Department of Human Services
Med-QUEST Division

QI HEALTH PLAN MANUAL

APPENDICES

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APPENDIX A: Member Enrollment Packet Requirements

A) This packet will include the following:

1. A confirmation of enrollment;
2. A Health Plan membership card that includes the Member number, which does not have to be the same as the Medicaid ID number which has been assigned by DHS;
3. A Member Handbook as described in RFP-MQD-2021-008 Section 9.4.E;
4. A flyer or other handout that is separate from the Member Handbook that includes:
    a. An explanation of the role of the Primary Care Provider (PCP) and the procedures to be followed to obtain needed services;
    b. Information explaining that the Health Plan will provide assistance in selecting a PCP and how the Member can receive this assistance; and
    c. Information explaining that the Health Plan will auto-assign a Member to a PCP if the Member does not select a PCP within ten (10) days;
5. A PCP selection form;
6. A flyer or other handout that is separate from the Member Handbook that includes:
    a. An explanation of the Member's rights, including those related to the grievance and appeals procedures;

b. A description of Member responsibilities, including an explanation of the information a Member must provide to the Health Plan and DHS upon changes in the status of the Member including marriage, divorce, birth of a child, adoption of a child, death of a spouse or child, acceptance of a job, obtaining other health insurance, change in address and telephone number, etc.;

c. Information on how to obtain advance directives; and

d. How to access assistance for those with limited English proficiency.

B) A provider directory as described in RFP-MQD-2021-008 Section 9.4.G that includes the names, location, telephone numbers of, and non-English languages spoken by contracted providers in the Member's service area including identification of providers that are not accepting new patients. The Health Plan shall make the provider directory available online and in a paper version.

APPENDIX B: Member Handbook Requirements

A) Pursuant to the requirements set forth in 42 CFR Section 438.10, the Member Handbook will include, but not be limited to:

1. A table of contents;
2. Information about the roles and responsibilities of the Member;
3. General information on managed care;
4. Information about the role and selection of the PCP including auto-assignment;
5. How to change your PCP;
6. Information on how to contact the toll-free call center both during and outside of business hours;
7. Information about reporting changes in family status and family composition;
8. Appointment procedures including the minimum appointment standards as identified in RFP-MQD-2021-008 Section 8.1.C;
9. Information that a provider cannot charge the Member a "no-show" fee;
10. Information on benefits and services that includes basic definitions;
11. Information on how to access services, including EPSDT services, non-emergency transportation services and maternity and family planning services;
12. An explanation of any service limitations or exclusions from coverage;

13. Information on how to obtain services that the Health Plan does not cover because of moral or religious objections, if applicable;
14. Benefits provided by the Health Plan not covered under the Contract;
15. The Health Plan's responsibility to coordinate care;
16. Information on services that are not provided by the Health Plan that the Member may have access to (i.e., early intervention program) and how to obtain these services including transportation;
17. A notice stating that the Health Plan will be liable only for those services authorized by the Health Plan;
18. A description of all pre-certification, prior authorization, or other requirements for treatments and services;
19. The policy on referrals for specialty care and for other covered services not furnished by the Member's PCP;
20. Information on how to obtain services when the Member is out-of-state or off-island;
21. Information on cost-sharing and other fees and charges;
22. A statement that failure to pay for non-covered services will not result in a loss of Medicaid benefits;
23. Notice of all appropriate mailing addresses and telephone numbers, to be utilized by Members seeking information or authorization, including the Health Plan's toll-free telephone line;

24. A description of Member rights and responsibilities as described in RFP-MQD-2021-008 Section 9.4.F;
25. Information on advance directives;
26. Information on how to access interpreter and sign language services, how to obtain information in alternative languages and formats, and that these services are available at no charge;
27. Information on the extent to which, and how, after-hours and emergency services are provided, including the following:
    a. What constitutes an urgent and emergency medical condition, emergency services, post-stabilization services in accordance with 42 CFR 422.113(c), and availability of a twenty-four (24) hour triage nurse;
    b. The fact that prior authorization is not required for emergency services;
    c. The process and procedures for obtaining emergency services, including the use of the 911 telephone systems or its local equivalent;
    d. The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered herein; and
    e. The fact that a Member has a right to use any hospital or other appropriate healthcare setting for emergency services.

28. Information on the Member grievance system policies and procedures, as described in RFP-MQD-2021-008 Section 9.5. This description must include the following:

    a. The right to file a grievance and appeal with the Health Plan;

    b. The requirements and timeframes for filing a grievance or appeal with the Health Plan;

    c. The availability of assistance in filing a grievance or appeal with the Health Plan;

    d. The toll-free numbers that the Member can use to file a grievance or an appeal with the Health Plan by phone;

    e. The right to a State administrative hearing, the method for obtaining a hearing, and the rules that govern representation at the hearing;

    f. Notice that if the Member files an appeal or a request for a State administrative hearing within the timeframes specified for filing, the Member may request continuation of benefits as described in RFP-MQD-2021-008 Section 9.5.K and may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the Member; and

    g. Any appeal rights that the State chooses to make available to providers to challenge the failure of the Health Plan to cover a service.

29. Additional information that is available upon request, including information on the structure and operation of the Health Plan and information on physician incentive plans.

APPENDIX C: Provider Contract Requirements

A) All contracts between providers and the Health Plan shall be in writing. The Health Plan's written provider contracts will:

1. Specify covered populations and specifically cite the QI program;
2. Specify covered services;
3. Specify rates of payment and applicable VBP arrangements;
4. Prohibit the provider from seeking payment from the Member for any covered services provided to the Member within the terms of the contract and require the provider to look solely to the Health Plan for compensation for services rendered, with the exception of cost sharing pursuant to the Hawai'i Medicaid State Plan;
5. Prohibit the provider from imposing a no-show fee for QI program Members who were scheduled to receive a Medicaid-covered service;
6. Specify that in the case of newborns, the provider will not look to any individual or entity other than the QI or the mother's commercial Health Plan for any payment owed to providers related to the newborn;
7. Require the provider to cooperate with the Health Plan's quality improvement activities;
8. Require that providers meet all applicable State and Federal regulations, including but not limited to all applicable HAR sections, and Medicaid requirements for licensing, certification, and recertification;

9. Require the provider to cooperate with the Health Plan's utilization review and management activities;

10. Not prohibit a provider from discussing treatment or non-treatment options with Members that may not reflect the Health Plan's position or may not be covered by the Health Plan;

11. Not prohibit, or otherwise restrict, a provider from acting within the lawful scope of practice, from 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 might be self-administered;

12. Not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice from advocating on behalf of the Member to obtain necessary healthcare services in any grievance system or utilization review process, or individual authorization process;

13. Require providers to meet appointment waiting time standards pursuant to the terms of the RFP-MQD-2021-008 in Section 8.1.C;

14. Provide for continuity of treatment in the event a provider's participation terminates during the course of a Member's treatment by that provider except in the case of adverse reasons on the part of the provider;

15. Require that providers maintain the confidentiality of Member's information and records as required by law, including, but not limited to, privacy and security regulations adopted under HIPAA;

16. Keep any records necessary to disclose the extent of services the provider furnishes the Members;

17. Specify that CMS, the State Medicaid Fraud Control Unit, and DHS or its respective designee will have 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 this Contract and for the monitoring of quality of care being rendered without the specific consent of the Member or the provider;

18. Require that provider comply with disclosure requirements identified in accordance with 42 CFR Part 455, Subpart B found in Section 8.2;

19. Require providers that are compensated by capitation payments to submit complete and accurate encounter data on a monthly basis and make available all medical records to support encounter data without the specific consent of the Member upon request from the Health Plan, DHS, or its designee for the purpose of validating encounters;

20. Require provider to certify claim/encounter submissions to the plan as accurate and complete;

21. Require the provider to provide medical records or access to medical records to the Health Plan and DHS or its designee, within sixty (60) days of a request. Refusal to provide medical records, access to medical records or inability to produce the medical records to support the claim/encounter will result in recovery of payment;

22. Include the definition and standards for medical necessity,

pursuant to the definition in RFP-MQD-2021-008 Section 2.2;

23. Specify acceptable billing and coding requirements;

24. Require that providers comply with the Health Plan's cultural competency requirements;

25. Require that the provider submit to the Health Plan any marketing materials developed and distributed by the provider related to the QI program;

26. Require that the provider maintain the confidentiality of Members' information and records as required by the RFP-MQD-2021-008 and in Federal and State law, including but not limited to:

    a. The Administration Simplification (AS) provisions of HIPAA, Public Law 104-191 and the regulations promulgated thereunder, including but not limited to 45 CFR Parts 160, 162, and 164, if the provider is a covered entity under HIPAA;

    b. 42 CFR Part 431 Subpart F;

    c. Chapter 17-1702, HAR;

    d. Section 346-10, HRS;

    e. 42 CFR Part 2;

    f. Section 334-5, HRS; and

    g. Chapter 577A, HRS.

27. Require that providers comply with 42 CFR Part 434 and 42 CFR Section 438.6, if applicable;

28. Require that providers not employ or subcontract with

individuals or entities whose owner, those with controlling interest, or managing employees are on any state or federal exclusion lists;

29. Prohibit providers 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 as defined in RFP-MQD-2021-008 Section 2.2;
30. Require providers of transitioning Members to cooperate in all respects with the Members' prior providers to assure the best health outcomes for Members;
31. Require the provider to comply with corrective action plans initiated by the Health Plan or DHS;
32. Specify the provider's responsibilities regarding third party liability;
33. Require the provider to comply with the Health Plan's compliance plan including all fraud and abuse requirements and activities;
34. Require that providers accept Members for treatment, unless theprovider applies to the Health Plan for a waiver of this requirement;
35. Require that the provider provides services without regard to race, color, creed, ancestry, sex, including gender identity or expression, sexual orientation, religion, health status, income status, or physical or mental disability;
36. Require that providers offer hours of operation that are no less than the hours of operation offered to commercial members or, ifthe provider has no commercial Members, that the hours of operation are comparable to hours offered to recipients under

Medicaid fee-for-service;

37. Require that providers offer access to interpretation services for Members that have a limited English proficiency (LEP) at no costto the Member, and to document the offer and provision of interpreter services to the same extent as the Health Plan under the Contract;

38. Require that providers offer access to auxiliary aids and servicesat no cost for Members living with disabilities, and to document the offer and provision of auxiliary aids to the same extent as the Health Plan under the Contract;

39. Include a statement that the State and the Health Plan Members will bear no liability for the Health Plan's failure or refusal to pay valid claims of subcontractors or providers for covered services;

40. Include a statement that the provider will accept Health Plan payment in full and cannot charge the patient for any cost of a

    Health Plan-covered service whether or not the service was reimbursed by the Health Plan;

41. Include a statement that the State and the Health Plan Members will bear no liability for services provided to a Member for which the State does not pay the Health Plan;

42. Include a statement that the State and the Health Plan Members will bear no liability for services provided to a Member for which the plan or State does not pay the individual or healthcare provider that furnishes the services under a contractual, referral, or other arrangement 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;

43. Require the provider to secure and maintain all necessary liability insurance and malpractice coverage as is necessary to protect the Health Plan's Members and the Health Plan;

44. Require the provider to secure and maintain automobile insurance when transporting Members, if applicable;

45. Require that the providers use the definition for emergency medical condition included in RFP-MQD-2021-008 Section 2.2;

46. Require that if the provider will be offering EPSDT services, the provider complies with all EPSDT requirements;

47. Require that the provider provides copies of medical records to requesting Members and allows them to be amended as specified in 45 CFR Part 164, HIPAA, or any other applicable Federal or State law;

48. Require that the providers provide record access to any authorized DHS personnel or personnel contracted by DHS without Member authorization so long as the access to the records is required to perform the duties of the Contract with the State and to administer the QI programs;

49. Require that the provider complies with Health Plan standards that provide DHS or its designee(s) prompt access to Members' medical records whether electronic or paper;

50. Require that the providers coordinate with the Health Plan in transferring medical records (or copies) when a Member changes PCPs;

51. Require that the providers comply with the advance directives requirements for hospitals, nursing facilities, providers of home and health care, hospices, and HMOs specified in 42 CFR Part

489, subpart I, and 42 CFR Section 417.436(d);

52. Require all Medicaid-related records 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;

53. Require that the provider complies with all credentialing and re-credentialing activities;

54. Require that the providers refund any payment received from a resident or family member (in excess of share of cost) on behalf of the Member for the prior coverage period;

55. Require that the providers submit annual cost reports to DHS, if applicable;

56. Require that the providers comply with all requirements regarding when they may bill a Member or assess charges as described in RFP-MQD-2021-008 Section 7.2.A;

57. Require that the provider is licensed in good standing in the State of Hawai'i; and

58. Require that providers (if they will be providing vaccines to children) enroll and complete appropriate forms for the Vaccines For Children (VFC) program, 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.

59. Require provider to report capitation payments or other overpayments in excess of amounts specified in the

Contract within sixty (60) calendar days when identified.

60. To allow same day insertion of long acting reversible contraceptive (LARC) devices requested by a Member, the HealthPlan 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.

61. Require that the Providers report adverse events related to Members' health care for various special populations including but not limited to Long-Term Services and Supports, Home and Community Integrated Services.

B) In addition, the provider contracts for providers who are serving as PCPs (including specialists acting as PCP) will include the following:

1. A requirement that the provider be responsible for supervising, coordinating, and providing all primary care to each assigned Member;

2. A requirement that the provider coordinates and initiates referrals for specialty care;

3. A requirement that the provider maintains continuity of each Member's healthcare and maintains the Member's health record;

C) The provider contract for Non-Emergency Transportation Provider(NEMT) shall include but not limited to the following:

1. The Each provider and individual driver is not excluded from participation in any federal health care program (as defined in section 1128B (F) or 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;

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.

D) Notably, these requirements apply to transportation network companies (such as, without endorsement or limitation, Uber, Lyft and other "ride sharing" companies) as well as individual drivers. However, this provision excludes those providers that are public transit authorities.

APPENDIX D: Provider Manual Requirements

A) The Health Plan will include, at a minimum, the following information in the provider manual:

1. A table of contents;
2. An introduction that explains the Health Plan's organization and administrative structure, including an overview of the Health Plan's provider services department, function, and how they may be reached;
3. Provider responsibilities and the Health Plan's expectations of the provider;
4. A listing and description of covered and non-covered services, requirements, and limitations;
5. Information about appropriate and inappropriate utilization of emergency department services as well as the definitions of emergency medical condition and emergency medical services as provided in RFP-MQD-2021-008 Section 2.2;
6. Health Plan fraud and abuse activities, including how to report suspected fraud and/or abuse;
7. Appointment and waiting time standards as described in RFP-MQD-2021-008 Section 8.1.C;
8. Formulary information which will be updated in advance of the change and sent to the providers;
9. The description of the referral process which explains the services requiring referrals and how to obtain referrals;

10. A description of the prior authorization (PA) process, including the services requiring PA and how to obtain PAs;
11. A description of who may serve as a PCP as described in RFP-MQD-2021-008 Section 8.1.E;
12. Applicable criteria for specialists or other healthcare practitioners to serve as PCPs for Members with chronic conditions as described in RFP-MQD-2021-008 Section 8.1.E;
13. The description of the roles and responsibilities of the PCP and PCMH, including:
    a. Serving as an ongoing source of primary care for the Member, including supervising, coordinating, and providing all primary care to the Member;
    b. Being primarily responsible for coordinating other healthcare services furnished to the Member, including;
        1) Coordinating and initiating referrals to specialty care (both in-network and out-of-network);
        2) Maintaining continuity of care; and
        3) Maintaining the Member's medical record (this includes documentation of services provided by the PCP as well as any specialty services).
14. Information on the stepped care approach and goals to enhance care;
15. Information on the Health Plan's policies and procedures for changing PCPs, including:
    a. The process for changing PCPs, (e.g., whether the

Member may make the request by phone, etc.); and

b. When PCP changes are effective.

16. Information on the availability of health coordination and how to access these services;
17. The description of the role of care and service coordination teams and the Hale Ola;
18. The descriptions of the availability of programs that support Members and providers including, but not limited to CIS, CoCM, the Hales, RHPs, and the Regional Enhanced Referral Network;
19. The description of Members' rights and responsibilities as identified in RFP-MQD-2021-008 Section 9.4.F;
20. A description of cost sharing responsibilities;
21. A description of reporting requirements, including encounter data requirements, if applicable;
22. Reimbursement information, including reimbursement for Members eligible for both Medicare and Medicaid (dual eligible), or Members with other insurance;

    a. A description of VBP, the importance of shifting to a VBP model and an overview of associated requirements when a provider elects to participate;

23. Explanation of remittance advices;
24. A statement that specifies that the provider may not bill the Member in the event that a provider fails to follow Health Plan procedures resulting in nonpayment;
25. The description of the exceptional circumstance when a

Provider may bill a Member or assess charges or fees, as follows:

a. If a Member self-refers to a specialist or other provider within the network without following Health Plan procedures (e.g., without obtaining prior authorization) and the Health Plan denies payment to the provider, the provider may bill the Member if the provider provided the Member with an Advance Beneficiary Notice of non-coverage; and

b. If a provider bills the Member for non-covered services, for exceeding established limits of coverage, or for self-referrals, the provider will inform the Member and obtain prior agreement from the Member regarding the cost of the procedure and the payment terms at time of service;

26. A description of the Health Plan's grievance system process and procedures for Members which will include, at a minimum:

a. The Member's right to file grievances and appeals with requirements and time frames for filing;

b. The Member's right to a State grievance review;

c. The Member's right to a State administrative hearing, how to obtain a hearing, and rules on representation at a hearing;

d. The availability of assistance in filing a grievance or an appeal;

e. The Member's right to have a provider or authorized

representative file a grievance and/or an appeal on his or her behalf, provided he or she has provided consent to do so;

f. The toll-free numbers to file a grievance or an appeal; and

g. When an appeal or hearing has been requested by the Member, the right of a Member to receive benefits while the appeal or hearing is pending and that the Member may be held liable for the costs of those benefits if the Health Plan's adverse action is upheld.

27. A description of the provider grievance system including how to file a grievance or appeal;

28. A description of how the provider can access language interpretation, auxiliary aids, sign language services, and specialized communication for its Members (e.g., Braille, translation in a language other than English, etc.);

29. A description of the provider's responsibility for continuity of treatment in the event a provider's participation with the Health Plan terminates during the course of a Member's treatment by that provider;

30. A description of credentialing and re-credentialing requirements and activities;

31. A description of the Health Plan's QAPI and the provider's responsibilities as it relates to the QAPI;

32. Medical records standards and the provider's responsibilities regarding medical records;

33. A description of confidentiality and HIPAA requirements with which the provider must comply;

34. A statement that the Health Plan will immediately transfer a Member to another PCP, Health Plan, or provider if the Member's health or safety is in jeopardy;

35. Claims submission and adjudication procedures;

36. Utilization review and management activities;

37. A description of D-SNP alignment activities that will impact provider practice, including any uniform appeals and grievance processes;

38. A description of value-added services;

39. A description of the provider's role in the development of treatment or service plans for Members; and

40. Processes surrounding provider termination to include transition of care.

APPENDIX E: Approach to Care Delivery

A) As a part of the Med-QUEST Division's (MQD) Hawai'i 'Ohana Nui Project Expansion (HOPE) initiative, DHS describes the framework and strategies to achieve healthier families and healthier communities, and the Triple Aim of better health, better outcomes, and sustainable costs. As a next step, DHS is further describing how DHS will approach and implement activities related to critical aspects of care delivery including primary care, behavioral health integration across the continuum of care, and addressing social equity and social risk factors (SRF).

1. Advancing Primary Care

    a. Primary care has evolved over time and advanced primary care models are emerging to better meet the needs of patients, especially patients with complex medical, behavioral, and social conditions. Advanced primary care models are described as providing care that is comprehensive, relationship-based, person-centered, whole-person oriented, coordinated across all elements of the health care system, accessible, evidence-based, and high quality.

    b. DHS's approach to supporting advanced primary care models is to include new requirements in the QUEST Integration Health Plan contracts. Some of the Health Plan requirements include:

        1) Supporting providers that are interested in implementing advanced primary care models.

This may include activities such as providing administrative support, technical assistance, training, and other support.

2) Continuing to adopt payment policies that shift from volume-based to value-based payment models that promote and reward value. These payment policies and methodologies should also consider the cost of essential infrastructure and systems needed to transition to advanced primary care models.

3) Increasing the proportional investing in primary care.

4) Providing a robust system of health coordination that is performed in the home, in the community, and at the site of care including in primary care practices.

5) Supporting increased utilization of telehealth services.

6) Supporting Project Extension for Community Healthcare Outcomes (ECHO). Project ECHO™ is an innovative medical education and mentoring model that builds provider capacity with multi-disciplinary teams while improving access to care.

c. In addition, DHS intends to support primary care by establishing a specialized health home pilot concept

called the Hale Ola. The Hale Ola is a type of advanced health home that for provides comprehensive and coordinated care to Members with complex medical, behavioral, and social conditions. The Hale Ola will integrate and coordinate all primary, acute, behavioral health, and other services to treat the whole person. The Hale Ola will have a strong focus on behavioral health, prevention, health promotion, disease management, medication management, and other services.

2. Behavioral Health Integration across the Continuum of Care

    a. DHS's overarching goals are to integrate behavioral health with physical health at the primary care level, through the continuum to the most intensive level for Members with complex conditions and social needs. Other goals include integrating care with value-based payment structures, and screening, diagnosing, and treating conditions as early as possible.

    b. In order to achieve the goals, DHS is implementing the stepped approach to behavioral health (Von Koroff and Tiemens, 2000). The concept of the stepped approach is that individuals can move fluidly up and down a continuum of services and that treatment level and intervention will be paired with the individual level of acuity to provide effective care without overutilization of resources.

c. There are three components of the stepped approach. They include:

1) Utilizing the Hawai'i Coordinated Access Resource Entry System (CARES);

2) Establishing clear protocols describing the criteria for moving along the continuum of care; and

3) Supporting behavioral health integration models at the point of care.

d. Utilizing and supporting Hawai'i CARES:

1) The Department of Health (DOH) Alcohol and Drug Abuse Division (ADAD) created the Hawai'i Coordinated Access Resource Entry System (CARES) to better address the needs of individuals with behavioral health conditions. Hawai'i CARES is a comprehensive and responsible system of care that aims to provide a continuum of care to deliver and reduce all barriers to substance use disorder, mental health, and co-occurring treatment and recovery support services, as well as crisis intervention and support services. One of the major functions of Hawai'i CARES is to establish a hub of providers that complete universal intakes and screenings of Members and provide other services that support improving access to whole

person care. All QUEST Integration Members needing mental health, substance use, and crisis intervention services need to utilize this multiple entry-point and coordinating center to access care.

2) The Health Plans are required to work with Hawai'i CARES to ensure their Members are receiving needed care. The Health Plans must also work with Hawai'i CARES so authorization of needed services are provided in a timely manner. Hawai'i CARES and the Health Plans will also collaboratively work together to improve access to behavioral health services, and to ensure there is coordination of care and communication among the physical and behavioral health care team members.

e. Establishing protocols for movement along the continuum of care:

i. Even though a system of care is being developed through Hawai'i CARES, there are still other areas that need to be further developed in order to implement a stepped approach. One of the areas is to establish clear protocols that provide guidance and criteria on how Members will "step up" or "step down" the continuum of care. This will ensure that the right Members receive the right services at the right time in the right

settings, and it will also ensure consistency and standardization across the delivery system and Health Plans. DHS will take the lead on this work and collaborate with the Health Plans, Hawai'i CARES, and other stakeholders to establish the protocols.

f. Supporting behavioral health integration at the point of care:

1) An important aspect of a stepped approach to behavioral health is ensuring that there is adequate capacity at the provider level to provide services along the continuum of care. This is why the Health Plans are required to support providers in adopting evidence-based behavioral health integration models at the point of care. Some of the evidence-base integration models include the Collaborative Care Model, Screening, Brief Intervention and Referral to Treatment (SBIRT), Medication Assisted Treatment (MAT), Motivational Interviewing, and other evidence-based models.

2) Health Plans will support integration at the point of care by providing administrative support, technical assistance, and other support to practices that are interested in implementing integrated models. Additionally, the Health Plans will support integration by adopting

payment models that support and promote integrated care. By providing support and implementing payment policies that promote and reward integrated care, providers are more likely to adopt and implement integrated care models and access to care will likely increase.

3. Addressing Health Equity and SRF

   a. Another important aspect of care delivery is ensuring health equity and addressing social factors that may have an impact on health. The HOPE guiding principles stress the importance of applying a lens of health equity to the implementation of HOPE vision and addressing the SRF. SRF are the conditions in which people are born, grow, live, work, and age that shape health. Socio-economic status, discrimination, education, neighborhood and physical environment, employment, housing, food insecurity and access to health food choice, access to transportation, social support networks and connection to culture, as well as access to healthcare are all determinants of health.

   b. DHS's approach to health equity and addressing SRF is to develop a SRF transformation plan in partnership with the Health Plans which, when complete, will represent DHS's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex (gender when available), primary language, and disability status. The SRF transformation plan is

expected to develop a shared DHS and Health Plan Road Map to comprehensively and systematically address health disparities.

c. Early implementation stages of the plan will emphasize the use of analytics and analytic methods by DHS and the Health Plans to identify and monitor health disparities, and increased identification of unmet social needs through enhanced data collection methods. Later implementation stages will focus on care delivery. This will include identifying and fortifying community-based SRF supports, addressing social needs through referrals and resources, and targeting efforts to address the needs of populations at high risk for adverse health outcomes through socially and culturally appropriate mechanisms and communication. Simultaneously, the SRF transformation plan will pave the way for the development of financial mechanisms to address and mitigate health disparities and unmet social needs. Health Plans will be expected to align to and describe their "on the ground" community and beneficiary-level activities that will realize the overall goals.

4. Next Steps

a. Following the execution of the new Health Plan Contract (estimated effective date is July 1, 2021), and in collaboration with the Health Plans and stakeholders, DHS will continue to develop the HOPE implementation plan and timeline. DHS will consider the importance of

administrative simplification and standardization of processes at DHS, Health Plan, and provider level to ensure the HOPE vision is implemented as effectively and efficiently as possible. Additionally, DHS will also consider contingency plans that may be needed to adapt to unforeseeable or impactful events such as public health emergencies or budget crises.

APPENDIX F: Early and Periodic Screening, Diagnostic & Treatment Screening

A) EPSDT Form Changes

1. DHS 8015/8016

a. The EPSDT forms are used to align with the most current recommendations and guidelines and in response to input from providers in the community. Refer to Med-QUEST Division for the latest DHS 8015/8016 forms.

b. DHS 8015 serves the purpose of guiding providers through the required components of an EPSDT exam, improving the quality of exams, and through the data collected, providing a better understanding of the health and health needs of our Medicaid clients.

c. DHS 8016 is used to document the completion of any screening(s) and/or immunization(s) that were attempted and not done during a comprehensive EPSDT screening visit, as well as to document any immunization or screening not captured on the 8015 or not associated with a comprehensive EPSDT screening visit.

d. A supply of these forms may be obtained by calling the Medicaid designated fiscal agent. The instructions for completing the form appear in detail on the back of the DHS 8015/8016.

B) EPSDT Billing Procedures

1. The enhanced reimbursement ($120 for FFS in 2019) for comprehensive EPSDT exams will apply under the following conditions:

    a. Submission of a completed DHS 8015.

        1) Attach the original completed and signed hard-copy DHS 8015 to the CMS 1500 claim, and mail to the appropriate Health Plan for QI Members or to the Medicaid designated fiscal agent for fee-for-service Medicaid Members. If the completed form is not attached to the claim, the claim cannot be processed as a comprehensive EPSDT visit; or

        2) Submit electronically a completed and signed/finalized EPSDT exam through the EPSDT online form prior to electronic submission of the claim. The Health Plans or Med-QUEST Division staff will match the completed electronic EPSDT form with the electronic claim.

        3) Without a completed EPSDT form submitted in either hard-copy or electronic as described above, the claim cannot be processed as a comprehensive EPSDT exam and enhanced reimbursement will not be provided.

2. No other claim for an evaluation and management (E&M) service (99201-99255; 99304-99499) is submitted on the same day by the same provider for that patient. The EPSDT exam includes the diagnosis of abnormal conditions and appropriate treatment rendered by the EPSDT examining provider on the day of the EPSDT examination. For example, otitis media found during an EPSDT exam should be submitted with the appropriate EPSDT code; a separate claim line for an office visit for the diagnostic and treatment of otitis media should NOT be submitted.
3. Eligible codes can be found in the Medicaid Provider Manual's EPSDT chapter.

