QUEST PROGRAM REQUIRED PROVISIONS

including Subcontractor Requirements

This Exhibit / Attachment shall only apply to medical services for Medicaid members. In case of conflict between the Agreement and this Exhibit / Attachment, this Exhibit / Attachment shall control as to the Medicaid program only. To the extent that any greater rights or obligations between the parties are created under this Exhibit / Attachment than are in the Agreement, such rights and obligations shall only apply to medical services provided under the Medicaid programs.

DEFINITIONS

Covered Benefit(s) mean(s) the health care services and benefits that a Member may be entitled to receive under Kaiser Permanente QUEST (see Attachment A, QUEST Covered Benefits).
Covered Service(s) mean(s) those Services rendered by Provider to Members that are (i) Covered Benefits and (ii) Authorized or otherwise approved for payment.
Emergency Medical Condition is defined as the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms, substance abuse) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of emergency services or immediate medical attention to result in: a. Placing the health of the individual (or with respect to a pregnant woman, the health of the woman, or her unborn child) in serious jeopardy; b. Serious impairment to body functions; c. Serious dysfunction of any bodily functions; d. Serious harm to self or others due to an alcohol or drug abuse emergency; e. Injury to self or bodily harm to others; or f. With respect to a pregnant woman who is having contractions: that there is inadequate time to affect a safe transfer to another hospital before delivery; or that transfer may pose a threat to the health or safety of the woman or her unborn child.
Medical Necessity refers to the procedures and services, as determined by DHS, which are considered to be necessary and for which payment will be made. Medically necessary health interventions (services, procedures, drugs, supplies, and equipment) shall be used for a medical condition. There shall be sufficient evidence to draw conclusions about the intervention's effects on health outcomes. The evidence shall demonstrate that the intervention can be expected to produce its intended effects on health outcomes. The intervention's beneficial effects on health outcomes shall outweigh its expected harmful effects. The intervention shall be the most cost-effective method available to address the medical condition. Sufficient evidence is provided when evidence is sufficient to draw conclusions, if it is peer-reviewed, is well- controlled, directly or indirectly relates the intervention to health outcomes, and is reproducible both within and outside of research settings.

A. Prohibit Billing Member

Except as expressly provided in this Agreement in addition to the exception of cost sharing pursuant to the Hawaii Medicaid State Plan, Provider (and any Subcontractors) shall look solely to the responsible Health Plan for compensation for Covered Services rendered to Medicaid/QUEST Members, and Provider agrees that in no event (including non-payment by Health Plan, insolvency of Health Plan or breach of the Agreement) shall Provider (or Subcontractor) bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member, person acting on the Member's behalf, Official, State or any Medicaid plans, for Covered Services provided under the

Agreement. Health Plan shall accept the capitation payment as payment in full for all services to be provided under the Health Plan's QUEST contract and all administrative costs associated with performance of that contract. Without limiting the foregoing, Provider shall not seek payment from Members for reasons including (i) amounts denied by Health Plan because billed charges were not customary or reasonable, (ii) Provider's failure to obtain Authorization for Services delivered, (iii) clinical data that was not submitted promptly, or (iv) Provider's failure to submit a Claim in accordance with the appropriate billing procedures or within the appropriate time frame, or in accordance with commonly accepted standard coding practices.

The provider will comply with all requirements regarding when billing a member or assessing charges is allowable, as described below:

1. Health Plan may collect fees directly from members for non-covered services or for services from unauthorized non-health plan providers.
2. Health Plan may deny payment to the provider when a member self-refers to a specialist or other provider without following the Health Plan's prior authorization procedures.
3. Health Plan has described the process for the provider on how to bill a member when non-covered or unauthorized services are provided as described below:

1. If a member self-refers to a specialist or other provider within the network without following the Health Plan's prior authorization procedures and the Health Plan does deny payment to the provider, the provider may bill the member if the provider provided the member with an Advance Beneficiary Notice of non-coverage;

2. If a provider fails to follow Health Plan procedures which results in nonpayment, the provider may not bill the member; and

3. If a provider bills the member for non-covered services or for self-referrals, he or she shall inform the member and obtain prior agreement from the member regarding the cost of the procedure and the payment terms at time of service.

