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April 30, 2018

MEMORANDUM

MEMO NO.
CCS-1801

TO: 'Ohana Behavioral Health Organization

FROM: Judy Mohr Peterson, PhD
Med-QUEST Division Administrator

SUBJECT: ANNUAL REPORTING AND MONITORING ACTIVITIES
PERIOD: JANUARY 1, 2018 – DECEMBER 31, 2018

Annually, the Med-QUEST Division's (MQD's) Health Care Services Branch (HCSB) and the External Quality Review Organization (EQRO) assess the quality and appropriateness of behavioral health care services being provided in the Community Care Services (CCS) program. MQD closely monitors access to those services, and evaluates the behavioral health organization's (BHO's) compliance with State and Federal Medicaid managed care requirements. When necessary, MQD imposes corrective actions and appropriate sanctions if the BHO is not in compliance with these requirements and standards. This memorandum includes the reporting/monitoring narrative and calendar of the monitoring activities. (Including reporting requirements for the Finance Office (FO) from *January 1, 2018 and continuing through December 31, 2018*).

The EQRO, Health Services Advisory Group, Inc. (HSAG), and MQD will be issuing separate memos with the information requirements related to the EQRO's monitoring of the BHO's compliance with the Medicaid managed care provisions of the 1997 Balanced Budget Act (BBA). The HSAG will be utilizing the compliance protocol Version 2.0, September 2012 by the Centers for Medicare & Medicaid Services (CMS), unless otherwise designated as National Committee for Quality Assurance (NCQA) protocols.

Clarification of the reporting/monitoring activities is as follows:

A quality improvement program is an important and necessary component of a BHO's activities to ensure that its members are provided with access to cost-effective quality care. Quality improvement programs provide the BHO with a means of ensuring the best possible behavioral health outcomes and functional health status of its members through delivery of the most appropriate level of care and treatment. Quality of care is defined as care that is accessible and efficient, provided in the appropriate setting, provided according to professionally accepted standards, and provided in a coordinated and continuous rather than episodic manner (RFP 50.410). The BHO retains ultimate responsibility for all delegated activities, and the results of these activities, where applicable, should be included in the appropriate reports.

MQD reviews focus primarily on Quality Improvement. Generally, the BHO will have 30-calendar days from the date of receipt of a report to respond to MQD's request for follow-up, actions, information, etc., as applicable. In instances when the BHO must respond to a finding, MQD's expectation is that the BHO will submit a written response and clearly describe the actions taken to resolve the issue(s). If the issue(s) has/have not been fully resolved, a comprehensive corrective action plan including the timetable(s) and the identification of the individual responsible for completing the action shall be submitted to MQD. In certain circumstances (i.e., concerns or issues that remain unresolved or repeated from previous reviews or urgent quality issues), MQD may require a 10-calendar day corrective action plan in lieu of the 30-calendar day response time. MQD reserves the right to extend our 30-day review period as circumstances dictate. Regarding report deadlines that end on the last day of the month, if the last day falls on a non-working day, then the report(s) is/are due the first working day after the due date.

Medical record reviews will normally require that you submit all components of requested information prior to the scheduled review. The BHO is responsible for assuring that MQD and the EQRO have access to the medical records throughout the on-site review as well as providing a copy of the requested records for MQD and the EQRO. The BHO is allotted 60-calendar days from the date of notification request to prepare for the medical record reviews. MQD reserves the right to request additional data, information and reports from the BHO as needed to comply with CMS requirements and for its own management purposes (RFP 50.780).

When MQD and/or the EQRO request policies and procedures (P&P's), the most current signed copy, with the official approval date, should be submitted. Please remember that if any subsequent changes are made to P&Ps, the BHO must submit a signed and dated approved copy to MQD within 30-calendar days of the P&P change. If the BHO has previously submitted a copy of a specific P&P to MQD and the EQRO and there have been no changes, the BHO must state so in writing and include information as to when and to whom the P&P was submitted. If there are no P&Ps for a specific area, then other written documentation such as workflow

charts, organizational charts, committee reporting structure diagrams, etc., must accurately document and reflect the actions taken by the BHO. These documents must also be dated and submitted to the appropriate MQD personnel for approval.

MQD and the EQRO staff may conduct an on-site review either independently or jointly. A follow-up on-site review may be scheduled as needed, to verify implementation or to monitor the progress of any requested corrective action plans submitted to MQD. Additionally, review of documentation that addresses other issues or deficiencies identified may initiate an on-site visit to the BHO for verification of implementation. MQD may inspect and audit any records of the BHO and its subcontractors or provider (RFP Section 50.610).

All information, data, reports and medical records, including behavioral health and substance abuse records, shall be provided to DHS by the specified deadlines in a format described by MQD. Each report shall be submitted to the FTP site using the appropriate code listed in this Memo. Timeliness of reporting must be maintained. The BHO may be assessed a penalty for each late report of $200/day until the required information, data, report and medical records are received by MQD (RFP Section 61.720).

In an effort to establish a central depository site for tracking of all health plan deliverables, we have designated key staff members to receive all required reports at mqdcmcs@dhs.hawaii.gov. ***Electronic versions of these reports shall be submitted in the form and format approved by MQD, and shall be submitted to MQD via the FTP server*** with the exception of the BHO Financial Reporting Guide which will be submitted directly to the Finance Office. Reports will then be distributed to the responsible MQD Branch staff for review and analysis.

Please contact Kris Tsuda, Behavioral Health Nurse Consultant, at (808) 692-8154 should you require clarification concerning any of the reporting/monitoring activities.

c: Tom Miller (HSAG)

Attachments:
CCS 2018 Calendar
Disclosure Attachment
QI Certification and Disclosure Forms
QI Financial Reporting Forms
QI Financial Reporting Guide
QI FQHC MCO Quarterly_Annual Reporting Requirements

1179 – Summary of Change of Member Demographics

RFP Requirements:	***RFP Section 50.730***
Report Scope:	***Monthly, reporting all activities during the report month***
Report Period(s):	***Twelve (12) one-month periods starting January and ending December of the report year***
Report Due Date(s):	***The 15th of each month***
Report Formats:	***Electronic file in a format described by MQD***
Code:	***1179_(YYMM)*** ***Example: 1179_1801, 1179_1802, 1179_1803, etc.***

Required Report Information:

Reports shall be submitted using the format provided by the DHS.

Behavioral Health Services Report

RFP Requirements:	***RFP Section 50.730 and 50.750.2***
Report Scope:	***Quarterly, reporting all activities during the report quarter***
Report Period(s):	***Four (4) three-month periods, from January through March, April through June, July through Septemberand October through December***
Report Due Date(s):	***Forty-five (45) days after period end***
Report Formats:	***Electronic file in a format described by MQD***
Code:	***BHS_1803, BHS_1806, BHS_1809, BHS_1812***

Required Report Information:

Reports shall include information on services provided by acuity of member as defined in Section 40.220, sentinel incident reporting related to SPMI diagnosis, follow-up within seven (7) days after discharge from acute psychiatric admission, and any other quality measure that the DHS deems necessary.

Reports shall be submitted using the format provided by the DHS.

