whole person approach which incorporates the use of both medication assistance and behavioral health therapy to help reduce the likelihood of relapse.
2. In the systematic approach, the Health Plan will have a well-defined process on how they will track the Member being referred for services and their sub-sequential participation in services.
3. Medications that have been approved are Buprenorphine, Methadone, and Naltrexone.

9.7 Hawai'i Coordinated Access Resource Entry System (CARES)

A) Hawai'i CARES is a partnership between the Hawai'i State DOH Behavioral Health Administration and the University of Hawai'i School of Social Work.

9.7.1 Hawai'i CARES Description of Services

A) The Hawai'i CARES is a statewide, 24/7 coordinated entry system thatprovides access to the Hawai'i Behavioral Health Continuum of Care(BH COC) network of service arrays including, but not limited to, SUD prevention; treatment and recovery support services;

mentalhealth support services; behavioral health crisis intervention; childand adolescent mental health services; and services for Members with intellectual and developmental disabilities.

B) This synchronized system of care unites an assortment of independent programs and treatment modalities in a coordinated and responsive system of care that provides clinically appropriate behavioral health and substance use treatment and recovery support services statewide. Services are accessible on demand to those who need it, when they need it, and where they need it. Thus, reducing barriers to behavioral health, SUD prevention, treatment and recovery support services, and crisis intervention. Improving accessibility and quality of care and minimizing or eliminating shortfalls in services availability are primary goals for Hawai'i CARES.

9.7.2 Hawai'i CARES Target Population

A) Members meeting criteria for referral to Hawai'i CARES can be found in HPM 9.6.3 SUD Target Population.

9.7.2.1 Defining the Target Population

A) The current United States Clinical Modification version of the ICD of the WHO criteria for SUD, severe and persistent mental illness ("SPMI"), or co-occurring substance use and mental health disorder; and/or

B) SUD: Adults, adolescents, and families with an adult or adolescent Member with an SUD who meets the most current United States Clinical Modification version of the ICD of the WHO criteria for a

SUD alone (per the ICD, a mental and behavioral disorder DUE to psychoactive substance use). All Members in any level of treatment will meet the most current version of the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC) for admission, continuance, and discharge; or

C) Severe Mental Illness (SMI): A mental disorder which exhibits emotional or behavioral functioning that is so impaired as to interfere substantially with a person's capacity to remain in the community without treatment or services of a long-term or indefinite duration. This mental disability is severe and persistent, encompassing Members with SMI, SPMI, or requiring SEBD, resulting in a long-term limitation of a person's functional capacities for primary ADL such as interpersonal relationships, homemaking, self-care, employment, and recreation.

D) Co-Occurring Disorder (COD): Adults, adolescents, and families with an adult or adolescent Member with a COD who meets the most current United States Clinical Modification version of the ICD of the criteria for A) and B) above. (Per the ICD, a mental, behavioral, or neurodevelopmental disorder DUE to psychoactive substance use and an additional mental, behavioral, or neurodevelopmental disorder NOT DUE to psychoactive substance use).

E) The most current United States Clinical Modification version of the ICD of the WHO lists codes F01-F99 for mental, behavioral and neurodevelopmental disorders (ICD-10-CM).

F) Presents with significant functional impairment in the areas of self-protection, impulse control, or social judgment, or a high risk of harm to self or others; and/or

G) Presents with an emotional, behavioral, or psychological crisis, and whose immediate health and safety may be in jeopardy due to a mental health issue; and/or

H) In assessment are suspected of a mental, behavioral, or neurodevelopmental disorder and exhibits symptoms of significant clinical distress and some degree of functional impairment expected to worsen because of the situation.

9.7.3 Services Provided to Members

A) Hawai'i CARES coordinates the following services:

1. SUD services.
    a. Support, consultation, and referral services based on initial assessment; and
    b. Initial contact for members seeking AMHD services and referral for eligibility assessments through AMHD's Utilization Management (UM).
2. Coordination with CCS, as applicable.
3. Crisis intervention and support services.
    a. Support, consultation, and referral services based on initial assessment;
    b. Initial contact for Members experiencing an active crisis; and

c. Initiation of crisis mobile outreach (CMO), as applicable.

9.7.4 Health Plan Role and Responsibility

A) The Health Plan:

1. Is to submit the following to Hawai'i CARES quarterly:
    a. A list of SUD COC treatment and recovery support service providers currently contracted with the Health Plan; and
    b. A list of the SUD COC treatment and recovery support services covered in the contract for each provider; and
    c. An SBIRT report to include utilization and referrals to treatment.
2. Collaborates with DHS and ADAD to provide guidance on how they will collaborate and support the effort during the first year of the contract.
3. Contracts with ADAD-contracted SUD COC treatment and recovery service providers that are part of the Hawai'i CARES network. ADAD will provide a list of all providers to DHS and the Health Plans annually. All contracts will be for the SUD services identified.
4. Collaborates with ADAD and Hawai'i CARES to be able to obtain the complete Hawai'i CARES intake packet (i.e., consent, screening, assessment, ASAM placement determination, and health and wellness plan) submitted by providers to Hawai'i CARES.

5. Collaborates with ADAD, AMHD, and Hawai'i CARES in the care and authorization of services for Members with co-occurring substance use and mental health disorders and/or those in acute behavioral health crisis.
6. Collaborates with ADAD, AMHD, and Hawai'i CARES to design and implement a system that allows for a blended funding approach for support of Members' behavioral health care.
7. Collaborates with ADAD, AMHD, and Hawai'i CARES to access and utilize billing codes, processes, and requirements.
8. Shares requirements set by NCQA and other governing entities on licensure requirements with ADAD, AMHD, and Hawai'i CARES.
9. Assists Members seeking services for SUD COC treatment and recovery support services by referring them to Hawai'i CARES to arrange for the utilization of a treatment slot.
10. Participates in training, data collection, and evaluation, to ensure that statewide substance use and mental health resources are utilized in the most effective and efficient manner possible. DHS will provide additional guidance on how the Health Plan will collaborate and support the effort during the first year of the contract.
11. Will coordinate with Hawai'i CARES on the process and services needed for Members that call in crisis requiring CMO services. CMO services provide assessment and intervention services for adults in an active state of crisis. These services are available twenty-four (24) hours a day, seven (7) days a

week and can occur in a variety of settings including the Member's home, local emergency department, etc. CMO services provide an opportunity for immediate crisis intervention and de-escalation, which includes a thorough assessment of risk, mental status, and medical stability, and exploration of service options in the community.