B. Cooperate with QUESTActivities

Provider acknowledges that Kaiser Permanente is required by Law and by accreditation standards to monitor the quality improvement (QUEST) activities of Provider, as described in the Provider Manual. With respect to Covered Services provided to Members, Provider shall participate in Kaiser Permanente's QUEST program as established and amended from time to time, which includes cooperating with Kaiser Permanente's QUEST activities to monitor and evaluate Covered Services provided to Members, facilitating review of such Covered Services by Kaiser Permanente's QUEST committees and staff, and cooperating with any independent quality review and improvement organization or other external review organization evaluating Kaiser Permanente as part of its QUEST program.

C. Member Transfer

1. Provider shall cooperate with Kaiser Permanente to refer or transfer Members to any other facility or another primary care provider if a reasonably prudent person may determine that the member's health or safety is in jeopardy. Provider shall immediately notify Kaiser Permanente and the attending Permanente Physician of any indication of an emergency or other significant change in a Member's condition that may require the Member's transfer to another facility. Except in emergency cases, any change in hospital must be agreed to by the attending Permanente Physician and Provider. In emergency

cases, Provider will obtain authorization for admission to any acute care facility from Kaiser Permanente as soon as reasonably practicable.

D. Communications with Members

Subject to applicable confidentiality requirements, Provider may freely communicate with a Member (or his/her authorized representative) about the Member's treatment options, without regard to benefit coverage limitations or which may not reflect the health plan's position. Information about health care service and treatment options (including the option of no treatment) must be provided to Members in a culturally competent manner, as required of Kaiser Permanente under applicable Law and by Government Officials.

E. Provision of Services

This Agreement does not prohibit, or otherwise restrict, Provider from (1) providing health care services to Members in a manner consistent with all laws, rules and regulations, customs and ethics relating to Provider's medical profession, (2) advising or advocating on behalf of a Member for the Member's health status, medical care, or treatment or non-treatment options, including any alternative treatments that may be self-administered, and (3) advocating on behalf of a Member to obtain necessary health care services in any grievance system or utilization review process, or individual authorization process.

F. Availability/Waiting Time

Provider shall accept all Members for treatment unless the Provider requests and Kaiser Permanente allows for a waiver from this requirement. Provider's hours of operation shall be no less than the hours of operation offered to commercial members or comparable FFS Medicaid members.

Provider shall ensure that Covered Services provided under the Agreement are readily available and accessible, provided in a prompt and efficient manner, meeting the appointment waiting time standards set forth below, and consistent with applicable recognized standards of practice and Program Requirements. The acceptable appointment waiting times are:

1. Immediate care (twenty-four (24) hours a day, seven (7) days a week) and without prior authorization for emergency medical situations;
2. Appointments within twenty-four (24) hours for urgent care and for PCP pediatric sick visits;
3. Appointments within seventy-two (72) hours for PCP adult sick visits;
4. Appointments within twenty-one (21) days for PCPs and routine visits for adults and children;
5. Appointments within twenty-one (21) days for behavioral health (routine visits for adults and children); and
6. Appointments within four (4) weeks or of sufficient timeliness to meet Medical Necessity for visits with a specialist or for non-emergency hospital stays.

G. Continuation of Treatment

Upon termination of this Agreement, except in the case of adverse reasons on the part of the Provider, Provider shall continue to provide Covered Services pursuant to all of the terms and conditions set forth in the Agreement and the Provider Manual to Members who are under the care of Provider at the time of termination for those specific conditions for which Member is under the care of Provider, and in accordance with the limitations and mandated time period applicable by Law to Health Plan to preserve

the continuity of care for those Members. As required by Law, in the event of Kaiser Permanente insolvency or other cessation of operations, Provider shall continue to provide Covered Services through the period for which dues or premiums have been paid, or if a Member is confined in a Facility on the date of insolvency or other cessation of operations, until the Member can be discharged in accord with an appropriate professional standard of care or Member's benefits expire.

H. Confidentiality

Provider understands and agrees that the Agreement and certain data exchanged hereunder may be subject to the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-91) and its corresponding regulations (45 CFR 160, 162, 164) (collectively, "HIPAA") and other confidentiality and privacy laws, including but not limited to 42 CFR parts 2 and 431 (subpart F), HAR Chapter 17-1702, HRS Sections 334-5, 346-10 and Chapter 577A. If Provider is or becomes a "Covered Entity" as defined by HIPAA, Provider shall comply with all relevant HIPAA requirements.

