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HAWAII ADMINISTRATIVE RULES

TITLE 17

DEPARTMENT OF HUMAN SERVICES

SUBTITLE 12

MED-QUEST DIVISION

CHAPTER 1735.2

GENERAL PROVISIONS FOR PARTICIPATING HEALTH PLANS

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Historical Note: This chapter is based substantially upon repealed subchapters 5 and 8 of chapter 17-1721.1 and subchapter 9 of chapter 17-1727.

The source notes for subchapters 5 and 8 of chapter 17-1721.1 are: [Eff 01/31/09; am 06/25/12; R 09/30/13].

The source notes for subchapter 9 of chapter 17-1727 is: [Eff 08/01/94; am 01/29/96; am 06/19/00; am 02/16/02; am 09/17/07; am 06/25/12; R 09/30/13].

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§17-1735.2-1 Purpose. This chapter describes the requirements for the participation of health plans under the medical assistance program.

[Eff 09/30/13] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1735.2-2 Health plan participation in the medical assistance program. (a) The department shall request proposals from managed care health plans for provision of healthcare services to an eligible individual to participate in the medical assistance program.

(b) The department shall evaluate the proposals from managed care plans to ensure that the plans meet the conditions and requirements described in the department's request for proposals.

(c) Contracts for participation in the medical assistance program shall be awarded to qualified health plans upon finalization of financial agreements with the department.

(d) The department shall develop a request for proposals prior to the lapse of existing contracts with participating health plans to ensure that beneficiaries receive continued health care coverage.

[Eff 09/30/13] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1735.2-3 Service areas. (a) The department shall designate geographic areas as the areas for which health plans will submit proposals to provide services.

(b) A health plan may submit proposals to service more than one service area.

(c) More than one health plan may be contracted by the department for each service area.

[Eff 09/30/13] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

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§17-1735.2-4 Requirements of participating health plans. (a) Health plans participating in the medical assistance program shall abide by the provisions of their respective contracts with the department as well as federal and state statutes and regulations.

(b) The requirements of each participating health plan shall include, but are not limited to, the following:

- (1) Provision of all services required by the contract between the respective plan and the department;
- (2) Provision of a primary care provider for each eligible individual who is enrolled in the health plan;
- (3) Provision of a case management system to ensure that health services identified by an eligible individual's primary care provider as medically necessary are received;
- (4) Development and maintenance of a sufficient network of health care providers to ensure the provision of required health services are provide to an eligible individual in a timely manner;
- (5) Maintenance of adequate support staff and systems to administer and conduct business functions;
- (6) Development and maintenance of required information systems;
- (7) Development and maintenance of a quality assurance program;
- (8) Development and maintenance of a grievance and appeal system for a dissatisfied eligible individual;
- (9) Development and maintenance of a toll-free telephone hotline in the State to confirm enrollment, respond to inquiries from an eligible individual, and provide information to the general public; and
- (10) Maintenance of a medical records system to enable the provision of information

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pertinent to the care and management of an eligible individual to the department.

[Eff 09/30/13] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1735.2-5 Capitated payments. (a) Each participating health plan shall be paid on a capitated basis, as negotiated with the department, for an eligible individual enrolled in that health plan.

(b) The department shall provide the capitated payment, as stipulated in the contract between the department and each health plan, in return for the health plan's provision of all contracted coverage for the health plan's eligible individuals. [Eff 09/30/13] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1735.2-6 Enforcement of contracts with participating health plan. (a) The department may monitor a participating health plan's performance during any contract period.

(b) The department may impose civil or administrative monetary penalties not to exceed the maximum amount established by federal and state statutes and regulations if the health plan:

- (1) Fails to provide medically necessary items and services that are required under law or under contract;
- (2) Imposes upon beneficiaries excess premiums and charges;
- (3) Acts to discriminate among an eligible individual;
- (4) Misrepresents or falsifies information;
- (5) Violates marketing guidelines established by the department;
- (6) Violates other contract provisions and requirements; or
- (7) Violates federal or state statutes or regulations.

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(c) If a health plan violates the contract conditions between the health plan and the department, federal or State statutes or regulations, the Hawaii Administrative Rules, or if there is a substantial risk to the health of an eligible individual, the department may:

- (1) Notify the affected individual of the violations;
- (2) Allow the affected individual to change plans without cause;
- (3) Suspend enrollment; or
- (4) Suspend payment.

The department may also impose financial sanctions as described under the provisions of the contract between the respective plan and the department for inaccurate, incomplete, and untimely data and reports submitted to the department.

(d) If a health plan continues to violate the contract conditions between the health plan and the department, federal or state statutes and regulations, or the Hawaii Administrative Rules, regardless of any other penalty that may be imposed, the department shall:

- (1) Appoint temporary management to oversee compliance efforts;
- (2) Notify the affected eligible individual of the violations; or
- (3) Allow the affected eligible individual to change plans without cause.

(e) Temporary management may continue until the department determines that the health plan can ensure that the behavior that caused the penalty will not recur.

(f) Before imposing a sanction, with the exception of appointing temporary management to oversee compliance efforts, the department shall give the health plan timely written notice, as specified in the contract with the participating health plans.

[Eff 09/30/13] (Auth: HRS §346-59.5) (Imp: HRS §346-14; 42 C.F.R. §§430.25; 438.700, 438.702; 438.706; 438.710)

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§17-1735.2-7 Termination of contract with participating health plan. (a) The department shall have the authority to terminate the participating health plan's contract for any or all of the following reasons:

- (1) Convenience;
- (2) Default by the health plan;
- (3) Expiration of the medical assistance program;
- (4) Failure by the health plan to abide by the contract conditions;
- (5) Insolvency of or declaration of bankruptcy by the health plan;
- (6) Failure to meet federal or state statutes, or both; or
- (7) Unavailability of funds.

(b) When termination of contract is due to reasons identified under subsections (a)(2), (4) or (6), the department shall provide a hearing for the affected health plan prior to termination of the contract.

(c) After the department notifies the health plan of its intent to terminate the contract due to reasons identified under subsections (a)(2), (4) or (6), the department may do the following:

- (1) Provide the affected eligible individual written notice of the department's intent to terminate the contract; and
- (2) Allow the affected eligible individual to change health plans immediately without cause. [Eff 09/30/13] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25; 438.708)

§§17-1735.2-8 to 17-1735.2-10 (Reserved).