CCS Financial Reporting Guide Report (BHO Financial Reporting Guide)

RFP Requirements:	***RFP Section 50.730 and 50.760.4***
Report Scope:	***Annually, reporting all activities during the report year***
	Quarterly, reporting all activities during the report quarter
Report Period(s):	***One (1) twelve month period, from January through December***
	Four (4) three-month periods, from January through March, April through June, July through September and October through December
Report Due Date(s):	***Annually, April 30th***
	Quarterly, Forty-five (45) days after period end
Report Formats:	***Electronic file in a format described by MQD***
Code:	***CFGA_18 (Annual Report)***
	CFG_1803, CFG_1806, CFG_1809, CFG_1812

Required Report Information:

Refer to attachments: **QI Financial Reporting Guide**, **QI FinancialReporting Forms** and **QI Certification and Disclosure Forms**

The BHO shall submit financial information on a regular basis in accordance with the BHO Financial Reporting Guide provided by DHS. The financial information shall be analyzed and compared to industry standards and DHS-established standards to ensure BHO's financial solvency. DHS may also monitor financial solvency of the BHO with onsite inspections and audits.

- Financial reports must adequately reflect all direct and indirect expenditures and management and fiscal practices related to the BHO's performance of services under this contract.

Disclosure of Information on Annual Business Transactions Report

RFP Requirements:	***RFP Section 50.730 and 60.600***
Report Scope:	***At a minimum, annually***
Report Period(s):	***Upon contract extension or renewal; Annually (if no contract extension or renewal); and within thirty-five (35) days after any change in ownership of the health plan.***
Report Due Date(s):	***Annually, October 31***
Report Formats:	***Electronic file in a format described by MQD***
Code:	***ABT_18 (Annual Report) ABT_date (Contract extension renewal date or 30-day report)***

Required Report Information:

Refer to attachment: **Disclosure Attachment**

Report must disclose information on the following types of transactions:

- Any sale, exchange, or lease of any property between the health plan and a party in interest (as defined in Section 1318(b) of the Public Health Service Act);
- Any lending of money or other extension of credit between the health plan and a party in interest; and
- Any furnishing for consideration of goods, services (including management services) or facilities between the health plan and the party in interest (does not include salaries paid to employees for services provided in the normal course of their employment).

Health plan shall include the following information in the transactions listed above:

- Name of the party in interest for each transaction;
- Description of each transaction and the quantity or units involved;
- Accrued dollar value of each transaction during the fiscal year; and
- Justification of the reasonableness of each transaction.

The health plan shall provide the information listed below to DHS in a format determined by the DHS:

(1)(i) The name and address of any person (individual or corporation) with an ownership or controlling interest in the health plan. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address(es).
(ii) Date of birth and Social Security Number (in the case of an individual).
(iii) Other tax identification number (in the case of a corporation) with an ownership or control interest in the health plan or in any subcontractor in which the health plan has a 5 percent or more interest.

(2) Whether the person with an ownership or control interest in the health plan is related to another person with ownership or control interest in the health plan as a spouse, parent, child, or sibling; or whether the person with an ownership or control interest in any subcontractor in which the health plan has a 5 percent or more interest is related to another person with ownership or control interest in the health plan as a spouse, parent, child, or sibling.

(3) The name of any other disclosing entity, as defined in 42 CFR Section 455.101 (or fiscal agent or managed care entity) in which an owner of the provider has an ownership or control interest.

(4) The name, address, date of birth, and Social Security Number of any managing employee of the health plan.

The health plan shall submit this information at the following times:

- Upon contract extension or renewal;
- Annually (if no contract extension or renewal); and
- Within thirty-five (35) days after any change in ownership of the health plan.

Encounter Data Reporting (BHO Certification)

RFP Requirements:	***RFP Section 50.770***
Report Scope:	***Monthly, reporting all claim activities during the report month***
Report Period(s):	***Twelve (12) one-month periods starting January and ending December of the report year***
Report Due Date(s):	***The first and/or third Wednesday of each month***
Report Formats:	***Based on Health Plan Encounter Manual***

The BHO is required to submit encounters to MQD at least once per month. The BHO has the option to submit encounters twice a month. Encounters must be submitted following the guidelines in the Health Plan Encounter Manual. Each encounter submission must be certified and submitted by the BHO as required in 42 CFR §438.606 and as specified in Section 50.770.

Reporting Timelines/Sanctions

- *BHO will be notified within 30 days of submission or completion of accuracy edits;*
- *If failed, BHO shall be granted a 30-day error resolution period; and*
- *If at the end of 30 days, the BHO accuracy and completion edits failure exceeds 15%, a penalty up to 10% of the monthly capitation shall be assessed.*

FQHC or RHC Services Rendered Report (Quarterly/ Annually)

RFP Requirements:	***RFP Section 50.730***
Report Scope:	***Annually, reporting all activities during the report year***
	Quarterly, reporting all activities during the report quarter
Report Period(s):	***One (1) twelve month period, from January through December***
	Four (4) three-month periods, from January through March, April through June, July through September and October through December
Report Due Date(s):	***May 31st following the report period end (Annual)***
	The last day of the first month following the report period end
Report Formats:	***Electronic file in a format described by MQD***
Code:	***FQHA_18 (Annual Report)***
	FQH_1803, FQH_1806, FQH_1809, FQH_1812

Required Report Information:

Refer to the attachment file: **QI FQHC MCO Quarterly_Annual Reporting Requirements**

Fraud and Abuse Summary Report

RFP Requirements:	***RFP Section 50.730 and 50.760.3***
Report Scope:	***Quarterly, reporting all activities during the report quarter***
Report Period(s):	***Four (4) three-month periods, from January through March, April through June, July through September and October through December***
Report Due Date(s):	***The last day of the first month following the reporting period end***
Report Formats:	***Electronic file in a format described by MQD***
Code:	***FAS_1803, FAS_1806, FAS_1809, FAS_1812***

The BHO shall submit *Fraud and Abuse Summary Report*s that include, at a minimum, the following information on all alleged fraud and abuse cases:

- A summary of all fraud and abuse referrals made to the State during the quarter, including the total number, the administrative disposition of the case, any disciplinary action imposed both before the filing of the referral and after, the approximate dollars involved for each incident and the total approximate dollars involved for the quarter;

- A summary of the fraud and abuse detection and investigative activities undertaken during the quarter, including but not limited to the training provided, provider monitoring and profiling activities, review of providers' provision of services (under-utilization and over-utilization of services), verification with members that services were delivered, and suspected fraud and abuse cases that were ultimately not fraud or abuse and steps taken to remedy the situation; and

- Trending and analysis as it applies to: utilization management, claims management, post-processing review of claims, and provider profiling.

Reports shall be submitted using the format provided by the DHS.

Member Grievances & Appeals Reports (Member Complaints, Grievances and Appeals)

RFP Requirements:	***RFP Section 50.730 and 50.750.1***
Report Scope:	***Quarterly, reporting all activities during the report quarter***
Report Period(s):	***Four (4) three-month periods, from January through March, April through June, July through September and October through December***
Report Due Date(s):	***The last day of the first month following the report period end***
Report Formats:	***Electronic file in an Excel file and spreadsheet format***
Code:	***MGA_1803, MGA_1806, MGA_1809, MGA_1812***

Required Report Information:

The BHO shall submit *Member Grievance and Appeals Reports*. These reports shall be submitted in the format provided by the DHS. At a minimum, the reports shall include:

- The number of grievances and appeals by type;
- Type of assistance provided;
- Administrative disposition of the case;
- Overturn rates;
- Percentage of grievances and appeals that did not meet timeliness requirements;
- Ratio of grievances and appeals per 100 members; and
- Listing of unresolved appeals originally filed in previous quarters.

Reports shall be submitted using the format provided by the DHS.