9.8 Screening, Brief Intervention and Referral to Treatment (SBIRT)

A) SBIRT is an evidence-based approach to identifying patients who use alcohol and other drugs at risky levels. SBIRT is an early intervention tool for individuals with non-dependent substance use to obtain help before they need more extensive or specialized treatment. This approach differs from specialized treatment for those with more severe substance misuse or a Substances Use Disorder (SUD).

B) Benefits of SBIRT Services

1. Using SBIRT services is easy to apply in primary care settings. You can systematically screen individual who may not normally seek substance use help and offer access to SBIRT treatment services that would assist in:
    a. Reducing health care costs
    b. Decreasing drug and alcohol use severity
    c. Reducing risk of physical trauma
    d. Reducing the percentage of patients who go without specialized treatment

*Please note that being a SBRIT Provider or an SBRIT Trainer is voluntary. Your decision to participate in this program will improve and better serve our community.

Additional information on SBIRT's can be found within the Health Plan Manual: Appendix V

CHAPTER 10: Reproductive Health Services

10.1 Family Planning Services

A) The Health Plan will inform Members of the availability of family planning services and provide services to Members wishing to prevent pregnancies, plan pregnancies, plan the spacing between pregnancies, or obtain confirmation of pregnancy. These services include, at a minimum, the following:

1. Education and counseling necessary to make informed choices and understand contraceptive methods;
2. Emergency contraception and counseling, as indicated;
3. Follow-up, brief, and comprehensive visits;
4. Pregnancy testing;
5. Contraceptive supplies and follow-up care;
6. Counseling related to risk behaviors and preventive strategies, and diagnosis and treatment of sexually transmitted infections; and
7. The Health Plan will furnish all services on a voluntary and confidential basis to all Members.
8. There will be no utilization control or requirement that limits or delays member access to in network family planning services or devices.
9. LARC devices are reimbursed separate from any global provider reimbursement agreement.

10.2 Pregnancy-Related Services for Pregnant Women and Expectant Parents

A) The Health Plan will inform pregnant women about the availability of EPSDT services within twenty-one (21) days after confirmation of pregnancy and new mothers within fourteen (14) days after birth that EPSDT services are available.

10.3 Sterilizations and Hysterectomies

A) The Health Plan will ensure that a Sterilization Required Consent Form (HHS 687) is completed appropriately before any sterilization procedure is performed. The HHS 687 form can be found in the "Consent for Sterilization Form" appendix in the "Health Plan Manual - Appendices" document.

B) The Health Plan will ensure that both a Sterilization Required Consent Form (HHS 687) and Hysterectomy Acknowledgement Form (DHS 1145) are completed appropriately for any hysterectomy performed. The Hysterectomy Acknowledgement Form (DHS 1145) can be found in the "Hysterectomy Acknowledgement Form" appendix in the "Health Plan Manual - Appendices" document.

CHAPTER 11: Early Periodic Screening, Diagnostic, and Treatment (EPSDT)

11.1 Early Periodic Screening, Diagnosis, and Treatment Plan

A) The Health Plan will develop an early periodic screening, diagnostic, and treatment (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 will emphasize outreach and compliance monitoring for Members under age twenty-one (21) years, considering the multi-lingual, multi-cultural nature of the Member population, as well as other unique characteristics of this population. The EPSDT plan will include procedures for follow-up of missed appointments, including missed referral appointments for problems identified through EPSDT screens and exams. The Health Plan will also include procedures for referrals to the DHS contractor providing dental health coordination services for the Medicaid fee-for-service program for needed dental care.

B) The Health Plan will submit its EPSDT plan in accordance with RFP-MQD-2021-008 Section 13.3.B to DHS upon request.

C) Refer to the "Early and Periodic Screening Diagnostic and Treatment" report in the "Health Plan Manual - Part III: Reporting Guide" document.

D) The Health Plan shall coordinate with DHS to allow providers additional options to electronically submit EPSDT visit forms/data through DHS. The Health Plan shall accept electronic visit forms/data from DHS, review to ensure minimum requirements are

met, match with associated claim and update status through the designated DHS portal.

11.2 Member Outreach and Education for EPSDT

A) The Health Plan's outreach and information process will include:

1. 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
2. Notification to EPSDT-eligible Members and their families about the benefits of preventive healthcare, 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.
3. The Health Plan's information will:
    a. Provide information to Members through multiple modalities of communication including, but not limited to, telephone, text, face-to-face, in person, virtual, video, and in writing. Information may be provided by Health Plan personnel or healthcare providers. The Health Plan will follow-up with families with EPSDT-eligible Members who, after six (6) months of

enrollment, have failed to access EPSDT screens and services;

b. Provide information to Members in non-technical language at or below a sixth (6^{th}) (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; and

c. The Health Plan will emphasize the following in Member communications:

   1) Stress the importance of preventive care;
   2) Describe the periodicity schedule;
   3) Provide information about where and how to receive services;
   4) Inform Members that transportation and scheduling assistance is available upon request;
   5) Describe how to access services;
   6) State that services are provided without cost;
   7) Describe what resources are available for non-plan services;
   8) Describe the scope and breadth of the health services available; and
   9) Annual information distribution by the Health Plan is required for EPSDT Members who have not accessed services during the prior year.

11.3 Health Plan Requirements for Providers

A) The Health Plan shall be responsible for training providers and monitoring compliance with DHS EPSDT requirements.

B) The Health Plan shall require that all providers participating in a Health Plan follow the most current EPSDT screening form and periodicity schedule prescribed by DHS when performing an EPSDT exam on EPSDT-eligible Members in accordance with the "Early and Periodic Screening, Diagnostic & Treatment Screening" appendix in the "Health Plan Manual - Appendices" document.