I. Provider Compliance with Laws, Regulations, and Rules

Provider shall comply with the provisions of (1) 42 CFR 434, 42 CFR 438.6, and 42 CFR 438.114, (2) Title IX of the Education Amendments Act of 1972 (regarding education programs and activities), (3) all corrective action plans initiated by the health plan or DHS, (4) all EPSDT requirements, (5) Kaiser Permanente's compliance plan, including all fraud and abuse requirements and activities, and all other applicable laws, regulations and rules.

J. Maintenance of Records

All Medicaid related records shall be retained in accordance with 42 CFR Section 438.3(u), for a minimum of ten (10) years after the last date of entry in the records. For minors, records must be preserved and maintained during the period of minority plus a minimum of ten (10) years after the minor reaches the age of majority.
Provider shall coordinate with the health plan in transferring member's medical records (or copies) when a member changes PCPs.

K. Access for and Disclosure to DHS

Provider shall provide record access to CMS, State Medicaid Fraud Control Unit or any authorized DHS personnel contracted by the DHS, without member consent so long as the access to the records is required to perform the duties of the contract with the State and to administer the QUEST Integration program. Provider shall comply with health plan standards that provide the DHS or its designee(s) prompt access to members' medical records whether electronic or paper.

Provider shall provide CMS, the State Medicaid Fraud Control Unit, and DHS or its respective designee the right to inspect, evaluate, and audit any pertinent books, financial records, medical records, lab results, documents, papers, and records of any provider involving financial transactions related to the QUEST contract and for the monitoring of quality of care being rendered without the specific consent of the member or the provider.

L. Submission Encounter Data Provision

Providers (if compensated by capitation payments) shall submit complete and accurate encounter data on a monthly basis, as well as any and all medical records to support such encounter data as requested by Kaiser Permanente, DHS, or its designee, with or without the specific consent of the Member for the purpose of validating encounters.

M. Access to Medical Records

Provider will, within sixty (60) days of a request, provide Kaiser Permanente and the DHS or its designee, with copies of Member's medical records, or access to such medical records. Any refusal to provide medical records, access to medical records, or inability to produce medical records to support the claim/encounter shall result in recovery of payment from Provider.

N. Certification of Accuracy of Data

Provider hereby represents and warrants that any data submitted to Kaiser Permanente by Provider shall be accurate, complete, and truthful. Upon Kaiser Permanente's request, Provider shall make such certification in the form and manner specified by Kaiser Permanente to meet Kaiser Permanente's legal, regulatory, accreditation and contractual requirements.

O. Cultural Competency Plan

Provider shall comply with the Kaiser Permanente's cultural competency plan to ensure that all Services are provided in a culturally competent manner. Information about health care service and treatment options (including the option of no treatment) must be provided to Members in a culturally competent manner, as required of Kaiser Permanente under applicable Law and by Government Officials.

P. Marketing Materials Submitted to DHS for Approval

If Provider desires to distribute any marketing material relating to the Medicaid program covered under this Agreement, Provider must submit such proposed material to Health Plan to submit to DHS for approval prior to its distribution. Provider will cooperate with Kaiser Permanente to obtain DHS's approval of such material and agrees that no such material shall be disseminated until DHS has agreed in writing to its contents.

Q. Medicaid Eligible Newborn Services

Kaiser Permanente shall pay for Medicaid eligible newborn services provided if such services are authorized under this Agreement. In the case of newborns, the provider will not look to any individual or entity other than the QUEST Integration or the mother's commercial Health Plan for any payment owed to providers related to the newborn.