Prior Authorization RequestDenied /Deferred Report (Behavioral Health and Pharmacy)

RFP Requirements:	***RFP Section 50.730 and 50.760.2***
Report Scope:	***Quarterly, reporting all activities during the report quarter***
Report Period(s):	***Four (4) three-month periods, from January through March, April through June, July through September and October through December***
Report Due Date(s):	***The last day of the first month following the report period end***
Report Formats:	***Electronic file in a format described by MQD***
Code:	***PAB_1803, PAB_1806, PAB_1809, PAB_1812*** ***PAP_1803, PAP_1806, PAP_1809, PAP_1812***

The BHO is required to correctly interpret the CCS program's benefits and appropriately apply the program's medical necessity criteria to all services requested. Report pharmaceutical and behavioral health denials/deferrals separate using format provided by DHS.

Required Report Information in section III:

- Date of the request;
- Name of the requesting provider;
- Member's name and ID number;
- Date of Birth;
- Diagnoses and service/medication being requested;
- Justification given by the provider for the member's need of the service/medication;
- Justification of the BHO's denial or the reason(s) for deferral of the request; and
- Date and method of notification of the provider and the member of the BHO's determination.

Reports shall be submitted using the format provided by the DHS. Ensure that all data is captured in the embedded files prior to submitting the report and do not merge cells in the Excel file.

Provider Grievance and Claims Report (Provider Complaints & Claims Report)

RFP Requirements:	***RFP Section 50.730 and 50.740.4***
Report Scope:	***Quarterly, reporting all activities during the report quarter***
Report Period(s):	***Four (4) three-month periods, from January through March, April through June, July through September and October through December***
Report Due Date(s):	***The last day of the first month following the reporting period end***
Report Formats:	***Electronic file in a format described by MQD***
Code:	***PGC_1803, PGC_1806, PGC_1809, PGC_1812***

Required Report Information:

The following is guidance on assembling the quarterly log of provider complaints/claims report:

- The total number of resolved grievances by category (benefits and limits; eligibility and enrollment; member issues; health plan issues);
- The total number of unresolved grievances by category (benefits and limits; eligibility and enrollment; member issues; health plan issues) and the reason code explaining the status (i.e., grievance is expected to be resolved by the reporting date and grievance is unlikely to be resolved by the reporting date);
- Status of provider grievances that had been reported as unresolved in previous report(s);
- Status of delays in claims payment, denials of claims payment, and claims not paid correctly which includes the following:
    - The number of claims processed for each month in the reporting quarter;
    - The number of claims paid for each month in the reporting quarter;
    - The percentage of claims processed (at 30 and 90 days) after date of receipt for each month of the reporting quarter;
    - The number of claims denied for each month in the reporting quarter; and
    - The percentage of claims denied for each of the following reasons: (1) prior authorization/referral requirements were not met for each month in the reporting

quarter; (2) late submissions; (3) provider ineligibility on date of service; (4) member ineligibility on date of service; and (5) member TPL was not billed first; (6) duplicated claims; (7) not member responsibility s.a. GET; and (8) other reasons

Reports shall be submitted using the format provided by the DHS.

Provider Network Adequacy and GeoAccess Report

RFP Requirements:	***RFP Section 50.730, 50.740.1 and 50.740.2***
Report Scope:	***Quarterly, reporting status at the end of the report quarter***
Report Period(s):	***Four (4) three-month periods, from January through March, April through June, July through September and October through December***
Report Due Date(s):	***The last day of the first month following the reporting period end***
Report Formats:	***Electronic file in a format described by MQD***
Code:	***PNA_1803, PNA_1806, PNA_1809, PNA_1812***

The Behavioral Health Organization must offer an appropriate range of behavioral health services that are adequate for an anticipated number of members for the service and that the network of providers is sufficient to meet the needs of the anticipated number of members in the service area.

Required Report Information:

- Listing of all providers, including specialty or type of practice;
- Provider's location;
- Mailing address including zip code;
- Telephone number;
- Professional license number and expiration date;
- Whether provider limits number of QUEST Integration program patients he/she will accept;
- Whether provider is accepting new patients;
- Non-English languages spoken (if applicable);
- Verification of valid license for in-state and out-of-state providers; and
- Verification that provider or affiliated provider is not on federal or state exclusions list.

The BHO shall provide a narrative that describes the BHO's strategy to maintain and develop their provider network to include but not limited to:

- Take into account the numbers of network providers who are not accepting new patients;
- Consider the geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities;
- Current network gaps and the methodology used to identify them;
- Immediate short-term interventions when a gap occurs including expedited or temporary credentialing; and
- Interventions to fill network gaps and barriers to those interventions.

The BHO shall submit reports using GeoAccess or similar software that allow DHS to analyze, at a minimum, the following:

Required Report Information:

- The number of providers by specialty and by location with a comparison to the zip codes of members;
- Indication as to whether the provider has a limit on the number of BHO members he/she will accept;
- Indication as to whether the provider is accepting new patients; and
- Non-English language spoken (if applicable).

The BHO shall assure that the providers listed on the GeoAccess reports are the same providers that are described in the Provider Network Adequacy and Capacity Report.

In addition to the due date as identified in Section 50.730, these reports shall be submitted to the DHS at the following times:

- Upon the DHS request;
- Upon enrollment of a new population in the BHO;
- Upon changes in services, benefits, geographic service area or payments; and
- Any time there has been a significant change in the BHO's operations that would affect adequate provider capacity and services. A significant change is defined as any of the following:

- A loss of providers in a specific specialty where another provider in that specialty is not available on the island; or
- A loss of a hospital.

Reports shall be submitted using the format provided by the DHS.

Provider Suspensions & Terminations Report (three business days and quarterly), Employee Suspension and Termination Report, and Provider Education and Training Report

RFP Requirements:	***RFP Section 50.730 and 50.740.3***
Report Scope:	***Quarterly, reporting all activities during the report quarter***
Report Period(s):	***Four (4) three-month periods, from January through March, April through June, July through September and October through December***
Report Due Date(s):	***The last day of the first month following the report period end***
Report Formats:	***Electronic file in a format described by MQD***
Code:	***PIE_1803, PIE_1806, PIE_1809, PIE_1812***

Required Report Information:

Please include:

- All providers (physicians, non-physicians, facilities, agencies, suppliers, etc.);
- Each provider's specialty;
- Their primary city and island of service;
- Reason(s) for the action taken; and,
- The effective date of the suspension or termination.

If the BHO has not suspended or terminated any provider during these respective periods, please report this in writing. This report should also indicate if the BHO reported a suspended and/or termination to the National Practitioner Databank.

The BHO shall notify MQD within three (3) business days of any provider suspensions and terminations, both voluntary and involuntary because of suspected or confirmed fraud or abuse. The immediate notification shall include provider's name, provider's specialty, reason for the action and the effective date of the suspension or termination.

The health plan shall also report if a subcontractor or employee resigns, is suspended, terminated or voluntarily withdraws from participation as a result of suspected or confirmed fraud and abuse.

These reports shall be submitted in the Provider/ Emplyee Integrity and Education Report (PIE) to be provided by DHS.

Public Summary Report (PSR)

RFP Requirements:	***RFP Section 51.510***
Report Scope:	***Annually, reporting all activities during the report year***
	Bi-annually, reporting all activities during the report period
Report Period(s):	***One (1) twelve-month period, from January through December***
	Two (2) six-month periods, from January through June and July through December
Report Due Date(s):	***Annually, reburary 15***
	Bi-annually, forty-five (45) days after period end
Report Formats:	***Electronic copy in a format described by MQD***
Code:	***PSRA_18 (Annual Report)***
	PSR_1806, PSR_1812

Required Report Information:

The health plan shall submit quarterly metrics identified as the Public Summary Report (PSR). Information on the PSR includes but is not limited to:

- Behavioral Health

The health plan shall utilize a format provided by the DHS. The PSR shall be posted on MQD website. (Note: OHANA may show this data the QI report.)