C) The Health Plan shall assist providers in transitioning to electronic submission of EPSDT visit forms/data and claim submission.

11.4 EPSDT Screens

A) The Health Plan will conduct the following three (3) types of screens on EPSDT-eligible Members:

1. Complete periodic screens according to the EPSDT periodicity schedule that can be found on the most current DHS 8015 EPSDT form. The Health Plan will 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;
2. Inter-periodic screens; and
3. Partial or follow-up screens.

B) The Health Plan will provide all medically necessary diagnostic and treatment services to correct or ameliorate a medical, dental, or behavioral health problem discovered during an EPSDT screen (complete periodic, inter-periodic, or partial) as described in the Health Plan Manual. This includes, but is not limited to:

1. Initial or interval history;
2. Measurements;
3. Sensory screening;
4. Developmental assessments (including general developmental and autism screening);
5. Tuberculosis risk assessments and screening;
6. Lead risk assessments;
7. Psychosocial and behavioral assessments (including maternal depression screening);
8. Alcohol and drug use assessments for adolescents;
9. Sexually transmitted infections and cervical dysplasia screening as appropriate;
10. Complete physical examinations;
11. Age appropriate surveillance;
12. Timely immunizations;
13. Procedures such as hemoglobin and lead level as appropriate;
14. Referral to a "dental home;"
15. Referral to providers for EPSDT dental services and other dental needs not provided by the Health Plan;
16. Referral to State or specialty services;
17. Referral for Health Coordination assistance if needed;
18. Age appropriate anticipatory guidance;
19. Diagnosis and treatment of any issues found including issues identified through general developmental and autism screening; and

20. Diagnosis and treatment of acute and chronic medical, dental, and behavioral health conditions.

11.5 Coverage Requirements

A) DHS follows the American Academy of Pediatrics Bright Futures Guidelines. The most current DHS periodicity schedule is included on the current DHS 8015 EPSDT form found in the "Early and Periodic Screening, Diagnostic & Treatment Screening" appendix in the "Health Plan Manual - Appendices" document.

B) Additional information on Hawaii's EPSDT benefit can be found on the EPSDT page of the DHS Med-QUEST Division website.

C) Additional information on CMS requirements of the EPSDT benefit can be found on the CMS EPSDT website.

CHAPTER 12: Developmental Disability Division (DDD)

12.1 Coordination between Health Plan and DDD

A) DOH-DDD is committed to providing choice of services and supports for Members with I/DD. The DDD provide HCBS through a waiver authority within the scope of section 1915(c) of the Social Security Act [hereafter called the I/DD Waiver]. Members must meet intermediate care facility for intellectual and/or developmental disability (ICF/IDD) Level of Care and long-term care (LTC) eligibility to access HCBS services through the I/DD Waiver.

B) DHS oversees and monitors all I/DD Waiver implementation, administration, and operation activities delegated to the DDD.

C) The I/DD Waiver services are carved out of the Health Plan's responsibilities. However, the Health Plan will still be responsible for services under the State Plan and RFP-MQD-2021-008.

D) If the Member does not meet ICF/IID level of care, the DDD will collaborate with Health Plan in transitioning the Member in and out of the program and for coordinating medically necessary services. The Health Plan is required to exchange HAP during these transitions. Additionally, the Health Plan is required to exchange Member data in a timely manner that is agreed upon by, and in collaboration with, respective agencies and is expected to include, but is not limited to, utilization management notifications, Member-specific utilization, quality data, information on medication adherence, and cost data.

E) Coordination between the Health Plan and the DDD is crucial for the Members and providers. The Health Plan coordinator, DDD, and

DDD case manager must coordinate with each other to ensure seamless care for the Member. The DDD case manager is the primary manager and ensures that there is good coordination with the Health Plan as well as non-Medicaid entities. The Health Plan coordinator may attend the multidisciplinary ISP meetings that the DDD case manager arranges, if the Member chooses.

F) Health Plan and DDD will collaborate and schedule regular or more frequent coordination meetings to discuss Members with complex medical needs and circumstances or Members on a case-by-case basis. DHS recommends that the medical director of the Health Plan and DDD, and other clinical or coordination staff attend these meetings, as appropriate. DHS may participate in these meetings when necessary to discuss special coordination cases.

G) Dispute resolution between the Health Plan and DDD, if there is no agreement on the coverage of services, will includea joint committee composed of a clinical and an administrative representative from the Health Plan, DDD, and DHS and will determine the delineation of covered services between the programs. The decision of this group will be the final decision regarding delineation of covered services. The committee will designate someone to clarify and document all decisions. All three (3) parties will receive copies of the delineation for their records.

H) There should be no duplication of HCBS services between the Health Plan and I/DD Waiver.

I) Refer to the "Coordination of Services" appendix in the "Health Plan Manual - Appendices" document for more information on Coordination between the Health Plan and DDD.

J) DHS may provide additional guidance during the Contract period.

12.2 Coordination for Members Under the Age of 21

A) The Health Plan will continue to provide early and periodic screening, diagnosis, and treatment (EPSDT) services within the scope of section 1905(a) of the Social Security Act to all DDD eligible Members.

B) The DDD will be responsible for the delivery of HCBS approved under I/DD Waiver. The goal for HCBS is to support the Member to live in their own home and participate in their community. HCBS approved under I/DD Waiver is considered a "wrap-around" to the EPSDT benefit, not a replacement.

C) Health Plan Coordination

1. The Health Plan will provide Health Coordination, as indicated,to coordinate the Member's medical care. The Health Plan is responsible for coordinating all medically necessary services that the Health Plan has responsibility to provide. The Member's physician(s)/family, DDD case manager, or clinical staff may request medically necessary services. In addition, the Health Coordinator may identify medically necessary services through an HFA.
2. The Health Coordinator will perform an HFA and create a HAP with the Member. The Health Coordinator will provide a copy of the assessment and HAP to the DDD case manager.

3. The Health Coordinator may serve as the liaison between the Health Plan and the DDD case manager. Refer to the "Coordination of Services" appendix in the "Health Plan Manual - Appendices" document for more information on coordination between the Health Coordinator and DDD case manager.