R. Individuals on the State or Federal Exclusion List

Provider shall not employ or contract with directly or indirectly, any individual or entity who is identified as "ineligible", as defined by the Department of Health and Human Services (HHS) Office of Inspector General (OIG), or who has opted out of Medicare for the provision of healthcare services, utilization review, medical social work or administrative services with respect to Members. "Ineligible" is defined by the OIG as an individual or entity who is currently excluded, debarred, suspended, or otherwise ineligible to participate in the Federal health care programs or in Federal procurement or non-procurement programs; or has been convicted of a criminal offense that falls within the ambit of 42 U.S.C. 1320a-7(a), but has not yet been excluded, debarred, suspended, or otherwise declared ineligible. Provider shall: (i) screen all persons or entities whom it employs or contracts and/or provides Services under this Agreement against the State provider exclusion list (available through the internet at: https://medquest.hawaii.gov), HHS/OIG List of Excluded Individuals/Entities (available through the Internet at http://oig.hhs.gov) and General Services Administration (GSA) excluded provider listing found on the GSA's List of Parties Excluded from Federal Programs (available through the Internet at http://epls.arnet.gov) (collectively, the "Exclusion Lists") prior to engaging their services; and (ii) require, as part of the hiring or contracting process, that such persons disclose whether they are an "ineligible" person.

S. Prohibit Financial Relationship Referrals

Provider represents and warrants that it is currently and for the term of the Agreement shall remain in compliance with all applicable Laws and CMS instructions necessary for participation in the Medicare and Medicaid programs, including fraud and abuse and Stark Laws, the patient self-determination amendments of the Omnibus Budget Reconciliation Act of 1990 (regarding advance directives), and the applicable Medicare and Medicaid conditions of participation. Provider is prohibited from making referrals for designated health services to healthcare entities with which the Provider or a member of the Provider's family has a financial relationship, defined as a direct or indirect ownership or investment interest (including an option or nonvested interest) in any entity. This direct or indirect interest may be in the form of equity, debt or other means and includes any indirect ownership or investment interest no matter how many levels removed from a direct interest, or a compensation management with an entity.

T. Transitioning Members

Provider shall fully cooperate with other health plans to assure maximum health outcomes for transitioning Members. Where a member is receiving transition services from Provider, Provider shall, at the option of Kaiser Permanente, continue to render Services in accordance with the terms and conditions of this Agreement until member is transitioned to another health plan.

U. No-Show Fee

Provider is prohibited from imposing a no-show fee for QUEST Integration Members who were scheduled to receive a Medicaid covered service.

V. Liens and Third-Party Claims

Provider shall not, directly or indirectly through assignment or otherwise, assert any lien claim, subrogation claim, or any other claim against a Member, or any other person or organization against which a Member may hold a potential claim for personal injury, or against the proceeds of a Member's personal injury recovery based on Services that Provider provided to the Member under this Agreement for an injury or illness allegedly caused by a third party. Unless prohibited by applicable Law, Health Plan (or the Payor that issues the applicable Membership Agreement) alone shall have the right to pursue and collect such claims for its own account, and Provider agrees to assist these collection efforts by promptly informing Health Plan (or the applicable Payor) or its designee of Services provided by Provider for which there may be potential third-party liability.

W. State and Member Hold Harmless

Except as expressly provided in this Agreement, the State and Members shall bear no liability (1) for health plan's failure or refusal to pay valid claims of subcontractors or providers for covered services, (2) for services provided to a member for whom the State does not pay the health plan, and (3) for services provided to a member for which the plan or State does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangements to the extent that the payments are in excess of the amount that the member would owe if the health plan provided the services directly.

X. Interpretation Services

Provider shall offer access to interpretation services (and document such offer and the provision of interpretation services to the same extent as the Health Plan under the QUEST contract) for Members that have a Limited English Proficiency (LEP) at no cost to the Member

Y. Member Access to PHI

Provider has the responsibility under HIPAA and the Privacy Rule to provide the patient with access to his or her PHI (45 CFR Section 164.524); to allow that patient to request an amendment of his or her PHI (45 CFR Section 164.526) and to provide an accounting of those disclosures identified under the Privacy Rule as reportable disclosures (45 CFR Section 164.528). Provider will extend these same rights to its Kaiser Permanente patients. If Provider amends, allows a Kaiser Permanente patient to amend or includes in its records any statement of a Kaiser Permanente patient pursuant to 45 CFR Section 164.526, it will give a copy of such to Kaiser Permanente.

Z. Overpayments

Provider shall be required to refund any payment from a Member or member's family (more than Member's share of cost) for the prior coverage period.
Provider shall report capitation payments or other overpayments in excess of amounts specified in the QUEST contract within sixty (60) calendar days when identified.

AA. Vaccines for Children Program

If Provider will be providing vaccines to children, he/she shall enroll and complete appropriate forms for the Vaccines for Children program. Provider shall include information on any VFC vaccinations provided in the Member's medical record and report all available vaccination information on Members to the Health Plan, including VFC vaccinations.