APPENDIX G: Level of Care and At-Risk Evaluation

DHS 1147

STATE OF HAWAII Department of Human Services Med-QUEST Division	**STATE OF HAWAII** **Level of Care (LOC) and At Risk Evaluation**	HEALTH SERVICES ADVISORY GROUP, INC. 1001 Kamokila Blvd., Suite 311, Kapolei, HI 96707 Phone: (808) 440-6000 Fax: (808) 440-6009

COMPLETE ALL SECTIONS OF THE FORM EXCEPT SECTION 14

1. PLEASE PRINT OR TYPE ☐ Initial Request ☐ Annual Review ☐ Reconsideration ☐ Other review

2. PATIENT NAME (Last, First, M.I.)	3. BIRTHDATE Month/Day/Year	4. SEX	5. MEDICARE Part A ☐ Yes ☐ No Part B ☐ Yes ☐ No ID#:_____	6. MEDICAID ELIGIBLE? ☐ Yes ID # _____ ☐ No If no, date applied for Medicaid (Required)_____
7. PRESENT ADDRESS: Present Address is ☐ Home ☐ Hospital ☐ NF ☐ Care Home ☐ EARCH ☐ CCFFH ☐ Other: _____				8. Medicaid Provider Number: (If applicable)

9. ATTENDING PHYSICIAN/PRIMARY CARE PROVIDER (PCP) (Last Name, First Name, Middle Initial) _____
Phone: ( )_____ Fax: ( )_____

10. RETURN FORM TO (SERVICE COORDINATOR OR CONTACT PERSON):_____
MANAGED CARE PLAN NAME (IF APPLICABLE): _____
Phone ( )_____ Fax ( ) _____ Email _____

11. REFERRAL INFORMATION (Completed by Referring Party)	**12. ASSESSMENT INFORMATION (Completed by RN, Physician, PCP)**
A. SOURCE(S) OF INFORMATION ☐ Client ☐ Records ☐ Other _____ B. RESPONSIBLE PERSON Name _____ Last First MI Relationship _____ PHONE ( )_____ FAX ( )_____ C. Language ☐ English ☐ Other _____	A. ASSESSMENT DATE ____/____/____ B. ASSESSOR'S NAME Name _____ Last First MI Title _____ Signature _____ ☐ Hard copy signature on file. PHONE: ( ) _____ FAX: ( ) _____ EMAIL: _____

13. REQUESTING

CHECK ONE BOX:	BEGIN and END DATES: _____ TO _____ LENGTH OF APPROVAL REQUESTED (CHECK ONE BOX): [ ] 1 month [ ] 3 months [ ] 6 months [ ] 1 year [ ] Other: _____
[ ] Nursing Facility (ICF) [ ] Nursing Facility (SNF) [ ] Nursing Facility (HOSPICE) [ ] Nursing Facility (Subacute I) [ ] Nursing Facility (Subacute II) [ ] Acute Waitlist (ICF) [ ] Acute Waitlist (SNF) [ ] Acute Waitlist (Subacute) [ ] At Risk	

14. MEDICAL NECESSITY DETERMINATION – DO NOT COMPLETE

APPROVAL: [ ] Nursing Facility (ICF) [ ] Nursing Facility (SNF) [ ] Nursing Facility (HOSPICE) [ ] Nursing Facility (Subacute I) [ ] Nursing Facility (Subacute II) [ ] Acute Waitlist (ICF) [ ] Acute Waitlist (SNF) [ ] Acute Waitlist (Subacute) [ ] At Risk	BEGIN AND END DATES: _____ TO _____ LENGTH OF APPROVAL (CHECK ONE BOX): [ ] 1 month [ ] 3 months [ ] 6 months [ ] 1 year [ ] Other: _____

DEFERRED: [ ] Current 1147 Version Needed [ ] Missing Information [ ] Clinical Question

NOT APPROVED:
[ ] DOES NOT MEET LEVEL OF CARE REQUESTED [ ] DOES NOT MEET AT RISK CRITERIA [ ] INCOMPLETE INFORMATION TO MAKE DETERMINATION

NOTE: THIS IS NOT AN AUTHORIZATION FOR PAYMENT OR APPROVAL OF CHARGES. PAYMENT BY THE MEDICAID PROGRAM IS CONTINGENT ON THE INDIVIDUAL BEING ELIGIBLE, THE SERVICES BEING COVERED BY MEDICAID AND THE PROVIDER BEING MEDICAID CERTIFIED AT THE TIME SERVICES ARE RENDERED. INDIVIDUAL'S ELIGIBILITY MUST BE VERIFIED BY THE PROVIDER AT THE TIME OF SERVICE.

DHS REVIEWER'S / DESIGNEE'S SIGNATURE: _____ DATE: _____

DHS 1147 |Rev. 01/2021|

APPENDICES

APPENDIX G: Level of Care and At-Risk Evaluation

COMPLETE ALL SECTIONS OF THE FORM

APPLICANT/CLIENT BACKGROUND INFORMATION (Please Type or Print)

1. **NAME** (Last, First, Middle Initial)	2. **BIRTHDATE**

3. FUNCTIONAL STATUS RELATED TO HEALTH CONDITIONS

I. LIST SIGNIFICANT CURRENT DIAGNOSIS(ES):

PRIMARY: _____

SECONDARY: _____

II. COMATOSE ☐ No ☐ Yes If "Yes," go to **XVIII.**

III. VISION / HEARING / SPEECH:
[0] a. Individual has normal or minimal impairment (with/without corrective device) of: ☐ Hearing ☐ Vision ☐ Speech
[1] b. Individual has impairment (with/without corrective device) of: ☐ Hearing ☐ Vision ☐ Speech
[2] c. Individual has complete absence of: ☐ Hearing ☐ Vision ☐ Speech

IV. COMMUNICATION:
[0] a. Adequately communicates needs/wants.
[1] b. Has difficulty communicating needs/wants.
[2] c. Unable to communicate needs/wants.

V. MEMORY:
[0] a. Normal or minimal impairment of memory.
[1] b. Problem with [ ] long-term or [ ] short-term memory.
[2] c. Individual has a problem with both long-term and short-term memory.

VI. MENTAL STATUS / BEHAVIOR: (only one selection for orientation – items a through c. Aggressive and/or abusive and wandering may also be checked with appropriate orientation.) *

[0] a. Oriented (mentally alert and aware of surroundings).
[1] b. Disoriented (partially or intermittently; requires supervision).
[2] c. Disoriented and/or disruptive.
[3] d. Aggressive and/or abusive. (Examples required in section XX)
[4] e. Wanders at [ ] Day [ ] Night [ ] Both, and/or [ ] in danger of self-inflicted harm or self-neglect. (Examples required in section XX)

VII. FEEDING:
[0] a. Independent with or without an assistive device.
[1] b. Needs supervision or assistance with feeding.
[2] c. Is spoon / syringe / tube fed, does not participate.

VIII. TRANSFERRING:
[0] a. Independent with or without a device.
[2] b. Transfers with minimal /stand-by help of another person.
[3] c. Transfers with physical / moderate assistance of another person.
[4] d. Does not assist in transfer / requires maximum assist / or is bedfast.

IX. MOBILITY / AMBULATION: (Check a maximum of 2 for items b through e. If an individual is either independently mobile or unable to walk, no other selections can be made.)
[0] a. Independently mobile with or without device / self-propels wheelchair.
[1] b. Ambulates with/without device / stand-by assist / unsteady / risk for falls.
[2] c. Able to walk/be mobile with minimal assistance.
[3] d. Able to walk/be mobile with one-person hands-on/moderate assistance.
[4] e. Able to walk/be mobile with more than one-person hands-on assistance.
[5] f. Unable to walk / immobile.

X. BOWEL FUNCTION / CONTINENCE:
[0] a. Continent / able to independently perform bowel care.
[1] b. Continent with cues / requires reminders to perform bowel care.
[2] c. Incontinent (at least once daily) / requires help with bowel care on a regular basis.
[3] d. Incontinent (more than once daily) / dependent for all bowel care.

XI. BLADDER FUNCTION / CONTINENCE:
[0] a. Continent / able to independently perform bladder care.
[1] b. Continent with cues / requires reminders to perform bladder care.
[2] c. Incontinent (at least once daily) / requires help with bladder care on a regular basis.
[3] d. Incontinent (more than once daily) / dependent for all bladder care.

XII. BATHING:
[0] a. Independent bathing.
[1] b. Unable to safely bathe without minimal assistance and supervision.
[2] c. Unable to safely bathe without moderate assistance.
[3] d. Cannot bathe without total assistance (tub, shower, whirlpool or bed bath).

XIII. DRESSING AND PERSONAL GROOMING:
[0] a. Appropriate and independent dressing, undressing and grooming.
[1] b. Can groom/dress self with cueing. (Can dress, but unable to choose or lay out clothes).
[2] c. Physical assistance needed on a regular basis.
[3] d. Requires total help in dressing, undressing, and grooming.

Complete questions XIV to XVII for At Risk requests only:

XIV. HOUSECLEANING:
[0] a. Independent
[2] b. Needs Assistance
[3] c. Unable to safely clean the home

XV. SHOPPING:
[0] a. Independent
[2] b. Needs Assistance
[3] c. Unable to safely go shopping

XVI. LAUNDRY:
[0] a. Independent
[1] b. Needs Assistance
[2] c. Unable to safely do the laundry

XVII. MEAL PREPARATION:
[0] a. Independent
[1] b. Needs Assistance
[2] c. Unable to safely prepare a meal

XVIII. TOTAL POINTS:

Comatose = 30 points Total Points Indicated: _____

XIX MEDICATIONS/TREATMENTS:

(List all Significant Medications, Dosage, Frequency, and mode) Attach additional sheet if necessary	Administers Independently	Requires Supervision/ Monitoring	Requires Admin	PRNs Only Actual Freq
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____

XX. ADDITIONAL INFORMATION CONCERNING PATIENT'S FUNCTIONAL STATUS *Include examples, frequency of occurrences, and interventions for aggressive and/or abusive behaviors, wandering, and/or self-inflicted harm or self-neglect behaviors.

_____

_____

_____

_____

DHS 1147 (Rev. 01/2021)

APPENDIX G: Level of Care and At-Risk Evaluation

STATE OF HAWAII
Department of Human Services

STATE OF HAWAII
Level of Care (LOC) and At Risk Evaluation

HEALTH SERVICES ADVISORY GROUP, INC.
1001 Kamokila Blvd., Suite 311, Kapolei, HI 96707
Phone: (808) 440-6000 Fax: (808) 440-6009

COMPLETE ALL SECTIONS OF THE FORM

APPLICANT/CLIENT BACKGROUND INFORMATION (Please Type or Print)

1. **NAME** (PRINT Last, First, Middle Initial)	2. **BIRTHDATE**

XXI. SKILLED PROCEDURES: D = Daily Indicate number of times per day **L** = Less than once per day **N** = Not applicable / Never

D #	L √	N √	PROFESSIONAL NURSING ASSESSMENT/CARE RELATED TO MANAGEMENT OF:
___	[ ]	[ ]	Tracheostomy care/suctioning in ventilator dependent person
___	[ ]	[ ]	Tracheostomy care/suctioning in non-ventilator dependent person
___	[ ]	[ ]	Nasopharyngeal suctioning in persons with no tracheostomy
___	[ ]	[ ]	Total Parenteral Nutrition (TPN) {Specify number of hours per day}: _____
___	[ ]	[ ]	Maintenance of peripheral/central IV lines
___	[ ]	[ ]	IV Therapy (Specify agent & frequency):_____
___	[ ]	[ ]	Decubitus ulcers (Stage III and above)
___	[ ]	[ ]	Decubitus ulcers (less than Stage III); wound care {Specify nature of ulcer/wound and care prescribed} _____
___	[ ]	[ ]	Wound care (Specify nature of wound and care prescribed) ☐ debridement ☐ Irrigation ☐ packing ☐ wound vac. _____
___	[ ]	[ ]	Instillation of medications via indwelling urinary catheters (Specify agent): _____ _____
___	[ ]	[ ]	Intermittent urinary catheterization
___	[ ]	[ ]	IM/SQ Medications (Specify agent.):_____
___	[ ]	[ ]	Difficulty with administration of oral medications (Explain): _____
___	[ ]	[ ]	Swallowing difficulties and/or choking
___	[ ]	[ ]	Stable Gastrostomy/Nasogastric/Jejunostomy tube feedings; Enteral Pump? ☐ Yes ☐ No
___	[ ]	[ ]	Gastrostomy/Nasogastric/Jejunostomy tube feedings in persons at risk for aspiration (Specify reason person at risk for aspiration) _____
___	[ ]	[ ]	Initial phase of Oxygen therapy
___	[ ]	[ ]	Nebulizer treatment
___	[ ]	[ ]	Complicating problems of patients on [ ] renal dialysis, [ ] chemotherapy, [ ] radiation therapy, [ ] with orthopedic traction (Check problem(s) and describe) : _____
___	[ ]	[ ]	Behavioral problems related to neurological impairment (Describe): _____ _____
___	[ ]	[ ]	Other (Specify condition and describe nursing intervention): _____ _____
☐ Yes	☐ No		Therapeutic Diet (Describe): _____
☐ Yes	☐ No		Restorative Therapy (check therapy and submit/attach evaluation and treatment plan): ☐ PT ☐ OT ☐ Speech
☐ Yes	☐ No		The patient is able to participate in therapy a minimum of 45 minutes per session 5 days a week.

XXII. SOCIAL SITUATION:

A. Person can return home ☐ Yes ☐ No ☐ N/A Community setting can be considered as an alternative to facility? ☐ Yes ☐ No ☐ N/A
B. If person has a home; caregiving support system is willing to provide/continue care. ☐ Yes ☐ No
Caregiver requires assistance? ☐ Yes ☐ No
Assistance required by Caregiver: _____ _____
C. Caregiver name:
Name: _____ Relationship: _____
Last First MI
Address: _____ Phone: (___) _____ Fax (___) _____

XXIII. COMMENTS ON NURSING REQUIREMENTS OR SOCIAL SITUATION:

_____
_____

I HAVE REVIEWED AND AGREE WITH THIS ASSESSMENT.
PHYSICIAN/PCP/RN SIGNATURE: _____
☐ Hard copy signature on file. This plan of care has been discussed with the MD/PCP/RN. **DATE:** ___/___/___
Physician/PCP/RN Name (PRINT): _____

INSTRUCTIONS
DHS FORM 1147
Rev. 05/14
LEVEL OF CARE (LOC) AND AT RISK EVALUATION

1. ***Check the appropriate box for the evaluation:*** Check type of request - initial, annual, reconsideration or other review, i.e. 3 month review to determine continued stay.

2. ***Patient Name***: Self-explanatory.

3. ***Birthdate***: Self-explanatory.

4. ***Gender***: Indicate whether the patient is "M" for male or "F" for female.

5. ***Medicare***: Check the appropriate box indicating whether patient has Medicare Part A and B and enter patient's Medicare I.D. number, if eligible for either Part A or B.

6. ***Medicaid Eligible***: Check "Yes" or "No" to indicate whether the patient is currently Medicaid eligible. Enter Medicaid I.D. number assigned by the Department of Human Services, if eligible. If the patient has applied for Medicaid but has not yet been deemed eligible, print or type in "pending" for I.D. # and print or type in date applied. Forms will be processed only if patient has a Medicaid number or has the date of the Medicaid application.

7. ***Present Address***: Indicate patient's present address, i.e. Home, Hospital, Nursing Facility (NF), Care Home, Extended Adult Residential Care Home (EARCH – Type I & Type II), Community Care Family Foster Home (CCFFH), or other.

   Home: Patient is at his or her residential home or is homeless.
   Hospital: Patient is currently residing in an Acute Care Hospital, i.e. waitlisted at an acute waitlisted level of care.
   Nursing Facility (NF): Patient is currently residing in a nursing facility.
   Care Home: Patient is currently residing in a care home – not at nursing facility level of care.
   Extended Adult Resident Care Home (EARCH): Patient is currently residing in a Department of Health or Shared Home with the Department of Human Services which include Patients at a care home and nursing facility level of care.
   Community Care Foster Family Home (CCFFH): Patient is currently residing in a Department of Human Services Foster Home which includes Patients at a nursing facility level of care.
   Other: Check this box if the patient's present address is not listed above. Write in the description.

8. ***Medicaid Provider Number***: Enter only if applicable. Patient must be pending Medicaid and currently NOT a patient in a managed care health plan.

9. ***Attending Physician/Primary Care Provider (PCP)***: Enter the name of the attending physician or primary care provider, telephone and fax number.

10. ***Return Form to***: Enter the name of the service coordinator or the contact person. Indicate the managed care plan name if applicable, telephone, fax number and email address of the person able to provide additional information about the patient.

11. ***Referral Information***: Complete all sections for an initial request. Skip this section, if this is an annual or "other" review.

    A. **Source(s) of Information**: Identify the source(s) of patient information received.

    B. **Responsible Person**: Provide the name, relationship, phone and fax numbers of the family member/personal agent who will be making decisions for the patient.

    C. **Language**: Check the box of the primary language spoken by the patient. If checking "Other," indicate the language spoken. Information is used to obtain interpreters.

12. ***Assessment Information***: Complete all sections.

    A. **Assessment Date**: Indicate the date of the most current assessment.

    B. **Assessor's Name, Title, Signature, Phone and Fax Numbers**: A registered nurse (RN), physician or primary care provider must perform the assessment. Enter the name, title and telephone, fax number and email address of the assessor. The assessor must sign the form.

    Electronic submittal of form(s) will be accepted with the box checked that a signature of the RN, physician or primary care provider has signed a hard copy of this form and the hard copy of the form(s) can be found in the patient's file.

13. ***Requesting***: Check what is being requested (either level of care or at risk). Indicate the begin and end date of the request. If hospice services have been elected by the patient AND the services will be provided in a nursing facility, attach the hospice election and physician verification form. *Hospice services in other settings do not require an 1147 form.*

    Indicate the length of approval requested. Check one box.

14. ***Medical Necessity Determination***: Completed by DHS reviewer or designee. Leave Blank. DO NOT COMPLETE.

PAGE 2 AND 3–APPLICANT/PATIENT BACKGROUND INFORMATION

1. ***Name***: Self-explanatory.

2. ***Birthdate***: Self-explanatory.

3. ***Functional Status Related to Health Conditions***: Complete all sections.

I. **List significant current diagnosis(es)**: List the primary and secondary diagnosis(es) or medical conditions related to the patient's need for long-term care.

II. **Comatose**: If patient is comatose, check "Yes" box and go directly to Section XVIII. If patient is not comatose, check "No" and complete rest of section.

III. **Vision/Hearing/Speech through XIII Dressing and Personal Grooming**: Select the description that best describes the patient's functioning.

Note: Make only one selection in all sections except VI. Mental Status/Behavior and IX. Mobility/Ambulation. For Mental Status/Behavior, make only one selection for orientation (items a through c). Aggressive and/or abusive and wandering may also be checked with the appropriate orientation. For Mobility/Ambulation, check a maximum of 2 for items b through e. If an individual is either mobile or unable to walk, no other selections can be made.

XIV. **Housecleaning through XVII Meal Preparation (complete only for At-Risk criteria):**

Select the description that best describes the patient's functioning.

a) Independent

b) Able to complete some tasks with some assistance, includes oversight/cuing

c) Unable to complete tasks on own or needs assistance

XVIII. **Total Points**: Add the points from each section to obtain total. Comatose patients are assigned 30 points.

XIX. **Medications/Treatments**: List the significant medications prescribed by a physician. They may be chronic and given on a fixed schedule (such as antihypertensives), or short term (such as antibiotics), or significant PRN medications (such as narcotics and sedatives). Do not list stool softeners, enemas, and other agents to treat constipation, acetaminophen, non-steroidal anti-inflammatory agents (NSAIDs) unless they are given at least daily. If a patient has more than significant medications than available lines, attach orders or treatment sheet.

XX. **Additional Information Concerning Patient's Functional Status**: Use the space to provide additional information on the patient's functional status. This section may be used to identify the extent of the assistance (minimal, with assistance or total) that is required. Attach a separate sheet if more space is required. See attachment Functional Status related to Health Conditions on scoring this section.

XXI. **Skilled Procedures**: Check the particular skilled procedure(s) that the patient requires. If the care is daily (D), indicate the number of times per

day that care is required. If care is less than once per day check "L". If the care is not applicable, check "N".

If restorative therapy is being requested, attach the evaluation and treatment plan(s) AND indicate whether the patient is able to participate in therapy a minimum of 45 minutes per session 5 days a week.

XXII. **Social Situation**:

A. **Person can return home**: Identify whether the patient can return home. The home can be a family member's (daughter, son, brother, sister, parents, etc.) home as well as the patient's own home. Check "NA" if the patient is already in a home environment. If the individual does not have a home, indicate whether the patient can be placed in a community setting. Check "NA" if the patient is already in a community setting.

B. **Caregiving support**: If the patient has a home, identify whether the caregiving support is willing/able to provide care. If caregiver requires assistance, identify the assistance required.

C. **Caregiver name**. Provide the caregiver's name, relationship, address, phone and fax numbers.

XXIII. **Comments on Nursing Requirements or Social Situation:** Provide any additional information that would help explain the Patient's nursing requirements or social situation.

Physician/PCP/RN Signature: Self-explanatory.

Electronic submittal of form(s) will be accepted with the box checked that the physician, the primary care provider, or the registered nurse has signed a hard copy of the form(s) and that the plan of care has been discussed with the physician, primary care provider, or registered nurse. The hard copy of the form(s) must be kept in the Patient's file.

Date: Indicate the date of the physician, Primary Care Provider, or Registered Nurses' signature.

Physician's/PCP/RN Name (Print): Self-explanatory.

Filing Instructions: Mail, fax, or send forms electronically to:

Health Services Advisory Group, Inc.
1440 Kapiolani Blvd., Suite 1110,
Honolulu, HI 96814
Phone: (808) 440-6000 Fax: (808) 440-6009

APPENDIX H: Aid to Disabled Review Committee

DHS 1127, DHS 1128, DHS 1180

STATE OF HAWAII
Department of Human Services

Med-QUEST Division

MEDICAL HISTORY AND DISABILITY STATEMENT

Instructions: It is very important that you read and answer all questions carefully. Your responses may help to determine if you are disabled. You may ask someone such as a relative, friend, eligibility worker, or someone from the health care field to help you complete this form. If someone helps you to complete the form, the answers should, to the extent possible, be in your own words.

Name of potentially disabled individual: _____
Last Name First Name

Beneficiary ID Number: _____ Case Number: _____

SOCIAL SECURITY DISABILITY INSURANCE (SSDI) INFORMATION

1. Are you receiving SSDI? [ ] Yes [ ] No
2. Have you ever received SSDI? [ ] Yes [ ] No
3. If yes to #2, why did the SSDI stop? _____

_____

4. Have you applied for social security benefits for your current disability? Check appropriate block(s):
   [ ] No
   [ ] Yes. Date applied for benefits: _____
   [ ] My application is pending.
   [ ] My application has been approved and I am currently or will soon be receiving benefits.
   [ ] My application was denied. Explain reason given for denial of benefits:

_____

_____

MEDICAL PROFILE

1. Describe your disability and explain the reason(s) why you are unable to work:

_____

_____

2. Describe the cause of your disability (i.e. accident, injury, illness, etc):

_____

_____

3. Describe all treatment(s) prescribed by any physician for your disability:

_____

_____

4. How often do you see your doctor for treatment? (Check one of the following blocks)
   [ ] weekly [ ] several times a month [ ] monthly [ ] quarterly or more

5. List hospitalization(s) within the past two years, reason for hospitalization(s), and duration(s) of stay:

_____

_____

_____

DHS 1127 (Rev. 03/14)

EDUCATION LEVEL

1. Are you able to understand and communicate in English: [ ] Yes [ ] No
2. Education: Circle the last grade you completed

   1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
3. List any educational Degree, Diploma, Training, or Certificate received:

   _____

   _____

PREVIOUS WORK EXPERIENCE

1. Have you ever been employed? [ ] Yes [ ] No
   If yes, list the last job and type of work: _____

   _____

   _____

   _____
2. List the date of your last employment and reason(s) why your job was terminated:

   _____

   _____

****

Check "A" or "B" below and sign. Also, read and initial to acknowledge "C" and "D". (Must be completed or form will not be accepted)

A. _____I certify that the information I have provided to be true, accurate, and correct to the best of my knowledge.
B. _____I choose not to complete this form.

Read and initial:

C. _____ I understand that if I am found to have a disability for one year or more, I will be disenrolled from my QUEST health plan and enrolled into a QExA health plan. I also understand that I may not be able to continue seeing my current provider(s).

D. _____ I understand that if I am found to have a disability for one year or more, the Department of Human Services will look at my assets to determine if I am still Medicaid eligible. If I go over my asset limit, I may lose my Medicaid eligibility.

Signature of Applicant/Beneficiary		Date
Signature of Person Applying for Applicant/Beneficiary	Relationship	Date

If applicant/beneficiary did not complete this form on their own, explain the reason(s) why: _____

_____

_____

_____ _____

Name of Person Who Assisted To Complete Form Date

MQD Remarks: _____

_____

DHS 1127 (Rev. 03/14)

STATE OF HAWAII
Department of Human Services

Med-Quest Division

DISABILITY REPORT

I. Name _____ DOB: _____/_____/_____ Sex: _____
Last First MI Mo Day Yr M/F

LICENSED TREATING PHYSICIAN/EVALUATOR: QUESTIONS MUST BE ANSWERED COMPLETELY and LEGIBLY OR FORM MAY BE RETURNED

II. Describe all significant physical and mental illnesses, accidents, deformities, injuries, illnesses and surgeries related to your patient's disability. Specify date(s) applicable to condition(s) listed and attach copies of all related reports.

_____
_____
_____
_____
_____
_____

III. Current diagnoses (List primary diagnosis first)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

IV. Indicate your treatment plan and duration of treatment:

_____
_____
_____
_____
_____
_____

V. Explain in detail your patient's functional limitation(s) in doing medium and/or light (sedentary) work. Base your decision on medical evidence and not on subjective judgment. Attach copies of all medical evidence to this report.

_____
_____
_____
_____
_____
_____

DHS 1128 (Rev. 11/09)

STATE OF HAWAII
Department of Human Services

Med-Quest Division

VI. LICENSED PHYSICIAN'S STATEMENT OF DISABILITY

Your patient's disability is expected to be:

[ ] **PERMANENT**

[ ] **AT LEAST 12 MONTHS, RE-EVALUATION NEEDED**: _____ (MO/YR)

[ ] **TEMPORARY TO**: _____ (MO/YR)

_____ (Print/Type Name of Licensed Treating Physician/Evaluator)

_____ (Signature of Licensed Treating Physician/Evaluator)

_____ (Address) (City) (Zip Code)

_____ (Phone No.) (Date)

_____ (Name of Health Plan)

_____ (Medical Provider No. or NPI)

VII. PATIENT ACKNOWLEDGEMENT

_____ (Print/Type Name of applicant/recipient)

_____ (Patient Contact Number)

_____ (Signature of applicant/recipient, Guardian or Representative)

_____ (Date)

If Applicant/Recipient or Guardian or Representative do not sign, indicate reason: _____

_____

FOR OFFICIAL USE ONLY

_____ (Case Name)

_____ (Case No.)

_____ (Worker's Name)

_____ (Section Unit)

_____ (Unit Address)

_____ (Phone No.) (Fax No.)

DHS 1128 (Rev. 11/09)

STATE OF HAWAII
Department of Human Services

Med-QUEST Division

ADRC REFERRAL AND DETERMINATION/RE-DETERMINATION

PART I: REFERRAL TO ADRC **Completed ADRC Packet Received, Date ____/____/____**

1. **APPLICANT/BENEFICIARY NAME** _____ **DATE OF BIRTH** ____/____/____
   CASE NO. _____ **MQD BENEFICIARY I.D. NO.** _____ **ELIG KEY CODE** _____
2. **TYPE OF REFERRAL:**
   - ☐ ADRC INITIAL DETERMINATION
   - ☐ ADRC REDETERMINATION, DATE LAST ADRC COMPLETED: ____/____/____ (attach a copy of last DHS 1180)
3. **REFERRAL SOURCE:**
   - ☐ MQD: _____
     Section / Unit Name of EW Phone No. Fax No.
   - ☐ HEALTH PLAN: _____
     Name of Health Plan Contact Person Phone No. Fax No.
4. ☐ DHS 1127
   - ☐ DHS 1128 ☐ HCFA 2728 submitted instead of DHS 1128
   - ☐ DHS 1147, SUB-ACUTE/LONG TERM CARE/HOSPICE LEVEL OF CARE EVALUATION, IF APPLICABLE, **AND**
   - ☐ ADDITIONAL INFORMATION OR SUPPORTING EVIDENCE FOR PHYSICAL or PSYCHIATRIC DISABILITY FROM THE HEALTH PLAN OR APPLICANT'S/BENEFICIARY'S MEDICAL PROVIDER.

   COMMENTS: _____

PART II: DETERMINATION BY ADRC:

1. ☐ UNIT: _____ EW: _____
   - ☐ HEALTH PLAN: _____ CONTACT: _____
   - ☐ TREATING PHYSICIAN: _____
2. **GAINFUL ACTIVITY DETERMINATION** (based on beneficiary's DHS 1127 statement, system verification of lack of income, other information sources, confirmed by MQD/CSO staff if needed)

   ☐ GAINFUL ACTIVITY IS **NOT** POSSIBLE. ☐ GAINFUL ACTIVITY IS POSSIBLE

   COMMENTS: _____

   CERTIFIED BY: _____
   MQD/CSO Staff Date
3. **ADRC DETERMINATION:**
   - ☐ NOT DISABLED
   - ☐ TEMPORARILY DISABLED TO: ____/____/____ (NOT ELIGIBLE FOR QExA)
   - ☐ DISABLED MORE THAN 12 MONTHS - MEETS SSI DISABILITY CRITERIA- MAKE REFERRAL to SSA
     - ☐ CONDITION REQUIRES RE-EVALUATION AFTER ONE YEAR ____/____/____
   - ☐ **EFFECTIVE DATE OF NEW HEALTH PLAN ENROLLMENT: ____/____/____** ☐ UNABLE TO DETERMINE

   COMMENTS: _____

   CERTIFIED BY: _____
   Medical/Psychiatric Consultant Date

PART III: PROGRAM ELIGIBILITY: To be completed by Eligibility Worker, if program change is required.

☐ Program changed ____/____/____ ☐ Not eligible for program change. Reason: _____

DHS 1180 (Rev. 03/14)

APPENDIX I: LTSS - PAI & PAII Service Descriptions

Description of LTSS Benefits (addendum to RFP-MQD-2021-008 Section 4.8.C)

A) Personal Assistance Services – Level I and Level II

1. Personal assistance sometimes also called "attendant care" for children needing these services, are services provided in an individual's home to help them with their IADLs and ADLs.