D) I/DD Waiver Targeted Case Management

1. The DDD case manager is the primary coordinator of HCBS for the Member. The DDD case manager is the point of contact for I/DD Waiver, coordinates services, conducts regular assessments, and develops an ISP with the Member. The DDD case manager will provide a copy of the ISP to the Health Plan Coordinator.
2. For primary care needs, the DDD case manager will work with the Health Plan Coordinator or other specified contact to coordinate the medically necessary services.

E) HCBS I/DD Waiver Services for Members Under the Age of 21

1. The I/DD Waiver defines the coverage of HCBS and the criteria for coverage. The DDD will adjust and deliver services in response to a comprehensive assessment in accordance with the program policies and standards. The I/DD Waiver will not supplant any services that are the responsibility of the Health Plan (i.e., medically necessary services under Medicaid State plan home health benefit or the EPSDT benefit), another state agency, or other insurance.

12.3 HCBS I/DD Waiver Services for Members

A) DDD provides HCBS services to Members who are eligible for the I/DD Waiver requirements. Members will continue to access medically necessary services though their Health Plan as specified in the RFP-MQD-2021-008. The Member must meet the enrollment criteria for the I/DD Waiver which includes meeting the:

1. Intellectual and/or developmental disability conditions as defined by the Hawai'i Revised Statute (HRS) Chapter 333F-1 and detailed in the DOH Hawai'i Administrative Rules (HAR) section 11-88.1-5;
2. Medicaid intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care as defined in 42 CFR §440.150; and
3. Medicaid long-term care eligibility requirement.

B) The HCBS services approved under the I/DD Waiver are described in the "Coordination of Services" appendix in the "Health Plan Manual - Appendices" document.

CHAPTER 13: DOH Family Health Services – Children with Special Needs Branch

13.1 Description of Children with Special Needs Branch (CSHNB)

A) CSHNB is working to assure that all children and youth with special healthcare needs (CYSHCN) will reach optimal health, growth, and development, by improving access to a coordinated system of family-centered healthcare services and improving outcomes, through systems development, assessment, assurance, education, collaborative partnerships, and family support.

13.2 Early Intervention Services (EIS) Description

A) The EIS is a federal and state-mandated program that provides services to support the development of infant and toddlers from birth (0) to three (3) years of age. EIS are provided to assist a child in five developmental areas:

1. Physical (sits, walks);
2. Cognitive (pay attention, solve problems);
3. Communication (talks, understand);
4. Social or (with others, has confidence); and
5. Adaptive (eats, dresses self).

B) The CSHNB administers and manages the EIS. CSHNB will evaluate and determine eligibility for EIS.

13.2.1 Health Plan Responsibilities for EIS

A) The Health Plan remains responsible for providing all other medically necessary services in the QI program while a Member is participating in EIS. This includes, but is not limited to, EPSDT

screens, medically necessary applied behavioral analysis (ABA) and any other services deemed medically necessary by a licensed health care professional.

B) The Health Plan shall coordinate the transition of care for Members exiting EIS, to ensure the Member continues to receive all medically necessary services. When the Member reaches thirty (30) months old, is within fifteen (15) days of exiting, or has already exited EIS, the Health Plan will screen for Health Coordination needs. The Health Plan shall document attempts to screen members prior to transitioning out of EIS.

13.3 Description of Children with Special Needs Program (CSHNP)

A) The CSHNP provides health coordination, social work, nutrition, and other services for children with special healthcare needs aged zero (0) to 21 years with chronic medical conditions. It serves children who have or may have long-term or chronic health conditions that require specialized medical care and their families.

13.3.1 Health Plan Responsibilities for CSHNP

A) The Health Plan will coordinate the referral of potentially eligible children to the DOH CSHNP and the provision of health data required by the CSHNP providers within the timeframe required by CSHNP, providers. The Health Plan will cover the cost of medically-necessary specialty formula.

13.4 DOH Women Infant and Children (WIC)

A) Members of QI Health Plans who are pregnant and/or parenting a QI Member under 5 years old are eligible for WIC. The Health Plan

will assist women, infants, and children to contact and set up an appointment with the WIC clinic nearest to the Member. The Health Plan will also encourage perinatal and pediatric providers to refer pregnant and parenting Members to WIC. Detailed instructions on how to assist Members to become a WIC client can be found here https://health.Hawai'i.gov/wic/program_details/#whatis

CHAPTER 14: Foster Care/Child Welfare Services

14.1 Description of Child Welfare Services (CWS)

A) CWS are services provided by the Department of Human Services (DHS), Social Services Division (SSD), Child Welfare Services Branch for children and their families:

1. When the children are reported to have been abused; and/or
2. Neglected; or
3. Are reported to be at risk for abuse; and/or
4. Neglect.

B) These services include:

1. Child protection;
2. Prevention; and
3. Diversion services to keep children out of foster care.

C) CWS also include:

1. Family support;
2. Foster care;
3. Adoption;
4. Legal guardianship;
5. Independent living;
6. Adoption assistance and guardianship payments; and
7. Licensing of resource caregivers, group homes, and child placing organizations.

14.2 Health Plan Responsibilities

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

B) The Health Plan will 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.

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

D) The Health Plan will 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.

E) The Health Plan will be familiar with the medical needs of CWS children and will 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.

F) If a PCP change is necessary and appropriate (e.g., the child has been relocated), the Health Plan will accommodate the PCP change request without timely restrictions and assist in the transition of care to the new PCP.

G) 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 will be effective at the end of the month in which the request is made.

CHAPTER 15: State of Hawai'i Organ and Tissue Transplant Program

15.1 General Description

A) Medicaid covers medically necessary transplantation services and the related medications (such as chemotherapy and immunosuppressant drugs) and services. Corneal transplants do not require authorization and are reimbursed directly by the Medicaid program. The transplants listed below are provided by the Medicaid program through the State of Hawai'i Organ and Tissue Transplant (SHOTT) Program. The policies for each of the transplantation services are provided separately as follows:

1. Kidney;
2. Pancreas;
3. Liver;
4. Heart-lung;
5. Heart;
6. Lung;
7. Small bowel with or without liver;
8. Allogeneic stem cell; and
9. Autologous stem cell.