Quality Assurance and Performance Improvement (QAPI) Report

RFP Requirements:	***RFP Section 50.730 and 50.760.1***
Report Scope:	***Annually***
Report Period(s):	***One (1) twelve month period, from January through December***
Report Due Date(s):	***June 15***
Report Formats:	***Electronic file appropriately named; hard copy with appropriate tabs***
Code:	***QAP_18***

Required Report Information:

The BHO shall provide an annual *QAPI Program Report*. The BHO's medical director shall review these reports prior to submittal to the DHS. The *QAPI Program Report* shall include the following:

- Any changes to the *QAPI* Program;
- A detailed set of *QAPI* Program goals and objectives that are developed annually and includes timetables for implementation and accomplishments;
- A copy of the BHO's organizational chart including vacancies of required staff, changes in scope of responsibilities, changes in delegated activities and additions or deletions of positions;
- A current list of the required staff as detailed in Section 50.400 including name, title, location, phone number and fax number;
- An executive summary outlining the changes from the prior *QAPI*;
- A copy of the current approved *QAPI* Program description, the *QAPI* Program work plan and, if issued as a separate document, the BHO's current utilization management program description with signatures and dates;
- A copy of the previous year's *QAPI* Program, if applicable, and utilization management program evaluation reports; and
- Written notification of any delegation of *QAPI* Program activities to contractors.

Reports shall be submitted using the format provided by the DHS or the External Review Quality Organization (EQRO).

Third Party Liability (TPL) Cost Avoidance Report

RFP Requirements:	***Section 50.730***
Report Scope:	***Monthly, reporting all activities during the report month***
Report Period(s):	***Twelve (12) one-month periods starting January and ending December of the report year***
Report Due Date(s):	***The 15th of the first month following the report period end***
Report Formats:	***Electronic copy in a format described by MQD***
Code:	***TPL_1801, TPL_1802, TPL_1803, etc.***

Required Report Information:

The health plan shall submit *Third Party Liability (TPL)* Cost Avoidance Reports, using the format received by the DHS, which identifies all cost-avoided claims for members with third party coverage from private insurance carriers and other responsible third parties. These reports shall include any member that has a TPL that is not identified on the 834 file received by the health plan. In addition, on a quarterly basis, the health plan shall notify MQD of all of its CCS members who have commercial insurance with the same or other health plan.

Reports shall be submitted using the format provided by the DHS.

DISCLOSURE- Definitions

DHS may refuse to enter into a contract and may suspend or terminate an existing contract, if the applicant fails to disclose ownership or controlling information and related party transaction as required by this policy.

a) Disclosures in accordance with 42 CFR 455 Subpart B
§ 455.104
Disclosure by Medicaid providers and fiscal agents: Information on ownership and control.
(a) Who must provide disclosures. The Medicaid agency must obtain disclosures from disclosing entities, fiscal agents, and managed care entities.
(b) What disclosures must be provided. The Medicaid agency must require that disclosing entities, fiscal agents, and managed care entities provide the following disclosures:
(1) (i) The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.
(ii) Date of birth and Social Security Number (in the case of an individual).
(iii) Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest.
(2) Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.
(3) The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.
(4) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).
(c) When the disclosures must be provided.
(1) Disclosures from providers or disclosing entities. Disclosure from any provider or disclosing entity is due at any of the following times:
(i) Upon the provider or disclosing entity submitting the provider application.
(ii) Upon the provider or disclosing entity executing the provider agreement.
(iii) Upon request of the Medicaid agency during the re-validation of enrollment process under § 455.414.
(iv) Within 35 days after any change in ownership of the disclosing entity.
(2) Disclosures from fiscal agents. Disclosures from fiscal agents are due at any of the following times:
(i) Upon the fiscal agent submitting the proposal in accordance with the State's procurement process.
(ii) Upon the fiscal agent executing the contract with the State.
(iii) Upon renewal or extension of the contract.
(iv) Within 35 days after any change in ownership of the fiscal agent.
(3) Disclosures from managed care entities. Disclosures from managed care entities (MCOs, PIHPs, PAHPs, and HIOs), except PCCMs are due at any of the following times:
(i) Upon the managed care entity submitting the proposal in accordance with the State's procurement process.
(ii) Upon the managed care entity executing the contract with the State.
(iii) Upon renewal or extension of the contract.

(iv) Within 35 days after any change in ownership of the managed care entity.
(4) Disclosures from PCCMs. PCCMs will comply with disclosure requirements under paragraph (c)(1) of this section.
(d) To whom must the disclosures be provided. All disclosures must be provided to the Medicaid agency.
(e) Consequences for failure to provide required disclosures. Federal financial participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by this section.

§ 455.105
Disclosure by providers: Information related to business transactions.
(a) Provider agreements. A Medicaid agency must enter into an agreement with each provider under which the provider agrees to furnish to it or to the Secretary on request, information related to business transactions in accordance with paragraph (b) of this section.
(b) Information that must be submitted. A provider must submit, within 35 days of the date on a request by the Secretary or the Medicaid agency, full and complete information about—
(1) The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and
(2) Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.
(c) Denial of Federal financial participation (FFP). (1) FFP is not available in expenditures for services furnished by providers who fail to comply with a request made by the Secretary or the Medicaid agency under paragraph (b) of this section or under § 420.205 of this chapter (Medicare requirements for disclosure).
(2) FFP will be denied in expenditures for services furnished during the period beginning on the day following the date the information was due to the Secretary or the Medicaid agency and ending on the day before the date on which the information was supplied.

§ 455.106
Disclosure by providers: Information on persons convicted of crimes.
(a) Information that must be disclosed. Before the Medicaid agency enters into or renews a provider agreement, or at any time upon written request by the Medicaid agency, the provider must disclose to the Medicaid agency the identity of any person who:
(1) Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and
(2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs.
(b) Notification to Inspector General. (1) The Medicaid agency must notify the Inspector General of the Department of any disclosures made under paragraph (a) of this section within 20 working days from the date it receives the information.
(2) The agency must also promptly notify the Inspector General of the Department of any action it takes on the provider's application for participation in the program.
(c) Denial or termination of provider participation. (1) The Medicaid agency may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the title XX Services Program.

(2) The Medicaid agency may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under paragraph (a) of this section.

b) Additional information which must be disclosed to DHS is as follows:

1) Names and addresses of the Board of Directors of the disclosing entity.

2) Name, title and amount of compensation paid annually (including bonuses and stock participation) to the ten (10) highest management personnel.

3) Names and addresses of creditors whose loans or mortgages are secured by a five (5) percent or more interest in the assets of the disclosing entity.

c) Additional Related Party Transactions which must be disclosed to DHS is as follows:

1) Describe transactions between the disclosing entity and any related party in which a transaction or series or transactions during any one (1) fiscal year exceeds the lesser of $10,000 or two (2) percent of the total operating expenses of the disclosingentity. List property, goods, services, and facilities involved in detail. Note the dollar amounts or other consideration for each item and the date of the transaction(s). Also include justification of the transaction(s) as to the reasonableness, potential adverse impact on the fiscal soundness of the disclosing entity, and the nature and extent of any conflict of interest. This requirement includes, but is not limited to, the sale or exchange, or leasing of any property; and the furnishing for consideration of goods, services or facilities.