2. Personal assistance services Level I are provided to individuals requiring assistance with IADLs to prevent a decline in the health status and maintain the individuals safely in their home and communities. Personal assistance services Level I are for individuals who are not living with their family who would otherwise perform these duties as part of a natural support. Personal assistance services Level I is limited to ten (10) hours per week for individuals who do not meet institutional level of care. Personal assistance services Level I may be self-directed by the Member, who is a social services recipient and consist of the following:

    a. Companion services, pre-authorized by the service coordinator in the Member's service plan, means non-medical care, supervision, and socialization provided to a Member who is assessed to need these services. Companions may assist or supervise the individual with such tasks as meal preparation, laundry, and shopping/errands, but do not perform these activities as discrete services. Providers may also perform light

housekeeping tasks that are incidental to the care and supervision of the individual.

b. Homemaker/chore services means any of the activities listed below, when the individual that is regularly responsible for these activities is temporarily absent or unable to manage the home and care for himself/herself or others. Homemaker/chore services, pre-authorized by the service coordinator in the Member's service plan, are of a routine nature and will not require specialized training or professional skills such as those possessed by a nurse or home health aide. The scope of homemaker/chore services specified in this section will cover only the activities that need to be provided for the Member, and not for other Members of the household, and will include the following:

    1) Routine housecleaning such as sweeping, mopping, dusting, making beds, cleaning the toilet and shower or bathtub, taking out rubbish;

    2) Care of clothing and linen by washing, drying, ironing, mending;

    3) Shopping for household supplies and personal essentials (not including cost of supplies);

    4) Light yard work, such as mowing the lawn;

    5) Simple home repairs, such as replacing light bulbs;

    6) Preparing meals;

7) Running errands, such as paying bills, and picking up medications;

8) Escorting the Member to clinics, physician office visits, or other trips for the purpose of obtaining treatment or meeting needs established in the service plan, when no other resource is available;

9) Providing standby/minimal assistance or supervision of activities of daily living such as bathing, dressing, grooming, eating, ambulation/mobility, and transfer;

10) Reporting and/or documenting observations and services provided, including observation of Member self-administered medications and treatments, as appropriate; and

11) Reporting to the assigned provider, supervisor or designee, observations about changes in the Member's behavior, functioning, condition, or self-care/home management abilities that necessitate a change in service provided.

3. Personal assistance services Level II are provided to individuals requiring assistance with moderate/substantial to total assistance to perform ADLs and health maintenance activities. Personal assistance services Level II will be provided by a home health aide (HHA), personal care aide (PCA), Certified Nurse Aide (CNA) or Nurse Aide (NA) with applicable skills competency. Personal

assistance services Level II may be self-directed by the Member, who is a social services recipient, and consist of the following:

a. Personal hygiene and grooming, including bathing, skin care, oral hygiene, hair care, and dressing;

b. Assistance with bowel and bladder care;

c. Assistance with ambulation and mobility;

d. Assistance with transfers;

e. Assistance with medications, which are ordinarily self-administered when ordered by Member's physician;

f. Assistance with routine or maintenance healthcare services by a personal care provider with specific training, satisfactorily documented performance, care coordinator consent and when ordered by Member's physician;

g. Assistance with feeding, nutrition, meal preparation and other dietary activities;

h. Assistance with exercise, positioning, and range of motion;

i. Taking and recording vital signs, including blood pressure;

j. Measuring and recording intake and output, when ordered;

k. Collecting and testing specimens as directed;

l. Special tasks of nursing care when delegated by a registered nurse, for Members who have a medically stable condition and who require indirect nursing supervision as defined in Chapter 16-89, HAR;

m. Proper utilization and maintenance of Member's medical and adaptive equipment and supplies. Checking and reporting any equipment or supplies that need to be repaired or replenished;

n. Reporting changes in the Member's behavior, functioning, condition, or self-care abilities which necessitate more or less service; and

o. Maintaining documentation of observations and services provided.

p. When personal assistance services Level II activities are the primary services, personal assistance services Level I activities identified on the service plan, which are incidental to the care furnished or that are essential to the health and welfare of the Member, rather than the Member's family, may also be provided.

APPENDIX J: Home and Community-Based Service Codes

LTSS HCBS Service Codes	
Home and Community-Based	**Service Code**
Adult Day Care	S5105
Adult Day Health	S5101-S5102
Assisted Living Facility	T2031
Attendant Care*	S5125
Community Care Management Agency	T2022
Counseling and Training	S5108-S5116
Counseling and Training – Nutrition	S9452
Environmental Accessibility Adaptations (EAA)	S5165
EAA – Pest Control	S5165
Home Delivered Meals	S5170
Home Maintenance	S5120 & S5121
Moving Assistance	T2038
Non-Medical Transportation (including transport and attendant)	T2001 & T2003-T2005
Personal Assistance (PA) Services Level I (Agency) – homemaker and companion services *	S5130 & S5135
Personal Assistance (PA) Services Level II (Agency) *	S9122
Self-Direction (SD) PA I Services *	S5130, S5135,
Self-Direction (SD) PA II Services *	S9122
Self-Direction (SD) PA II – Delegated *	S9122+ modifier
Private Duty Nursing (SN) – LPN *	S9124
Private Duty Nursing (SN) – RN *	S9123
Personal Emergency Response Systems (PERS)	S5160-S5162/S5185
Residential Care including CCFFH	S5140
Level I	Modifier
Level II	Modifier
Level III	Modifier
Residential Care including E-ARCH	T2033
Level I	Modifier
Level II	Modifier

APPENDIX J: Home and Community-Based Service Codes

LTSS HCBS Service Codes	
Home and Community-Based	**Service Code**
Level III	Modifier
Respite Care – Unskilled*	S5150 & S5151
Respite Care – Skilled *	T1005
Respite Care – Institutional Overnight	H0045
Respite Care – Community Based Overnight (i.e., CCFFH) Unskilled Daily	S5151
Respite Care – Community Based Overnight (i.e., CCFFH) Skilled Daily	S9125
Specialized Medical Equipment and Supplies	
DMEs/Assistive Technology (not covered by State Plan)	T2029
Specialized Supplies (not covered by State Plan)	T2028
Vehicle Modification	T2039
Electric Utility	T2035

*A complete list of EVV procedure codes is located on the DHS website.

APPENDIX K: I/DD Coordination of Services

QI Health Plan Service Coordinator	DDD Case Manager

• The Health Plan will assign a service coordinator, as appropriate.
• Responsible for coordinating the medical-related issues (i.e., physician, hospital, home health, medication, etc.).
• Helps the Member navigate the health care system.
• The service coordinator will:
  ○ Find physicians or specialists.
  ○ Assure that Member has medically-necessary durable medical equipment (DME) or medical supplies.
  ○ Support client during a hospital discharge for new medication, home health, etc.
• Coordinate benefits with primary insurance to assure that Member has medically-necessary services, including medications.
• Coordinate for social determinates of health and medically-necessary services.
• Coordinate with the Going Home Plus (GHP) program for services not covered by the I/DD waiver.
	• The case manager coordinates home and community-based services.
	• Make referrals to Health Plan for medical related issues (i.e., physician, hospital, home health, medication, etc.).
	• Make referrals to other Medicaid or federally funded programs including, but not limited to, dental services, etc.
	• The case manager is the liaison to other government programs other than Medicaid (i.e., Early Intervention, Department Of Education, Child and Adolescent Mental Health Division, Adult Mental Health Division, Community Care Services, Child Welfare Services, Adult Protective Services, etc.).

Information to share during coordination:
- Change in condition/status/contact information with/for the Member/participant.
- Invite the service coordinator/case manager to any meeting that DDD or the Health Plan attends (i.e., discharge planning meeting at hospital, meeting with provider/family on complex cases).
- Emergency department visits and hospital admissions, if able.

Initial Assessment

QI Health Plan Service Coordinator	DDD Case Manager
• If Member is new to Medicaid or is identified as special health care needs (SHCN), performs the health and functional assessment (HFA). • May authorize time-limited services in place while referring to the I/DD Waiver.	• Performs the initial assessment prior to enrollment into the I/DD Waiver. • Note: Enrollment into the I/DD Waiver may take up to 90 days. After enrollment, the delivery of services may also take up to 90 days (combined up to 180 days).
Information to share during coordination: - Recommendation for additional services needed (i.e., Health Plan recommends to increase I/DD Waiver services or DDD recommend increase in health services). - Health Plan to DDD- Copy of the HFA to case manager. - DDD to Health Plan- Copy of the Initial Assessment to service coordinator.	

Re-Assessments

QI Health Plan Service Coordinator	DDD Case Manager
• Performs re-assessment, if applicable: ○ Every 12 months and more frequently as needed (e.g., after hospitalization, or change in condition, as indicated). ○ Every 3 months (if Health Plan HCBS are in place while awaiting enrollment to the I/DD Waiver). ○ Every 6 months (if identified as SHCN and in I/DD Waiver). • Supports the case manager in accessing primary and specialty medical appointments.	• Performs the annual re-assessment and more frequent as needed.
Information to share during coordination: - Health Plan to DDD- Copy of the HFA re-assessment to case manager. - DDD to Health Plan- Copy of the re-assessment to service coordinator.	

Person-Centered Service Plan

QI Health Plan Service Coordinator	DDD Case Manager

• Develops the initial person-centered service plan with the Member and circle of support (may include family, friends, caregivers, provider agency representative, case manager, etc.).
• Developed within 15 business days (if identified as SHCN).
• Updates service plan, if applicable:
  ○ Every 3 months (if Health Plan HCBS are in place while awaiting enrollment to the I/DD Waiver).
  ○ Every 6 months (if identified as SHCN).
	• Develops the initial individualized service plan (ISP) with the participant and circle of support (may include family, friends, caregivers, provider agency representative, service coordinator, etc.).
	• Updates ISP annually and as needed.

Information to share during coordination: - Health Plan to DDD- Copy of the Service Plan to case manager. - DDD to Health Plan- Copy of the Individualized Service Plan to service coordinator.	

Planning Meetings

QI Health Plan Service Coordinator	DDD Case Manager
• Attends ISP meetings, if applicable.	• Assist participant with coordination of ISP meetings and encourages the participant to choose the circle of support to attend.

Approval of Services

QI Health Plan Service Coordinator	DDD Case Manager
• The Health Plan approves services that are: ○ Based on medical necessity. ○ Coordinated with Member's primary insurance. ○ Services include primary and acute care benefit package, Attachment B. • Note: The Health Plan provides QI services, as appropriate, in tandem with I/DD Waiver services. If the Member chooses to receive HCBS through I/DD Waiver, the Health Plan may provide HCBS while awaiting enrollment to the program.	• I/DD Waiver approves services within the guidelines developed for case managers, utilization review committee, and clinical inter disciplinary team: ○ Services are appropriate and supports the participant to remain at home and community setting versus institutionalization. ○ Approved services for I/DD Waiver, Attachment A. ○ Services promote community integration and are home and community-based.
Information to share during coordination: - Health Plan to DDD- Copy of the Service Plan to case manager when approved for DME, medical supplies, or personal assistance or nursing hours. - DDD to Health Plan- Copy of the Individualized Service Plan to service coordinator when approved to HCBS services.	

Denial of Services

QI Health Plan Service Coordinator	DDD Case Manager
• Health Plan denies services that are: ○ Not medically-necessary. ○ Should be covered by Members' primary health insurance. ○ Not part of the primary and acute care benefit package.	• I/DD Waiver denies services within guidelines developed for case managers utilization review committee and clinical inter disciplinary team: ○ Not needed by the participant. ○ Not included in the I/DD Waiver services.
Information to share during coordination: - Health Plan to DDD- Notify case manager when there is a denial for DME, medical supplies, or personal assistance or nursing hours and any item that DDD has requested. - DDD to Health Plan- Notify service coordinator when there is a denial of HCBS services.	

Grievances

QI Health Plan Service Coordinator	DDD Case Manager
• Process Member's grievance in accordance with the Health Plan policies and procedures. • Refers Member to case manager if grievance is related to I/DD Waiver.	• Works with the participant to try to resolve issues prior to becoming a grievance. • Process participant's grievance in accordance with policies and procedures. • Refers participant to the Health Plan if grievance is related to medical needs such as medically-necessary services, equipment and supplies.
Information to share during coordination: - Health Plan to DDD- Notify case manager of grievance resolution that involves I/DD Waiver. - DDD to Health Plan- Notify service coordinator of grievance resolution that involves Health Plan.	

Appeals

QI Health Plan Service Coordinator	DDD Case Manager
• Process Member's appeal in accordance with the Health Plan policies and procedures. • Refers Member to case manager if appeal is related to I/DD Waiver.	• Supports DDD staff in development of response to the appeal. • Process participant's appeal in accordance with policies and procedures. • Refers participant to the Health Plan if appeal is related to medical needs such as medically-necessary services and medical equipment and supplies.
Information to share during coordination: - Health Plan to DDD- Notify case manager of appeal resolution that involves I/DD Waiver. - DDD to Health Plan- Notify service coordinator of appeal resolution that involves Health Plan.	

1915(c) Intellectual and/or Developmental Disabilities (I/DD) Home and Community-Based Services

List of Services		Brief Service Description
1	Adult Day Health	Adult Day Health covers structured age-relevant activities as specified in the individualized service plan (ISP), in a non-institutional center or facility encompassing both health and social services needed to ensure the optimal functioning of the participant. The desired outcomes include measurable improvements in individual independence, increased participation in the community, and other skill building that leads to increased community integration. Progress towards the participant's independence, community integration, and skill development goals will be assessed and reviewed regularly to evaluate the measurable gains being made toward the goals.
2	Additional Residential Supports	This service provides direct support worker staff hours to assist the residential habilitation (ResHab) caregiver when a participant experiences a physical or behavioral change that exceeds the level of staffing funded through their ResHab rate. The outcome of this service is to stabilize a participant's placement in the ResHab home, support the family unit, prevent loss of placement, and/or prevent a crisis. The service is intended to be short-term (less than 60 days) but can be renewed for additional periods depending on the participant's needs.
3	Assistive Technology	Assistive Technology device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. The assistive technology must be for the use of the participant and necessary as specified in the ISP to assist the participant in achieving identified measurable goals, has high potential to increase autonomy and reduce the need for physical assistance, and is the most cost-effective option.
4	Chore	Chore services are needed to maintain the participant`s home in a clean, sanitary, and safe manner. This service includes heavy household chores such as washing floors, windows, and walls; tacking down loose rugs and tiles; and moving heavy items of furniture, in order to provide safe access and egress as well as more routine or regular services such as the performance of general household tasks such as meal preparation and routine household care for the participant only. These services are available to participants living independently who need chore services and are without natural (non-paid) supports or who are living with family but the natural supports are physically unable to perform the chores. Documentation must indicate that no other party is capable of and responsible for providing chore services, including the participant, anyone else financially providing for the participant, and another relative,

List of Services		Brief Service Description
		caregiver, landlord, community/volunteer agency, or third-party payer.
5	Community Learning Services	Community Learning Services (CLS) support the participant's integration in the community. Services will meet the participant's needs and preferences for active community participation, including the participant's choice whether to do the activity individually or with a small group of others who share that interest. The intended outcome of CLS is to improve the participant's access to the community through increasing skills, improving communication, developing and maintaining friendships, gaining experience with the opportunities available in the community each as public events and enrichment activities, functioning as independently as possible, and/or relying less on paid supports. These services assist the participant to acquire, retain, or improve social and networking skills, develop and retain social valued roles, independently use community resources, develop adaptive and leisure skills, hobbies, and exercise civil rights and self-advocacy skills required for active community participation.
6	Discovery and Career Planning	Discovery and Career Planning (DCP) combines elements of traditional prevocational services with career planning in order to provide supports that are ongoing throughout the participant's work career. Discovery and Career Planning is based on the belief that all individuals with intellectual and developmental disabilities can work when given the opportunity, training, and supports that build on an individual's strengths, abilities, and interests.
7	Environmental Accessibility Adaptations	Those physical adaptations permanently installed to the participant's home, required by the participant's ISP, that are necessary to ensure the health, welfare, and safety of the participant and enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, environmental control devices that replace the need for physical assistance, and increase the participant's ability to live independently, such as automatic door openers, or the installation of specialized electric and plumbing systems needed to accommodate the medical equipment and supplies that are necessary for the welfare of the participant and directly related to the participant's developmental disability.
8	Individual Employment Supports	Individual Employment Supports are based on the belief that all individuals with intellectual and developmental disabilities can work and that individuals of working age should be provided the supports necessary not only to gain access to and maintain employment in the community, but to advance in their chosen fields and explore new

List of Services		Brief Service Description
		employment options as their skills, interests, and needs change. Individual Employment Supports are designed to maximize the participant's skills, talents, abilities, and interests.
9	Non-Medical Transportation	Non-Medical Transportation enables participants to gain access to community services, activities, jobs, and resources as specified in the Individualized Service Plan (ISP) and when no other waiver service is responsible for providing the transportation. Limitations: This service shall not be used to provide medical transportation required under 42 CFR §431.53 and transportation services under the State plan delivered through the QUEST Integration Health Plans. Non-medical transportation may not duplicate transportation that is included within another waiver service or to transport the participant to a setting that is the responsibility of another agency, such as the Department of Education. An individual serving as a designated representative for a waiver participant using the consumer-directed option may not provide non-medical transportation. Non-medical transportation may not be provided to children less than 18 years of age, by parents, step-parents, or the legal guardian of the minor. Non-medical transportation may not be provided to a participant by their spouse.
10	Personal Assistance/ Habilitation	Personal Assistance/Habilitation (PAB) is a range of assistance or habilitative training provided primarily in the participant's home to enable a participant to acquire, retain and/or improve skills related to living in his or her home. PAB services are identified through the person-centered planning process and included in the individualized service plan (ISP) to address measurable outcomes related to the participant's skills in the following areas: 1) activities of daily living (ADL) skills: eating, bathing, dressing, grooming, toileting, personal hygiene, and transferring; 2) instrumental activities of daily living (IADL): light housework, laundry, meal preparation, arranging public transportation, preparing a grocery or shopping list, using the telephone, learning to self-administer medication, and budgeting; 3) mobility; 4) communication; and 5) social skills and adaptive behaviors. Limitations: For participants under age 21, PAB may not be delivered if such services have been determined to be medically-necessary EPSDT services to be provided through the QUEST Integration Health Plans.

List of Services		Brief Service Description
11	Personal Emergency Response System	PERS is a commercially-available system used by waiver participants who need assistance to secure help in an emergency while maintaining independence at home.
12	Private Duty Nursing	Private duty nursing (PDN) services are defined as services determined medically-necessary to support an adult (21 years of age and older) with substantial complex health management support needs. PDN services must be specified in the ISP. PDN services are within the scope of the State's Nurse Practice Act and require the education, continuous assessment, professional judgment, nursing interventions, and skilled nursing tasks of a registered nurse (RN) or licensed practical nurse (LPN) under the supervision of an RN. The RN and LPN are licensed to practice in the State of Hawai'i. Limitations: PDN services are provided to participants age 21 and older up to a maximum of 8 hours on average per day during the authorization period. If DOH/DDD authorizes a short-term increase above the 8 hours-per-day limit, the authorized increase shall not exceed 30 days. For participants under age 21, all medically-necessary nursing services for children are covered in the state plan pursuant to the EPSDT benefit and to be provided through the QUEST Integration Health Plans.
13	Residential Habilitation	Residential habilitation (ResHab) are individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living and instrumental activities of daily living, community inclusion, transportation, and social and leisure skill development that assist participants to reside in the most integrated setting appropriate to their needs. Residential habilitation does not include general care supervision which are required under the home's license or certification requirements. Residential habilitation is a service, not a setting.

List of Services		Brief Service Description
14	Respite	Respite services are only provided to participants living in family homes and are furnished on a short-term basis to provide relief to those persons who normally provide uncompensated care for the participant for at least a portion of the day. If the participant requires nursing assessment, judgment and interventions during respite, the service may be provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) under the supervision of an RN. Limitation: For participants under the age of 21, respite services provided by a RN or LPN are available only to participants receiving private duty nursing (PDN) through QUEST Integration EPSDT services.
15	Specialized Medical Equipment	Specialized medical equipment and supplies include: 1) devices, controls, appliances, equipment, and supplies, specified in the plan of care, which enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live; 2) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; 3) such other durable and non-durable medical equipment not available under the State Plan that are necessary to address participant functional limitations; and 4) necessary medical supplies.
16	Training and Consultation	Training and consultation services assist unpaid caregivers, paid service supervisors, contractors, and/or paid support staff in implementing the goals and outcomes developed from the person-centered planning process and included in the individualized service plan (ISP). The goals and outcomes are necessary to improve the participant's independence and inclusion in their community.
17	Vehicle Modifications	Adaptations to a vehicle to accommodate the special needs of the participant. Vehicle adaptations are specified in the ISP as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare, and safety of the participant.
18	Waiver Emergency Services	Waiver emergency services (outreach) shall be defined as the initial call requesting outreach and the immediate on-site crisis support for situations in which the individual's presence in their home or program is at risk due to the display of challenging behaviors that occur with intensity, duration, and frequency, that endangers his/her safety or the safety of others or that results in the destruction of property.

APPENDIX L: Medicaid Eligibility for Long-Term Care Services

DHS 1148

STATE OF HAWAII
Department of Human Services

Med-QUEST Division

MEDICAID ELIGIBILITY FOR LONG-TERM CARE (LTC) SERVICES

SECTION 1: AUTHORIZED MEDICAID PROVIDER AND MED-QUEST DIVISION			
TO: **Med-QUEST Eligibility Branch**	Contact Name:		Sent Date:
Phone No.	Fax No.		Email Address:
***FROM:** ☐ Med-QUEST Health Plan		☐ Case Management Agency (CMA)	
☐ Nursing Home/Intermediate Care (ICF-ID) Facility/Hospital WL		☐ DDD Case Manager	
Contact Name:		Email Address:	
Phone No.	Fax No.		
SECTION 2: APPLICANT/BENEFICIARY INFORMATION			
Applicant/Beneficiary Name (last, first, M.I)		CLIENT ID No. /last 4 digits of SSN	Date of Birth
Case Name (if different from Applicant/Beneficiary)		Phone No.	Email Address
Marital Status: Single ☐ Widowed ☐ Divorced ☐ Separated ☐ Married ☐ Spouse Name: _____			
SECTION 3: NEW ADMISSION OF LONG-TERM CARE (LTC) SERVICES REQUEST			
Approved Level of Care (LOC) DHS 1147 DHS 1150 (CSO) DHS1150C (CSO) Start/End Date:			
☐ **A. Nursing Home Placement (NH)**			
Facility/Address:		Phone No.	Date of Admission Revised
☐ **B. Hospital Waitlisted Placement (WL)**			
Hospital/Address:		Phone No.	Date of Admission Revised
☐ **C. Home and Community Based Services Placement in a Private Home (HCBS) Code: 299**			
Physical Address		Phone No.	Date of Admission
☐ **D. Community Care Foster Family Home (HCBS) Code 299 *** CMA ONLY			
Caregiver Name		Date of Admission	Revised
Physical Address		Phone No.	
Assisted Living Facility (ALF) D1 (Dom. Level I, CCFFH or EARCH) D2 (Dom. Level II, EARCH only)			
Caregiver Name		Date of Admission	Revised
Physical Address		Phone No.	
☐ **E. Going Home Plus (Codes-Check one) Aged (131) Disabled (132) I/DD (403) ***			
Living Setting: HO (Private Home) Assisted Living Facility (ALF) D1 (Dom. Level I, CCFFH, EARCH, DD DOM, DD AFH)			
Caregiver Name		Date of Admission	Revised
Physical Address		Phone No.	
☐ **F. Intellectual/Developmental Disability Waiver (I/DD) Code: 404** DDD Case Manager ONLY			
Living Setting: HO (Private Home) D1 (Dom. Level I, DD Dom, DD-AFH, E/ARCH) D2 (Dom. Level II, E/ARCH)			
Caregiver Name		Date of Admission Revised	Pending Medicaid
Physical Address		Phone No.	
DHS 1150C attached ADRC 1180 attached (as needed) Medical Expenses Worksheet (attached as needed)			
G. Intermediate Care Facility-I/DD Placement (ICF-I/DD)			
Facility/Address:		Phone No.	Date of Admission Revised
DHS 1150 attached ADRC 1180 attached (as needed)			
SECTION 4: EXISTING LTC BENEFICIARY CHANGE REQUEST *			
Beneficiary no longer eligible for LTC Effective Date NO LOC Date of Death Other Reason:			
Beneficiary changed residence Effective Date Phone No.			
New Physical Address			

APPENDIX L: Medicaid Eligibility for Long-Term Care Services

TO: Living Setting	HO (Private Home) Assisted Living Facility Nursing Facility ICF/ID Facility D1 (Domiciliary Level I, DD Dom, DD-AFH, E/ARCH, CCFFH) D2 (Domiciliary Level II, E/ARCH)
New Caregiver Name and Physical Address	
Other/Comments:	
SECTION 5: LTC ELIGIBILITY DETERMINATION (completed by MQD)	**Medicaid Approval Date:**
LTC Services Effective Date(s)	☐ Denied/Date ☐ Terminated/Date_____
Denial Reason: Excess Assets/Resources Transfer of Assets Excess Property No LOC Failure to Provide	
Other/Comments:	
Change does not affect Medicaid eligibility	No Cost Share Cost Share $_____
Spousal/Dependent Contribution Applied $_____	
MQD Eligibility Staff (Print Name and Signature)	Response Date

DHS 1148 (Rev. 02/2022)

APPENDICES

APPENDIX L: Medicaid Eligibility for Long-Term Care Services

INSTRUCTIONS

DHS 1148 (Rev. 02/2022)

MEDICAID ELIGIBILITY FOR LONG-TERM CARE (LTC) SERVICES

PURPOSE:

An Authorized Medicaid Provider such as the Med-QUEST Health Plan, Nursing Home and Intermediate Care (ICF-ID) Facilities or Hospital Waitlist (WL), Case Management Agencies (CMA) or Developmental Disabilities Division (DDD) Case Manager, shall use the DHS 1148, "Medicaid Eligibility for Long-Term Care (LTC) Services" form for a Medicaid applicant or beneficiary requesting Long-Term Care (LTC) services.

GENERAL INSTRUCTIONS:

An Authorized Medicaid Provider shall complete and route this form to MQD. MQD shall review the information submitted on this form and determine applicant/beneficiary eligibility for LTC services. If an individual is determined eligible for LTC services, MQD shall transfer information on this form into the Kauhale On-Line Eligibility Assistance (KOLEA) system. Re-evaluations shall be completed at least annually for beneficiaries that are receiving home and community- based services to determine if the beneficiary continues to need the level of care provided. Note: The revised DHS 1148 incorporates the DHS 1138 and 1138A forms, which have been rescinded. (See ICF Revised DHS 1148 "Medicaid Eligibility for Long-Term Care Services" Form.)

SECTION 1: AUTHORIZED MEDICAID PROVIDER AND MED-QUEST DIVISION

All requested information in Section 1 must be completed by the Authorized Medicaid Provider as applicable.

SECTION 2: APPLICANT/BENEFICIARY INFORMATION (completed by Authorized Medicaid provider)

All requested information in Section 2 must be completed by the Authorized Medicaid Provider as applicable.

SECTION 3: NEW ADMISSION OF LONG-TERM CARE (LTC) SERVICES REQUEST (completed by Authorized Medicaid provider)

Approved LTC: The DHS 1147, DHS 1150 or DHS 1150C must be selected as evidence that Level of Care was approved in addition to the Start and End Date of Level of Care approval for I/DD services, where indicated.

For section **3.A.-3. G**, please select which type of LTC placement applicant/beneficiary is requesting and complete the placement contact information. The Authorized Medicaid Provider must complete the "Date of Admission" and attach the DHS 1150 and DHS 1150c forms.

Note: If the date of admission is delayed or changed the Authorized Medicaid Provider will need to resubmit the DHS 1148, and in this section, they will select the "Revised" box and complete "Date of Admission" with the new date.

Living Setting:

HCBS Program Enrollment and GHP Codes	Living Setting
• Home and Community Based Services (HCBS 299) • Going Home Plus (Aged 131, Disabled 132, I/DD-403) • Intellectual/Developmental Disability Waiver (I/DD-404)	• **HO**-Home and Community Based Services in a Private Home **ALF** Assisted Living Facility • **D1**-Domicilliary Level I- Community Care Foster Family Home (CCFFH), Adult Residential Care Home (E/ARCH), DD-Dom or DD-AFH. • **D2**-Domicilliary Level II- E/ARCH only

SECTION 4: EXISTING LTC BENEFICIARY CHANGE REQUEST (completed by Authorized Medicaid provider)

If there are any changes in applicant/beneficiary LTC request, the Authorized Medicaid Provider shall complete all information requested in Section 4.

SECTION 5: LTC ELIGIBILITY DETERMINATION (completed by MQD)

MQD eligibility staff shall complete all information in Section 5 as appropriate and inform the Authorized Medicaid Provider/requesting party of the applicant/beneficiary LTC services determination. Once Completed MQD Eligibility Staff shall print their name, sign, and date the completed form.

If you have additional questions regarding the completion of this form, please email amanuel@dhs.hawaii.gov or call (808) 692-8109.

FILING/DISTRIBUTION INSTRUCTIONS:

MQD shall complete the DHS 1148 and shall:

1) Send the response/referral to the referring party; and
2) File/scan a copy in the case record and update form information as appropriate to LTC section in KOLEA.

APPENDIX M: Eligibility Diagnoses for QI Specialized BHS

CAMHD Support for Emotional and Behavior Development (SEBD) Program for Members 3 through 20 Years Old

A) Eligible SEBD Diagnoses:

1. Demonstrates the presence of a primary DSM (most current edition) Axis I diagnosis for at least six (6) months or is expected to demonstrate the diagnosis for the next six (6) months. See excluded diagnoses in the next section.

B) Excluded SEBD Diagnoses*

1. *Mental Retardation** (317, 318.0, 318.1, 318.2, 319)
2. Pervasive Developmental Disorders** (299.0, 299.80, 299.10)
3. Learning Disorders (315.0, 315.1, 315.2, 315.9)
4. Motor Skills Disorders (315.3)
5. Communication Disorders (315.31, 315.32, 315.39, 307.0, 307.9)
6. Substance Abuse Disorders
7. Mental Disorders Due to a General Medical Condition
8. Delirium, Dementia, Amnestic, and other Cognitive Disorders
9. Factitious Disorders
10. Feeding Disorders of Infancy or Childhood
11. Elimination Disorders
12. Sexual Dysfunctions
13. Sleep Disorders

*If a diagnosis listed above is the **ONLY** DSM (most current edition) diagnosis, the child/youth is ineligible for SEBD services. However, these diagnoses may and often do co-exist with other DSM diagnoses, which would not make the child/youth ineligible for SEBD services.