15.2 State of Hawai'i Organ and Tissue Transplant Program

A) The State's transplant program is called the SHOTT Program. It is administered by DHS's contracted third-party administrator (TPA) called the SHOTT contractor.

15.3 Authorization and Determination Process

A) Determination Process

1. Transplant Referral

a. Physicians within the community work with QI Health Plans to identify persons who meet the medical conditions for a transplant evaluation.

b. For a QI Member, the Health Plan or facility completes and submits:

1) An Aid to Disabled Review Committee (ADRC) application packet to the DHS ADRC coordinator for disability determination, with 'Transplant Candidate' noted on top of Form 1180. The ADRC packet consistsof:

a) DHS Form 1180 "ADRC REFERRAL ANDDETERMINATION'

b) DHS Form 1127 "MEDICAL HISTORY ANDDISABILITY STATEMENT"

c) DHS 1128 "DISABILITY REPORT"

2) The ADRC packet should be faxed to:

Clinical Standards Office

Med-QUEST Division

(808) 692-8131

c. A SHOTT Referral Packet to DHS SHOTT coordinator should include the DHS 1144 REQUEST FOR MEDICAL AUTHORIZATION requesting a transplant evaluation, Transplant Evaluation Form, as well as appropriate medical information documenting the Member's medical condition, including results of laboratory

tests,studies, clinical notes, psychosocial assessment, etc.

d. The SHOTT referral packet should be submitted via secure file transfer protocol (SFTP) or faxed to:

   Health Care Services Branch
   Med-QUEST Division
   (808) 692-8087

e. The DHS Medical Director reviews the Form 1144 and the supporting documentation to make a determination on the SHOTT referral. If additional information is required, the DHS Medical Director or the DHS Transplant Coordinator will request additional information from the referring QI plan and/or the referring physician's office. Determination to forward to SHOTT will be made after all necessary information is available.

f. The DHS Medical Director approves or disapproves the transplant request to move forward to SHOTT.

g. If the request for the transplant evaluation is not approved to move forward to SHOTT, the referring QI plan and referring physician are notified by DHS and the QI Member stays with the QI plan.

h. If the request for the transplant evaluation is approved to move forward to SHOTT, the DHS Transplant Coordinator notifies the SHOTT program

coordinator/case manager, the referring QI plan, and the referring physician that the referral is forwarded to SHOTT.

i. Upon approval for the SHOTT program by the DHS Medical Director, the QI Member will be dis-enrolled from the Health Plan and enrolled in SHOTT.

   1) Upon notification of SHOTT approval from DHS, theSHOTT contractor contacts patient, obtains the patient's consent to coordinate care, and begins collaboration with the transplant facility.
   2) The SHOTT contractor assumes financial responsibilityfrom the date the Form 1144 was signed and approved by the DHS Medical Director.

j. If the patient is determined not to be a suitable transplant candidate by the transplant facility or if the patient decides against transplantation, SHOTT and the DHS Medical Director, in consultation with the transplant facility, will decide:

   1) Whether the patient should remain in SHOTT untiltransplant criteria are met; or
   2) Whether the patient should be transitioned back orcontinue with the QI Health Plan.

k. SHOTT will notify the patient of the decision and if the decision is to transition care to the QI plan, SHOTT will begin coordinating the transfer with the QI plan.

l. Throughout the transplant evaluation process of the referral, the QI plan will communicate closely with the DHS Transplant Coordinator to ensure that the referred transplant facility is contracted with Hawai'i Medicaid.

m. Throughout the referral process, the SHOTT contractor communicates closely with DHS's Transplant Coordinator and Medical Director regarding the status of referred clients. Throughout the referral process, the SHOTT Contractor and DHS Transplant Coordinator will also communicate closely with the Health Plan/provider requesting the referral.

n. EMERGENT and URGENT Requests:

1) Emergent requests are made when the patient's death is expected during the hospitalization unless the Member receives a transplant. The transplant facility in collaboration with the transplant physician directly contacts the DHS Medical Director. If the DHS Medical Director gives verbal approval for the transfer to SHOTT, the transplant facility and QI plan must follow up by sending the completed DHS 1144, relevant medical records, and ADRC packet to DHS. The date of the verbal approval is the effective date of SHOTT enrollment.

2) Urgent request can also be made by the QI plan or referring physician in cases when the patient is

in need of an urgent transplant (e.g., patient with acute myelogenous leukemia is in remission and has a ready and willing donor)

a) For urgent and emergent requests, the Health Plan or transplant facility should indicate URGENT TRANSPLANT REQUEST or EMERGENT TRANSPLANT REQUEST on both the ADRC packet and the 1144 and should communicate with DHS Transplant Coordinator. These requests will be given priority.

2. Documentation Necessary for Transplant Referral

a. Information needed by the DHS Medical Director or Transplant Coordinator, in addition to a complete DHS 1144 and an ADRC packet includes:

1) Requesting physician's name and contactinformation.
2) Primary care giver (PCG) name and contactinformation.
3) Type of organ(s) needed.
4) List of medications the patient is taking.
5) List of diagnoses the patient has.
6) Laboratory studies from the last six months before application and a hemoglobin A1C level if the patient is a diabetic.

7) Any diagnostic studies done, including: ultrasounds, EKG, CT scans, biopsies, catheterizations, MRI scans, PET scans, etc.
8) Doctor's clinic or office notes from the last six months.
9) Results of one (1) toxicology screen.
10) Results of HIV testing.
11) Any psychosocial evaluation.

B) Additional Documentation

1. Heart Transplant
    a. Cardiac catheterization report(s).
    b. History of any cerebral or peripheral vascular problems.
    c. Echocardiogram and MUGA scan reports, if available.
2. Lung Transplant
    a. Lung biopsy results, pulmonary function test, or bronchoscopy reports.
    b. Oxygen saturation with acuity.
    c. Any previous thoracic surgery.
3. Heart/Lung Transplant
    a. Please provide requested information from both the heart and lung categories.
4. Liver Transplant
    a. Liver biopsy results (if available).