2) Describe all transactions between the disclosing entity and any related party which includes the lending of money, extensions of credit or any investments in a related party. This type of transaction requires advance administrative review by the Director before being made.

3) As used in this section, "related party" means one that has the power to control or significantly influence the applicant, or one that is controlled or significantly influenced by the applicant. "Related parties" include, but are not limited to agents, managing employees, persons with an ownership or controlling interest in the disclosing entity, and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any of such entities or persons.

§ 455.101
Definitions.
Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.
Convicted means that a judgment of conviction has been entered by a Federal, State or local court, regardless of whether an appeal from that judgment is pending.
Disclosing entity means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Other disclosing entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:
(a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);
(b) Any Medicare intermediary or carrier; and
(c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Group of practitioners means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

Health insuring organization (HIO) has the meaning specified in § 438.2.

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Managed care entity (MCE) means managed care organizations (MCOs), PIHPs, PAHPs, PCCMs, and HIOs.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an ownership or control interest means a person or corporation that—
(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
(e) Is an officer or director of a disclosing entity that is organized as a corporation; or
(f) Is a partner in a disclosing entity that is organized as a partnership.

Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of a provider's total operating expenses.

Subcontractor means—
(a) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or

(b) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Termination means—
(1) For a—
(i) Medicaid or CHIP provider, a State Medicaid program or CHIP has taken an action to revoke the provider's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired; and
(ii) Medicare provider, supplier or eligible professional, the Medicare program has revoked the provider or supplier's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired.
(2) (i) In all three programs, there is no expectation on the part of the provider or supplier or the State or Medicare program that the revocation is temporary.
(ii) The provider, supplier, or eligible professional will be required to reenroll with the applicable program if they wish billing privileges to be reinstated.
(3) The requirement for termination applies in cases where providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause which may include, but is not limited to—
(i) Fraud;
(ii) Integrity; or
(iii) Quality.

Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

Annual Disclosure of Ownership (ADO) Instructions

FIELD #	DESCRIPTION
1	Enter name of individual or entity depending on who the ADO is in regards to.
2	Enter current NPI/Medicaid Provider number combination that this ADO is in reference to, if applicable.
3	If there has been a change of ownership or a Federal Tax Identification number, list previous Medicaid provider numbers and effective dates for each, if applicable.
4	Describe relationship or similarities between the provider disclosing information on this form and items "A" through "C". **a. Describe the relationship between the old owner and the new owner. Are they totally different owners or some of the owners the same, etc.?** **b. Describe the relationship between the old board members (under old owner) and the new board members (under the new owner). Are any of the board members under the old ownership also board members under the new ownership structure?** **c. Why is the old owner disenrolling? Essentially, why was there a change in ownership?**
5	Do you plan to have a change in ownership, management company or control within the next year? If so, when?
6	Do you anticipate filing bankruptcy? If so, when?
7	Enter the Federal Tax Identification Number **(if there is an affiliation with a chain)** along with name, address, city, state and zip code.
8	List name, address, SSN/FEIN of each person or organization having direct or indirect ownership or control interest in the disclosing entity. ***Complete question 9 with the officers' and board members' information of the owning entities. If no one owns 5% or more of provider, check box and completed question 9 with the officers' and board members' information.*** If you are enrolled as an individual and do not own a FEIN, please enter **your** name and information. Corporate entities disclosed in this question must disclose every business location.

Indirect Ownership Interest - means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Ownership Interest - means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an Ownership or Control Interest - means a person or corporation that:

- Has an ownership interest totaling 5% or more in a disclosing entity;
- Has an indirect ownership interest equal to 5% or more in a disclosing entity;
- Has a combination of direct and indirect ownership interests equal to 5% or more in a disclosing entity;
- Owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5% of the value of the property or assets of the disclosing entity;
- Is an officer or director of a disclosing entity that is organized as a corporation; or,
- Is a partner in a disclosing entity that is organized as a partnership?

9	List officers' and board members' information of the owning entities. If no one owns 5% or more and/or the provider is non-profit, the officers' and board members' information must be disclosed.
10	If applicant is related to persons listed in #8 and 9, list the relationship.

11	List name of managing company, if not applicable enter N/A.
12	List names of the disclosing entities in which persons have ownership of other Medicare/Medicaid facilities.

Other Disclosing Entity - means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Act. This includes:

- Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII).
- Any Medicare intermediary or carrier.
- Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX or the Act.

13	If entity engages with subcontractors (such as physical therapist, pharmacies, etc.,) which exceeds the lesser of $25,000 or 5% of applicant's operating expense, list subcontractor's name and address.

Significant Business Transaction- means any business transaction or series of transactions that, during any one fiscal year, exceeds the lesser of $25,000 or 5% of applicant's operating expense.

14	List any significant business transactions between this provider and any wholly owned supplier, or between this provider and any subcontractor, during the previous 5-year period.
15	List name, SSN, address of any immediate family member who is authorized to prescribe drugs, medicine, devices or equipment.
16	List anyone disclosed in question #8 who has been convicted of a criminal offense related to the involvement of such persons or organizations in any problem established under Title 19 (Medicaid) or Title 20 (Social Services Block Grants) of the Social Security Act (SSA) or any criminal offense in this state or any other state. Please also indicate any HI Medicaid provider number(s) associated with individual or organization.
17	List any agent and/or managing employee who has been convicted of a criminal offense related to any program established under Title XVIII, XIX or XX of the SSA or any criminal offense in this state or any other state. Indicate any HI Medicaid provider number(s) associated with individual or organization.

Agent - means any person who has been delegated the authority to obligate or act on behalf of a provider.
Managing Employee - means a general manager, business manager, administrator, director or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.

18	List the name, title, FEIN/SSN, and business address of all managing employees as defined in 42 CFR 455.101.
19	List name, address and SSN/FEIN of each person with an ownership or control interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more.

Subcontractor - means an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients, OR an individual, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or lease of real property) to obtain space, supplies, equipment or services provided under the Medicaid agreement.

20	Please indicate which number you will be using for reporting monies to you from Medicaid for 1099 purposes. *Example: If you are an individual completing this question, please input your Social Security Number unless you are own a FEIN 100%. An individual provider can bill under his/her individual provider number even If they are working in a group selling. The individual must complete a Map-347 in order to be linked to the group selling under which they are reporting.* ***IRS verification letter or Social Security Card must be attached verifying FEIN/SSN.*
21	Enter your initials if you maintain electronic medical records and are HIPAA compliant. Check the box if you do not keep electronic medical records.
22	Please enter the contact information for OMS to contact should there be any questions regarding this form.
23	Signature: Enter original signature from the individual provider, owner, or officer/board member if the provider does not have an owner. If you are an individual provider, *your* signature is required. Printed Name: The individual signing this form must enter their printed name. Date: Enter the date this disclosure is signed. Title: Must be title of person signing this form. EXAMPLE: individual provider, owner, etc.
24	For Internal Purposes Only: DHS Authorized Signature

Please return form to:

DHS Med-QUEST
Finance Office – TPL
P.O. Box 700190
Kapolei, HI 96709-0190

Annual Disclosure of Ownership (ADO)

THIS FORM IS REQUIRED BY FEDERAL AND STATE LAW AND REGULATION (42 CFR 455.101, 455.104, 455.105 AND 455.106 and HAR §17-1736-19).
Note: See the instructions of this form for definitions of underlined terms according to 42 CFR 455.101, 455.104, 455.105, and HAR §17-1736-19. ***All attachments must be labeled and reference to the question the attachment pertains.***