BB. **Insertion of Long-Acting Reversible Contraceptive (LARC) Devices**

To allow same day insertion of LARC devices requested by a Member, the Health Plan will reimburse non-FQHC providers for all formulary LARC devices supplied by the provider in addition to any capitation, visit, or other global reimbursement rate.

CC. Alternate Providers

A Provider with an ambulatory practice shall have admitting and treating privileges with at least one general acute care hospital within the health plan's network and on the island of services. If a Provider does not have admitting and treating privileges, the Provider shall have a written agreement with at least one other provider with admitting and treatment privilege with an acute care hospital within the health plan's network on the island of service.

DD. Advanced Directive Requirements
In addition to advance directive requirements specified in the Agreement, Provider shall comply with the required regulations as specified in 42 CFR Part 49 subpart I and 42 CFR Section 417.436 (d).

EE. Provider Qualifications

In addition to the qualification requirements specified in the Agreement, Provider shall also comply with all applicable Hawaii Administrative Rules ("HAR") sections and Medicaid requirements for licensing, certification, and recertification. Provider shall comply with disclosure requirements identified in accordance with 42 CFR Part 455, Subpart B and applicable sub-regulatory guidance. Provider shall be enrolled with the State as a Medicaid provider, unless an exception applies.

FF. Quality Assurance and Utilization Review

Provider shall participate in and cooperate with Health Plan's utilization review program and its quality assurance and improvement programs, including the timely submission of requested data and participating in the interpretation of performance data, instituting needed change, and cooperating with appropriate remedial action.

GG. Disclosure Requirements

- Provider shall comply with disclosure requirements identified in accordance with 42 CFR Part 455.104-106. Disclosure requirements include:
  - **§455.104 Disclosure by Medicaid providers and fiscal agents: Information on ownership and control.**

    What disclosures must be provided. The Medicaid agency must require that disclosing entities, fiscal agents, and managed care entities provide the following disclosures:

    (1)(i) The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.
    (ii) Date of birth and Social Security Number (in the case of an individual).
    (iii) Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest.
    (2) Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.
    (3) The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.
    (4) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

    When the disclosures must be provided.

    (1) *Disclosures from providers or disclosing entities.* Disclosure from any provider or disclosing entity is due at any of the following times:
    (i) Upon the provider or disclosing entity submitting the provider application.
    (ii) Upon the provider or disclosing entity executing the provider agreement.
    (iii) Upon request of the Medicaid agency during the re-validation of enrollment process under §455.414.
    (iv) Within 35 days after any change in ownership of the disclosing entity.
  - **§455.105 Disclosure by providers: Information related to business transactions.**

Information that must be submitted. A provider must submit, within 35 days of the date on a request by the Secretary or the Medicaid agency, full and complete information about—

(1) The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

(2) Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

- **§455.106 Disclosure by providers: Information on persons convicted of crimes.** *Information that must be disclosed.* Before the Medicaid agency enters or renews a provider agreement, or at any time upon written request by the Medicaid agency, the provider must disclose to the Medicaid agency the identity of any person who:

  (1) Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and

  (2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs.

HH. Auxiliary Aids and Services

Providers shall offer access to auxiliary aid and services at no cost to QUEST Integration Members living with disabilities and to document the offer and provision of auxiliary aids to the same extent as Kaiser Permanente under the QUEST Integration contract.

II. Annual Cost Reports

If applicable, Provider shall submit annual cost reports to the State's Med-QUEST Division.

JJ. Breach of Confidentiality

Provider shall immediately notify the health plan in writing of all privacy and security breaches (as such term is defined in Federal and State law or rules) of confidential information related to Medicaid recipients within two business days of discovery and to provide a written report of investigation and mitigation of the breach within 10 calendar days of discovery.

