ALOHACARE

QUEST Integration Program Attachment

THIS ATTACHMENT ("Attachment") is entered into by AlohaCare, a Hawaii corporation (hereinafter referred to as "Plan"), and (hereinafter referred to as "Provider").

WHEREAS, Plan provides or arranges for health care services for individuals enrolled in Plan who are eligible for benefits under the federal/state Medicaid program authorized by Title XIX of the Social Security Act ("Medicaid program");

WHEREAS, the Medicaid program requires certain clauses in the agreements between providers and Plan;

WHEREAS, Plan and Provider seek to amend their Agreement to meet all the applicable federal and state Medicaid laws, regulations and program guidance.

NOW, THEREFORE, it is hereby mutually agreed by and between the parties as follows:

ALOHACARE		**PROVIDER**	
SIGNATURE	DATE	SIGNATURE	DATE
NAME		NAME	
TITLE		TITLE	

ARTICLE I

DEFINITIONS

1.1 "Advance Beneficiary Notice" means a notice issued by Provider to a Member identifying a service or item that is not a Covered Service or may not otherwise be approved for payment by Plan. Such notice gives the Member sufficient information to make an informed choice about whether or not to receive or accept the service or item, including the cost.

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

1.3 "Medicaid" means a Federal / State program authorized by Title XIX of the Social Security Act, as amended, which provides Federal matching funds for a state-operated medical assistance program for specified populations. Certain mandatory populations and services must be included to receive federal financial participation; however, states may add additional optional populations and services with Centers for Medicare and Medicaid Services (CMS) approval.

1.4 "Med-QUEST Division (MQD)" means an organization unit within the Hawaii Department of Human Services (DHS) that has the responsibility for the administration and operations of the health assistance programs, including QUEST Integration.

1.5 "Plan" means AlohaCare, a not-for-profit Hawaii corporation formed as a medical delivery system which has been awarded a contract by and with the Med-QUEST Division of the Department of Human Services to participate in the QUEST Integration program to provide or arrange for the provision of Covered Services to Members enrolled in Plan.

1.6 "Prior Period Coverage" means the period from the Member's eligibility effective date as determined by the DHS up to the date of the Member's enrollment in Plan.

ARTICLE II

PROVIDER OBLIGATIONS

2.1 Provision of Covered Services. Provider shall provide or arrange to have provided all Covered Services to enrollees of QUEST Integration consistent with this Attachment and within the scope Provider's licenses and certifications to practice and for which Provider has been credentialed.

2.2 Early, Periodic, Screening and Diagnosis and Treatment ("EPSDT") Services. Primary Care Providers shall comply with all EPSDT requirements for all assigned Members from birth through 20 years of age, including but not limited to:

2.2.1 provide EPSDT services in accordance with the EPSDT periodicity schedule and utilize the standardized EPSDT tracking forms prescribed by the MSP when performing exam on EPSDT eligible members; and

2.2.2 achieve Member participation in the EPSDT program at least at the minimum Plan or MSP standard for participation rate for EPSDT-eligible Members during the term hereof. "Participation" is defined as per the periodicity schedule and shall be measured using encounter data submitted to Plan.

2.3 Identification of Certain Members. Provider shall notify Plan if, in the opinion of Provider and as defined by Plan or the Hawaii Department of Human Services, a Member who is not currently identified as such meets the criteria for the following designations:

2.3.1 Members With Disability. Provider shall submit Form DHS 1180 to the Agency and Disability Resource Center ("ADRC") when Provider identifies an individual they believe is eligible.

2.3.2 Members Requiring Long Term Services and Support. Provider shall submit Form DHS 1147 to DHS or its designee when Provider identifies an individual they believe is eligible.

2.3.3 Members With Special Health Care Needs. Provider shall notify Plan when Provider identifies an individual they believe is eligible. "Special Health Care Needs" means a chronic physical, developmental, behavioral, or emotional or social condition that requires health related services of a type or amount beyond that generally required by children or adults.

2.4 Holding Members and MQD Harmless and Without Liability. Provider shall indemnify and hold MQD, Members, and persons legally authorized to act on Member's behalf harmless from any and all liability arising from all claims related to or arising out of payment for Covered Services rendered to Members and shall bear all costs in defense of any action over such liability, including attorney's fees. Member and MQD shall bear no liability for Plan's failure to pay valid claims of subcontractors or Provider for Covered Services; for services provided to a member for which MQD does not pay Plan; or for which Plan or MQD does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangement; or for payment for Covered Services furnished under a contract, referral, or other arrangement, to the extent that these payments are in excess of the amount that the Member would owe if Plan provided the services directly. This provision shall not prohibit collection of Co-payments from Members in accordance with the terms of Member's Plan. Provider shall refund any payment in excess of an allowable Co-payment that was received from a Member or other person who made a payment on the Member's behalf for Covered Services provided during Prior Period Coverage.