1	Entity Name that this ADO pertain to:		
2	Enter current NPI/Medicaid Provider number combination that this ADO is in reference to, if applicable. NPI:_____ Provider number:_____ Provider number (Enter only if you aren't required to have a NPI/Taxonomy Code for billing purposes): _____ ☐ *Check here for N/A*		
3	If there has been a change in ownership, change of tax ID number (FEIN), or change in Medicaid Provider Number for a previously enrolled Hawaii Medicaid provider, enter the previous provider number(s) and their effective date(s): ☐ *Check here/or N/A*		
	Previous Medicaid Prov. #: Start Date: End Date:		
4	If you completed #3, describe the relationship between the provider disclosing information on this form, and the following: (a) previous Medicaid owner (b) corporate boards of disclosing provider and previous Medicaid owner; i.e. board members and ownership or control interest (c) disenrollment circumstances. (Attach extra page if necessary.)		
a.			
b.			
c.			
5.	If you anticipate any change of ownership, management company or control within the year, state anticipated date of change and nature of the change. ☐ *Check here for N/A*		
	Date Change		
6.	If you anticipate filing for bankruptcy within the year, enter anticipated date of filing. ☐ *Check here for N/A*		
7.	If this facility is a subsidiary of a parent corporation, enter corporate FEIN#: ☐ *Check here for N/A*		
	Name:		
	Address:		
	City:	State:	Zip Code:
8.	List name, date of birth, SSN#/FEIN#, and address of each person or entity that owns 5% or more direct or indirect ownership or controlling interest in the applicant provider. (Attach extra pages if necessary.) *Complete question 9 with the officer's and board members' information of the owning entities.*		
Name/Business Name:		SSN:	
Business Address:		FEIN:	DOB:
City:		State:	Zip
** If a corporate entity is disclosed in question #8 above, all business location(s) of this corporate entity must be disclosed. Please attach a sheet to disclose this information.			

9.	List officers' and board members' information of owning entities. However, if no one owns 5% or more direct or indirect ownership, please list the officers' and board member's information. (Attach extra sheet if necessary listing same details below.) ☐ *Check here for N/A*

Name(a)	Title:	
Address:	DOB:	SSN:
City:	State:	Zip:
Name(b)	Title:	
Address:	DOB:	SSN:
City:	State:	Zip:

10.	If any individuals listed in questions 8 and 9 are related to each other as spouse, parent, child, or sibling (including step or adoptive relationships), provide the following information: (Attach extra page if necessary.) ☐ *Check here for N/A*

Name (a):	SSN:
Relationship:	FEIN:
Name (b):	SSN:
Relationship:	FEIN:

11.	If this facility or organization employs a management company, please provide following information: ☐ *Check here for N/A*

Name:		
Address:		
City:	State:	Zip:

12.	List the names of any other disclosing entity in which person(s) listed on this application have ownership of other Medicare/Medicaid facilities. ☐ *Check here for N/A*

Name:	Provider #, if applicable:	
Address:		
City:	State:	Zip:

13.	List the names and addresses of all other Hawaii Medicaid providers with which your health service and/or facility engages in a significant business transaction and/or a series of transactions that during any one (1) fiscal year exceed the lesser of $25,000 or 5% of your total operating expense. (Attach extra page if necessary.) ☐ *Check here for N/A*

Name:		
Address:		
City:	State:	Zip:

14.	List any significant business transactions between this provider and any wholly owned supplier, or between this provider and any subcontractor, during the previous 5-year period. (Attach extra page if necessary.) ☐ *Check here for N/A*

Name:		
Address:		
City:	State:	Zip:

15.	List the name, SSN, and address of any immediate family member who is authorized under Hawaii Law or any other states' professional boards to prescribe drugs, medicine, medical devices, or medical equipment. ☐ *Check here for N/A*		
Name(a)		Title:	
Address:		DOB:	SSN:
City:		State:	Zip:
Name(b)		Title:	
Address:		DOB:	SSN:
City:		State:	Zip:
16.	List the name of any individuals or organizations having direct or indirect ownership or controlling interest of 5% or more, who have been convicted of a criminal offense related to the involvement of such persons, or organizations in any program established under Title XVIII (Medicare), or Title XIX (Medicaid), or Title XX (Social Services Block Grants) of the Social Security Act or any criminal offense in this state or any other state since the inception of those programs. (Attach extra page if necessary.) If individual or organization is associated with a HI Medicaid provider number(s), please indicate below. (Attach extra page if necessary.) ☐ *Check here for N/A*		
Name (a)/HI Medicaid Provider Number(s), if applicable:			
Name (b)/HI Medicaid Provider Number(s), if applicable:			
17.	List the name of any agent and/or managing employee of the disclosing entity who has been convicted of a criminal offense related to the involvement in any program established under Title XVIII, XIX, or XX, or XXI of the Social Security Act or any criminal offense in this state or any other state since the inception of those programs. (Attach extra page if necessary.) If individual or organization is associated with a HI Medicaid provider number(s), indicate below. (Attach extra page if necessary.) ☐ *Check here for N/A*		
Name (a)/HI Medicaid Provider Number(s), if applicable:			
Name (b)/HI Medicaid Provider Number(s), if applicable:			
18.	List the name, title, FEIN/SSN, and business address of all managing employees below as defined in 42 CFR 455.101. ☐ *Check here for N/A* (Attach extra page if necessary listing same details below.)		
Name(a)		Title:	
Address:		DOB:	SSN:
City:		State:	Zip:
Name(b)		Title:	
Address:		DOB:	SSN:
City:		State:	Zip:

19.	List the name, address, SSN#, FEIN# of each person with an ownership or control interest in any subcontractor in which the provider applicant has direct or indirect ownership of 5% or more. (Attach extra page if necessary.) ☐ *Check here for N/A*		
Name:			SSN:
Address:			FEIN:
City:		State:	Zip:
Name:			SSN:
Address:			FEIN:
City:		State:	Zip:

20.	If you keep medical records on an electronic database, you hereby certify by your initials in the space provided that electronic records are confidential and patient privacy is protected. Every health care provider or organization, regardless of size, who creates or maintains individual protected health information in any form (written, oral, or electronic) for the purpose of treatment, payment, or operation is a covered entity and must comply with HIPAA Privacy and Security Rules. Initials _____

21.	Contact Information - This information is used only for questions regarding the information on this form.	
	Contact Name:	Contact Telephone:
	E-mail address:	

22.	I certify that all the Information I have provided on this DHS, Med-QUEST Division Annual Disclosure of Ownership Form is accurate. Failure to provide accurate information could result in termination from the Medicaid program.	
	Signature	Date Signed:
	Printed Name:	
	Title:	

23.	**For Internal Use Only:**		
	Signature		Date Signed:
	Printed Name:		
	Title:		
EPLS/SAM:		OIG/HHS:	SSA Death Master File:

CERTIFICATION STATEMENT OF

_____

(Name of Plan)

TO THE

Hawaii QUEST Integration Program

FOR THE QUARTER ENDING

_____, 20_____

(Month and Day) (Year)

Name of Preparer _____

Title _____

Phone Number _____

I hereby attest that the information submitted in the reports herein is current, complete and accurate to the best of my knowledge. I understand that whoever knowingly and willfully makes or causes to be made a false statement or representation on the reports may be prosecuted under applicable state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate, or where the entity already participates, a termination of a Plan's agreement or contract with the Hawaii QUEST Integration Program.