KK. Subcontractor Requirements

Subcontractor shall comply with Federal requirements at 42 CFR §438.230, *Subcontractual relationships and delegation* and:

a. Meet all established criteria prescribed and provide services in a manner consistent with the minimum standards specified in the Health Plan's Quest Integration contract with the State;

b. Fulfill the requirements of 42 CFR §438.6 *Special contract provisions related to payment* that are appropriate to the service(s) delegated under the subcontract;

c. Provide information regarding the Member rights and processes regarding the Member Grievance and Appeal System found in §9.5 *Member Grievance and Appeals System* of the Health Plan's Quest Integration contract with the State, if applicable;

d. Allow the Health Plan to evaluate Subcontractor's ability to perform the activities to be delegated;

e. Health Plan shall monitor the Subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the Department of Human Services and consistent with industry standards or State laws and regulations;

f. Health Plan shall identify any of the Subcontractor's deficiencies or areas for improvement; and

g. Health Plan shall take corrective action or impose other sanctions including, but not limited to, revoking delegation, if Subcontractor's performance is inadequate.

h. Subcontractor shall submit to the Health Plan proof from the IRS that all federal taxes have been paid and a tax clearance certificate from the Director of the Department of Taxation, State of Hawaii, showing that all delinquent taxes, if any, levied or accrued under State law against Subcontractor have been paid;

i. Health Plan is the sole point of recovery for Subcontractor;

j. Neither the State nor the Health Plan Members shall bear any liability of the Health Plan's failure or refusal to pay valid claims of Subcontractor;

k. Subcontractor shall have in place and follow written policies and procedures for processing requests for initial and continuing authorization of services.

l. Subcontractor shall track and report complaints against itself to the Health Plan;

m. Subcontractor shall fully adhere to the privacy, confidentiality and other related requirements stated in the Health Plan's Quest Integration contract with the State and in applicable federal and state law and, if applicable, execute a BAA pursuant to HIPAA;

n. Subcontractor shall follow all audit requirements as outlined in §14.18, *Audit Requirements* of the Health Plan's Quest Integration contract with the State:
Subcontractor shall adhere to State and Federal standards for audits of Department of Human Services designees, contractors and programs conducted under contract. Department of Human Services, the U.S. Department of Health and Human Services, the Secretary of Health and Human Services, the Centers for Medicare and Medicaid Services, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any records, inspect the premises, physical facilities, and equipment of the Health Plan and Subcontractor, Subcontractor's contractors, or providers where Medicaid-related activities or work is conducted. There shall be no restrictions on the right of the State or Federal government to conduct whatever inspections and audits are necessary to ensure quality, appropriateness or timeliness of services and reasonableness of their costs. The right to audit shall exist for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later. The Health Plan shall, in accordance with generally accepted accounting practices, maintain records and supporting documents and

related files, papers and reports that adequately reflect all direct and indirect expenditures and management and fiscal practices related to the Health Plan's performance of services under its Quest Integration contract with the State. The Health Plan's accounting procedures and practices shall conform to generally accepted accounting principles and the costs properly applicable to the contract shall be readily ascertainable from the records. The Health Plan shall submit audited financial reports specific to its Quest Integration contract with the State to the Department of Human Services annually. The audit shall be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.

o. Subcontractor shall retain medical records in compliance with §14.5, *Retention of Records and Documents* of the Health Plan's Quest Integration Contract with the State. Subcontractor shall retain all records and documents, in accordance with 42 CFR §438.3(h), for a minimum of ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later. For minors, the Subcontractor shall retain all records and documents during the period of minority plus a minimum of ten (10) years after the age of majority. During the period that records and documents are retained, Subcontractor shall allow the State and Federal government full access to inspect and audit any records or documents, and inspect the premises physical facilities, and equipment where Medicaid-related activities or work is conducted, to the extent allowed by law. Subcontractors shall retain, as applicable, the Member grievance and appeal records in 42 CFR §438.416, base data in 42 CFR §438.5(c), MLR reports in 42 CFR §438.8(k), and the data, information, and documentation specified in 42 CFR §§438.604, 438.606, 438.608, and 438.610 for a period of no less than ten (10) years.