**Co-occurring diagnoses of Mental Retardation and Pervasive Developmental Disorders require close collaboration and coordination with

State of Hawai'i Department of Health (DOH) and State of Hawai'i Department of Education (DOE) services. The Health Plan, with CAMHD, is responsible for coordinating these services. These diagnoses may be subject to a forty-five (45) day limit on hospital-based residential services, after which utilization review and coordination of services with DOE need to occur.

CCS - Severe Mental Illness/Serious and Persistent Mental Illness (SMI/SPMI) Program for Members ≥18 Years Old

A) Eligible CCS Diagnoses:

1. Substance-Induced Psychosis:
    a. Alcohol-Induced Psychosis (F10.15x, F10.25x, F10.95)
    b. Opioid-Induced Psychosis (F11.15x, F11.25x, F11.95x)
    c. Cannabis-Induced Psychosis (F12.15x, F12.25x, F12.95x)
    d. Sedative-Induced Psychosis (F13.15x, F13.25x, F13.95x)
    e. Cocaine-Induced Psychosis (F14.15x, F14.25x, F14.95x)
    f. Other Stimulant-Induced Psychosis (F15.15x, F15.25x, F15.95x)
    g. Hallucinogen-Induced Psychosis (F16.15x, F16.25x, F16.95x)
    h. Inhalant-Induced Psychosis (F18.15x, F18.25x, F18.95x)
    i. Other Substance-Induced Psychosis (F19.15x, F19.25x, F19.95x)
2. PTSD (F43.1x)
3. Schizophrenia (F20.x, includes Schizophreniform disorder F20.81)
4. Schizoaffective Disorder (F25.x)
5. Delusional Disorder (F22)
6. Bipolar Disorder (F30.xx, F31.xx)
7. Major Depressive Disorder, Severe: (F32.3, F33.2, F33.3)

APPENDIX N: Behavioral Health Service Delivery

	Adults without SMI/ SPMI	Adults with SMI/ SPMI	Adults with SMI/ SPMI Enrolled in AMHD	Adults with SMI/SP MI Enrolled in CCS	Children with SEBD Enrolled in CAMHD
Standard Behavioral Health Services					
Acute Psychiatric Hospitalization	HP	HP	HP	CCS	HP
Diagnostic/laboratory Services	HP	HP	HP	CCS	HP
Electroconvulsive Therapy	HP	HP	HP	CCS	HP
Evaluation and Management	HP	HP	HP	CCS	CAMHD/HP
Methadone Treatment	HP	HP	HP	CCS	HP
Prescription Medications	HP	HP	HP	CCS	HP
Substance Abuse Treatment	HP	HP	HP	CCS	HP
Transportation	HP	HP	HP	CCS	HP
Specialized State Plan Behavioral Health Services					
Biopsychosocial Rehabilitation	n/a	HP	AMHD	CCS	n/a
Community Based Residential Programs	n/a	n/a	n/a	n/a	CAMHD
Crisis Management	n/a	HP	AMHD	CCS	CAMHD
Crisis Residential Services	n/a	n/a	AMHD	CCS	CAMHD
Hospital-based Residential Services	n/a	n/a	n/a	n/a	CAMHD
Intensive Case Management	n/a	n/a	AMHD	CCS	CAMHD
Intensive Family Intervention	n/a	n/a	n/a	n/a	CAMHD
Intensive Outpatient Hospital Services	n/a	n/a	AMHD	CCS	CAMHD
Therapeutic Living Supports and Therapeutic Foster Care Supports	n/a	n/a	AMHD	CCS	CAMHD
Specialized 1115 Behavioral Health Services					
Clubhouse	n/a	n/a	AMHD	CCS	n/a

APPENDICES

APPENDIX N: Behavioral Health Service Delivery

	Adults without SMI/ SPMI	Adults with SMI/ SPMI	Adults with SMI/ SPMI Enrolled in AMHD	Adults with SMI/SP MI Enrolled in CCS	Children with SEBD Enrolled in CAMHD
Peer Specialist	n/a	n/a	AMHD	CCS	n/a
Representative Payee	n/a	n/a	AMHD	CCS	n/a
Supportive Employment	n/a	n/a	AMHD	CCS	n/a
Supportive Housing	n/a	n/a	AMHD	CCS	n/a

Legend:

ABD	Aged, Blind, or Disabled
AMHD	Adult Mental Health Division in the Department of Health
HP	Health Plan
CAMHD	Child and Adolescent Mental Health Division in the Department of Health
CCS	Community Care Services program
SEBD	Support for Emotional and Behavioral Development
SMI	Severe Mental Illness
SPMI	Serious and Persistent Mental Illness

APPENDIX O: Details of Covered Behavioral Health Services

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
Payment methods	N/A	**Payment to Health Plans** Capitation	**Payment to DOH-AMHD** Billed FFS to DHS	**Payment to the Behavioral Health Organization** Capitation/FFS	**Payment to DOH- CAMHD** Billed FFS to DHS
Standard Behavioral Health Services					
Acute psychiatric hospitalization	Hospitals licensed to provide psychiatric services	Twenty-four (24) hour care for acute psychiatric illnesses including: ○ Room and board ○ Nursing care ○ Medical supplies and equipment ○ Diagnostic services ○ Physician services ○ Other practitioner services as needed ○ Other medically-necessary services ○ Pharmaceuticals ○ Rehabilitation	Provided by Health Plan	Twenty-four (24) hour care for acute psychiatric illnesses including: ○ Room and board ○ Nursing care ○ Medical supplies and equipment ○ Diagnostic services ○ Psychiatric services ○ Other practitioner services, as needed ○ Physical, occupational, speech, and language therapy ○ Post-	Provided by Health Plan

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
		services, as needed		stabilization services ○ Other medically-necessary services	
Diagnostic/ laboratory services	Laboratories	Diagnostic/ laboratory services including: ○ Psychological testing ○ Screening for drug and alcohol problems ○ Other medically-necessary diagnostic services	Provided by Health Plan	Diagnostic/ laboratory services including: ○ Psychological testing ○ Psychiatric or psychological evaluation and treatment (including neuropsychological evaluation) ○ Psychosocial history ○ Screening for and monitoring treatment of mental illness and substance use shall include tobacco and alcohol use disorders ○ Other medically-necessary behavioral	Provided by Health Plan

APPENDIX O: Details of Covered Behavioral Health Services

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
				health diagnostic services to include labs.	
Electro convulsive therapy (ECT)	Acute psychiatric	ECT	Provided by Health Plan	ECT	Provided by Health Plan
	Hospital outpatient facility	○ Medically-necessary, may do more than one/day ○ Inclusive of anesthesia		○ Medically-necessary, may do more than one/day ○ Inclusive of anesthesia	
Evaluation and management	Qualified licensed behavioral health professional: psychiatrists, psychologists, behavioral health advanced practice registered nurse (APRN) with prescriptive authority (APRN Rx), clinical social workers, mental health counselors, and marriage family therapists	Psychiatric or psychological evaluation Individual and group counseling and monitoring	Psychiatric or psychological evaluation for SMI/SPMI Individual and group counseling and monitoring for SMI/SPMI Health Plan provides individual and group counseling and monitoring for non-SMI/SPMI	Psychiatric or psychological (including neuro-psychological evaluation) for SMI/SPMI Individual, group therapy and counseling and monitoring for SMI/SPMI Health Plan provides individual and group counseling and monitoring for non-SMI/SPMI	Psychiatric, psychological or neuro-psychological evaluation for SEBD Individual and group counseling and monitoring for children requiring SEBD Health Plan provides individual and group counseling and monitoring for all other children

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
Methadone treatment	Methadone clinics	Methadone treatment services which include the provision of methadone or a suitable alternative (e.g., LAAM), as well as outpatient counseling services	Provided by Health Plan	Methadone treatment services which include the provision of methadone or a suitable alternative (e.g., LAAM or buprenorphine), as well as outpatient counseling services	Provided by Health Plan
Prescription medications	Providers licensed to prescribe (e.g., psychiatrist and APRN Rx). Medications are dispensed by licensed pharmacies.	Prescribed drugs including medication management and patient counseling	Provided by Health Plan	Prescription medications that are determined medically-necessary to optimize Member's psychiatric/medical condition. Medication manage-ment and patient counseling are also included in this service.	Provided by Health Plan

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
Substance use treatment	Certified substance use counselors* Specialized residential treatment facilities Facilities licensed to perform substance use treatment	Substance use – residential: ○ Medically-necessary services based on American Society of Addiction Medicine (ASAM) Substance use – out-patient: ○ Screening ○ Treatment and treatment planning ○ Therapy/counseling ○ Therapeutic support & education ○ Homebound services ○ Continuous treatment teams ○ Other medically-necessary ○ Screening for drugs and alcohol	Provided by Health Plan	Assures that Members have access to residential and outpatient substance use resources and providers including [Certified Substance Abuse Counselors (CSAC)] Substance use – residential: ○ Medically-necessary services based on American Society of Addiction Medicine (ASAM) Substance use – out-patient: ○ Screening ○ Treatment and treatment planning ○ Therapy/ counseling ○ Therapeutic support & education	Provided by Health Plan

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
				○ Homebound services ○ Continuous treatment teams ○ Other medically-necessary ○ Screening for drugs and alcohol	
Transportation	Approved transportation providers to include medical vans, taxi cabs, bus services, and handicap bus services.	Transportation Air Ground for medically-necessary services	Provided by Health Plan	Transportation Air Ground for medically-necessary services Accessible transportation services Emergency medical transportation Non-medical transportation	Provided by Health Plan
Specialized Behavioral Health Services					
Biopsychosocial rehabilitative programs	AMHD Qualified mental health provider**		Psychosocial rehabilitative programs	Psychosocial rehabilitative programs Psycho-social rehabilitation/ rehabilitative/ rehabilitation services (including	Not provided

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
				clubhouse) in inpatient and/or outpatient settings.	
Clubhouse*	AMHD		Beneficiaries participate in programs that support them in obtaining employment, Education, and housing.	Beneficiaries participate in Clubhouse program services that support them in obtaining social skills, employment, education, housing, and personal independence	Not provided
Community-based residential programs	Small homes certified to perform community-based residential programs. Each home is staffed with several qualified mental health professionals.	Not provided	These programs provide twenty-four (24) hour integrated services that address behavioral health needs.	N/A	These programs provide twenty-four (24) hour integrated evidence-based services that address the behavioral and emotional problems related to sexual offending, aggression, or deviance, which prevent the youth from taking part in family and/or community life.

APPENDICES

APPENDIX O: Details of Covered Behavioral Health Services

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
Crisis management	Qualified mental health provider**	Crisis management services ○ 24-hour crisis hotline ○ Mobile outreach services ○ Crisis intervention/ stabilization services	Crisis management services ○ 24-hour crisis hotline ○ Mobile outreach services ○ Crisis intervention/ stabilization services	Crisis management services ○ 24-hour crisis hotline ○ Mobile outreach services ○ Crisis intervention/ stabilization services Ambulatory BH services includes 24-hr, 7 days/ week ER/crisis intervention: ○ Mobile crisis response ○ Crisis stabilization ○ Crisis hotline ○ Crisis residential services	Crisis management services ○ 24-hour crisis hotline ○ Mobile outreach services ○ Crisis intervention/ stabilization services
Crisis residential services	Qualified mental health provider**	Not provided	Crisis residential services	Crisis residential services ○ Individualized housing crisis plan ○ Housing crisis management	Crisis residential services

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
				○ Work to ensure crisis resolution	
Hospital-based residential programs	Acute psychiatric hospital	Not provided	Not provided	N/A	Hospital-based residential treatment
Intensive case management	Qualified mental health provider** Health Plan	Service coordination	Intensive case management/ community-based case management Targeted case management	Intensive case management ○ Case assessment ○ Case planning (service and care planning) ○ Outreach ○ Ongoing monitoring and service coordination ○ Coordination with Member's Health Plan and PCP	Intensive case management/ community-based case management Targeted case management

APPENDIX O: Details of Covered Behavioral Health Services

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
Intensive family intervention	Qualified licensed behavioral health professional: psychiatrists, psychologists, behavioral health advanced practice registered nurse (APRN) with prescriptive authority (APRN Rx), clinical social workers, mental health counselors, and marriage family therapists	Not provided	Not provided	Therapeutic services include: ○ Family therapy and aftercare ○ Caregiver/ family support ○ Family/ collateral therapeutic support and education ○ Family counseling ○ Ensures meaningful participation by family/ significant others in ITP	Intensive family intervention

APPENDIX O: Details of Covered Behavioral Health Services

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
Intensive outpatient hospital services	Acute psychiatric hospitals Qualified mental health provider**		Intensive outpatient hospital services ○ Medication management ○ Pharmaceuticals ○ Medical supplies ○ Diagnostic testing ○ Therapeutic services including individual, family, and group therapy and aftercare ○ Other medically-necessary services	Partial hospitalization or intensive outpatient hospital services: ○ Medication management ○ Pharmaceuticals ○ Prescribed drugs ○ Medical supplies ○ Diagnostic testing ○ Therapeutic services including individual, family, and group therapy and aftercare ○ Other medically-necessary services	Intensive outpatient hospital services: ○ Medication management ○ Pharmaceuticals ○ Medical supplies ○ Diagnostic testing ○ Therapeutic services including individual, family, and group therapy ○ Other medically-necessary services

APPENDIX O: Details of Covered Behavioral Health Services

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
Peer specialist*	Certified peer specialists		Structured activities within a peer support center that promote socialization, recovery, wellness, self-advocacy, development of natural supports, and maintenance of community skills.	Peer specialist (Someone who has gone through the same or similar life experience as the Member, and will collaborate with the Community Health Worker to address and support the Member's needs and goals in a holistic manner.) Structured activities within a peer support center that promote socialization, recovery, wellness, self- advocacy, development of natural supports, and maintenance of community skills.	Not provided
Representative payee*	Qualified mental health provider**	Not provided	Assist beneficiary in managing their financial status.	Assist beneficiary in managing their financial status.	Not provided
Supportive employment*	Qualified mental health provider**	Not provided	Activities to obtain and sustain paid work by beneficiaries.	Activities to obtain and sustain paid work by	Not provided

				beneficiaries. Services include: ○ Work assessment ○ Discovery pre-employment service ○ Job skills training/ coaching ○ Employment activities with goal to promote community integration	
Supportive housing*	Qualified mental health provider**	Not provided	Housing-based care management focused on ensuring housing stability.	Housing-based care management focused on ensuring housing stability. Ensure Members are provided the CIS needed to secure and maintain permanent housing.	Not provided
Therapeutic living supports and therapeutic foster care supports	Specialized residential treatment facility		Specialized residential treatment facilities	Therapeutic living supports to include specialized residential treatment facilities for CCS Members with substance use disorders (SUD)	Therapeutic living and therapeutic foster care supports

APPENDIX O: Details of Covered Behavioral Health Services

Legend:

*	Approved waiver services.
**	Medicaid provider that offers multiple behavioral health services in one organization in order to provide continuity for the members/participants in the behavioral health program. Qualified providers are licensed or certified as required by Hawai'i Revised Statutes.

APPENDIX P: Referral for SMI CCS Program

DHS 1157

State of Hawaii
Department of Human Services

Med-QUEST Division, Clinical Standards Office

REFERRAL FOR SERIOUS MENTAL ILLNESS (SMI) COMMUNITY CARE SERVICES (CCS) PROGRAM

CLIENT NAME _____ ☐ MALE ☐ FEMALE
Last First M.I.

HOME ADDRESS _____ PHONE NO. _____

_____ CASE NO. _____

MAILING ADDRESS _____ CLIENT ID NO. _____

_____ SOCIAL SECURITY NUMBER _____

DATE OF BIRTH _____ AGE _____ COUNTY ☐ OAHU ☐ HAWAII ☐ MAUI ☐ KAUAI

HEALTH PLAN: ☐ UNITED HEALTHCARE ☐ OHANA ☐ ALOHA CARE ☐ HMSA ☐ KAISER FOUNDATION

PRIMARY DIAGNOSIS _____ DSMIV CODE _____

SECONDARY DIAGNOSIS _____ DSMIV CODE _____

CURRENT MEDICAL CONDITIONS (Indicate, if none) _____

_____

DATE OF REFERRAL: _____ NAME OF PCP: _____ PCP NOTIFIED: Y / N

HOSPITALIZATIONS	**CURRENTLY AT:** ☐ **Castle** ☐ **Queen's** ☐ **Other:** _____ *(list)* **Admitted on** _____/_____/_____			
Past Hospitalizations- Facility	Location	Date Admitted	Date Discharged	Diagnosis
MEDICATIONS	Strength	Dosage	Start Date	End Date
OUTPATIENT THERAPISTS	Diagnosis		Start Date	End Date

Section below to be completed by MQD/CSO Evaluation Panel

Date of Evaluation _____ Date of Enrollment/Disenrollment of CCS Services_____

Approved for CCS Referral: ☐ Yes ☐ No ☐ Additional Information Needed

Re-Evaluation Required: ☐ Yes ☐ No If Yes, date to be re-evaluated: ____/____/____

Reason for denial/comments _____

_____

_____

Signature: _____

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State of Hawaii
Office
Department of Human Services

Med-QUEST Division, Clinical Standards

FOR ADULTS ONLY

Client Name: _____ Client I.D. No.: _____

I. MENTAL STATES

A. General:

1. Appearance: Within Normal Limits [ ] Other [ ] _____
2. Dress: Appropriate [ ] Bizarre [ ] Clean [ ] Dirty [ ]
3. Grooming: Neat [ ] Disheveled [ ] Needs improvement [ ]

B. Behavior:

1. Eye Contact: Good [ ] Fair [ ] Poor [ ]
2. Posture: Good [ ] Slumped [ ] Rigid [ ] Other [ ] _____
3. Body Movements: None [ ] Involuntary [ ] Akathisia [ ] Other [ ] _____

C. Speech: Clear [ ] Mumbled [ ] Rapid [ ] Whispers [ ] Monotone [ ]
Slurred [ ] Slow [ ] Loud [ ] Constant [ ] Mute [ ]
Other [ ] _____

D. Mood: Anxious [ ] Fearful [ ] Friendly [ ] Euphoric [ ] Calm [ ]
Aggressive [ ] Hostile [ ] Depressed [ ]
Other [ ] _____

E. Affect: Full range [ ] Flat [ ] Constricted [ ] Inappropriate [ ]
Other [ ] _____

F. Thought:

1. Process or Form: Loose associations [ ] Poverty of content [ ] Flight of ideas [ ]
Neologism [ ] Perseveration [ ] Blocking [ ]
2. Content: Delusions [ ] Thought broadcasting [ ]
Thought insertion [ ] Thought withdrawal [ ] Other [ ] _____

G. Perception – Hallucinations:

Auditory [ ] Tactile [ ] Somatic [ ] Other [ ] _____

H. Reality Orientation:

1. Mark all areas which the recipient can name:
Time: Day [ ] Month [ ] Year [ ]
Place: (can describe location) Yes [ ] No [ ]
Person: Self [ ] Family or friend [ ]
2. Memory: Recent intact? Yes [ ] Remote intact: Yes [ ]
No [ ] No [ ]

I. Insight: Aware of illness [ ] Denies illness [ ] Other [ ] _____

J. Judgment: Good [ ] Fair [ ] Poor [ ]

State of Hawaii
Office
Department of Human Services

Med-QUEST Division, Clinical Standards

FOR ADULTS ONLY

Client Name: _____ Client I.D. No.: _____

II. **FUNCTIONAL SCALES:** *(Check and specify any problem(s) in the following areas)*

[ ] **Medical/Physical**

_____

_____

[ ] **Family/Living**

_____

_____

[ ] **Interpersonal Relations**

_____

_____

[ ] **Role Performance**

_____

_____

[ ] **Socio-Legal**

_____

_____

[ ] **Self-Care/Basic Needs**

_____

_____

III. **SUPPORTING DOCUMENTATION:** Please supply additional comprehensive information and assessments (if available) which would be of assistance in the evaluation of the criteria for eligibility.

Signed: _____ Date: _____

Reporting Psychiatrist/Psychologist *(Print Name)*: _____

Reporting Psychiatrist/Psychologist Phone No.: _____

Signed: _____ Date: _____

Medical Director or Attending Physician for in-patients *(Print Name)*: _____

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APPENDIX Q: Dental Services to Treat Medical Conditions

CDT Procedure Code	Description
D7340	Vestibuloplasty-ridge extension (secondary epithelialization)
D7350	Vestibuloplasty-ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)
	Excision of Intra-Osseous Lesions
D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm
D7441	Excision of malignant tumor – lesion diameter over 1.25 cm
	Removal of Cysts and Neoplasms
D7450	Removal of benign odontogenic cyst or tumor lesion diameter up to 1.25 cm
D7451	Removal of benign odontogenic cyst or tumor lesion diameter over 1.25 cm
D7460	Removal of benign non-odontogenic cyst or tumor lesion diameter up to 1.25 cm
D7461	Removal of benign non-odontogenic cyst or tumor lesion diameter over 1.25 cm
D7465	Destruction of lesions by physical methods; electrosurgery, chemotherapy, cryotherapy or laser
	Excision of Bone Tissue
D7471	Removal of lateral exostosis – mandible or maxilla
D7472	Removal of torus palatinus
D7473	Removal of torus mandibularis
D7490	Radical resection of mandible or maxilla
	Surgical Incision
D7511	Incision and drainage of abscess-intra oral soft-tissue-complicated
D7520	Incision and drainage of abscess-extra oral soft tissue

APPENDIX Q: Dental Services to Treat Medical Conditions

CDT Procedure Code	Description
D7530	Removal of foreign body, skin, or subcutaneous alveolar tissue
D7540	Removal of reaction-producing foreign bodies, musculoskeletal system
D7550	Sequestrectomy for osteomyelitis
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body
	Treatment of Fractures - Simple
D7610	Maxilla – open reduction (teeth immobilized if present)
D7620	Maxilla – closed reduction (teeth immobilized if present)
D7630	Mandible – open reduction (teeth immobilized if present)
D7640	Mandible closed reduction (teeth immobilized if present)
D7650	Malar and/or zygomatic arch-open reduction
D7660	Malar and/or zygomatic arch-closed reduction
D7670	Alveolus – Closed reduction, may include stabilization of teeth, splinting
D7671	Alveolus – Open reduction, may include stabilization of teeth, splinting
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches
	Treatment of fractures - Compound
D7710	Maxilla – open reduction
D7720	Maxilla – closed reduction
D7730	Mandible – open reduction
D7740	Mandible – closed reduction
D7750	Malar and/or zygomatic arch-open reduction
D7760	Malar and/or zygomatic arch-closed reduction
D7770	Alveolus – open reduction stabilization of teeth
D7771	Alveolus – closed reduction stabilization of teeth

CDT Procedure Code	Description
D7780	Facial bones – complicated reduction with fixation and multiple surgical approaches
	Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions
D7810	Open reduction of dislocation
D7820	Closed reduction of dislocation
D7830	Manipulation under anesthesia
D7840	Condylectomy
D7850	Surgical discectomy, with/without implant
D7852	Disc repair
D7854	Synovectomy
D7856	Myotomy
D7858	Joint reconstruction
D7860	Arthrotomy
D7870	Arthrocentesis
D7872	Arthroscopy – diagnosis, with or without biopsy
D7873	Arthroscopy – surgical; lavage and lysis of adhesions
D7874	Arthroscopy – surgical; disc repositioning and stabilization
D7875	Arthroscopy – surgical; synovectomy
D7876	Arthroscopy – surgical; discectomy
D7877	Arthroscopy – surgical; debridement
D7880	Occlusal – orthotic devise, by report
	Other Oral Surgery – Repaid of Traumatic Wounds
D7910	Suture of recent small wounds up to 5 cm
D7911	Complicated suture up to 5 cm
D7912	Complicated suture over 5 cm
D7920	Skin grafts (identify defect covered, location and type graft)
	Other Repair Procedures
D7940	Osteoplasty for orthognathic deformities

APPENDIX Q: Dental Services to Treat Medical Conditions

CDT Procedure Code	Description
D7941	Osteotomy – mandibular rami
D7943	Osteotomy mandibular rami with bone graft; including obtaining the graft
D7944	Osteotomy, segmented or subapical, per sextant or quadrant
D7945	Osteotomy, body of mandible
D7946	Le Fort I (maxilla – total)
D7947	Le Fort I (maxilla – segmented)
D7948	Le Fort II or Le Fort III – (osteoplasty of facial bones for midface hypoplasia retrusion) without bone graft)
D7949	Le Fort II or Le Fort III – with bone graft
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla – autogenous or nonautogenous
D7955	Repair of maxillofacial soft and hard tissue defects
D7980	Sialolithotomy
D7981	Excision of salivary glands, by report
D7982	Sialodochoplasty
D7983	Closure of salivary fistula
D7990	Emergency tracheotomy
D7990	Coronoidectomy
D7995	Synthetic graft – mandible or facial bones, by report
D7996	Implant – mandible for augmentation purposes (excluding alveolar ridge), by report
D7997	Appliance removal (not by dentist who replaced appliance), includes removal or arch bar
D7999	Unspecified oral surgery procedure, by report
	Adjunctive General Services
D9222	Deep Sedation/ General Anesthesia – first 15 minutes
D9223	Deep Sedation/ General Anesthesia – each subsequent 15 minute increment

APPENDIX Q: Dental Services to Treat Medical Conditions

CDT Procedure Code	Description
D9420	Hospital or Ambulatory Surgical Center Call (limitation: Confinement must be approved; only under Physician's request; no routine follow up visits)

Rev. 03/2021

APPENDIX R: Hysterectomy Acknowledgement Form

DHS 1145

State of Hawaii
Department of Human Services

Med-QUEST Division

HYSTERECTOMY ACKNOWLEDGEMENT

Identification Number	Name of Health Plan	Patient's Full Name (Last, First, M.I.)	Sex M ( ) F ( )	Birthdate / /

I have informed _____
Name of Person to have Hysterectomy

or _____ orally and by this statement that the
Name of Her Representative, If Applicable

Hysterectomy she is to have will render her permanently incapable of reproducing.

_____ _____
Signature of Person Obtaining Authorization to Perform the Hysterectomy — Date

TO BE COMPLETED BY PATIENT OR HER REPRESENTATIVE

I acknowledge that I received the above information,

_____ _____
Signature of Person Having the Hysterectomy — Date

Or, if applicable:

_____ _____
Signature of Her Representative — Date

DHS 1145 (Rev. 6/20) Page 1 of 1 Original – Physician Second Copy - Patient

APPENDIX S: Consent for Sterilization Form

HHS-687

Form Approved: OMB No. 0937-0166
Expiration date: 4/30/2022

CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____ (*Doctor or Clinic*). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____ (*Specify Type of Operation*). The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: _____ (*Date*)

I, _____, hereby consent of my own free will to be sterilized by _____ (*Doctor or Clinic*) by a method called _____ (*Specify Type of Operation*). My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ (*Signature*) _____ (*Date*)

You are requested to supply the following information, but it is not required: *(Ethnicity and Race Designation) (please check)*

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (mark one or more):
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ (*Interpreter's Signature*) _____ (*Date*)

HHS-687 (04/22)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ (*Name of Individual*) signed the consent form, I explained to him/her the nature of sterilization operation _____ (*Specify Type of Operation*), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

_____ (*Signature of Person Obtaining Consent*) _____ (*Date*)

_____ (*Facility*)

_____ (*Address*)

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon _____ (*Name of Individual*) on _____ (*Date of Sterilization*)

I explained to him/her the nature of the sterilization operation _____ (*Specify Type of Operation*), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraph**: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery
  Individual's expected date of delivery: _____
- ☐ Emergency abdominal surgery *(describe circumstances)*:

_____

_____

_____ (*Physician's Signature*) _____ (*Date*)

PAPERWORK REDUCTION ACT STATEMENT

A Federal agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays the currently valid OMB control number. Public reporting burden for this collection of information will vary; however, we estimate an average of one hour per response, including for reviewing instructions, gathering and maintaining the necessary data, and disclosing the information. Send any comment regarding the burden estimate or any other aspect of this collection of information to the OS Reports Clearance Officer, ASBTF/Budget Room 503 HHH Building, 200 Independence Avenue, SW., Washington, DC 20201.

Respondents should be informed that the collection of information requested on this form is authorized by 42 CFR part 50, subpart B, relating to the sterilization of persons in federally assisted public health programs. The purpose of requesting this information is to ensure that individuals requesting sterilization receive information regarding the risks, benefits and consequences, and to assure the voluntary and informed consent of all persons undergoing sterilization procedures in federally assisted public health programs. Although not required, respondents are requested to supply information on their race and ethnicity. Failure to provide the other information requested on this consent form, and to sign this consent form, may result in an inability to receive sterilization procedures funded through federally assisted public health programs.