_____ _____

Date Signed Chief Executive Officer/Chief Financial Officer
(Name and Title typewritten)

_____

Signature

DISCLOSURE STATEMENT (CMS REQUIRED)

DHS may refuse to enter into a contract and may suspend or terminate an existing contract, if the offeror fails to disclose ownership or controlling information and related party transaction as required by this policy.

Financial Disclosure requirements in accordance with 42 CFR 455.100 through 455.106 are:

455.104 Information on Ownership & Control

(1) The name and address of each person with an ownership or controlling interest in the disclosing entity.

(2) The name and address of each person with an ownership or controlling interest in any subcontractor in which the disclosing entity has direct or indirect ownership of five (5) percent or more.

(3) Names of persons named in (a) and (b) above who are related to another as spouse, parent, child or sibling of those individuals or organizations with an ownership or controlling interest.

(4) The names of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity also has an ownership or controlling interest.

455.105 Information Related to Business Transactions

(5) The ownership of any subcontractor with whom the offeror has had business transactions totaling more than $25,000 during the past 12-month period.

(6) Any significant business transactions between the offeror and any wholly owned supplier or between the offeror and any subcontractor during the past five-year period.

455.106 Information on Persons Convicted of Crimes

(7) Name of any person who has an ownership or controlling interest in the offeror, or is an agent or managing employee of the offeror, and has been convicted of a criminal offense related to that person’s involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

b) Additional information which must be disclosed to DHS is as follows:

(1) Names and addresses of the Board of Directors of the disclosing entity.

(2) Name, title and amount of compensation paid annually (including bonuses and stock participation) to the ten (10) highest management personnel.

(3) Names and addresses of creditors whose loans or mortgages are secured by a five (5) percent or more interest in the assets of the disclosing entity.

c) Additional Related Party Transactions which must be disclosed to DHS is as follows:

(1) Describe transactions between the disclosing entity and any related party in which a transaction or series or transactions during any one (1) fiscal year exceeds the lesser of $10,000 or two (2) percent of the total operating expenses of the disclosing entity. List property, goods, services, and facilities involved in detail. Note the dollar amounts or other consideration for each item and the date of the transaction(s). Also include justification of the transaction(s) as to the reasonableness, potential adverse impact on the fiscal soundness of the disclosing entity, and the nature and extent of any conflict of interest. This requirement includes, but is not limited to, the sale or exchange, or leasing of any property; and the furnishing for consideration of goods, services or facilities.

(2) Describe <u>all</u> transactions between the disclosing entity and any related party which includes the lending of money, extensions of credit or any investments in a related party. This type of transaction requires <u>advance</u> administrative review by the Director before being made.

(3) As used in this section, “related party” means one that has the power to control or significantly influence the offeror, or one that is controlled or significantly influenced by the offeror. “Related parties” include, but are not limited to, agents, managing employees, persons with an ownership or controlling interest in the disclosing entity, and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister

companies, holding companies, and other entities controlled or managed by any of such entities or persons.

42 CFR 455.101 DEFINITIONS

a) "Agent" means any person who has been delegated the authority to obligate or act on behalf of a provider.

b) "Convicted" means that a judgment of conviction has been entered by a Federal, State or local court, regardless of whether an appeal from that judgment is pending.

c) "Disclosing entity" means a QUEST Integration provider or health plan.

d) "Other disclosing entity" means any other QUEST Integration disclosing entity and any entity that does not participate in QUEST Integration but is required to disclose certain ownership and control information because of the participation in any of the programs established under Title V, XVIII or XX of the Social Security Act.
This includes:

(1) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII);

(2) Any Medicare intermediary or carrier; and

(3) Any entity that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XIX of the Social Security Act.

a) "Fiscal agent" means a contractor that processes or pays vendor claims on behalf of DHS.

b) "Group of practitioners" means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

c) "Indirect ownership interest" means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

d) "Managing employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or

managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.

e) "Ownership interest" means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

f) "Person with an ownership or controlling interest" means a person or corporation that:

(1) Has an ownership interest totaling five (5) percent or more in a disclosing entity;

(2) Has an indirect ownership interest equal to five (5) percent or more in a disclosing entity;

(3) Has a combination of direct and indirect ownership interests equal to five (5) percent or more in a disclosing entity;

(4) Owns an interest of five (5) percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five (5) percent of the value of the property or assets of the disclosing entity;

(5) Is an officer or director of a disclosing entity that is organized as a corporation; or

(6) Is a partner in a disclosing entity that is organized as a partnership.

k) "Significant business transaction" means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and five (5) percent of an offeror's total operating expenses.

l) "Subcontractor" means:

(1) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or

(2) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the DHS agreement.

m) “Supplier” means an individual, agency, or organization from which a Provider purchases goods and services used in carrying out its responsibilities under its DHS contract (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

n) “Wholly owned subsidiary supplier” means a subsidiary or supplier whose total ownership interest is held by an offeror or by a person, persons, or other entity with an ownership or controlling interest in an offeror.

DISCLOSURE STATEMENT

PLAN NAME/NO. _____
DISCLOSURE STATEMENT FOR THE YEAR ENDED _____

I hereby attest that the information contained in the Disclosure Statement is current, complete and accurate to the best of my knowledge. I also attest that these reported transactions are reasonable, will not impact on the fiscal soundness of the Health Plan, and are without conflict of interest. I understand that whoever knowingly and willfully makes or causes to be made a false statement or representation on the statement may be prosecuted under applicable state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate in QUEST Integration.

_____ _____

Date Signed

Chief Executive Officer
(Name and Title Typewritten)

Notarized _____ _____

Signature

DISCLOSURE STATEMENT
OWNERSHIP

Health Plan Name, Plan No.: _____
Address (City, State, Zip): _____
Telephone: _____

For the period beginning: _____ and ending: _____

Type of Health Plan:

- o Staff – A health plan that delivers services through a group practice established to provide health services to health plan members; doctors are salaried.

- o Group – A health plan that contracts with a group practice to provide health services; the group is usually compensated on a capitation basis.

- o IPA – A health plan that contracts with an association of doctors from various settings (some solo practitioners, some groups) to provide health services.

- o Network – A health plan that contracts with two or more group practices to provide health services.

Type of Entity:

- o Sole Proprietorship
- o Partnership
- o Corporation
- o Governmental
- o For-Profit
- o Not-For-Profit
- o Other (Specify) _____

455.104 Information on Ownership and Control

a. List the names and addresses of any individuals or organizations with an ownership or controlling interest in the disclosing entity. "Ownership or control interest" means, with respect to the entity, an individual or organization who (A)(i) has a direct or indirect ownership interest of 5 per centum or more in the entity, or in the case of a nonprofit corporation, is a member; or (ii) is the owner of a whole or part interest in any mortgage, deed or trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets thereof, which whole or part interest is equal to or exceeds 5 per centum of the total property and assets of the entity; or (B) has the ability to appoint or is otherwise represented by an officer or director of the entity, if the entity is organized as a corporation; or (C) is a partner in the entity, if the entity is organized as a partnership.

Name	Address	Percent of Ownership of Control

b. List the names and addresses of any individuals or organizations with an ownership or controlling interest in any subcontractor in which the disclosing entity has direct or indirect ownership of five (5) percent or more.

Name	Address	Percent of Ownership of Control

a. Names of persons named in (a) and (b) above who are related to another as spouse, parent, child, or sibling of those individuals or organizations with an ownership or controlling interest.

d. List the names of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity also has an ownership or controlling interest.

455.105 Information related to Business Transactions

e. List the ownership of any subcontractor with whom the offeror has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request.