p. Subcontractor shall comply with all requirements related to confidentiality of information as outlined in §14.17, *Confidentiality of Information* of Health Plan's Quest Integration Contract with the State. Subcontractor understands that the use and disclosure of information concerning applicants, beneficiaries or the Members is restricted to purposes directly connected with its performance under the Health Plan's Quest Integration contract with the State and the administration of the Hawaii Medicaid program, and agrees to guard the confidentiality of an applicant's, Member's or the Member's information as required by law. Subcontractor shall not disclose confidential information to any individual or entity except in compliance with the following: 42 CFR Part 431, Subpart F; the Administrative Simplification provisions of HIPAA and the regulations promulgated thereunder, including but not limited to the Security and Privacy requirements set forth in 45 CFR Parts 160 and 164; HRS §346-10; and all other applicable federal and State statutes and administrative rules, including but not limited to: HRS §325-101, relating to persons with HIV/AIDS; HRS §334-5, relating to persons receiving mental health services; HRS §577A, relating to emergency and family planning services for minor females; 42 CFR Part 2 relating to persons receiving substance abuse services; HRS §487J, relating to social security numbers; HRS §487N, relating to personal information, and Session Laws of Hawaii, Act 139(16), relating to insurance. Access to the Member identifying information shall be limited by Subcontractor to persons or agencies that require the information in order to perform their duties in accordance with the Health Plan's Quest Integration contract with the State, including DHHS, the Secretary, DHS, and other individuals or entities as may be required by DHS. (See 42 CFR §431.300, et seq. and 45 CFR Parts 160 and 164.) Any other party shall be granted access to confidential information only after complying with the requirements of State and Federal laws, including but not limited to HIPAA, and regulations pertaining to such access. Subcontractor is responsible for knowing and understanding the confidentiality laws listed above as well as any other applicable laws. Nothing herein shall prohibit the disclosure of information in summary, statistical or other form that does not identify particular individuals,

provided that de-identification of PHI is performed in compliance with the HIPAA Privacy Rule. Federal and State Medicaid rules, and some other Federal and State statutes and rules, including but not limited to those listed above, are often more stringent than the HIPAA regulations. For purposes of this subcontract, Subcontractor agrees that the confidentiality provisions contained in HAR Chapter 17-1702 shall apply to the Subcontractor to the same extent as they apply to the Department of Human Services. Subcontractor shall implement a secure electronic mail (email) encryption solution to ensure confidentiality, integrity, and authenticity of email communications that contain information relating to Members. The Health Plan is a business associate of the Department of Human Services, as defined in 45 CFR §160.103. and agrees to the terms of the BAA in Appendix F of its Quest Integration contract with the State.

q. Subcontractor shall notify the Health Plan and the Department of Human Services of all breaches of confidential information relating to Medicaid applicants and recipients, as Health Plan Members, to enable Health Plan to provide notice to the State within two (2) business days of discovery of the breach and a written report of the investigation and resultant mitigation of the breach to the State within thirty (30) days of the discovery of the breach;

r. Subcontractor shall adhere to requirements of 42 CFR §434.6 that are appropriate to the service delegated under the subcontract.

s. Subcontractor shall not bill Members for Covered Services in any amount greater than would be owed if the entity provided the services directly (i.e., no balance billing by Subcontractor);

t. Health Plan or Subcontractor will provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the Health Plan determines that the Subcontractor has not performed satisfactorily;

u. Subcontractor shall allow the State and Federal government full access to audit, evaluate, and inspect any books, records, contracts, documents, computer or other electronic system that pertain to any aspect of services and activities performed, or determination of amounts payable under the Health Plan's Quest Integration contract with the State;

v. Subcontractor shall make available its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Medicaid Members for the purposes of an audit, evaluation, or inspection by the State or Federal government;

w. Subcontractor agrees that the right to audit by the State, CMS, the DHHS Inspector General, the Comptroller General or their designees, will exist through ten (10) years from the final date of the contract period or from the date of the completion of any audit, whichever is later;

x. Subcontractor shall comply with all applicable Medicaid laws, regulations, including applicable sub regulatory guidance and contract provisions;

y. Subcontractor shall submit data in standard claims submission formats on all services provided, and be subject to accuracy, completeness, timeliness, and other requirements described in §6.5 *Report Submission* of the Health Plan’s Quest Integration contract with the State;

z. If the State, CMS, or the DHHS Inspector General determine that there is a reasonable possibility of fraud or similar risk, then the State, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Subcontractor at any time; and

aa. If Members require physical access to Subcontractor's facilities, reasonable accommodations, and accessible equipment for the Members with physical or mental disabilities shall be provided.

LL. Adverse Event Reporting

Provider shall report to the health plan adverse events related to Member's health care for various special populations including, but not limited to: Long-Term Services and Supports, Home and Community Based Services, Special Health Care Needs, and Community Integration Services.