All information as to personal facts and circumstances obtained through this form will be held confidential, and not disclosed without the individual's consent, pursuant to any applicable confidentiality regulations. [43 FR 52165, Nov. 8, 1978, as amended at 58 FR 33343, June 17, 1993; 68 FR 12308, Mar. 14, 2003]

HHS-687 (04/22)

APPENDIX T: Medical Standard Records

A) As part of the record standards, the Health Plan will require that providers adhere to the following requirements:

1. All medical records are maintained in a detailed and comprehensive manner that conforms to good professional medical practice;
2. All medical records are maintained in a manner that permits effective professional medical review and medical audit processes;
3. All medical records are maintained in a manner that facilitates an adequate system for follow-up treatment;
4. All medical records will be legible, signed and dated;
5. Each page of the paper or electronic record includes the patient's name or ID number;
6. All medical records contain patient demographic information, including age, sex, address, home and work telephone numbers, marital status and employment, if applicable;
7. All medical records contain information on any adverse drug reactions and/or food or other allergies, or the absence of known allergies, which are posted in a prominent area on the medical record;
8. All forms or notes have a notation regarding follow-up care, calls or visits, when indicated;
9. All medical records contain the patient's past medical history that is easily identified and includes serious accidents, hospitalizations, operations and illnesses. For children, past medical history including prenatal care and birth;

10. All pediatric medical records include a complete immunization record or documentation that immunizations are up-to-date;
11. All medical records contain a history of screenings performed and the findings of those screenings, along with appropriate follow up actions, as needed, including counseling and interventions provided as well as referral actions taken;
12. All medical records include provisional and confirmed diagnosis(es);
13. All medical records contain medication information;
14. All medical records contain information on the identification of current problems (i.e., significant illnesses, medical conditions, and health maintenance concerns);
15. All medical records contain information about consultations, referrals, additional medical supports offered through health coordination, and specialist reports;
16. All medical records contain information about emergency care rendered with a discussion of requirements for physician follow-up;
17. All medical records contain discharge summaries for: (1) all hospital admissions that occur while the member is enrolled; and (2) prior admissions as appropriate;
18. All medical records for members eighteen (18) years of age or older include documentation as to whether or not the member has executed an advance directive, including an advance mental health care directive;
19. All medical records will contain written documentation of a rendered, ordered or prescribed service, including documentation of medical necessity; and

20. All medical records will contain documented patient visits, which includes, but is not limited to:
    a. A history and physical exam;
    b. Treatment plan, progress and changes in treatment plan;
    c. Laboratory and other studies ordered, as appropriate;
    d. Working diagnosis(es) consistent with findings;
    e. Treatment, therapies, and other prescribed regimens;
    f. Documentation concerning follow-up care, telephone calls, emails, other electronic communication, or visits, when indicated;
    g. Documentation reflecting that any unresolved concerns from previous visits are addressed in subsequent visits;
    h. Documentation of any referrals and results thereof, including evidence that the ordering physician has reviewed consultation, lab, x-ray, and other diagnostic test results/reports filed in the medical records and evidence that consultations and significantly abnormal lab and imaging study results specifically note physician follow-up plans;
    i. Hospitalizations and/or emergency department visits, if applicable; and
    j. All other aspects of patient care, including ancillary services.

APPENDIX U: Financial Responsibility Guideline for QI and CCS Health Plans

A) IP Facility:

1. If only billing BH rev codes, then CCS pays all.
2. If only billing medical rev codes with primary dx of BH, then CCS pays all.
3. If only billing medical rev codes with primary dx is medical, QI pays all.
4. If only billing medical rev codes with primary admitting dx of BH, but primary dx is medical, then QI pays all (i.e., metastatic cancer discovery).
5. If both BH and medical rev codes, but discharge dx is BH, then CCS pays. (overflow from Kekela)
6. If both BH and medical rev codes, then BH rev codes, then CCS should pay. QI pays for all other rev codes. Bill is split by day proportional.
7. Sample Scenarios in which CCS would be payor.
    a. Admitted for psychiatric care but requires infectious disease treatment/clearance for scabies or MRSA on medical floor. CCS is payor.
8. Sample Scenarios in which QI plan would be payor
    a. Admitted for obstetrical care and has concurrent psychiatric care.
    b. Admitted for psychiatric care but required surgical intervention. Surgery and follow up treatment QI payor.

B) OP Facility:

1. Based on ordering MD's specialty, either CCS or QI.

C) Professional:

1. Based on specialty, either CCS or QI.

D) Supportive Housing Services (SHS):

1. For eligible CCS members, CCS pays all SHS.

APPENDIX V: SBIRT Process to Treatment:

A) **Pre- Screening**: (A pre-screening may be administered by a delegate and the authorized provider is responsible for tallying the score).

1. Alcohol Use: *Audit C*
2. Drug Use: *Single-item drug screen question* "How many times in the past year have you used an illegal drug…"
3. Mental Health:
    a. *PHQ-2* inquiries about the frequency of depressed mood and anhedonia over the past two weeks. PHQ-2 is not an established diagnosis to monitor depression severity, but rather to screen for depression in a "first step" approach. Positive results will be further evaluated with a full screening of the PHQ-9.
    b. *GAD-2* is the item 2 form of the GAD-7. A score of greater than or equal to 2 is a positive pre-screen

B) **Full Screening**: Indicated for patients with a positive brief screen. Any evidence-based tools such as: AUDIT, DAST 10, and CRAFFT can be used to categorize the patient's substance use.

1. Alcohol: If positive on the AUDIT-C, *AUDIT s*creen is used. Responses in AUDIT can be used in your BI
2. Drug Use: If positive on the Single item drug Screening, *DAST-10* is used. Responses in *DAST 10* can be used in the BI
3. Both alcohol and/or drug use: *CAGE-AID* used for Adults; *CRAFFT* and *ASSIST* used for Children and Youth.
4. Mental Health:

a. If positive on the PHQ-2, then the PHQ-9 is used to determine whether they meet criteria for depressive disorder.

b. *GAD-7* is self-administered when the GAD-2 is positive. The GAD-7 has seven items, which measure severity of various signs of GAD (General Anxiety Disorder). Assessment is indicated by the total score, which is determined by adding together the scores of the 7 items.

C) **Brief intervention**: Performed after a full screen. A motivational conversation is held with the patient with the intent of eliciting and supporting healthy behavior change.

D) **Follow up**: Services that occur after initial intervention. Reassessment of patient's status, progress, and/or need for additional services.

1. The questions below are to be asked at a 6 month follow up after completing a SBRIT screening and member was found to need a Brief Intervention or Referral to Treatment.

   a. <u>Follow-up QUESTIONS</u> at six months follow a positive SBIRT and members need BI or RT.

1) Remind the patient of goals discussed during BI or RT and Assess steps/actions taken.

2) When you were here, we talked about your use of alcohol/drugs, and you set a goal to..... (e.g., consider cutting back, not drink and drive, etc.). Tell me about what you've done, any steps you've taken (if any) toward this goal?

3) YES, steps taken: (place information in member's medical record)

4) NO steps taken (place information in member's medical record)

5) Assess/Reaffirm commitment to the patient's goal.

b. Ask about commitment.

1) On a scale of 1-10, how committed are you to… (change)?

2) Why did you give it that number and not a lower number?

3) What would it take to raise that number? 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

4) Not at all Committed

5) Very Committed

6) Have you contacted your health plan or community resource for additional assistance in the last six months? Note type of provider/treatment if disclosed.

7) Contacted someone but didn't set an appointment

8) Set an appointment

9) Went to appointment

10) Offer 24/7 Referral Resource # for additional assistance, if needed.

11) Give positive feedback and encouragement to members.

E) **Referral to treatment**:

1. Indicated for patients who are likely to have substance use disorder (SUD) which requires more in-depth assessment and treatment.

F) **Who can bill for SBIRT:**

1. Per CMS, the current providers allowed to bill MQD are:

   a. Physicians (MDs),

   b. Physician Assistant (PA),

c. Nurse Practitioner (NP),

d. Clinical Nurse Specialist (CNS),

e. Clinical Psychologist (CP),

f. Clinical Social Worker (CSW),

g. Certified Nurse-Midwife (CNM),

h. Independently Practicing Psychologist (IPP)

i. Who are licensed, accredited, or a certified professional who meets the State requirements of a healthcare professional. The above-mentioned provider and/or his/her delegate may receive training. If the provider chooses to utilize a delegate, they are responsible to oversee and monitor delegate. In addition, they have voluntarily undergone SBIRT training provided by ADAD or have been grandfather into the program.

G) **Eligibility:**

1. *All Medicaid beneficiaries who are 12 years and older who are identified positive via the brief screen.

   a. Codes:

#	**SCREENING & BRIEF INTERVENTION**	**Procedure Codes for Screening**	**Diagnosis Codes for All Screens**

APPENDIX V: Screening, Brief Intervention, and referral (SBIRT) Process

1	**Positive** Screen (i.e. Alcohol and/or substance abuse structured screening with brief intervention and/or referral services)	CPT G0396/99408: Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes; CPT G0397/99409: Alcohol and/or substance use structured screening and brief intervention services; greater than 30 minutes	Z71.41 Alcohol abuse counseling and surveillance of alcohol user; and/or Z71.51 Drug abuse counseling and surveillance of drug user; and Additional diagnostic codes applied per clinician discretion
2	**Negative** Screen (i.e. Alcohol and/or substance use structured screening services **without** the need for BI/RT)	H0049: Alcohol and/ or drug screening	Z13.9 Encounter for screening, unspecified

2. *Please note that a modifier code may be added to ensure that there is alignment between the description and the code being used.

H) **What to do with Results:**

1. Positive:

   a. Brief intervention service and note on member's medical file

   b. Member names,

c. SBRIT Scoring,

d. Alcohol and Drug in use at the time of screening,

e. Member pregnant or breastfeeding, and

f. Services rendered

2. Negative:

a. Note within a medical record:

1) Date of Screening

2) SBRIT Scoring,

I) **Referral:**

1. Option 1: In house referral and information noted on member's medical file

a. Member name and confirm current contact information,

b. SBRIT Scoring,

c. Alcohol and Drug in use at the time of screening,

d. Member pregnant or breastfeeding, and

e. Treating Substance Abuse Program or Individual

2. Option 2: Hawaii Cares or MCO-Care Coordinator referrals – this should be done with a member present and no later than COB on the second day that the SBRIT was administered

a. Member names and confirm current contact information,

b. SBRIT Scoring,

c. Alcohol and Drug in use at the time of screening,

d. Member pregnant or breastfeeding, and

J) **Training Requirements:**

1. Class Information:

Class	Information
Tour of Motivational Interviewing	• 4 hours • Online, self-paced training can be accessed at any time (link below) • https://healtheknowledge.org/course/index.php?categoryid=53#TourOfMI
SBIRT 101	• 4 hours • Registration for course enrollment can be accessed online at: • https://psattcelearn.org/courses/4hr_sbirt/

K) **Initial Certification:**

1. Requirement for SBIRT Certification

   a. Participate take the 4-hour SBIRT 101 course, and

   b. Participate take the 4-hour Tour of Motivational Interviewing

L) **Re-Certification Requirement** for SBIRT Certification

1. Every person who has been certified on or before January 2020 will need to be re-certified by 12/30/22 utilizing ADAD approved program.
2. Participate take the 2-hour SBIRT, and
3. Participate take the 2-hour Tour of Motivational Interviewing

   a. Upon completion, a certificate will be generated to the participant. If you are a delegate, please include the name of the PCP you are representing. Upon obtaining your certification, you

should place items inside your locker

on https://adad.dialogedu.com/e-learning . Once ADAD confirms and verifies both certificates, the participant will be informed that they are officially a Hawaii SBIRT Provider. The certification will be valid for a two-year period. MQD will expect that provider, or their delegate will renew their certification by or before the end of the two-year period.

M) **SBIRT TRAINER:**

1. All SBIRT Train the Trainer programs have been suspended until further Notice.
2. At present time all in-person and virtual training done by an ADAD approved SBRIT Trainer or a Grandfather SBIRT trainer have been placed on hold. It's recommended that all providers and their use the ADAD-approved LMS system until further notice.

APPENDIX W: Health and Functional Assessment (HFA), Health Action Plan (HAP), and Personal Assistance and/or Nursing Tool (PANS)

Health and Functional Assessment (HFA) and Health Action Plan (HAP)

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STATE OF HAWAII
Personal Assistance Tool Instructions

A) ***The State recommends that this tool be formatted in Excel for calculation functionality.***

1. **Member Name**- Enter member's legal name (Last, First, Middle Initial). If member has no middle initial, leave blank.
2. **Degree of Assistance**- The assessor will determine the member's degree of assistance.
    a. *Independent*- No assistance, set up, or supervision.
    b. *Minimal*- Able to complete some tasks with assistance, includes oversight, encouragement or cueing, or supervision
    c. *Moderate*- Able to complete some of task but need assistance with most of task
    d. *Total*- Unable to complete tasks on own or needs assistance to complete the task
3. **Suggested Times (Minutes) -** The assessor will enter the minutes based on the Degree of Assistance. Refer to Table 1. Personal Assistance Guidelines for allocating hours. If the minutes exceed the maximum suggested minutes, please document reason in the Justification for Allocation of Hours.

Table 1. Personal Assistance Guidelines

TASKS	Degree of Assistance	
Personal Assistance Level 1		
Routine House Cleaning • Dusting • Cleaning up after personal care tasks (bathing, toileting, meal preparation, etc.) • Cleaning floors in living areas used by member • Cleaning counters, stovetop, washing dishes • Carrying out trash and setting out garbage for pickup • Emptying and cleaning bedside commode • Cleaning bathroom (floor, toilet, tub/shower, sink) • Changing bed linens • Making up bed	**Minimum**	*Lives alone:* Up to 120 minutes per week
		Lives with family or friends: Up to 60 minutes per week
	Moderate	*Lives alone:* Up to 180 minutes per week
		Lives with family or friends: Up to 120 minutes per week
	Total	*Lives alone:* Up to 240 minutes per week
		Lives with family or friends: Up to 180 minutes per week
Laundry • Gathering and sorting • Hand washing garments • Loading and unloading of washer or dryer in residence • Hanging clothes to dry • Folding and putting away clothes • Laundromat	Member has a washer and dryer : Up to 60 minutes per week Member has no washer and dryer but a Laundromat on premises: Up to 90 minutes per week Member has no washer and dryer and Laundromat is not within walking distance: Up to 120 minutes per week	
Shopping/Errands • Preparing shopping list • Grocery shopping • Picking up medication, medical supplies, or household items • Putting groceries away • Paying bills	Members that live alone: Up to 90 minutes per week Member that lives with family or friends: Up to 60 minutes per week	
Transportation/Escort • Transportation arrangements • Accompanying member to doctor's office, clinic or other trips made for the purpose of obtaining medical diagnosis or treatment. • Wait time at the doctor's office or clinic with a member when necessary due to member's condition and/or distance from home.	As needed. Member that live alone: Up to 90 minutes per week visit Member that lives with family or friends: Up to 90 minutes per week visit	
Meal Preparation • Meal planning • Preparing foods • Cooking full meal • Warming up prepared food • Cutting food for member • Serving food • Grinding and pureeing food	**Minimum**	Up to 10 minutes per meal
	Moderate	Up to 20 minutes per meal
	Total	Up to 30 minutes per meal

Other - List Other Personal Assistance Level 1 not listed above, e.g. light yard work, simple home repairs	As needed. Up to 60 minutes per week.	
Personal Assistance Level 2		
Eating/Feeding • Standby assistance and encouragement • Assistance with using eating or drinking utensils or adaptive devices • Spoon feeding • Bottle feeding	**Minimum**	Up to 5 minutes per meal
	Moderate	Up to 20 minutes per meal
	Total	Up to 30 minutes per meal
Bathing • Standby assistance • Drawing water in sink, tub or basin • Hauling/heating water • Gathering and setting up supplies • Assisting with transferred in/out of tub or shower • Sponge bath • Bed bath • Washing, rinsing, and toweling the body or body parts	**Minimum**	Up to 5 minutes per bath
	Moderate	Up to 30 minutes per bath
	Total	Up to 45 minutes per bath
Dressing (Upper and Lower Body) • Undressing • Dressing • Gathering and laying out clothes • Assisting with applying on and removing orthotics or prosthetic devices	**Minimum**	Up to 5 minutes per activity
	Moderate	Up to 20 minutes per activity
	Total	Up to 30 minutes per activity
Grooming/Personal Hygiene • Gathering and laying supplies • Oral care- brushing teeth, cleaning dentures • Shaving facial or body hair • Laying out supplies • Washing hair • Drying hair • Combing/brushing hair • Washing hands and face • Applying nonprescription lotion to skin	**Minimum**	Up to 5 minutes per task
	Moderate	*Female:* Up to 30 minutes per task
		Male: Up to 15 minutes per task
	Total	*Female :* Up to 45 minutes per task
		Male: Up to 30 minutes per task
Toileting (do not include transfer and ambulation) • Standby assistance • Assisting with clothing during toileting • Preparing toileting equipment and supplies • Assisting with feminine hygiene needs • Assisting with toilet hygiene such as use of toilet paper and hand washing • Assisting on/off bed pan • Assisting with urinal • Brief changes • Colostomy bag empty/change • External catheter change • Catheter bag empty/change	**Minimum**	Up to 10 minutes per activity
	Moderate	Up to 20 minutes per activity
	Total	Up to 30 minutes per activity
Ambulation • Assisting member in positioning for use of assistive devices • Standby assistance • Assisting with ambulation using steps • Assisting with ambulation indoors/outdoors	**Minimum**	Up to 5 minutes per activity
	Moderate	Up to 15 per activity
	Total	Up to 30 per activity
Bed Mobility/Transfers • Assisting/repositioning in Bed/Chair • Assisting Chair/Bed transfer • Assisting Toilet transfer • Assisting Car transfer • Hoyer lift transfer	**Minimum**	Up to 5 minutes per activity
	Moderate	Up to 15 per activity
	Total	Up to 30 per activity

Manual Wheelchair Mobility • Assisting Indoors/Outdoors	Up to 30 minutes per day
Medication Assistance • Medication reminding • Getting a glass of water • Bringing medication container to member • Opening medication container at request of member	Up to 15 minutes per day
Other – Other PA2 not listed above • Checking and reporting any equipment or supplies that need to be repaired or replenished. • Taking and recording vital signs, including blood pressure	Up to 30 minutes per day.

4. **Total Minutes of Care Required/Week**
    a. *Frequency/Day*- Enter how many times the member needs the skill done each *day*.
    b. *Minutes/Task*- Enter how many minutes it takes to do the skill each time.
    c. *Days/Week*- Enter how many days a skill is needed in a week. Most skills are done daily, but there may be something like an IM injection that may be done once or twice a week etc.
    d. *Total Minutes/Week*- Minutes will be added up and totaled at the end of column. This provides the assessor the ability to check that all minutes required per week are performed by either Support System or Health Plan Provider.
    e. *For example: A member needs assistance with meal preparation 3 times a day. It takes 10 minutes each time which will total 30 minutes required per day and total 210 minutes per week.*
5. **Total Minutes of Care Performed by Unpaid Support System/Week**
    a. *Frequency Per Day/Total Minutes Per Week*- The assessor will ask how many times a skill is done for the member by Support System which include care provided by family, friends, or other programs such as DDD, DOE etc. Enter how many minutes the member needs the skill done each *day* and place in the appropriate day of the week for each skill.
    b. *Total Minutes/Week*- Minutes will be added up and totaled at the end of column. This provides the assessor the total minutes per week that will be performed by the Support System.
    c. For example: Support System will provide assistance with meal preparation 2 times daily, 20 minutes per day, which total 140 minutes per week.
6. **Total Minutes of Care Performed by Health Plan Provider/Week**
    a. *Frequency Per Day/Total Minutes Per Week*- The assessor must calculate the Health Plan Provider frequency of skills each day and the total time based on all the information entered into the form.
    b. *Total Minutes/Week*- Minutes will be added up and totaled at the end of column. This provides the assessor the total minutes per week that will be performed by the Health Plan Provider.
    c. *For example: The Paid Caregiver will provide meal preparation 1 time daily, 10 minutes per day, which total 70 minutes per week.*
7. **Subtotal Skilled Minutes/Week**
    a. Total Minutes of Care Required/Week- Total time the skills take to perform per week.
    b. Total Minutes of Care Performed by Support System/Week- Total time the Support System performs per week.
    c. Total Minutes of Care Performed by Health Plan Provider/Week-Total time the Health Plan Provider will perform per week.
8. **Final Calculation of Hours**
    a. The assessor will recheck totals and then calculate total minutes to hours.

b. All fields will need to be populated:

Total Minutes of Care Required/Week
Total Minutes of Care Performed by Unpaid Support System/Week
Total Minutes of Care Performed by Health Plan Provider/Week
Total Hours of Care Performed by Health Plan Provider/Week
Total Hours of Care Performed by Health Plan Provider/Month (based on 7 Days/Week x 31 Days/Month)

9. **Justification for Allocation of Hours-** Provide reason the hours are more than the suggested times.
10. **Assessor Signature-** The assessor must print and sign tool to acknowledge that the appropriate hours have been allotted.
11. **Member/Authorized Representative Signature-** The member/authorized representative must print and sign tool to acknowledge that the appropriate hours have been allotted by the assessor.

STATE OF HAWAII
Personal Assistance Tool

Member Name:						*Medicaid #:*								*Date of Assessment:*							
Task		**Total Minutes of Care Required/Week**				**Total Minutes of Care Performed by Unpaid Support System/Week**								**Total Minutes of Care Performed by Health Plan Provider/Week**							
		Frequency/ Day	Minutes/ Task	Days/ Week	Total Minutes/ Week	SUN	MON	TUE	WED	THU	FRI	SAT	Total Minutes/ Week	SUN	MON	TUE	WED	THU	FRI	SAT	Total Minutes/ Week
Personal Assistance Level 1																					
1	Routine House Cleaning																				
2	Laundry																				
3	Shopping/Errands																				
4	Transportation/Escort																				
5	Meal Preparation																				
6	Other **, e.g. light yard work, simple home repairs**																				
Personal Assistance Level 2																					
1	Eating/Feeding																				
2	Bathing																				
3	Dressing (Upper and Lower Body)																				
4	Grooming/Personal Hygiene																				
5	Toileting																				
6	Ambulation/																				
7	Bed Mobility/Transfers																				
8	Manual Wheelchair Mobility																				
9	Medication Assistance																				
10	Other																				
SUBTOTAL MINUTES/WEEK				**Total Minutes/Week**									**Total Minutes/Week**								**Total Minutes/Week**

Total Minutes of Care Required/Week	
Total Minutes of Care Performed by Unpaid Support System/Week	
Total Minutes of Care Performed by Health Plan Provider/Week	
Total Hours of Care Performed by Health Plan Provider/Week	
Total Hours of Care Performed by Health Plan Provider/Month (based on 7Days/Week x 31Days/Month)	

Justification for Allocation of Hours:

Assessor Signature **Print Name/Title**

Member/Authorized Representative Signature **Print Name/Relationship to Member**

STATE OF HAWAII

Skilled Nursing Tool Instructions (Rev. 2/22/22)

A) The State recommends that this tool be formatted in Excel for calculation functionality.

1. **Member Name**: Enter member's legal name (Last, First, Middle Initial). If member has no middle initial, leave blank.
2. **Frequency/Complexity**: How often and complexity of skill.
3. **Suggested Times (Minutes)**: The assessor will enter the minutes based on the frequency and complexity of each skill. If the minutes exceed the maximum suggested minutes, please document reason in the Justification for Allocation of Hours.
4. **Total Minutes of Care Required/Week**
    a. *Frequency/Day*- Enter how many times the member needs the skill done each *day*.
    b. *Minutes/Task*- Enter how many minutes it takes to do the skill each time.
    c. *Days/Week*- Enter how many days a skill is needed in a week. Most skills are done daily, but there may be something like an IM injection that may be done once or twice a week etc.
    d. *Total Minutes/Week*- Minutes will be added up and totaled at the end of column. This provides the assessor the ability to check that all minutes required per week are performed by either Support System or Health Plan Provider.
    e. *For example: A member gets nebulizer treatments 3 times a day and it takes 10 minutes each time which will total 30 minutes required per day. Treatment orders are daily which total 210 minutes per week.*
5. **Total Minutes of Care Performed by Support System/Week**
    a. *Frequency Per Day/Total Minutes Per Week*- The assessor will ask how many times a skill is done for the member by Support System which include care provided by family, friends, or other programs such as DDD, DOE etc. Enter how many minutes the member needs the skill done each *day* and place in the appropriate day of the week for each skill.
    b. *Total Minutes/Week*- Minutes will be added up and totaled at the end of column. This provides the assessor the total minutes per week that will be performed by the Support System.
    c. *For example: Support System provides 2 nebulizer treatments daily, 20 minutes per day, which total 140 minutes per week.*
6. **Total Minutes of Care Performed by Health Plan Provider/Week**
    a. *Frequency Per Day/Total Minutes Per Week*- The assessor must calculate the Health Plan Provider frequency of skills each day and the total time based on all the information entered into the form.
    b. *Total Minutes/Week*- Minutes will be added up and totaled at the end of column. This provides the assessor the total minutes per week that will be performed by the Health Plan Provider.
    c. *For example: The Paid Caregiver will provide 1 nebulizer treatment daily, 10 minutes per day, which total 70 minutes per week.*
7. **Subtotal Skilled Minutes/Week:** The assessor will recheck totals and then calculate total minutes
8. **Final Calculation of Hours:** The assessor will recheck totals and then calculate total minutes to hours.
9. **Justification for Allocation of Hours:** Provide reason the hours are more than the suggested times.
10. **Assessor Signature:** The assessor must print and sign tool to acknowledge that the appropriate hours have been allotted.
11. **Member/Authorized Representative Signature:** The member/authorized representative must print and sign tool to acknowledge that the appropriate hours have been allotted by the Assessor.

STATE OF HAWAII
Skilled Nursing Tool (Rev. 2/22/22)

Member Name:

APPENDICES

Medicaid #:

Date of Assessment:

	Nursing Intervention	Frequency/Complexity	Suggested Time (Minutes)	Total Minutes of Care Required/Week				Total Minutes of Care Performed by Support System/Week								Total Minutes of Care Performed by Health Plan Provider/Week							
				Frequency /Day	Minutes/ Task	Days/ Week	Total Minutes/ Week	SUN	MON	TUE	WED	THU	FRI	SAT	Total Minutes/ Week	SUN	MON	TUE	WED	THU	FRI	SAT	Total Minutes/ Week
1	Ventilator Care	>12 hours (per day)	Up to 40																				
		<12 hours (per day)	Up to 30																				
2	BIPAP/CPAP Care	>12 hours (per day)	Up to 40																				
		<12 hours (per day)	Up to 30																				
3	Tracheostomy Care	Per day	Up to 15																				
4	Suctioning (oral, nasal, tracheal)	Per episode	Up to 10																				
5	Nebulization therapy	Per episode	Up to 15																				
6	Cough insufflators and exsufflators	Per episode	Up to 15																				
7	Chest vest therapy	Per episode	Up to 15																				
8	Nutrition (parenteral, G-tube, J-tube)	Bolus feeds per episode	Up to 15																				
		Continuous (per day)	Up to 30																				
9	Special Skin Care (wounds, burns, ulcers, G/J tube site care)	Simple (dry gauze, tape) per episode	Up to 10																				
		Moderate (duoderm) per episode	Up to 15																				
		Complex (per episode)	Up to 20																				
10	Orthopedic appliance	Splint/cast per episode	Up to 10																				
		Complex (describe) per episode	Up to 20																				
11	Urinary bladder catheterization, irrigation	Per episode	Up to 15																				
12	Vascular access catheter care	Per day	Up to 15																				
13	Ileostomy/colostomy care	Per day	Up to 20																				
14	Medications administered by LPN/RN (oral, nasal, ophthalmic, ear, enteral-G or J tube, rectal, IM, subcu)	Per dose	Up to 10																				
15	Intravascular medications	Per dose	Up to 15																				
16	Monitors	Cardio-respiratory (per day)	Up to 10																				
		Pulse oximeter (per day)	Up to 10																				
17	Glucose Monitoring	Per episode	Up to 10																				
	SUBTOTAL SKILLED MINUTES/WEEK					**Total Minutes/Week**									**Total Minutes/Week**								**Total Minutes/Week**
							Total Hours of Care Performed by Health Plan Provider/Month (based on 7Days/Week x 31Days/Month)															

Justification for Allocation of Hours:

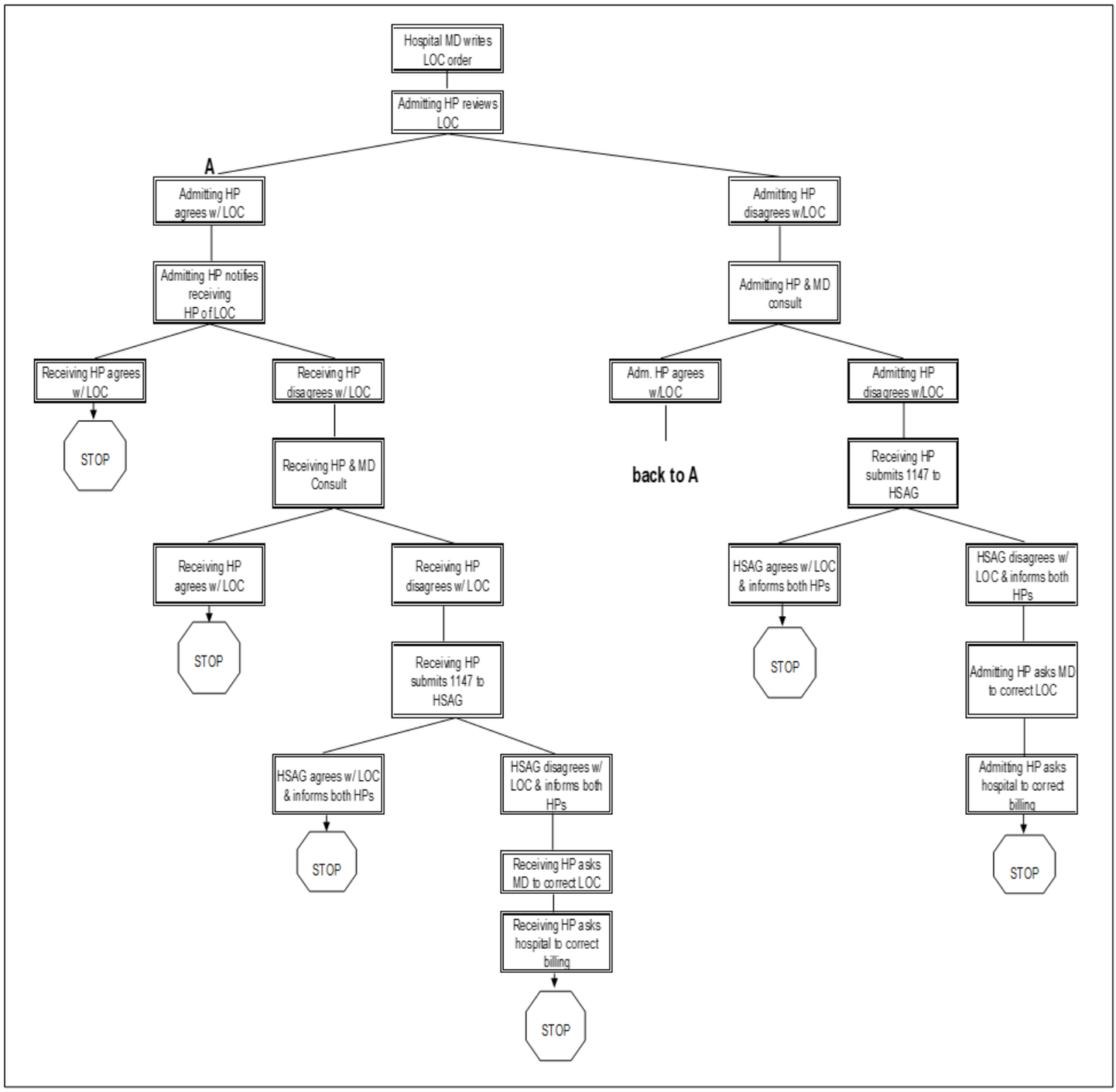
Assessor Signature **Print Name/Title**

Member/Authorized Representative Signature **Print Name/Relationship to Member**

APPENDIX X: Transition of Care

A) LEVEL OF CARE RULES:

1. A level of care change is defined for the purposes of this memo as the first change in acuity level of care (acute to sub-acute, waitlisted sub-acute, SNF, waitlisted SNF, ICF, waitlisted ICF). See attached flow chart for details.