1) Liver enzymes (e.g., SGPT, SGOT, Bili, etc.) andclotting studies (e.g., APTT, PTT, etc.).
2) Other liver studies such as liver scan, U/S or CT scanresults are helpful.

5. Small Bowel

   a. History of hyper-alimentation and nutritional studies.

   b. History of previous abdominal surgery.

   c. Colonoscopy reports, CT scans, any type of GI studies (if a liver transplant is performed in conjunction, please provide the requested information from the liver category as well).

6. Stem Cell Transplant (SCT)

   a. Requesting physician's name and contact information plus what type of transplant is anticipated.

   b. For allogeneic SCT, matching donor source must be identified.

   c. List of medications the patient is taking.

   d. List of diagnoses the patient has and the stage of cancer, if malignancy is the reason for transplant.

   e. Doctor's clinic or office notes from the last three (3) months.

   f. Laboratory studies from the last three (3) months before application, including pathology reports.

g. Any diagnostic studies done, including: ultrasounds, EKG, CT scans, bone marrow biopsies, flow cytometry results, catheterizations, MRI scans, PET scans, etc.

h. Results of HIV testing.

7. Autologous Bone Marrow Transplant

a. Same as SCT except no donor information required.

15.4 Transplant Facility Accepts Patient

A) The QI plan refers the patient to a transplant facility that is contracted with the SHOTT program. If the transplant facility determines that the patient meets its criteria and is willing to accept the patient, this information is included in the medical records sent to the DHS Medical Director with the DHS 1144 form.

1. If enrollment in the SHOTT program is approved by the DHS Medical Director, SHOTT's case manager contacts the transplant facility and arranges for the patient to obtain services needed by the transplant facility.

15.5 One-Year Anniversary – After Successful Transplant

A) The SHOTT case manager arranges with the transplant facility for the client's one-year post transplant follow-up visit following the twelve (12) month anniversary of the successful transplantation. Telemedicine may be used as an alternate source.

B) The transplant facility notifies SHOTT if the patient is cleared for discharge from transplant facility services. The SHOTT case manager notifies the DHS Transplant Coordinator, transitions care to the QI plan, DHS dis-enrolls the patient from SHOTT, notifies QI

Health Plan of dis-enrollment from SHOTT and enrolls him/her in a QI Health Plan.

CHAPTER 16: Cognitive Rehabilitation Services

16.1 Cognitive Rehabilitation Services

A) The Health Plan will 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).

B) Reassessments are completed at regular intervals, determined by the provider and according to the Member's assessed needs, and treatment goals and objectives.

C) Five cognitive skills areas should be comprehensively assessed and, as appropriate, treated:

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

D) 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.

E) There are several approaches and techniques/strategies that can be used to provide cognitive rehabilitation services. Selected approaches should match the appropriate level of awareness of cognitive skills. The approaches include:

1. Education;
2. Process training;
3. Strategy development and implementation; and
4. Functional application.
5. Selected approaches should match the appropriate level of awareness of cognitive skills.
6. 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 forms needed to effectively communicate wants and needs.
7. 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.

8. 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.
9. 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.
10. Reading/writing skills retraining – Process to relearn levels of writing and reading structure and content to the Member's maximum potential.

CHAPTER 17: Provider

17.1 Provider Manual Requirements

A) In accordance with RFP-MQD-2021-008 Section 8.4.C, Health Plans shall have a Provider Manual on their website and paper form for all participating providers. The Provider Manual shall contain all the elements described in the "Provider Manual Requirements" appendix in the "Health Plan Manual - Appendices" document.

17.2 Provider Contract Requirements

A) In accordance with RFP-MQD-2021-008 Section 8.3.A, Health Plans shall include all the elements described in the "Provider Contract Requirements" appendix in the "Health Plan Manual - Appendices" document.

B) Refer to the "Health Plan Manual - Part III: Reporting Guide" document for specific provider reports.

17.3 Medical Record Standards

A) In accordance with RFP-MQD-2021-008 Section 5.3, Health Plan shall establish medical record standards listed in Section 5.3.A and requires providers to establish medical standard records with all elements described in the "Medical Standard Records" Appendix T in the "Health Plan Manual – Appendices" document.

17.4 Non-Emergency Medical Transportation (NEMT) Provider Eligibility

A) In accordance with the Consolidation Appropriations Act, 2021, Section 209, section 1902(a)(87), Health Plans shall ensure that any provider (including a transportation network company) or individual driver of non-emergency transportation to medically necessary

services receiving payment under such plan (but excluding any public transit authority), meets the following requirements:

1. Each provider and individual driver is not excluded from participation in any federal health care program (as defined in section 1128B(f) of the Act) and is not listed on the exclusion list of the Inspector General of the Department of Health and Human Services;
2. Each such individual driver has a valid driver's license;
3. Each such provider has in place a process to address any violation of a state drug law; and
4. Each such provider has in place a process to disclose to the state Medicaid program the driving history, including any traffic violations, of each such individual driver employed by such provider, including any traffic violations.

B) The Health Plan shall develop and maintain policies and procedures that comply with the requirements in 17.4.A.3 and 17.4.A.4.

1. The policies and procedures for requirement 17.4.A.3 must include:
    a. Guidelines on how and when the health plan will find out and/or be notified when NEMT a provider/driver is convicted with a state drug law violation.
    b. Actions the health plan will take when a NEMT provider/driver is convicted with a state drug law violation.
        1) Procedures the health plan will follow when notified about a specific provider/driver.
        2) Description of how the health plan will ensure the driver/provider does not service Medicaid beneficiaries.

c. Statement that the health plan shall notify Med-QUEST Division (MQD) in the Provider Network Adequacy Verification (PNA) report if there are any NEMT deficiencies due to an increase in the number of drivers/providers convicted of a state drug law violation.

2. The policies and procedures for requirement 17.4.A.4 must include:
   a. Guidelines to describe the process on how and when the NEMT provider/subcontractor will notify the health plan when a driver/provider has a traffic violation.
   b. Description of the actions the health plan will take when the health plan determined that a NEMT provider/driver should no longer be on the available driver list.
      1) Description of how the health plan will ensure the driver/provider does not service Medicaid beneficiaries.
   c. Statement that the health plan shall notify Med-QUEST Division (MQD) in the Provider Network Adequacy Verification (PNA) report if there are any NEMT deficiencies due to an increase in the number of drivers/providers removed from the available driver list.