2.5 Billing Members Prohibited. Provider shall not seek nor obtain payment from Members for Covered Services, except for co-payments or deductibles pursuant to the Hawaii Medicaid State Plan and in accordance with MQD rules. If MQD so stipulates, Covered Services shall not be withheld from a Member if the Member is unable to pay Co-payment. Provider shall accept Plan's payment in full; Member shall not be liable and shall not be billed for any Provider or Plan obligations under any circumstances, including if either Provider or Plan becomes insolvent, whether or not the service was reimbursed by Plan, or if there is otherwise a breach of this Agreement.

2.6 Non-Covered Services. If the Member requests and receives a non-covered service, and if the Member was notified of the non-covered status of such services before receiving the non-covered service, then Provider may bill the Member. Provider shall document each such event with a clear statement by Provider and the Member's signed acceptance of payment responsibility, which must be placed in the Member's medical record.

2.6.1 If a Member self-refers to a specialist or other provider within Plan's network without following procedures, including obtaining prior authorization, Plan may deny payment to Provider. If Plan does deny payment, Provider may bill Member if Provider supplied Member with an Advance Beneficiary Notice of non-coverage prior to performing the service.

2.6.2 Provider shall not impose a "no-show" fee for Members who were scheduled to receive a Covered Service.

2.6.3 Prior notices for non-covered and self-referred services shall include the cost of the procedure and the payment terms at the time of service.

2.7 Compliance with QUEST Integration. In providing services to Members, Provider shall provide all services and perform its duties under this Contract in accordance with, and subject to, QUEST Integration policies as may be set forth in existing QUEST Integration provider notices, provider manuals, QUEST Integration required subcontract provisions, and rules and regulations which may be issued or promulgated by MQD from time to time during the term of this Contract. Provider shall comply with all applicable federal, state, and municipal laws in providing services under this Contract. If applicable, Provider shall submit its annual cost reports to the MSP.

2.8 Subcontractor Relationship and Delegations. Plan is responsible to monitor Provider's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the State, consistent with industry standards or state laws and regulations. Provider acknowledges that MQD has the authority to require Plan to remove Provider from Plan's network if Provider fails to meet or violates any state, federal laws, rules, and regulations or if Provider's performance is deemed inadequate by the State based upon accepted community of professional standards. If Plan identifies deficiencies or areas for improvement, Plan shall take corrective action up to and including termination as set forth in Article VI of the Agreement.

2.9 Appointment Availability. Provider shall ensure that timely access to Covered Services is available to Members by offering appointment availability consistent with the level of availability provided to other patients within the Provider's practice and the standards outlined in this section, as applicable. If Provider is unable to render timely care, Provider shall inform the Member of his or her care options, including the option to contact Plan for referral to another available Provider. Appointment availability standards are as follows:

2.9.1 PCP urgent care and pediatric sick visits [available within twenty-four (24) hours].

2.9.2 PCP adult sick visits [available within seventy-two (72) hours].

2.9.3 PCP routine adult and pediatric visits [available within twenty-one (21) days].

2.9.4 Specialist visits or non-emergency hospital stays [available within four (4) weeks].

2.9.5 Behavioral health routine visits for adults and children [available within twenty-one (21) days].

2.9.6 Plan shall ensure that emergency room services are available for immediate care for emergency medical situations without prior authorization [available twenty-four (24) hours a day, seven (7) days a week].

2.10 Hours of Availability. Provider shall offer reasonable normal business hours and call-coverage arrangements, if applicable, that are no less than the hours of operation offered to other commercial patients or comparable Fee-For-Service Medicaid patients within Provider's practice.

2.11 Access to Auxiliary Aids for Members with Disabilities. Provider shall offer access to auxiliary aids and services that are Covered Services for Members living with disabilities. Provider shall offer aids and services at no cost to Members and shall document any such offer and provision.

ARTICLE III

COMPENSATION AND BILLING

3.1 Compensation. Plan compensation to Provider for Covered Services shall be set forth in the following exhibit:

☒ QUEST Integration Fee For Service Compensation Exhibit

3.2 Billing. Provider shall document each encounter or episode of service provided to a Member involving a Covered Service by submitting to Plan the appropriate Billing Form and any necessary medical documentation within 365 days from the date of service or date of discharge, as applicable.

3.3 Newborns. Plan shall be responsible for payment of Covered Services provided to a Member's newborn child for at least 30 days following the birth. Provider shall not seek payment from any individual or entity other than Plan or the mother's commercial health plan, if applicable, for payments related to the newborn.