APPENDIX X: Transition of Care

Hospital, P = Professional services, E = Enabling services, LOC = Level of care, OOS = Out of state

Insurance Coverage Scenario	QUEST Integration (QI) Responsibility	State of Hawaii Organ and Tissue Transplant (SHOTT) Responsibility	Community Care Services (CCS) Responsibility	Fee-for-Service (FFS) Responsibility	Comments
ACUTE INPATIENT					
1. QI health plan from admission to discharge.	Covers H, P, and E from admission to discharge.				Health Plan financial responsibility ends when member ineligible for Medicaid
2. FFS admission to discharge.				Covers H, P, and E from admission to discharge.	
3. One QI health plan on admission switches to another QI health plan after admission.	Admitting QI health plan covers H until LOC change and covers P and E once enrolled in the receiving QI health plan. Receiving QI health plan picks up H after LOC change and covers P and E once enrolled into the receiving health plan.				If the LOC remains acute for the entire hospitalization, the admitting QI health plan is responsible for H from admission to discharge.
4. QI health plan on admission. Break in coverage. Member reenrolled in QI health plan when regains eligibility.	Covers H, P, and E until eligibility ends. Restarts H, P, and E with new eligibility segment.				If there is a break in QI health plan coverage and the member becomes eligible again, the member will be reenrolled in their QI health plan (as long as the break in coverage is less than 180 days).
5. FFS on admission. Change to QI health plan during admission.	Covers P and E once enrolled in the QI health plan. Covers H after LOC change.			Covers H until LOC change. Covers P and E until enrolled in a QI health plan.	If the LOC remains acute for the entire hospitalization, FFS is responsible for H from admission to discharge.
NEWBORNS					
6. Mom has QI health plan as primary insurance.	QI health plan covers both maternity and newborn.				Newborn is enrolled in mom's QI health plan for at least first 30 days following the birth.
7. Mom has QI health plan as secondary insurance and enrolls newborn in commercial plan within 30 days.	QI health plan covers secondary after primary insurance covers both maternity and newborn.				Newborn is enrolled in mom's QI health plan for at least first 30 days following the birth.
8. Mom has QI health plan as secondary insurance and does not add newborn to primary insurance policy.	QI health plan covers secondary after primary insurance covers maternity. QI health plan covers newborn primary.				Newborn is enrolled in mom's QI health plan for at least first 30 days following the birth.

Insurance Coverage Scenario	QUEST Integration (QI) Responsibility	State of Hawaii Organ and Tissue Transplant (SHOTT) Responsibility	Community Care Services (CCS) Responsibility	Fee-for-Service (FFS) Responsibility	Comments
9. Mom has commercial only and does not add newborn to commercial plan within 30 days.	QI health plan does not cover maternity. QI health plan covers newborn primary.				If mom's commercial health plans has a QI contract, then newborn is enrolled in mom's QI health plan for at least first 30 days following the birth. If not, then newborn is auto-assigned into QI health plan.
10. Mom has commercial only and adds newborn to commercial plan within 30 days. Mom also enrolls newborn in QI.	QI health plan does not cover maternity. QI health plan covers secondary after primary insurance covers newborn.				If mom's commercial health plans has a QI contract, then newborn is enrolled in mom's QI health plan for at least first 30 days following the birth. If not, then newborn is auto-assigned into QI health plan.
TRANSFER FROM ACUTE TO ACUTE HOSPITAL IN-STATE					
11. QI health plan on admission to both first and second facility.	Covers H, P, and E from admission to discharge at both facilities.				Transfer = discharge
12. QI health plan on admission to first facility. Change to another QI health plan before transfer/discharge to the second facility.	First QI health plan covers H during first hospitalization until transfer. Covers P and E until change to second QI health plan. Second QI health plan covers P and E during first hospitalization. Second QI health plan covers H, P, and E for the second hospital.				Transfer = discharge
OUT OF STATE SERVICES					
13. QI health plan authorizes OOS hospital services.	Covers H, P, and E from admission to discharge at both Hawaii and OOS facilities.				
14. QI health plan on admission to first facility. Change to another QI health plan before	First QI health plan covers H during first hospitalization until transfer.				Second QI health plan covers costs for transfer to OOS facility.

transfer/discharge to the OOS facility.	Covers P and E until change to second QI health plan. Second QI health plan covers P and E for first hospitalization. Second QI health plan covers H, P, and E for second hospital.				
15. QI health plan on admission to first facility. Change to another QI health plan after transfer/discharge to the OOS facility.	First QI health plan covers H, P, and E during first hospitalization. Covers H until decrease in level of care at OOS facility. Second QI health plan covers P and E for OOS facility until change in level of care. At change in level of care, second QI health plan covers H.				If the first QI health plan has round trip ticket(s), they may bill the second QI health plan for the return ticket(s).
OUTPATIENT HOSPITAL, REHAB AND OTHER SERVICES IN THE STATE					
16. First QI health plan authorizes outpatient services. Second QI health plan at the time of services.	Second QI health plan honors first QI health plan's authorization for 45 days or until PCP sees member. Covers H, P, and E once enrolled in the second QI health plan.				
17. Dental Services authorized by HDS. Member QI health plan or FFS at the time of the service.	Covers H and P for hospital and anesthesia.			Covers H and P for hospital and anesthesia.	Dental services covered by Hawaii Dental Services (HDS). Anesthesiologist and hospital covered by the health plan at the time of procedure. Enabling services covered by HDS.

SHOTT					
18. QI health plan or FFS on admission SHOTT before discharge and transplant.	Covers H, P and E until enrolled into SHOTT.	Covers H, P, E once enrolled into the SHOTT program		Covers H, P and E until enrolled into SHOTT.	
19. SHOTT on admission. Member's SHOTT eligibility terminates during admission and enrolled in QI health plan or FFS.	Covers P and E once enrolled in the QI health plan. Picks up H after LOC change.	Covers H from admission to LOC change.		Covers P and E once enrolled in FFS. Picks up H after LOC change.	Member is dis-enrolled from SHOTT and enrolled into QI health plan or FFS on the 1st of the following month.
20. Dental services provided to SHOTT eligible members.		Covers anesthesiologist and hospital services associated with dental services. Covers H, P, and E.			
CCS					
ACUTE BEHAVIORAL HEALTH INPATIENT					
21. CCS from admission to discharge.			Covers H, P and E from admission to discharge.		
22. QI health plan on admission. Member is enrolled in CCS during that admission.	Admitting QI health plan covers H until LOC changes and covers P and E up until enrolled in CCS.		CCS picks up H after LOC change and covers P and E from enrollment into CCS.		If the LOC remains acute for the entire hospitalization, the admitting QI health plan is responsible for H from admission to discharge.
BEHAVIORAL HEALTH OUTPATIENT HOSPITAL, REHAB AND OTHER SERVICES IN THE STATE					
23. QI health plan authorized outpatient services. CCS covers at the time of services.			CCS honors the QI health plan's authorization for 45 days or until PCP sees member. Covers H, P, and E as soon as member is enrolled.		

APPENDIX Y: Waiver Request SOP

QUEST Integration Health Plan's
Waiver Request Submission Procedures

A) This instruction sheet shall be used by the health plans when submitting a Waiver request for review. Below are guidelines the health plans shall follow effective immediately.

1. **A Waiver Submission:** "A Waiver Submission" includes, but is not limited to, a brand-new Waiver request (i.e., an Initial Submission), renewal submissions to renew an expiring active Waiver (with or without changes) and replacing of an active Waiver. If the new Waiver submission includes significant portions of text from an active Waiver plus new edits (ex. a Waiver submission to renew an active Waiver with changes), health plan shall submit both a Redline version and a Clean version.

2. **New Waiver Title:** Waiver requests that are new Waiver submissions, are titled with a brand-new title in accordance with the waiver nomenclature provided by MQD on page 2.

B) New Waiver submissions that affect, or are linked to, an active waiver, shall reference the title of the active waiver, within the body of the new Waiver submission.

a. Examples:

1. New (Initial) Waiver Submission:
   a. **New Waiver Submission Title:** HP W22-01 [Brief Description]
   b. **Include in the body of the new Waiver submission description:** [Description of contract process heath plan is requesting to be waived, rationale and timeline, if applicable.
2. Renewal of an Active Waiver:
   a. **Waiver Title:** HP W22-01 [Brief Description] (Reference to HP W21-03)
   b. **Include in body of Waiver renewal:** "With approval of this Waiver submission, health plan seeks to renew previously approved and still active Waiver HP W22-03 [Brief Description], which will expire on 08/31/22."
   c. [Waiver renewal of an expiring active Wavier, must be submitted one month prior to the existing Waiver expiration date, to allow time for MQD to review and provide a final decision.]
3. Replacing an Active Waiver:
   a. **Waiver Submission Title:** HP W22-01 [Brief Description] (Reference to HP W21-03)
   b. **Include in the body of the Waiver submission description:** "With approval of this Waiver submission, health plan seeks to replace active Waiver HP W21-03 [Brief Description]."

C) Initial Submission:

1. Health plans shall name the waiver request form with the following nomenclature: Health Plan ID, a "W", two-digit year, two-digit number, and a brief description of the waiver.

   a. Health plan ID:
2. This is a unique identifier for each health plan. The health plans shall use the following IDs:
   a. AC – AlohaCare
   b. HM – HMSA
   c. KP - Kaiser Permanente
   d. OH - Ohana Health Plan
   e. UN - UnitedHealthcare Community Plan

3. A "W" means "Waiver"
4. Two-digit year:

a. This will identify what year the material is being submitted. (For example: W22, W23, W24…).

5. Two-digit number:
   a. The number shall be in chronological order of submission (For example: 01, 02, 03…).

6. Brief description of waiver request.

7. Examples:
   a. Example 1: HP W22-01 Service Coordinator ratio
   b. Example 2: HP W22-02 Promotion item value
   c. **Note**: Leave 1 space between the number and brief description of the waiver request.

8. The health plan shall fill out the Number Issued, Contract Section, Health Plan name, and Date Submitted on the waiver request form.

9. The health plan shall provide the contract section and a description of the contract requirement that the health plan is requesting to have waived by DHS.

10. The health plan shall provide the rational for requesting the waiver and provide a timeline for the plan of action, as applicable.

11. The health plan may provide additional information related to the waiver request for DHS to consider, as needed. If no additional information is needed, put "None."
12. The health plan shall submit the waiver request through the MQD CMCS mailbox (mqdcmcs@dhs.hawaii.gov). The health plan shall include "Waiver Request:" followed by the file name in the email subject line.

    a. Example:
       1) Waiver Request: HP W22-01 [Brief Description]

13. MQD will provide the health plan a copy of the finalized decision on the waiver request through the MQD CMCS (mqdcmcs@dhs.hawaii.gov) email.

14. If the health plan wants to continue the waiver, the health plan shall submit a new waiver request prior to the expiration of the current waiver request. The new waiver request shall include the nomenclature of the current waiver request as a reference.

    a. Example:
       1) Waiver Request: HP W22-01 [Brief Description] (Reference to HP W20-01)

D) <u>Resubmission:</u>

1. Health plans shall reuse the original submission file name and include the letter "a" after the nomenclature. (Additional resubmissions shall be identified by the ascending alphabet ex: a, b, c…).

   a. Examples:
      1) Example 1: HP W22-01a [Brief Description]
      2) Example 2: HP W22-02a [Brief Description]
      3) **Note**: Leave 1 space between the number and brief description of the waiver request.

2. The health plan shall fill out the Number Issued, Contract Section, Health Plan name, and Date Submitted on the waiver request form.

3. The health plan shall provide the contract section and a description of the contract requirement that the health plan is requesting to have waived by DHS.

4. The health plan shall provide the rational for requesting the waiver and provide a timeline for the plan of action, as applicable.

5. The health plan may provide additional information related to the waiver request for DHS to consider, as needed. If no additional information is needed, put "None."

6. The health plan shall submit the waiver request through the MQD CMCS mailbox (mqdcmcs@dhs.hawaii.gov). The health plan shall include "Waiver Request:" followed by the file name in the email subject line.
   b. Example:
      - Waiver Request: HP W22-01a [Brief Description]
7. MQD will provide the health plan a copy of the finalized decision on the waiver request through the MQD CMCS (mqdcmcs@dhs.hawaii.gov) email.

8. If the first resubmission is denied, repeat procedures for "Resubmission." Send a second resubmission and include the letter "b" after the nomenclature.
   c. Examples:
      1) Example 1: HP W22-01b [Brief Description]
      2) Example 2: HP W22-02b [Brief Description]

   d. If the first resubmission is denied, repeat procedures for "Resubmission."

APPENDIX Y1: Waiver Request Form

Number Issued: Choose Health Plan.Choose Waiver Year.Choose Waiver Number.Choose Resubmission version.
Contract Section:

Requests for Waiver of RFP-MQD-2021-008 Contract Processes

Health Plan: Choose an item. **Date Submitted:** Click here to enter a date.

Description of Contract requirement that the health plan is requesting to have waived by DHS, including Contract Section:

Provide rationale for DHS to waive Contract requirements, and provide a timeline for the plan of action, as applicable. (If necessary, attach information to justify reasons for DHS to grant waiver):

Additional Information for DHS to consider:

Contract Requirement Disposition (for DHS' use only):

☐APPROVED Expires on: Click here to enter a date.
☐DISAPPROVED

_____ _____
Med-QUEST Division Administrator Date

DHS reserves the right to revoke this waiver at any time, except for waivers that are specifically agreed to by the parties in the RFP-MQD-2021-008 contract or as amended, if necessary.

Rev. 08/2022

APPENDIX Z: Material Submission SOP

QUEST Integration
Material Submission Procedures

A) This instruction sheet will be used by the health plans when submitting materials for review. All materials shall be sent to the MQD/CMCS mailbox: mqdcmcs@dhs.hawaii.gov. Below are guidelines the health plans shall follow effective October 11, 2021.

1. **INITIAL SUBMISSION:**
   a. Health plans shall attach a Material Review Tool, a clean copy of the material in MS Word 2016 or lower format and the reading grade level.

   b. Health plans shall name the material files with a Health Plan ID, two-digit year, three-digit number, title of material and type of file.
      2) Health plan ID:
         a) This is a unique identifier for each health plan. The health plans shall use the following IDs:
   d. AC- AlohaCare
   e. HM- HMSA
   f. KP- Kaiser Permanente
   g. OH- Ohana Health Plan
   h. UN- UnitedHealthcare Community Plan

      3) Two-digit year:
         a) This will identify what year the material is being submitted.

      4) Three-digit number:
         a) The number shall be in chronological order of submission (ex: 001, 002, 003…).

      5) Title of material:
         a) Title shall be a clear indication of what type of material is being submitted for review/approval (example.: Health Plan Event, Survey Cover Letter, Provider Manual, Member Handbook, or Complex Care Script), **no abbreviations** shall be used.

      6) Type of File:
         a) RT – Completed Review Tool
         b) Clean – Clean version of material
         c) Reading Level – Contains any words removed (in track changes) and screenshot of material's reading level (Health plan may abbreviate reading level, ex: Rdglvl)
         d) Redline – Material revisions in track changes for resubmitted materials.

      7) Examples:
         a) Example 1:
            ii. AC21-001 Health Plan Event RT
            iii. AC21-001 Health Plan Event Reading Level
            iv. AC21-001 Health Plan Event Clean
         b) Example 2:
            i. HM21-002 Survey Cover Letter RT
            ii. HM21-002 Survey Cover Letter Rdglvl
            iii. HM21-002 Survey Cover Letter Clean
         c) **Note**: Leave 1 space between the number and title of the material

d) **Note**: MQD is not specific on what the health plan chooses to put in between title of material and the type of file (ex: health plan can use a space, underscore or dash)

c. If the material is a previously approved deliverable from the Readiness Review, health plan shall add the deliverable identifier to the material file name:
   1) Example 1: AC21-001 PN1.5 Pharmacy Contract
   2) Example 2: HM21-001 A2 Subcontractor Agreements

d. In the event the health plan revises a material that was approved in the previous year(s), the health plan shall submit as a new material. Health plan shall provide the previous year's nomenclature in the "Health Plan's Additional Information" section of the review tool.

e. If the material was previously approved in the current year and the health plan submits as a new material, a redline version of the material with track changes identifying any revisions made from the previous approved material shall be included.

f. All written materials shall be worded such that the materials are understandable to a member who reads at the 6th grade reading level (6.9 or below).

g. Insert the material file name in header or footer of the material submitted for review

   1) Example 1: AC21-001 Health Plan Event
   2) Example 2: HM21-002 Survey Cover Letter

2. **RESUBMISSION:**
   a. When resubmitting a denied material or a material that has been previously approved in the same year, add the next sequential material version number to the same material file name and submit the following:
      1) Material Review Tool with action taken by health plan,
      2) Redline version of the material with track changes identifying any revisions made from the previous submission or approved material,
      3) A clean copy of the material in MS Word 2016 or lower format (this is how the material will look once approved in its present form), and
      4) Grade level for readability.
         a) Example:
            i. HM21-001 LTSS Survey Cover Letter RT v2
            ii. HM21-001 LTSS Survey Cover Letter Rdglvl v2
            iii. HM21-001 LTSS Survey Cover Letter Redline v2
            iv. HM21-001 LTSS Survey Cover Letter Clean v2

   b. All written materials shall be worded such that the materials are understandable to a member who reads at the 6th grade reading level (6.9 or below).
   c. Insert the material file name in the header or footer of the material submitted for review:
      1) Example 1: AC21-001 Health Plan Event
      2) Example 2: HM21-002 Survey Cover Letter

3. **MATERIAL REVIEW TOOL:**

a. Health plans shall submit a completed Material Review Tool following the guidelines below:
   1) Item #
      a) Shall be the same health plan identifier, two-digit year, and three-digit number utilized material file name.
      b) Select from the drop-down box provided:
         i. Example: AC21-001
   2) Material Title:
      a) Title shall be a clear indication of what type of material is being submitted for review/approval (example.: Health Plan Event, Survey Cover Letter, Provider Manual, Member Handbook, or Complex Care Script), **no abbreviations** shall be used.
         i. Example 1: West Oahu Newspaper
         ii. Example 2: PN 1.5 Pharmacy Contract
   3) Purpose of Material (Brief):
      a) Health plans shall provide MQD a brief description of the material's purpose.
   4) Health Plan
      a) Select name of health plan from the drop-down box provided.
   5) Medicaid Program
      a) Select appropriate program that applies to the material from the drop-down box.
   6) Category
      a) Select the appropriate category that applies to the material from the drop-down box:
         i. Administration
         (1) Examples: Policies, procedures, contract templates, etc.
         ii. Marketing
         (1) Examples: Website advertisement, television or radio advertisement, newspaper articles, social networks, etc.
         iii. Member Services
         (1) Examples: Member newsletters, flyers, or any material mailed to the member, member portal, etc.
         iv. Provider Services
         (1) Examples: Provider manual, provider directory, provider educational material, provider portal, etc.
   7) Grade Level
      a) Select the resulting grade reading level of the material, when applicable.
   8) Health Plan Submission/Resubmission Date
      a) The health plan shall fill out the date the material is being submitted/resubmitted to MQD for review.
   9) Health Plan's Additional Information

a) This area shall be utilized to provide a summary of the material and provide MQD with an explanation on how the material will be issued/used.
   i. Examples: Summary and explanation for television/radio ad advertisements, member newsletter, event flyers, social media posts, newspaper articles, website updates, member handbooks, etc.

10) Material Review Comments
   a) This area shall be utilized to respond to MQD reviewer comments regarding the material.

4. MQD Material Status Description

a. Below are descriptions of each material status.
   1) Approved – Material content is approved and can be issued, posted or utilized by health plans.
   2) Approved w/Condition(s) – Material content is approved under the circumstance that the health plan adheres to MQD's condition(s) before issuing, posting or utilizing material.
   3) Approved w/Comment(s) – Material content is approved and can be issued, posted or utilized by health plans. MQD may have comments/suggestions based on the material content, however, health plan is not required to incorporate it.
   4) Denied – Material content is denied and reviewer will indicate comments on the review tool.

QUEST Integration / CCS: MATERIALS REVIEW TOOL

Item #: Select HP Select Year-Select Material #
Material Title: Click or tap here to enter text.
Purpose of Material (Brief): Click or tap here to enter text.

Health Plan: Select HP
Medicaid Program: Select Program
Category: Select Category
Grade Level: Select Grade Level

Material Status:

HEALTH PLAN TO COMPLETE	MQD REVIEWER TO COMPLETE	
Initial Health Plan Submission: Date	**MQD 1st Reviewer Name:** Select Name **MQD 2nd Reviewer Name:** Select Name	**Date Review Completed:** Date ***Status*:** Select Status [Condition]
v2 Health Plan Resubmission: Date	**MQD 1st Reviewer Name:** Select Name **MQD 2nd Reviewer Name:** Select Name	**Date Review Completed:** Date ***Status*:** Select Status [Condition]
v3 Health Plan Resubmission: Date	**MQD 1st Reviewer Name:** Select Name **MQD 2nd Reviewer Name:** Select Name	**Date Review Completed:** Date ***Status*:** Select Status [Condition]

Health Plan's Additional Information: *[Include a summary with an explanation on how this material will be issued/used.]*

Material Review Comments:

APPENDIX AA: Staffing Notification

Health Plan QI Staffing Table

Health Plan: _____

Date Submitted to MQD: : _____

Instructions: Health Plan (HP) fills in yellow fields with updated information. Each yellow field within the table applies to the mandated position in the row above it. Use track-change to highlight the latest update(s).

For "**If Interim Contact, start date of HP recruitment**", provide the date on which the Health Plan began (or will begin) its formal recruitment processes to fill the vacancy with a permanent hire, *if* the named individual is the Interim Contact for the applicable QI RFP mandated position.

Mandated QI Staff		Requirements			
	Position	**FTE or # of Positions**	**Hawaii**	**Resume**	**Change Notification**
1	**Administrator/CEO/Executive Director**	**1.0**	✓	✓	✓
	Name: Health Plan Job Title: Phone: Email: If Interim Contact, start date of HP recruitment: Notes (optional):	Individual's FTE dedicated to the mandatory position above:	Does the individual reside and work in Hawaii (yes/no)?:	Was resume submitted to MQD (yes/no)? If so, when (date)?:	Date of change notification to MQD for individual currently in this position, if applicable:
2	**Behavioral Health Coordinator**	**1.0**	✓	✓	✓
	Name: Health Plan Job Title: Phone: Email: Notes (e.g., "Interim Contact"):	Individual's FTE dedicated to the mandatory position above:	Does the individual reside and work in Hawaii (yes/no)?:	Was resume submitted to MQD (yes/no)? If so, when (date)?:	Date of change notification to MQD for individual currently in this position, if applicable:

Mandated QI Staff		Requirements			
	Position	**FTE or # of Positions**	**Hawaii**	**Resume**	**Change Notification**
3	**Business Continuity Planning, Disaster Preparedness and Recovery Manager/Coordinator**	**Adequate to meet the Contract requirements**			✓
	Name: Health Plan Job Title: Phone: Email: Notes (e.g., "Interim Contact"):	Individual's FTE dedicated to the mandatory position above:	N/A	N/A	Date of change notification to MQD for individual currently in this position, if applicable:
4	**CIS Coordinator**	**1.0**	✓		
	Name: Health Plan Job Title: Phone: Email: Notes (e.g., "Interim Contact"):	Individual's FTE dedicated to the mandatory position above:	Does the individual reside and work in Hawaii (yes/no)?:	N/A	N/A
5	**Claims Administrator/Manager** (See QI RFP section 11.2.C.2 for Hawaii residence requirement exception)	**1.0**	✓		✓
	Name: Health Plan Job Title: Phone: Email:	Individual's FTE dedicated to the mandatory position above:	Does the individual reside and work in Hawaii (yes/no)?:	N/A	Date of change notification to MQD for individual currently in this position, if

APPENDIX AA: Staffing Notification

	Mandated QI Staff Position	Requirements FTE or # of Positions	Hawaii	Resume	Change Notification
	Notes (e.g., "Interim Contact"):				applicable:
6	**Claims Processing Staff**	**Adequate to meet the Contract requirements**			
7	**Compliance Officer**	**1.0**	✓	✓	✓
	Name: Health Plan Job Title: Phone: Email: Notes (e.g., "Interim Contact"):	Individual's FTE dedicated to the mandatory position above:	Does the individual reside and work in Hawaii (yes/no)?:	Was resume submitted to MQD (yes/no)? If so, when (date)?:	Date of change notification to MQD for individual currently in this position, if applicable:
8	**Data Analytics Officer**	**0.5**		✓	✓
	Name: Health Plan Job Title: Phone: Email: Notes (e.g., "Interim Contact"):	Individual's FTE dedicated to the mandatory position above:	N/A	Was resume submitted to MQD (yes/no)? If so, when (date)?:	Date of change notification to MQD for individual currently in this position, if applicable:
9	**EPSDT Coordinator**	**1.0**	✓	✓	✓

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APPENDIX AA: Staffing Notification

Mandated QI Staff		Requirements			
	Position	**FTE or # of Positions**	**Hawaii**	**Resume**	**Change Notification**
	Name: Health Plan Job Title: Phone: Email: Notes (e.g., "Interim Contact"):	Individual's FTE dedicated to the mandatory position above:	Does the individual reside and work in Hawaii (yes/no)?:	Was resume submitted to MQD (yes/no)? If so, when (date)?:	Date of change notification to MQD for individual currently in this position, if applicable:
10	**Financial Officer/CFO**	**0.5**	✓	✓	✓
	Name: Health Plan Job Title: Phone: Email: Notes (e.g., "Interim Contact"):	Individual's FTE dedicated to the mandatory position above:	Does the individual reside and work in Hawaii (yes/no)?:	Was resume submitted to MQD (yes/no)? If so, when (date)?:	Date of change notification to MQD for individual currently in this position, if applicable:
11	**Health Coordination Director**	**1.0**	✓	✓	✓
	Name: Health Plan Job Title: Phone: Email: Notes (e.g., "Interim Contact"):	Individual's FTE dedicated to the mandatory position above:	Does the individual reside and work in Hawaii (yes/no)?:	Was resume submitted to MQD (yes/no)? If so, when (date)?:	Date of change notification to MQD for individual currently in this position, if applicable:

APPENDICES

APPENDIX AA: Staffing Notification

Mandated QI Staff		Requirements			
	Position	**FTE or # of Positions**	**Hawaii**	**Resume**	**Change Notification**
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**	(Not required but, see QI RFP section 11.2.C.2)	✓	✓
	Name: Health Plan Job Title: Phone: Email: Notes (e.g., "Interim Contact"):	Individual's FTE dedicated to the mandatory position above:	Does the individual reside and work in Hawaii (yes/no)?: If no, HP must have an IT Hawaii Manager (position #15 below).	Was resume submitted to MQD (yes/no)? If so, when (date)?:	Date of change notification to MQD for individual currently in this position, if applicable:
15	**IT Hawaii Manager (If no Hawaii-based IT Director or CIO)** (See QI RFP section 11.2.C.2)	**Adequate to meet Contract requirements**	✓	✓	✓

APPENDICES

APPENDIX AA: Staffing Notification

Mandated QI Staff		Requirements			
	Position	**FTE or # of Positions**	**Hawaii**	**Resume**	**Change Notification**
	Name: Health Plan Job Title: Phone: Email: Notes (e.g., "Interim Contact"):	Individual's FTE dedicated to the mandatory position above:	Does the individual reside and work in Hawaii (yes/no)?:	Was resume submitted to MQD (yes/no)? If so, when (date)?:	Date of change notification to MQD for individual currently in this position, if applicable:
16	**IT Staff**	**Adequate to meet Contract requirements**			
17	**LTSS Coordinator**	**1.0**	✓		
	Name: Health Plan Job Title: Phone: Email: Notes (e.g., "Interim Contact"):	Individual's FTE dedicated to the mandatory position above:	Does the individual reside and work in Hawaii (yes/no)?:	N/A	N/A
18	**Medical Director**	**1.0**	✓	✓	✓
	Name: Health Plan Job Title: Phone: Email: Notes (e.g., "Interim Contact"):	Individual's FTE dedicated to the mandatory position above:	Does the individual reside and work in Hawaii (yes/no)?:	Was resume submitted to MQD (yes/no)? If so, when (date)?:	Date of change notification to MQD for individual currently in this position, if applicable:

Mandated QI Staff		Requirements			
	Position	**FTE or # of Positions**	**Hawaii**	**Resume**	**Change Notification**
19	**Member Grievance Coordinator**	**0.5**	✓	✓	✓
	Name: Health Plan Job Title: Phone: Email: Notes (e.g., "Interim Contact"):	Individual's FTE dedicated to the mandatory position above:	Does the individual reside and work in Hawaii (yes/no)?:	Was resume submitted to MQD (yes/no)? If so, when (date)?:	Date of change notification to MQD for individual currently in this position, if applicable:
20	**Member Services Director**	**1.0**	✓	✓	✓
	Name: Health Plan Job Title: Phone: Email: Notes (e.g., "Interim Contact"):	Individual's FTE dedicated to the mandatory position above:	Does the individual reside and work in Hawaii (yes/no)?:	Was resume submitted to MQD (yes/no)? If so, when (date)?:	Date of change notification to MQD for individual currently in this position, if applicable:
21	**Member Services Staff (to include Call Center staff)**	**Adequate to meet Contract requirements**	✓		

Mandated QI Staff		Requirements			
	Position	**FTE or # of Positions**	**Hawaii**	**Resume**	**Change Notification**
22	**Pharmacy Coordinator/Director/Manager**	**1.0**	✓	✓	✓
	Name: Health Plan Job Title: Phone: Email: Notes (e.g., "Interim Contact"):	Individual's FTE dedicated to the mandatory position above:	Does the individual reside and work in Hawaii (yes/no)?:	Was resume submitted to MQD (yes/no)? If so, when (date)?:	Date of change notification to MQD for individual currently in this position, if applicable:
23	**PA/Utilization Management/Medical Management Director**	**1.0**	✓	✓	✓
	Name: Health Plan Job Title: Phone: Email: Notes (e.g., "Interim Contact"):	Individual's FTE dedicated to the mandatory position above:	Does the individual reside and work in Hawaii (yes/no)?:	Was resume submitted to MQD (yes/no)? If so, when (date)?:	Date of change notification to MQD for individual currently in this position, if applicable:
24	**PA/Utilization Management/Medical Management/Concurrent Review Staff**	**Adequate to meet Contract requirements**	✓		
25	**Provider Grievance Coordinator**	**0.5**	✓	✓	✓

Mandated QI Staff		Requirements			
	Position	**FTE or # of Positions**	**Hawaii**	**Resume**	**Change Notification**
	Name: Health Plan Job Title: Phone: Email: Notes (e.g., "Interim Contact"):	Individual's FTE dedicated to the mandatory position above:	Does the individual reside and work in Hawaii (yes/no)?:	Was resume submitted to MQD (yes/no)? If so, when (date)?:	Date of change notification to MQD for individual currently in this position, if applicable:
26	**Provider Services/Contract and Credentialing Manager**	**1.0**	✓	✓	✓
	Name: Health Plan Job Title: Phone: Email: Notes (e.g., "Interim Contact"):	Individual's FTE dedicated to the mandatory position above:	Does the individual reside and work in Hawaii (yes/no)?:	Was resume submitted to MQD (yes/no)? If so, when (date)?:	Date of change notification to MQD for individual currently in this position, if applicable:
27	**Provider Services/Contract and Credentialing Staff**	**Adequate to meet Contract requirements**	✓		
28	**Quality Management Coordinator**	**1.0**	✓	✓	✓
	Name: Health Plan Job Title: Phone: Email:	Individual's FTE dedicated to the mandatory position above:	Does the individual reside and work in Hawaii (yes/no)?:	Was resume submitted to MQD (yes/no)? If so, when (date)?:	Date of change notification to MQD for individual currently in this position, if

APPENDIX AA: Staffing Notification

Mandated QI Staff	Requirements			
Position	**FTE or # of Positions**	**Hawaii**	**Resume**	**Change Notification**
Notes (e.g., "Interim Contact"):				applicable:

APPENDIX AA1: Staffing Change Notification
STAFFING CHANGE NOTIFICATION FORM

Use this form (Notification Form) to notify Med-QUEST Division (MQD) of staffing changes, for which written notification to MQD is a requirement under the Request for Proposal (RFP). The submission to MQD of this Notification Form, will serve as written notification to MQD. Complete a Notification Form for each position affected for which written notification is required. (See sample Notification Form provided.) If this Notification Form is not adequate to describe, or is not applicable to, the staffing change to be reported, please notify MQD using written correspondence that explains the staffing change in detail.

1. **Date Notification Form is submitted to MQD:**

2. **Date Health Plan has knowledge of the subject staffing change:**

(For example: the date of the employee's resignation letter; the date of the decision to terminate an employee; the date an applicant accepts the offer of employment; or the date an employee receives the promotion to a new position.)

3. ☐ QI ☐ CCS ☐ Other

4. **Health Plan Position Title** and **FTE**:

5. **RFP Position Title** and **Required FTE** (as listed in the RFP):

6. **Name of person *exiting*** the above position:

7. **Name & contact information of person *entering*** the above position and **FTE** this person will serve in the position & program:

(If there is no *entering* person at this time, please provide information for the *Interim Contact Employee* below in item #10.)

Name: FTE: Phone: Email:

8.

- **Does the *entering* person reside in the State of Hawaii?** ☐ Yes ☐ No
- **Does the *entering* person work in the State of Hawaii?** ☐ Yes ☐ No
- ****Submit to MQD, a current RESUME of the *entering* person, along with this Notification Form.** (This resume submission may not apply to the above position. Please refer to the RFP.)

9. **Describe the staffing change:**

(For example: "Jane Doe is retiring and will no longer be the ***QI Member Services Director*** as of 11/1/20. Effective 11/1/20, Bob Sox will be the ***QI Member Services Director***. Bob Sox accepted the promotion to the ***QI Member Services Director*** (Officer, Medicaid Member Services) position, from his position as the *QI Member Grievance Coordinator*. A separate Notification Form will be submitted for the *QI Member Grievance Coordinator* position that Bob Sox will be vacating.") (Complete separate Notification Forms for each position affected that requires a written notification.)

10. ***Interim Contact Employee*** **(if applicable):**

Name: Position Title: Phone: Email:

11. Name, position title, and contact information of the person who completed this Notification Form:

STAFFING CHANGE NOTIFICATION FORM (10/20) INSTRUCTIONS

PURPOSE:

The purpose of this form (Notification Form) is to notify Med-QUEST Division (MQD) of staffing changes, for which written notification to MQD is a requirement under the Request for Proposal (RFP). The submission to MQD of this Notification Form, will serve as written notification to MQD. Complete a Notification Form for each position affected for which written notification is required. (See SAMPLE Notification Form provided.) If this Notification Form is not adequate to describe, or is not applicable to, the staffing change to be reported, please notify MQD using written correspondence that explains the staffing change in detail.

FORM INSTRUCTIONS:

1. **Date Notification Form is submitted to MQD**

Enter the date that this Notification Form is submitted to MQD.

2. **Date Health Plan has knowledge of the subject staffing change**

Enter the date that the Health Plan is informed of, or decides upon, the staffing change being reported. Health Plans must notify MQD in writing within seven (7) days of learning of a change in the status of particular positions.

3. ☐ **QI** ☐ **CCS** ☐ **Other**

Check the box next to the program to which the staffing change being reported applies. Only one box shall be checked. If "Other" is checked, provide the name of the applicable program in the space provided.

4. **Health Plan Position Title** and **FTE**

If more than one position is affected by the staffing change, select one to be the "subject position" for this Notification Form, and complete separate Notification Forms for each position affected that requires written notification. Enter the official name of the subject position given by the Health Plan. Also, enter the full-time equivalent (FTE) assignment from the Health Plan for the subject position. The FTE indicates the extent to which an individual serving in the subject position is required by the Health Plan to dedicate work to that position as it relates to the program specified above (QI, CCS, or Other). For example, a 1.0 FTE assignment by a Health Plan regarding QI, indicates that its employee serving in the subject position is specifically designated and assigned to perform only the work of the position as it relates to QI, in an amount equal to a full-time schedule. Likewise, a 0.6 FTE assignment by a Health Plan regarding QI, of a full-time employee indicates that the full-time employee serving in the subject position, may perform other work not pertaining to the QI program or QI position, in an amount equal to 40% of a full-time schedule.

5. **RFP Position Title** and **Required FTE** (as listed in the RFP)

Enter the name of the position listed in the RFP (as it is listed in the RFP) to which the subject position of this Notification Form corresponds. Also, enter the FTE requirement (if any) for this position as stated in the RFP.

6. **Name of person *exiting*** the above position

Enter the name of the person leaving the subject position.

7. **Name & contact information of person *entering*** the above position and **FTE** this person will serve in the position & program

Enter the name, phone number, and email address of the person hired or promoted to officially fill the subject position. Also, enter the FTE this person is required by the Health Plan to dedicate toward this position and program. If no one has yet been hired or promoted to fill the subject position, provide information for the *Interim Contact Employee* in item #10.)

8.

- **Does the *entering* person reside in the State of Hawaii?** ☐ Yes ☐ No
- **Does the *entering* person work in the State of Hawaii?** ☐ Yes ☐ No

Check one box for each question. For some positions, the RFP requires that the employee reside and work in the State of Hawaii.

- ****Submit to MQD, a current RESUME of the *entering* person, along with this Notification Form**

Submit to MQD along with this Notification Form, an updated resume of the person officially hired or promoted to fill the subject position. Most positions for which a staffing change notification is required, also require the submission of a resume. If a resume for the person officially hired or promoted to fill the subject position has already been submitted to MQD within the past year, and there are no updates for the resume, then state so below in the space provided for "Describe the staffing change", and re- submission of the same resume is not necessary.

9. Describe the staffing change

In the space provided, briefly describe the staffing change.

For example: "Jane Doe is retiring and will no longer be the ***QI Member Services Director*** as of 11/1/20. Effective 11/1/20, Bob Sox will be the ***QI Member Services Director***. Bob Sox accepted the promotion to the ***QI Member Services Director*** (Officer, Medicaid Member Services) position, from his position as the *QI Member Grievance Coordinator*. A separate Notification Form will be submitted for the *QI Member Grievance Coordinator* position that Bob Sox will be vacating."

(Note: Complete separate Notification Forms for each position affected that requires a written notification.)

10. *Interim Contact Employee* (if applicable)

Complete this section only if the subject position has not been officially filled. Enter the name, position title, phone number, and email address of the person designated as the Interim Contact for the subject position while the subject position remains vacant.

11. Name, position title, and contact information of the person who completed this Notification Form

Enter the name, position title, phone number, and email address of the person who filled-out this form.

SAMPLESTAFFING CHANGE NOTIFICATION FORM**SAMPLE**

Use this form (Notification Form) to notify Med-QUEST Division (MQD) of staffing changes, for which written notification to MQD is a requirement under the Request for Proposal (RFP). The submission to MQD of this Notification Form, will serve as written notification to MQD. Complete a Notification Form for each position affected for which written notification is required. (See sample Notification Form provided.) If this Notification Form is not adequate to describe, or is not applicable to, the staffing change to be reported, please notify MQD using written correspondence that explains the staffing change in detail.

1. Date Notification Form is submitted to MQD: 10/18/20

2. Date Health Plan has knowledge of the subject staffing change: 10/14/20

(For example: the date of the employee's resignation letter; the date of the decision to terminate an employee; the date an applicant accepts the offer of employment; or the date an employee receives the promotion to a new position.)

3. ☒ QI ☐ CCS ☐ Other

4. Health Plan Position Title and **FTE**: Officer, Medicaid Member Services (1.0 FTE)

5. RFP Position Title and **Required FTE** (as listed in the RFP): Member Services Director (1.0 FTE)

6. Name of person *exiting* the above position: Jane Doe

7. Name & contact information of person *entering* the above position and **FTE** this person will serve in the position & program:
(If there is no *entering* person at this time, please provide information for the *Interim Contact Employee* below in item #10.)

Name: Bob Sox
FTE: 1.0 FTE
Phone: 808-123-4567
Email: B.sox@healthplan.org

8.

- **Does the *entering* person reside in the State of Hawaii?** ☒ Yes ☐ No
- **Does the *entering* person work in the State of Hawaii?** ☒ Yes ☐ No
- ****Submit to MQD, a current RESUME of the *entering* person, along with this Notification Form.** (This resume submission may not apply to the above position. Please refer to the RFP.)

9. Describe the staffing change:

Jane Doe is retiring and will no longer be the *QI Member Services Director* as of 11/1/20. Effective 11/1/20, Bob Sox will be the *QI Member Services Director*. Bob Sox accepted the promotion to the *QI Member Services Director* (Officer, Medicaid Member Services) position, from his position as the *QI Member Grievance Coordinator*. A separate Notification Form will be submitted for the *QI Member Grievance Coordinator* position that Bob Sox will be vacating. (Complete separate Notification Forms for each position affected that requires a written notification.)

10. *Interim Contact Employee* (if applicable):

Name: N/A
Position Title: N/A
Phone: N/A
Email: N/A

11. Name, position title, and contact information of the person who completed this Notification Form:

Charles Brown QI Compliance Officer 808-222-5555 C.brown@healthplan.org

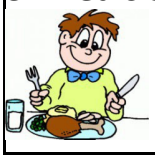
APPENDIX AB: HCBS Provider Self-Assessment Survey
Day Program Survey

How many clients do you currently provide services to? Date you did this survey:

This survey will help us understand the services you provide at your day program. We want to hear about your services and how they help our clients to be independent, make decisions and choices.

Things to **THINK** about when you are doing this survey:

1. Think about the **SETTING** your client(s) go to.
2. Tell us what it is like to be at your **DAY PROGRAM.**
3. Tell us about the **CHOICES** your client(s) get to make.
4. Check the box to answer **YES**  or **NO**  to the questions.

		YES	NO
CHOICE			
1. Day Program 	***Does your client(s)***		
	a. Know about his/her rights?	☐	☐
	b. Have a copy of his/her rights?	☐	☐
	Does your day program		
	c. Post the clients rights where they can see it?	☐	☐
	d. Talk to clients about making choices?	☐	☐
	e. Allow clients to go to voting sites?	☐	☐
2. Program Activities 	***Does your client(s) choose***		
	a. Their program activities?	☐	☐
	b. What time to do them?	☐	☐
	c. Who the activity is done with?	☐	☐
	Does your day programhave		
	d. People without a disability at the activities?	☐	☐
	e. Volunteer opportunities?	☐	☐
	f. Job opportunities?	☐	☐
	g. A safe place to put their personal items?	☐	☐
	h. Activities that keep s/he involved and active?	☐	☐
	i. Activities that help s/he relax and slow down?	☐	☐
	j. Activities s/he can do alone?	☐	☐
	k. Group activities?	☐	☐
	l. Activities that encourage s/he to learn new things?	☐	☐
3. Meals & Snacks 	***Does your client(s) choose***		
	a. What s/he wants to eat?	☐	☐
	b. What time s/he wants to eat?	☐	☐
	c. Who s/he eats with?	☐	☐

		YES	NO
4. Person-Centered Plan 	***Does your client(s)***		
	a. Attend a Person-Centered Planning meeting?	☐	☐
	b. Pick the time, place, and who attends the meeting?	☐	☐
	c. Get to be in charge of their meeting?	☐	☐
	d. Have a person centered plan with his/her interests?	☐	☐
	e. Get to change the plan?	☐	☐
	Does your day program staff know when to		
	f. Help clients stay calm and relaxed?	☐	☐
	g. Help clients who are stressed and upset?	☐	☐
	h. Ask for clients consent before use of restraints and/or restrictive interventions?	☐	☐
PRIVACY			
5. At the program 	***Do you and other staff***		
	a. Provide care in private?	☐	☐
	b. Keep the client's personal and health information private?	☐	☐
	c. Know not to talk about the clients in front of other people?	☐	☐
	d. Have a place for the client to meet with their family and friends in private?	☐	☐
	e. Have a place for the client to talk on the telephone or use the computer (or other device) in private?	☐	☐
DIGNITY & RESPECT			
6. Respect 	***Do you and other staff***		
	a. Say hello and use the client's name?	☐	☐
	b. Talk to the client with respect?	☐	☐
	c. Use words that the client can understand?	☐	☐
7. Free from being bullied 	***Do you and other staff***		
	a. Know what to do if s/he has a problem with the staff or service?	☐	☐
	b. Know that his/her complaint is private?	☐	☐
	c. Listen to the client if s/he has concerns?	☐	☐

		YES	NO
ACCESS			
8. Inside the program 	***Does your day program***		
	a. Allow client(s) to get around safely?	☐	☐
	b. Have ramps, wide doorways, hallways, stair lift or elevator to help clients get around?	☐	☐
	c. Have any gates, Velcro strips, locked doors, or other things that stop clients from going in or out of places?	☐	☐
	d. Have locks or straps on the refrigerator or cabinets that make it hard for clients to get a snack or a drink?	☐	☐
	Does your client(s)		
	e. Have visitors at the day program?	☐	☐
	f. Have certain visitor hour?	☐	☐
9. Outside the program 	***Does your client(s)***		
	a. Have ramps, wide doorways, hallways, stair lift or elevator to help get inside the program?	☐	☐
	b. Have access to other houses, stores, and businesses?	☐	☐
	c. Have access to transportation?	☐	☐
10. Employment 	***Does your client(s)***		
	a. Have a job?	☐	☐
	b. If no, know who can help to find them a job?	☐	☐
	c. If yes, work with people who do not have a disability?	☐	☐
	d. Get paid $7.75 per hour (minimum wage) or more?	☐	☐
	e. Have a service worker at their job?	☐	☐
	f. Choose their work schedule?	☐	☐
	g. Volunteer?	☐	☐
11. Money 	***Does your client(s)***		
	a. Have a bank account?	☐	☐
	b. If no, want a bank account?	☐	☐
	c. If yes, know how to get money when s/he needs it?	☐	☐
	d. Pick the person to help manage his/her money?	☐	☐

Comments:

If you have any questions, want more information or would like someone to contact you regarding your comments, please leave your name and most convenient way to contact you.

Name: _____

Phone: _____

Mailing address: _____

Email address: _____

Thank you for participating and your answers are very important to us!

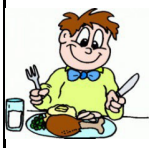
Primary Caregiver Residential Survey

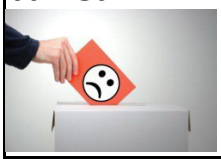
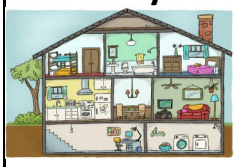
How many clients do you currently provide services to?
How many beds or clients are you licensed or certified for?
If you are a certified CCFFH, did you provide care to any private-pay clients during the past year?
Date you did this survey:

This survey will help us understand the services you provide in the home. We want to hear about your services and how they help our clients to be independent, make decisions and choices.

Things to **THINK** about when you are doing this survey:

1. Think about the home your client(s) **LIVE** in**.**
2. Tell us what it is like living in your **HOME.**
3. Tell us about the **CHOICES** your client(s) get to make.
4. Check the box to answer **YES**  or **NO**  to the questions.

		YES	NO
CHOICE			
1. Clients Home 	***Does your client(s)***		
	a. Have an agreement in writing for where s/he lives?	☐	☐
	b. Know the housing rights in regards to their agreement?	☐	☐
	c. Share a room?	☐	☐
	d. Choose their roommate?	☐	☐
	e. Get to decorate their room with their favorite things?	☐	☐
	f. Pick the clothes s/he wants to wear?	☐	☐
2. Going out 	***Does your client(s)***		
	a. Go out into the community?	☐	☐
	b. Pick how often s/he goes out?	☐	☐
	c. Choose what to do?	☐	☐
	d. Pick who goes out with him/her?	☐	☐
3. Schedule 	***Does your client(s) pick the time s/he***		
	a. Gets up and goes to bed?	☐	☐
	b. Takes a bath?	☐	☐
	c. Watches TV?	☐	☐
	d. Talks on the phone?	☐	☐
	e. Goes on the computer?	☐	☐
4. Meals & Snacks 	***Does your client(s) choose***		
	a. What s/he wants to eat?	☐	☐
	b. What time s/he wants to eat?	☐	☐
	c. Where s/he sits to eat?	☐	☐
	d. Who s/he eats with?	☐	☐
5. Person-Centered Plan 	***Does your client(s)***		
	a. Attend a Person-Centered Planning meeting?	☐	☐
	b. Pick the time, place, and who attends the meeting?	☐	☐
	c. Get to be in charge of their meeting?	☐	☐
PRIVACY			
6. Inside your home 	***Does your client(s)***		
	a. Have a key to the home?	☐	☐
	b. Close and lock the bedroom door?	☐	☐
	c. Have a key to their bedroom?	☐	☐
	d. Close and lock the bathroom door?	☐	☐

		YES	NO
6. Inside your home 	***Do you and other caregiver(s)***		
	e. Knock and ask permission to enter the client's bedroom or bathroom?	☐	☐
	f. Provide care in private?	☐	☐
	g. Keep the client's personal and health information private?	☐	☐
	h. Know not to talk about the clients in front of other people?	☐	☐
	i. Know not to talk about other people in front of the client?	☐	☐
	j. Have a place for the client to meet with their family and friends in private?	☐	☐
	k. Have a place for the client to talk on the telephone or use the computer (or other device) in private?	☐	☐
DIGNITY & RESPECT			
7. Respect 	***Do you and other caregiver(s)***		
	a. Say hello and use the client's name?	☐	☐
	b. Talk to the client with respect?	☐	☐
	c. Use words that the client can understand?	☐	☐
8. Free from being bullied 	***Do your client(s)***		
	a. Know what to do if s/he has a problem with the caregiver or service?	☐	☐
	b. Know that his/her complaint is private?	☐	☐
	c. Listen to the client if s/he has concerns?	☐	☐
ACCESS			
9. Inside your home 	***Does your home***		
	a. Allow client(s) to get around safely?	☐	☐
	b. Have ramps, wide doorways or hallways to help the client get around the home?	☐	☐
	c. Have any gates, Velcro strips, locked doors, or other things that stop clients from going in or out of some places?	☐	☐
	d. Have locks or straps on the refrigerator or cabinets that make it hard for the client to get a snack or a drink?	☐	☐
	Does your client(s)		

	e. Use the kitchen when s/he wants?	☐	☐
		YES	**NO**
9. Inside your home 	f. Get scolded for getting a snack or drink when s/he wants?	☐	☐
	g. Use the washer and dryer when s/he wants?	☐	☐
	h. Have visitors in your home?	☐	☐
	i. Have certain visitor hours?	☐	☐
	j. Have internet connection that s/he can use?	☐	☐
10. Outside your home 	***Does your client(s)***		
	a. Have access to other houses, stores, and businesses?	☐	☐
	b. Know their neighbors?	☐	☐
	c. Neighbors say hello or greets him/her?	☐	☐
	d. Have access to transportation?	☐	☐
	e. Have a curfew or a rule that says what time s/he will have to be back?	☐	☐
11. Employment 	***Does your client(s)***		
	a. Have a job?	☐	☐
	b. If no, know who can help them to find a job?	☐	☐
	c. If yes, work with people who do not have a disability?	☐	☐
12. Money 	***Does your client(s)***		
	a. Have a bank account?	☐	☐
	b. If no, want a bank account?	☐	☐
	c. If yes, know how to get money when s/he needs it?	☐	☐
	d. Pick the person to help manage his/her money?	☐	☐

Comments:

If you have any questions, want more information or would like someone to contact you regarding your comments, please leave your name and most convenient way to contact you.

Name: _____

Phone: _____

Mailing address: _____

Email address: _____

Thank you for participating and your answers are very important to us!

APPENDIX AC: HCBS Provider Attestation and Evidence Tool

HCBS Final Rule Compliance: Non-Residential Provider Attestation and Evidence Tool

Instructions: This is completed by a licensed/certified residential care services provider (e.g., ADC and ADH). The setting must be integrated, least restrictive, and affords the member to have full access to the benefits of community living.

Complete each section by providing a YES, NO, or NA answer, if applicable. The provider must demonstrate compliance with HCBS setting rules by completing this attestation form. This form will serve as evidence of compliance to policies, procedures, and operating practices implemented and evaluated during the credentialing and contracting process with a health plan.

Any "Yes" response, the provider must provide evidence to demonstrate compliance. Evidence documentation includes, but is not limited to:

- Provider policies and procedures
- Member rights and responsibilities
- Example of member choice of activities and schedules
- Example of member transportation log
- Example of member visitor log
- Member individualized schedules (redacted)
- Member Health and Functional Assessment (redacted)
- Member Health Action Plan (redacted)
- Member Rights Modification Plan (redacted)
- Photos and/or architectural renderings of physical space
- Training curriculum and materials

Any "No" response with no health and safety risk preventing the member from exercising the right, the provider must provide a copy of documentation that the health plan reeducated the member of their individual rights, informed member of the intent of the HCBS final rule, and/or discussed person-centered goal setting. ****** Applies to HCBS Questions 1-26 only. ******

*Any "No" response with a health and safety risk preventing the member from exercising the right, the provider must provide a copy of the risk modification plan, section entitled 'Member's Rights Modification Plan' of Health Action Plan. ************ The completion of a modification plan applies to HCBS Questions 27-31 only. *************

EXAMPLE: A provider responded "No" to HCBS Requirement 8 Physical Accessibility. A member with Alzheimer's has a health and safety risk which limits access to areas of the setting. The provider shall submit to the health plan, but not limited to:

1) Policies and procedures to address individual rights and modifications process to HCBS Requirement 8 Physical Accessibility.
2) Member rights and responsibilities
3) Member residency or legal agreement (blank or redacted)
4) Member Health and Functional Assessment (redacted)
5) Member Health Action Plan (redacted)
6) Member Rights Modification Plan (redacted)

Please attach full copies of each evidence document referenced. For each evidence line, please provide the name of the document, the specific excerpt or language from that document that demonstrates compliance, and cite the section, page number, or other appropriate reference from the document.

*****PLEASE ENSURE PROTECTED HEALTH INFORMATION/PERSONAL INFORMATION IS REDACTED FROM EVIDENCE*****

HCBS Final Rule Compliance: Non-Residential Provider Attestation and Evidence Tool

Date:	
Health Plan Name: (Check all that apply)	AlohaCare .....◯ HMSA.....◯ Kaiser Permanente .....◯ Ohana .....◯ UnitedHealth Care.....◯
Medicaid Provider Name:	
Medicaid Provider ID#:	
NPI#: (if applicable)	
Phone:	
Email:	
Servicing Address:	

I, _____, attest to have reviewed the HCBS Settings Final Rule requirements (Name of Authorized Person)
and understand the expectations as a Medicaid provider. The evidence presented to the health plans as part of credentialing is true, accurate and complete and understand that any falsification or omission of information may warrant further evaluation by the health plan.

_____ _____ _____

Signature of Authorized Person | Title | Date

HCBS Requirement - Physical Location: Home and community-based settings do not include nursing facilities, institutions for mental diseases, intermediate care facilities for individuals with intellectual disabilities, hospitals, settings that isolate members from the broader community, or any other locations that have qualities of an institutional setting. **Responses to this section is based on the provider evaluation of the servicing address.*		**Mark the answer that applies**	
		Yes	**No**
A.	The setting is NOT located in a building, attached to a building, on the grounds of, or immediately adjacent to a publicly or privately operated facility that provides inpatient institutional treatment (e.g., nursing home, hospital)		
B.	The setting is NOT located where there are multiple settings serving people with disabilities co-located and operated or controlled by the same provider agency (e.g., a street with multiple care homes, in a row, owned by same provider)		
C.	The setting is NOT surrounded by high walls, high fences, security locks or gates.		
D.	The setting IS located in a community with other private homes, retail businesses, food establishments, and other community resources.		

HCBS Final Rule Compliance: Non-Residential Provider Attestation and Evidence Tool

Requirement 1: The setting is integrated in the community and supports the same access for Medicaid and non-Medicaid enrollees receiving HCBS services. [42 CFR 441.301 (c)(4)(i)]		**Mark the answer that applies**		
		NA	**Yes**	**No**
1.	Are Members able to control their own daily schedules and activities?			
2.	Are Members able to come and go (with or without supports) from the setting at any time without restrictions?			
3.	Are Members supported to explore and pursue competitive integrated employment in the community if Members choose to do so?			
4.	Are Members supported to engage in off-site community activities based on their individual preferences, such as shopping, dining, religious activities, voting, volunteering, personal appointments?			
5.	Are Members provided (or supported to access) transportation to/from the setting for community and social activities of their choosing?			
6.	Are Members supported to access and keep/carry their own money?			
7.	Are Members supported to control their own personal belongings and resources?			
HCBS Requirement 2: Person-centered plan is based on the individual's needs and preferences. [42 CFR 441.301 (c)(4)(ii)]			**Yes**	**No**
8.	Are Members supported to lead and actively participate in their person-centered planning process, including pre-planning and planning meetings?			
9.	Do Members have regular opportunities to update their plan, including their activities and preferences, or when there is a change in their needs?			
10.	Are Members able to receive services and supports in location(s) of their choosing?			
HCBS Requirement 3: Right to privacy, dignity, and respect and freedom from coercion and restraint. [42 CFR 441.301 (c)(4)(iii)]		NA	Yes	No
11.	Are Members supported to know and understand their program rights, including access to a copy of the rights in a manner and format that is accessible and understandable for them?			
12.	Do Members know what to do if Members have a problem with support staff or their services (i.e., do Members know how to reach out to their case manager, or how to file an anonymous complaint)?			
13.	Are Members supported to access information on resources like the Hawaii Disability Rights Center (HDRC) and Adult Protective Services (APS)?			
14.	Do Members feel that support staff interact and communicate with Members respectfully and in a manner that Members would like to be addressed?			
15.	Do Members know that support staff are trained on appropriate use of restrictive interventions if written in individualized plan?			
16.	Do Members know if their personal information is kept private and maintained in a secure location?			
17.	Do Members have privacy when personal care is provided?			
18.	Do Members have support staff promote informed decision-making?			
19.	Do Members have privacy when using the phone or internet?			