CHAPTER 18: Member

18.1 Member Enrollment

A) In accordance with RFP-MQD-2021-008 Section 9.2.A.4, Health Plans will issue a Member Enrollment Packet to their newly eligible Members. The Enrollment Packet will contain all the elements described in the "Member Enrollment Packet Requirements" appendix in the "Health Plan Manual - Appendices" document.

18.2 Member Handbook Requirements

A) In accordance with RFP-MQD-2021-008 Section 9.4.E, Health Plans will have a Member Handbook on their website and paper form for all Members. The Member Handbook will contain all the elements described in "Member Handbook Requirements" appendix in the "Health Plan Manual - Appendices" document.

CHAPTER 19: Coordination with Other State Programs

19.1 Medical Services Related to Dental Needs

A) In accordance with RFP-MQD-2021-008 Section 4.3.D, Health Plans will be responsible for treating medical conditions of the dental services. Refer to dental procedure codes listed in the "Dental Services to Treat Medical Conditions" appendix in the "Health Plan Manual - Appendices" document

19.2 Intentional Termination of Pregnancy (ITOPs)

A) The State covers ITOPs through DHS's fiscal agent.

B) The Health Plan will not cover any claims for ITOP procedures, medications, transportation, meals, or lodging associated with ITOPs.

C) The Health Plan will refer Members to family planning providers providing full-range pregnancy option counseling as needed.

D) The Health Plan will cover treatment for medical complications resulting from elective termination and treatments, spontaneous, incomplete, or threatened terminations, and for ectopic pregnancies.

CHAPTER 20: Healthcare-Acquired Conditions

20.1 Provider Preventable Conditions

A) On June 30, 2011, CMS published a final rule implementing the requirements of Section 2702. The final rule requires that states implement non-payment polices for provider preventable conditions (PPCs)including health care-acquired conditions (HCACs) and other provider- preventable conditions (OPPCs). The minimum set of conditions, includinginfections and events, that states must identify for non-payment are:

B) Category 1 – Health Care-Acquired Conditions (For Any Inpatient HospitalSettings in Medicaid)

1. Foreign object retained after surgery
2. Air embolism
3. Blood incompatibility
4. Stage III and IV pressure ulcers
5. Falls and trauma; including fractures, dislocations, intracranialinjuries, crushing injuries, burns, electric shock
6. Catheter-associated urinary tract infection (UTI)
7. Vascular catheter-associated infection
8. Manifestations of poor glycemic control including: diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma,secondary diabetes with ketoacidosis, secondary diabetes with hyperosmolarity
9. Surgical site infection following:

a. Coronary artery bypass graft (CABG) - mediastinitis

b. Bariatric surgery including laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery

c. Orthopedic procedures including spine, neck, shoulder, elbow

C) Deep vein thrombosis (DVT)/pulmonary embolism (PE) following total knee replacement or hip replacement with pediatric and obstetric exceptions

D) Category 2 – Other Provider Preventable Conditions (For Any HealthCare Setting)

1. Wrong surgical or other invasive procedure performed on a patient.
2. Surgical or other invasive procedure performed on the wrong bodypart.
3. Surgical or other invasive procedure performed on the wrongpatient.
4. OPPCs identified in the state's plan and according to therequirements of the final regulation.

CHAPTER 21: Non-Emergency Medical Transportation

21.1 Non-Emergency Medical Transportation Policy

Non-Emergency Medical Transportation (NEMT) is only for medically necessary visits when no other form of transportation is available. The most cost-effective means of transportation that best meets the individual circumstances of the health plan member (Member) should be utilized when medically necessary as indicated by the Members' Health Coordinator or Primary Care Physician (PCP) in their plan of care (POC). The availability of free transportation to include Members' vehicle, transportation provided by relatives, friends, volunteer services, and by the facility serving the Member should be explored first.

To improve the quality and efficiency of NEMT, health plans are directed to implement procedures consistent with MQD policy. These procedures should be submitted to MQD for review and approval.

Health plan procedures should:

A) Provide curb-to curb services by Handi-van.

B) Consider members eligible for a bus pass if:

1. Member resides less than half (½) a mile from transit stop.
2. Member appointment is less than half (1/2) a mile from transit stop.
3. Member is ambulatory or capable of negotiating a wheelchair and handicap public transit is available.
4. The number of trips required per month indicates monthly bus pass is most cost effective method of transportation.

C) Require that Members not using the Handi-Van or bus must have a determination from the PCP or Health Coordinator for medically necessary higher level mode of transportation.

D) Encourage providers of recurring appointments to schedule

transportation.

1. For recurring appointment such as dialysis or adult day care, the provider may make appointments in advance for the quarter.
2. Providers shall set up transportation appointments with the NEMT vendors of each health plan.
3. Provider requests must specify mode of transportation as determined by the health plan POC.

E) Require 48 hour advance notification for appointments.
1. Members who call in less than forty-eight (48) hours may be asked to re-schedule the doctor's appointment unless meeting urgent criteria.
2. Requests for urgent care may be made with less than 48 hours notice when a Member has a medical problem that is serious and requires medical attention within 24 hours but is not an immediate threat to the Member's life or health.

F) Pursue ride-sharing standards so long as no member travels more than thirty (30) minutes longer than if he or she had traveled directly.

G) Must not allow ride sharing when a member exhibits signs and symptoms of a possible contagious illness such as coughing, fever, open lesions, etc.

H) Allow escorts only when determined medically necessary by the PCP or Health Coordinator for the QI program.

I) Not pay General Excise Tax (GET) as a separate, additional cost as it is included as part of the NEMT and taxi meter rate structures.

J) Not allowed side trips to include:
1. Pharmacy with exception;
2. Shopping;

3. Visiting;
4. Pick up or drop off for durable medical equipment or supplies;
5. SSI Determination medical appointment or Medicaid eligibility; and
6. Trips to classes, support groups, community events, etc., unless included as part of the member's plan of care.