HCBS Requirement 4: Individual initiative, autonomy, and independence in making life choices including but not limited to daily activities, physical environment, and with whom to interact. [42 CFR 441.301 (c)(4)(iv)]		Yes	No
20.	Do Members have individualized and variable schedules that change (daily or weekly) consistent with their individual preferences and needs?		
21.	Are Members supported to make informed choices, and to exercise those choices, about opportunities to participate in activities of interest, both within the setting and in the broader community?		
22.	Are Members supported if Members want to use, or learn how to use, public transportation options (e.g., bus schedules, training to use the bus, etc.)?		
23.	Do Members have opportunities to develop and maintain relationships with people from the broader community, including people without disabilities?		
HCBS Requirement 5: Choice regarding services, supports, and who provides them. [42 CFR 441.301 (c)(4)(v)]		Yes	No
24.	Are Members asked about their needs and preferences, and are Members provided support to understand their choices and make informed decisions?		
25.	Are Members supported to know how to request a change in service provider, setting, or support staff?		
26.	Do Members know how to relocate or request new day program if Members choose to move?		

HEALTH AND SAFETY RISKS

HCBS Requirement 6: Freedom and support [42 CFR 441.301 (c)(4)(vi)(C)]		Yes	No
27.	Are Members able to control their own daily schedules and activities?		
28.	Do Members have access food of their choosing at any time, without restrictions? (e.g., without limitations on where food can be consumed, or offering substitute meal options in residential settings)		
HCBS Requirement 7: Right to visitors and access to family and friends. [42 CFR 441.301 (c)(4)(vi)(D)]		Yes	No
29.	Are Members allowed to have visitors at any time, without restrictions?		
30.	Do Members have a comfortable private place for Members to meet with visitors?		
HCBS Requirement 8: Physically accessible to the member. [42 CFR 441.301 I(4)(vi)(E)]		Yes	No
31.	Do Members have physical access to areas around the setting (i.e., are Members able to maneuver through the hallways, doorways, bathrooms, and common areas with or without assistive devices such as walkers and wheelchairs)?		

HCBS Final Rule Compliance: Residential Provider

Instructions: This is completed by a licensed/certified residential care setting (e.g., CCFFH, EARCH, or ALF). The setting must be integrated, least restrictive, and affords the member to have full access to the benefits of community living.

Complete each section by providing a YES, NO, or NA answer, if applicable. The provider must demonstrate compliance with HCBS setting rules by completing this attestation form. This form will serve as evidence of compliance to policies, procedures, and operating practices implemented and evaluated during the credentialing and contracting process with a health plan.

Any "Yes" response, the provider must provide evidence to demonstrate compliance. Evidence documentation includes, but is not limited to:

- Provider policies and procedures
- Member rights and responsibilities
- Member residency or legal agreement (blank or redacted)
- Example of member choice of activities and schedules
- Example of member transportation log
- Example of member visitor log
- Member individualized schedules (redacted)
- Member Health and Functional Assessment (redacted)
- Member Health Action Plan (redacted)
- Member Rights Modification Plan (redacted)
- Photos and/or architectural renderings of physical space
- Training curriculum and materials

Any "No" response with no health and safety risk preventing the member from exercising the right, the provider must provide a copy of documentation that the health plan reeducated the member of their individual rights, informed member of the intent of the HCBS final rule, and/or discussed person-centered goal setting. ****** Applies to HCBS Questions 1-26 only. ******

*Any "No" response with a health and safety risk preventing the member from exercising the right, the provider must provide a copy of the risk modification plan, section entitled 'Member's Rights Modification Plan' of Health Action Plan. ************ **The completion of a modification plan applies to HCBS Questions 27-36 only.** *************

EXAMPLE: A provider responded "No" to HCBS Requirement 10 Physical Accessibility. A member with Alzheimer's has a health and safety risk which limits access to areas of the setting. The provider shall submit to the health plan, but not limited to:

1) Policies and procedures to address individual rights and modifications process to HCBS Requirement 10 Physical Accessibility.
2) Member rights and responsibilities
3) Member residency or legal agreement (blank or redacted)
4) Member Health and Functional Assessment (redacted)
5) Member Health Action Plan (redacted)
6) Member Rights Modification Plan (redacted)

Please attach full copies of each evidence document referenced. For each evidence line, please provide the name of the document, the specific excerpt or language from that document that demonstrates compliance, and cite the section, page number, or other appropriate reference from the document.

*****PLEASE ENSURE PROTECTED HEALTH INFORMATION/PERSONAL INFORMATION IS REDACTED FROM EVIDENCE*****

HCBS Final Rule Compliance: Residential Provider

Date:	
Health Plan Name: (Check all that apply)	AlohaCare..... ◯ HMSA ..... ◯ Kaiser Permanente..... ◯ Ohana..... ◯ UnitedHealth Care ◯
Medicaid Provider Name:	
Medicaid Provider ID#:	
NPI#: (if applicable)	
Phone:	
Email:	
Servicing Address:	

I, _____, attest to have reviewed the HCBS Settings Final Rule requirements (Name of Authorized Person)
and understand the expectations as a Medicaid provider. The evidence presented to the health plans as part of credentialing is true, accurate and complete and understand that any falsification or omission of information may warrant further evaluation by the health plan.

_____ _____ _____

Signature of Authorized Person Title Date

HCBS Requirement - Physical Location: Home and community-based settings do not include nursing facilities, institutions for mental diseases, intermediate care facilities for individuals with intellectual disabilities, hospitals, settings that isolate members from the broader community, or any other locations that have qualities of an institutional setting.
**Responses to this section is based on the provider evaluation of the servicing address.*

	HCBS Requirement - Physical Location: Home and community-based settings do not include nursing facilities, institutions for mental diseases, intermediate care facilities for individuals with intellectual disabilities, hospitals, settings that isolate members from the broader community, or any other locations that have qualities of an institutional setting. **Responses to this section is based on the provider evaluation of the servicing address.*	**Mark the answer that applies**	
		Yes	**No**
A	The setting is NOT located in a building, attached to a building, on the grounds of, or immediately adjacent to a publicly or privately operated facility that provides inpatient institutional treatment (e.g., nursing home, hospital)		
B	The setting is NOT located where there are multiple settings serving people with disabilities co-located and operated or controlled by the same provider agency (e.g., a street with multiple care homes, in a row, owned by same provider)		
C	The setting is NOT surrounded by high walls, high fences, security locks or gates.		
D	The setting IS located in a community with other private homes, retail businesses, food establishments, and other community resources.		

HCBS Final Rule Compliance: Residential Provider

	Requirement 1: The setting is integrated in the community and supports the same access for Medicaid and non-Medicaid enrollees receiving HCBS services. [42 CFR 441.301 (c)(4)(i)]	**Mark the answer that applies**		
		NA	**Yes**	**No**
1.	Are Members able to control their own daily schedules and activities?			
2.	Are Members able to come and go (with or without supports) from the setting at any time without restrictions?			
3.	Are Members supported to explore and pursue competitive integrated employment in the community if Members choose to do so?			
4.	Are Members supported to engage in off-site community activities based on their individual preferences, such as shopping, dining, religious activities, voting, volunteering, personal appointments?			
5.	Are Members provided (or supported to access) transportation to/from the setting for community and social activities of their choosing?			
6.	Are Members supported to access and keep/carry their own money?			
7.	Are Members supported to control their own personal belongings and resources?			
	HCBS Requirement 2: Person-centered plan is based on the individual's needs and preferences. [42 CFR 441.301 (c)(4)(ii)]		**Yes**	**No**
8.	Are Members supported to lead and actively participate in their person-centered planning process, including pre-planning and planning meetings?			
9.	Do Members have regular opportunities to update their plan, including their activities and preferences, or when there is a change in their needs?			
10.	Are Members able to receive services and supports in location(s) of their choosing?			
	HCBS Requirement 3: Right to privacy, dignity, and respect and freedom from coercion and restraint. [42 CFR 441.301 (c)(4)(iii)]	NA	Yes	No
11.	Are Members supported to know and understand their program rights, including access to a copy of the rights in a manner and format that is accessible and understandable for them?			
12.	Do Members know what to do if Members have a problem with support staff or their services (i.e., do Members know how to reach out to their case manager, or how to file an anonymous complaint)?			
13.	Are Members supported to access information on resources like the Hawaii Disability Rights Center (HDRC) and Adult Protective Services (APS)?			
14.	Do Members feel that support staff interact and communicate with Members respectfully and in a manner that Members would like to be addressed?			
15.	Do Members know that support staff are trained on appropriate use of restrictive interventions if written in individualized plan?			
16.	Do Members know if their personal information is kept private and maintained in a secure location?			
17.	Do Members have privacy when personal care is provided?			
18.	Do Members have support staff promote informed decision-making?			
19.	Do Members have privacy when using the phone or internet?			

HCBS Requirement 4: Individual initiative, autonomy, and independence in making life choices including but not limited to daily activities, physical environment, and with whom to interact. [42 CFR 441.301 (c)(4)(iv)]		Yes	No
20.	Do Members have individualized and variable schedules that change (daily or weekly) consistent with their individual preferences and needs?		
21.	Are Members supported to make informed choices, and to exercise those choices, about opportunities to participate in activities of interest, both within the setting and in the broader community?		
22.	Are Members supported if Members want to use, or learn how to use, public transportation options (e.g., bus schedules, training to use the bus, etc.)?		
23.	Do Members have opportunities to develop and maintain relationships with people from the broader community, including people without disabilities?		
HCBS Requirement 5: Choice regarding services, supports, and who provides them. [42 CFR 441.301 (c)(4)(v)]		Yes	No
24.	Are Members asked about their needs and preferences, and are Members provided support to understand their choices and make informed decisions?		
25.	Are Members supported to know how to request a change in service provider, setting, or support staff?		
26.	Do Members know how to relocate or request new day program if Members choose to move?		

HEALTH AND SAFETY RISKS

***HCBS Requirement 6:** Lease or other legally enforceable agreement providing the same responsibilities and protections from eviction that tenants have under state landlord or local landlord tenant laws. [42 CFR 441.301 (c)(4)(vi)(A)]		Yes	No
27.	Do Members have a legally enforceable residential agreement with the same responsibilities and protections from evictions that tenants have under state or local landlord-tenant laws?		
***HCBS Requirement 7:** Right to privacy in their living unit [42 CFR 441.301 (c)(4)(vi)(B)(1)], [42 CFR 441.301 (c)(4)(vi)(B)(2)], [42 CFR 441.301 (c)(4)(vi)(B)(3)]		Yes	No
28.	Are Members able to close and lock doors to their personal or private spaces in the setting, including their bedroom and bathroom, with only appropriate staff able to access keys?		
29.	Do Members have the opportunity to choose to have a private room if one is available?		
30.	Do Members have the opportunity to choose and change their roommate situation?		
31.	Are Members able to furnish and decorate their personal or private spaces as Members choose, as described within the lease or residential agreement?		
***HCBS Requirement 8:** Freedom and support [42 CFR 441.301 (c)(4)(vi)(C)]		Yes	No
32.	Are Members able to control their own daily schedules and activities?		
33.	Do Members have access food of their choosing at any time, without restrictions? (e.g., without limitations on where food can be consumed, or offering substitute meal options in residential settings)		
***HCBS Requirement 9:** Right to visitors and access to family and friends. [42 CFR 441.301 (c)(4)(vi)(D)]		Yes	No
34.	Are Members allowed to have visitors at any time, without restrictions?		
35.	Do Members have a comfortable private place for Members to meet with visitors?		
***HCBS Requirement 10:** Physically accessible to the member. [42 CFR 441.301 (4)(vi)(E)]		Yes	No

36.	Do Members have physical access to areas around the setting (i.e., are Members able to maneuver through the hallways, doorways, bathrooms, and common areas with or without assistive devices such as walkers and wheelchairs)?		

APPENDIX AD: Health Plan HCBS Quality Monitoring Tool

HCBS Non-Residential Provider Setting Quality Monitoring Tool

A. Review Date: Self-Explanatory.
B. Review Method: Desk review or onsite review.
C. Health Plan Name: Self-Explanatory.
D. Provider Information: Enter first and last name. Enter street address, city, and zip code.
E. HCBS Requirements: Reviewers shall be familiar with the requirements and expectations.
F. Meets: Check appropriate box to indicate if the provider meets the requirements based on findings.
G. Explain: ONLY provide details as to why the provider does not meet the requirements. Note which documents were reviewed for verification.

Techniques to use to obtain information: The purpose of this review to evaluate and observe the member's life experience and the presence or absence of the qualities of home and community-based settings.

a. A minimal amount of time is observational in nature.
b. A significant amount of time is spent reviewing provider attestation and evidence documents submitted such *Evidence documentation includes, but is not limited to:*

- Provider policies and procedures
- Member rights and responsibilities
- Member residency or legal agreement (blank or redacted)
- Example of member choice of activities and schedules
- Example of member transportation log
- Example of member visitor log
- Member individualized schedules (redacted)
- Member Health and Functional Assessment (redacted)
- Member Health Action Plan (redacted)
- Member Rights Modification Plan (redacted)
- Photos and/or architectural renderings of physical space
- Training curriculum and materials

A. Review Date:	B. Review Method:
C. Health Plan Name:	
D. Provider Information First Name: _____Last Name: _____ Street Address: _____City: _____Zip _____	

	E. HCBS Requirements	F. Meets	G. Explain
1	The setting is integrated in and supports full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as members not receiving Medicaid HCBS. [42 CFR 441.301 (c)(4)(i)] *Expectations:* *The settings allow members to have fully access to the larger community. Transportation is provided or arranged to community activities such as shopping, restaurants, religious institutions, senior centers, etc. Note: Scheduled medical appointments are not considered community integrated activities.* ***Recommend review of provider attestation, member file, HFA/HAP, flow sheets, transportation log, activities/outing logs, etc.***	☐ **YES** ☐ **NO**	
2	The setting is selected by the member from among setting options, including non-disability specific settings. The settings options are identified and documented in the person-centered plan and are based on the member's needs and preferences. [42 CFR 441.301 (c)(4)(ii)] *Expectations:* *The member should be given options and a choice of which service setting meet their needs. The setting should be chosen by the member and detailed on the health action plan.* ***Recommend review of provider attestation, admission policy and agreement, member HFA/HAP, choice form, etc.***	☐ **YES** ☐ **NO**	

3	The setting ensures member's right of privacy, dignity, and respect and freedom from coercion and restraint. [42 CFR 441.301 (c)(4)(iii)]	☐ **YES** ☐ **NO**	

	Expectations: *The member's right to dignity and privacy is protected and respected. For privacy, members may have a curtain or screen and a door that closes. Ensure the member is treated with dignity and respect and spoken to in an age-appropriate manner. Information about the member's conditions and service plan should be maintained in a secure file with only appropriate staff provided access to this information.* ***Recommend review of provider attestation, admission policy and agreement, program assessment, observation, etc.***		
4	The setting optimizes, but does not regiment, member initiative, autonomy, and independence in making life choices including but not limited to daily activities, physical environment, and with whom to interact. [42 CFR 441.301 (c)(4)(iv)] *Expectations:* *The service setting encourages member autonomy and choice and is not regimented.* ***Recommend review of provider attestation, member HFA/HAP, flow sheets, CM monthly visit forms, observation, etc.***	☐ **YES** ☐ **NO**	
5	The setting facilitates member choice regarding services, supports, and who provides them. [42 CFR 441.301 (c)(4)(v)] *Expectations:* *Members and/or their representatives are active members in the person-centered planning process. Members should have a choice of service provider and location where services are provided.* ***Recommend review of provider attestation, member HFA/HAP, etc.***	☐ **YES** ☐ **NO**	
6	Members have the freedom and support • to control their schedules and activities [42 CFR 441.301 (c)(4)(vi)(C)] • to have access to food anytime [42 CFR 441.301 (c)(4)(vi)(C)] *Expectations:*	☐ **YES** ☐ **NO**	

	Members are allowed to choose and vary their schedule including how to spend their day, sleeping schedule, and when to eat. *Members have access to a kitchenette (microwave, refrigerator, and sink), a food preparation area (a place to prepare and reheat foods) that are accessible at any time. Members have a choice of what to eat and are offered a substitute meal if they prefer.* ***Recommend review of provider attestation, member HFA/HAP, admission policy and agreement, daily logs, program assessment, observation i.e., Is food readily available to get or accessible, etc.***		
7	Members have the right to visitors and access to family and friends. [42 CFR 441.301 (c)(4)(vi)(D)] <u>*Expectations:*</u> *Members are able to have visitors at any time of their choosing. Visitors must be allowed outside of visiting hours with reasonable notice. Visitation is not restricted by policies or practices.* ***Recommend review of provider attestation, member HFA/HAP, admission policy and agreement, visitor logs, etc.***	☐ **YES** ☐ **NO**	
8	Setting is physically accessible to the member. [42 CFR 441.301 I(4)(vi)(E)] <u>*Expectations:*</u> *Members are able to maneuver though the hallways, doorways, and common areas with or without assistive devices. Supports are available to members that require them.* ***Recommend review of provider attestation, member HFA/HAP, program assessment i.e., If the member has a walker or wheelchair, does the program have accessible hallways, doorways, etc.***	☐ **YES** ☐ **NO**	

HCBS Residential Provider Setting Quality

A. Review Date: Self-Explanatory.
B. Review Method: Desk review or onsite review.
C. Health Plan Name: Self-Explanatory.
D. Provider Information: Enter first and last name. Enter street address, city, and zip code.
E. HCBS Requirements: Reviewers shall be familiar with the requirements and expectations.
F. Meets: Check appropriate box to indicate if the provider meets the requirements based on findings.
G. Explain: ONLY provide details as to why the provider does not meet the requirements. Note which documents were reviewed for verification.

Techniques to use to obtain information: The purpose of this review to evaluate and observe the member's life experience and the presence or absence of the qualities of home and community-based settings.

a. A minimal amount of time is observational in nature.
b. A significant amount of time is spent reviewing provider attestation and evidence documents submitted such *Evidence documentation includes, but is not limited to:*

- Provider policies and procedures
- Member rights and responsibilities
- Member residency or legal agreement (blank or redacted)
- Example of member choice of activities and schedules
- Example of member transportation log
- Example of member visitor log
- Member individualized schedules (redacted)
- Member Health and Functional Assessment (redacted)
- Member Health Action Plan (redacted)
- Member Rights Modification Plan (redacted)
- Photos and/or architectural renderings of physical space
- Training curriculum and materials

HCBS Residential Provider Setting Quality

A. Date:	B. Review Method:
C. Health Plan Name:	
D. Provider Information First Name: _____Last Name: _____ Street Address: _____City: _____Zip _____	

	E. HCBS Requirements	F. Meets	G. Explain
1	The setting is integrated in and supports full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as members not receiving Medicaid HCBS. [42 CFR 441.301 (c)(4)(i)] *Expectations:* *The settings allow members to have fully access to the larger community. Transportation is provided or arranged to community activities such as shopping, restaurants, religious institutions, senior centers, etc. Note: Scheduled medical appointments are not considered community integrated activities.* ***Recommend review of provider attestation, member file, HFA/HAP, flow sheets, transportation log, activities/outing logs, etc.***	☐ **YES** ☐ **NO**	
2	The setting is selected by the member from among setting options, including non-disability specific settings. The settings options are identified and documented in the person-centered plan and are based on the member's needs and preferences. [42 CFR 441.301 (c)(4)(ii)] *Expectations:* *The member should be given options and a choice of which service setting meet their needs. The setting should be chosen by the member and detailed on the health action plan.* ***Recommend review of provider attestation, admission policy and agreement, member HFA/HAP, choice form, etc.***	☐ **YES** ☐ **NO**	

3	The setting ensures an member's right of privacy, dignity, and respect and freedom from coercion and restraint. [42 CFR 441.301 (c)(4)(iii)]	☐ **YES** ☐ **NO**	

	Expectations: *The member's right to dignity and privacy is protected and respected. For privacy, members may have a curtain or screen and a door that closes. Ensure the member is treated with dignity and respect and spoken to in an age-appropriate manner. Information about the member's conditions and service plan should be maintained in a secure file with only appropriate staff provided access to this information.* ***Recommend review of provider attestation, admission policy and agreement, home assessment, observation, etc.***		
4	The setting optimizes, but does not regiment, member initiative, autonomy, and independence in making life choices including but not limited to daily activities, physical environment, and with whom to interact. [42 CFR 441.301 (c)(4)(iv)] *Expectations:* *The service setting encourages member autonomy and choice and is not regimented.* ***Recommend review of provider attestation, member HFA/HAP, flow sheets, CM monthly visit forms, observation, etc.***	☐ **YES** ☐ **NO**	
5	The setting facilitates member choice regarding services, supports, and who provides them. [42 CFR 441.301 (c)(4)(v)] *Expectations:* *Members and/or their representatives are active members in the person-centered planning process. Members should have a choice of service provider and location where services are provided.* ***Recommend review of provider attestation, member HFA/HAP, etc.***	☐ **YES** ☐ **NO**	
6	Members have a lease or other legally enforceable agreement providing the same responsibilities and protections from eviction that tenants have under state landlord or local landlord tenant laws. [42 CFR 441.301 (c)(4)(vi)(A)] *Expectations:*	☐ **YES** ☐ **NO**	

	The member has the same landlord/tenant protections, is protected from eviction and afforded appeal rights as persons not receiving Medicaid HCBS services. ***Recommend review of provider attestation, member HFA/HAP, etc.***		
7	Members have the right to privacy in their living unit including • lockable doors [42 CFR 441.301 (c)(4)(vi)(B)(1)] • choice of roommates [42 CFR 441.301 (c)(4)(vi)(B)(2)] • the freedom to furnish or decorate unit [42 CFR 441.301 (c)(4)(vi)(B)(3)] *Expectations:* *Members have the right to privacy including lockable doors unless the member's physical or cognitive condition means their safety could be compromised if afforded privacy.* *Note: A single motion lockable door is recommended.* *Members have the right to choose to change rooms and/or change roommate.* *Members have the ability furnish or decorate unit to maintain personal space according to preferences.* ***Recommend review of provider attestation, member HFA/HAP, admission policy and agreement, home assessment, etc.***	☐ **YES** ☐ **NO**	

8	Members have the freedom and support • to control their schedules and activities [42 CFR 441.301 (c)(4)(vi)(C)] • to have access to food anytime [42 CFR 441.301 (c)(4)(vi)(C)] *<u>Expectations:</u>* *Members are allowed to choose and vary their schedule including how to spend their day, sleeping schedule, and when to eat.* *Members have access to a kitchenette (microwave, refrigerator and sink), a food preparation area (a place to prepare and reheat foods) that are accessible at any time. Members have a choice of what to eat and are offered a substitute meal if they prefer.* ***Recommend review of provider attestation, member HFA/HAP, admission policy and agreement, daily logs,***	☐**YES** ☐**NO**	

	home assessment, observation i.e., Is food readily available to get or accessible, etc.		
9	Members have the right to visitors and access to family and friends. [42 CFR 441.301 (c)(4)(vi)(D)] *Expectations:* *Members are able to have visitors at any time of their choosing. Visitors must be allowed outside of visiting hours with reasonable notice. Visitation is not restricted by policies or practices.* ***Recommend review of provider attestation, member HFA/HAP, admission policy and agreement, visitor logs, etc.***	☐ **YES** ☐ **NO**	
10	Setting is physically accessible to the member. [42 CFR 441.301 I(4)(vi)(E)] *Expectations:* *Members are able to maneuver though the hallways, doorways, and common areas with or without assistive devices. Supports are available to members that require them.* ***Recommend review of provider attestation, member HFA/HAP, home assessment i.e., If the member has a walker or wheelchair, does the home have accessible hallways, doorways, etc.***	☐ **YES** ☐ **NO**	

APPENDIX AE: Health Plan HCBS Member Satisfaction Survey

Name of Member: _____ Date: _____

HCBS Services (select all that apply): PA Level 1 PA Level 2 PA CD SN/PDN

Instructions: This survey is completed when the member receives personal care assistance or nursing services in own home. These setting must be integrated, least restrictive, and affords the member to have full access to the benefits of community living. This survey shall reflect the setting is of the member's choosing, provides support to the member to integrate into their community of choice as defined by their interests, preferences, abilities and health and safety risks. Health plan must complete this survey within 3 months of the annual reassessment. For adult members only. Health plan must document reason if unable to administer survey.

Any "No" response with no health and safety risk preventing the member from exercising the right will require documentation that the health plan reeducated the member of their individual rights, informed member of the intent of the HCBS final rule, and/or discussed person-centered goal setting. ****** Applies to HCBS Questions 1-26 only. ******

Any "No" response with a health and safety risk preventing the member from exercising the right will require the health plan to complete a risk modification plan, section entitled 'Member's Rights Modification Plan' of Health Action Plan. ********** ***The completion of a modification plan applies to HCBS Questions 27-31 only.*** **********

HCBS Requirement 1: The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS. [42 CFR 441.301 (c)(4)(i)]

1	Are you able to control your own daily schedules and activities?	Y/N
2	Are you able to come and go (with or without supports) from the setting at any time without restrictions?	Y/N
3	Are you supported to explore and pursue competitive integrated employment in the community if you choose to do so?	Y/N/NA
4	Are you supported to engage in off-site community activities based on your individual preferences, such as shopping, dining, religious activities, voting, volunteering, personal appointments?	Y/N
5	Are you provided (or supported to access) transportation to/from the setting for community and social activities of your choosing?	Y/N
6	Are you supported to access and keep/carry your own money?	Y/N
7	Are you supported to control your own personal belongings and resources?	Y/N

HCBS Requirement 2: The setting is selected by the individual from among setting options, including non-disability specific settings. The settings options are identified and documented in the person-centered plan and are based on the individual's needs and preferences. [42 CFR 441.301 (c)(4)(ii)]

8	Are you supported to lead and actively participate in your person-centered planning process, including pre-planning and planning meetings?	Y/N
9	Do you have regular opportunities to update your plan, including your activities and preferences, or when there is a change in your needs?	Y/N
10	Are you able to receive services and supports in location(s) of your choosing?	Y/N/NA

HCBS Requirement 3: The setting ensures an individual's right of privacy, dignity, and respect and freedom from coercion and restraint. [42 CFR 441.301 (c)(4)(iii)]

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11	Are you supported to know and understand your program rights, including access to a copy of the rights in a manner and format that is accessible and understandable?	Y/N
12	Do you know what to do if you have a problem with support staff or your services (i.e., do you know how to reach out to your health plan coordinator, or how to file an anonymous complaint)?	Y/N
13	Are you supported to access information on resources like the Hawaii Disability Rights Center (HDRC) and Adult Protective Services (APS)?	Y/N
14	Do you feel that support staff interact and communicate with you respectfully and in a manner that you would like to be addressed?	Y/N
15	Do you know that support staff are trained on appropriate use of restrictive interventions if written in individualized plan?	Y/N/NA
16	Do you know if your personal information is kept private and maintained in a secure location?	Y/N
17	Do you have privacy when personal care is provided?	Y/N
18	Do you have support staff promote informed decision-making?	Y/N
19	Do you have privacy when using the phone or internet?	Y/N

HCBS Requirement 4: The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices including but not limited to daily activities, physical environment, and with whom to interact. [42 CFR 441.301 (c)(4)(iv)]

20	Do you have individualized and variable schedules that change (daily or weekly) consistent with your individual preferences and needs?	Y/N
21	Are you supported to make informed choices, and to exercise those choices, about opportunities to participate in activities of interest, both within the setting and in the broader community?	Y/N
22	Are you supported if you want to use, or learn how to use, public transportation options (e.g., bus schedules, training to use the bus, etc.)?	Y/N
23	Do you have opportunities to develop and maintain relationships with people from the broader community, including people without disabilities?	Y/N

HCBS Requirement 5: The setting facilitates individual choice regarding services, supports, and who provides them. [42 CFR 441.301 (c)(4)(v)]

24	Are you asked about your needs and preferences, and are you provided support to understand your choices and make informed decisions?	Y/N
25	Are you supported to know how to request a change in service provider, setting, or support staff?	Y/N
26	Do you know how to relocate or request new day program if you choose to move?	Y/N

***HCBS Requirement 6**: Members have the freedom and support

- to control their schedules and activities [42 CFR 441.301 (c)(4)(vi)(C)]
- to have access to food anytime [42 CFR 441.301 (c)(4)(vi)(C)]

27	Are you able to control your own daily schedules and activities?	Y/N
28	Do you have access food of your choosing at any time, without restrictions? (e.g., without limitations on where food can be consumed, or offering substitute meal options in residential settings)	Y/N

***HCBS Requirement 7:** Members have the right to visitors and access to family and friends. [42 CFR 441.301 (c)(4)(vi)(D)]

29	Are you allowed to have visitors at any time, without restrictions?	Y/N

30	Do you have a comfortable private place for you to meet with visitors?	Y/N

***HCBS Requirement 8**: Setting is physically accessible to the member. [42 CFR 441.301 (c)(4)(vi)(E)]

31	Do you have physical access to areas around the setting (i.e., are you able to maneuver through the hallways, doorways, bathrooms, and common areas with or without assistive devices such as walkers and wheelchairs)?	Y/N

At the conclusion of the survey, the Health Plan must check all that apply:

☐ Any "No" response with no health and safety risk preventing the member from exercising the right the health plan reeducated of member's individual rights, informed member of the intent of the HCBS final rule, and/or discussed person-centered goal setting. ****** Applies to HCBS Questions 1-26 only. ******

☐ Any "No" response with a health and safety risk preventing the member from exercising the right the health plan verified and completed the Member's Rights Modification Plan section of the Health Action Plan. ****** Applies to HCBS Questions 27 and 31 only. ******