K) Pharmacy exception:

1. Transportation for medication prescription pickup will only be allowed when there is a serious medical condition that requires the immediate administration of medication to prevent further or serious medical complications.

L) Have a Member appeals process.

CHAPTER 22: Encounters for Health Plan Staff Delivered Services

22.1 Encounters for Health Plan

A) The Health Plan shall submit encounter records for direct services rendered to beneficiaries by Health Plan personnel that may otherwise be delegable to providers in the community. Examples of such services include care coordination, service coordination, housing coordination, case management, outreach efforts, medication reconciliation, and quality improvement activities. The value of these encounters should tie to the costs captured by the Health Plan as part of its general ledger.

B) The mechanisms for submitting encounter records for services rendered by Health Plan personnel will be specified in the QI Health Plan Manual Part IV: HPMMIS Technical Guide – Encounters.

CHAPTER 23: Staffing Notification

23.1 Staffing Change Notification

A) The health plan shall notify DHS in writing, within seven (7) calendar days of learning of a change in the status of the positions that have a check mark within the change notification column of the table below. A complete and up-to-date Health Plan QI Staffing Table as provided in Appendix AA, shall accompany each staffing change notification submission to MQD.

B) 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.

C) The Staffing Change Notification Form, the Staffing Change Notification Form Instructions, and the Staffing Change Notification Form Sample, are included as part of this HPM Appendix AA1.

Staffing Table

Mandated QI Staff		Requirements			
Position		FTE or # of Positions	Hawaii	Resume	Change Notification
1	Administrator/CEO/Executive Director	1.0	✓	✓	✓
2	Behavioral Health Coordinator	1.0	✓	✓	✓
3	Business Continuity Planning, Disaster Preparedness and Recovery Manager/Coordinator	Adequate to meet the Contract requirements			✓
4	CIS Coordinator	1.0	✓		
5	Claims Administrator/Manager (See below for Hawaii residence requirement exception)	1.0	✓		✓
6	Claims Processing Staff	Adequate to meet the Contract requirements			
7	Compliance Officer	1.0	✓	✓	✓
8	Data Analytics Officer	0.5		✓	✓
9	EPSDT Coordinator	1.0	✓	✓	✓
10	Financial Officer/CFO	0.5	✓	✓	✓
11	Health Coordination Director	1.0	✓	✓	✓
12	Health Coordination Managers	Adequate to meet Contract requirements	✓		
13	Health Coordination Team	Adequate to meet Contract requirements	✓		
14	IT Director or Chief Information Officer (CIO)	0.5		✓	✓

15	IT Hawaii Manager (If no Hawaii-based IT Director or CIO)	Adequate to meet Contract requirements	✓	✓	✓
16	IT Staff	Adequate to meet Contract requirements			
17	LTSS Coordinator	1.0	✓		
18	Medical Director	1.0	✓	✓	✓
19	Member Grievance Coordinator	0.5	✓	✓	✓
20	Member Services Director	1.0	✓	✓	✓
21	Member Services Staff (to include Call Center staff)	Adequate to meet Contract requirements	✓		
22	Pharmacy Coordinator/Director/Manager	1.0	✓	✓	✓
23	PA/Utilization Management/Medical Management Director	1.0	✓	✓	✓
24	PA/Utilization Management/Medical Management/Concurrent Review Staff	Adequate to meet Contract requirements	✓		
25	Provider Grievance Coordinator	0.5	✓	✓	✓
26	Provider Services/Contract and Credentialing Manager	1.0	✓	✓	✓

27	Provider Services/Contract and Credentialing Staff	Adequate to meet Contract requirements	✓		
28	Quality Management Coordinator	1.0	✓	✓	✓

Glossary

ACE	Adverse Childhood Events
ADAD	Alcohol and Drug Abuse Division
ADRC	Aid to Disabled Review Committee
ALF	Assisted Living Facilities
ASAM	American Society of Addiction Medicine
ASI	Assessment Screening Intake
BH	Behavioral Health
BHO	Behavioral Health Organization
BHS	Behavioral Health Services
CAMHD	Child Welfare Services, Child and Adolescent Mental Health Division
CARES	Coordinated Access Resource Entry System
CBCM	Community-Based Case Management
CCFFH	Community Care Foster Family Homes
CCMA	Community Care Case Management Agencies
CCS	Community Care Services
CIS	Community Integration Services
CMO	Crisis Mobile Outreach
COC	Continuum of Care
CSHN	Children with special health care needs
CSHNP	Children with Special Needs Program
CSNB	Children with Special Needs Branch
CWS	Child Welfare Services
CYSHCN	Children and youth with special health care needs
DDD	Developmental Disabilities Division
DHS	Department of Human Services
DME	Durable Medical Equipment
DOE	Department of Education
DOH	Department of Health
E-ARCH	Expanded Adult Residential Care Homes
EHCN	Expanded Health Care Needs
EIS	Early Intervention Services
EVV	Electronic Visit Verification
FMAP	Federal Medical Assistance Percentage
GHP	Going Home Plus
HAP	Health Action Plans
HCBS	Home and Community-Based Services

HCS	Health Coordination Services
HFA	Health and Functional Assessment
I/DD	Intellectual and/or Developmental Disabilities
ITOPS	Intentional Termination of Pregnancy
LOC	Level of Care
LTC	Long-Term Care
LTSS	Long-Term Services and Supports
MOA	Memorandum of Agreement
MQD	Med-QUEST Division
NQF	National Quality Forum
PCG	Primary Care Giver
PHPDM	Prevention, Health Promotion, and Disease Management
QI	QUEST Integration
QUEST	**Q**uality care, **U**niversal access, **E**fficient utilization, **S**tabilizing costs, **T**ransforming the way health care is provided to members
SBIRT	Screening, Brief Intervention, Referral to Treatment
SCT	Stem Cell Transplant
SEBD	Support for Emotional and Behavioral Development
SHCN	Special Health Care Needs
SHOTT	State of Hawaii Organ and Tissue Transplant
SMI	Serious Mental Illness
SRF	Social Risk Factors
SUD	Substance Use Disorder
TPA	Third-Party Administrator