Describe Ownership of Subcontractors	Type of Business Transaction with Provider	Dollar Amount of Transaction

f. List any significant business transactions between the offeror and any wholly owned supplier or between the offeror and any subcontractor during the five-year period ending on the date of the request.

Describe Ownership of Subcontractors	Type of Business Transaction with Provider	Dollar Amount of Transaction

455.106 Information on Persons Convicted of Crime

g. List the names of any person who has ownership or controlling interest in the offeror, or is an agent or managing employee of the offeror and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs.

Name	Address	Title

2. Additional information which must be disclosed to DHS as follows:

a. List the names and addresses of the Board of Director of the Plan.

Name/Title	Address

b. Names and titles of the ten (10) highest paid management personnel including but not limited to the Chief Executive Officer, the Chief Financial Officer, Board of Chairman, Board of Secretary, and Board of Treasurer:

Name/Title	Address

c. List names and addresses of creditors whose loans or mortgages exceeding five percent (5) and are secured by the assets of the Health Plan.

Name	Address	Amount of Debt	Description of Security

DISCLOSURE STATEMENT

a. Instructions

DHS is concerned with monitoring the existence of related party transactions in order to determine if any significant conflicts of interest exist in the offeror's ability to meet QUEST Integration objectives. Related party transactions include transactions which are conducted in an arm's length manner or are not reflected in the accounting records at all (e.g., the provision of services without charge).

Transactions with related parties maybe in the normal course of business or they may represent something unusual for the offeror. In the normal course of business, there may be numerous routine and recurring transactions with parties that meet the definition of a related party. Although each party may be appropriately pursuing its respective best interests, this is usually not objectively determinable. In addition to transactions in the normal course of business, there may be transactions which are neither routine nor recurring and may be unusual in nature or in financial statement impact.

1) Describe transactions between the offeror and any related party in which a transaction or series of transactions during any one (1) fiscal year exceeds the lesser of $10,000 or two (2) percent of the total operating expenses of the disclosing entity. List property, goods, services and facilities in detail noting the dollar amounts or other consideration for each and the date of the transaction(s) including a justification as to the reasonableness of the transaction(s) and its potential adverse impact of the fiscal soundness of the disclosing entity.

a) The sale or exchange, or leasing of any property:

Description of Transaction(s)	Name of Related Party and Relationship	Dollar Amount for Reporting Period

Justification

b) The furnishing for consideration of goods, services or facilities:

Description of Transaction(s)	Name of Related Party and Relationship	Dollar Amount for Reporting Period

Justification

2) Describe all transactions between the disclosing entity and any related party which includes the lending of money, extensions of credit or any investments in a related party. This type of transaction requires advance administrative review by the Director before being made.

Description of Transaction(s)	Name of Related Party and Relationship	Dollar Amount for Reporting Period

Justification

CONTROLLING INTEREST FORM

The offeror must provide the name and address of any individual which owns or controls more than ten percent (10%) of stock or that has a controlling interest (i.e., ability to formulate, determine or veto business policy decisions, etc.). Failure to make full disclosure may result in rejection of the offeror's proposal as unresponsive.

NAME	ADDRESS	OWNER OR CONTROLLER	HAS CONTROLLING INTEREST YES	NO

BACKGROUND CHECK INFORMATION

The offeror must provide sufficient information concerning key personnel (i.e., Chief Executive Officer, Medical Director, Financial Officer, Consultants, Accountants, Attorneys, etc.) to enable DHS to conduct background checks. Failure to make full and complete disclosure may result in rejection of your proposal as unresponsive. Attach resumes for all individuals listed below.

NAME**	EVER KNOWN BY ANOTHER NAME* YES NO	SOCIAL SECURITY ACCOUNT NUMBER	DATE OF BIRTH (DAY/MO/YR)	PLACE OF BIRTH CITY/COUNTRY /STATE

* If yes, provide all other names. Use a separate sheet if necessary.
** For each person listed:

a) Give addresses for the last 10 years.
b) Ever suspended from any federal program for any reason? (Yes / No) If yes, please explain.

OPERATIONAL CERTIFICATION SUBMISSION

The offeror must complete the attached certification as documentation that it shall maintain a member handbook, appointment procedures, referral procedures and other operating requirements in accordance with either DHS rule(s) or policies and procedures.

By signing below the offeror certifies that it shall at all times during the term of this contract provide and maintain a member handbook, appointment procedures, referral procedures, quality assurance program, utilization management program and other operating requirements in accordance with either DHS rule(s) or policies and procedures. The offeror warrants that in the event DHS discovers, through an operational review, that the offeror has failed to maintain these operating procedures, the offeror will be subject to a non-refundable, non-waivable sanction in accordance with DHS rules.

_____ _____

Signature Date

GRIEVANCE SYSTEM FORM

The offeror must complete the form below and submit with this proposal.

I hereby certify that _____
(Offeror Name)
will have in place on the commencement date of this contract a system for reviewing and adjudicating grievances by recipients and providers arising from this contract in accordance with DHS Rules and as set forth in the Request for Proposal.

I understand such a system must provide for prompt resolution of grievances and assure the participation of individuals with authority to require corrective action.

I further understand the offeror must have a grievance policy for recipients and providers which defines their rights regarding any adverse action by the offeror. The grievance policy shall be in writing and shall meet the minimum standards set forth in this Request for Proposal.

I further understand evaluation of the grievance procedure shall be conducted through documentation submission, monitoring, reporting, and on-site audit, if necessary, by DHS and deficiencies are subject to sanction in accordance with DHS rules.

_____	_____
Authorized Signature	Date
_____	_____
Printed Name	Title

CERTIFICATION FOR CONTRACTS, GRANTS, LOANS AND COOPERATIVE AGREEMENTS

1. The undersigned certifies, to the best of his or her knowledge and belief, that no Federal appropriated funds have been paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of Federal grant, the making of any Federal loan, the entering into of any cooperative Federal contract, grant, loan or cooperative agreement.

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan or cooperative agreement, the undersigned shall complete and submit "Disclosure Form to Report Lobbying" in accordance with its instructions.

3. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed under 31U.S.C §1352. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000.00 and not more than $100,000.00 for such failure.

Offeror: _____

Signature: _____

Title: _____

Date: _____

STATEMENT AS OF _____ OF _____
(Quarter Ending) (Plan Name)

Plan Fiscal Year End _____

Report #5 - Amounts Due From (To) Affiliates

COMPANY/AFFILIATE	DESCRIPTION OF AFFILIATION	AMOUNT DUE FROM (TO) CURRENT	AMOUNT DUE FROM (TO) NON-CURRENT
TOTALS		*	**

* Equals amounts on Report #1, Assets, Line 8 or Liabilities, Line 8.
** Equals amounts on Report #1, Assets, Line 17 or Liabilities, Line 12.

NOTE: All loans, disbursements or other transfer of funds to affiliates must be approved (in writing) by the QI Program.

STATEMENT AS OF _____ OF _____
(Quarter Ending) (Plan Name)

Listing of Changes to Plan Officers and Directors (Quarterly)
Listing of All Plan Officers and Directors (Annual)

Name, Title	Other Relationship to Plan	Type of Compensation (if applicable)

STATEMENT AS OF _____ OF _____
(Quarter Ending) (Plan Name)

Plan Fiscal Year End _____

Report #1 - Balance Sheet

CURRENT ASSETS	CURRENT QUARTER
1. Cash and Cash Equivalents (Report #3)	
2. Short-term Investments (Report #4)	
3. Capitation Receivable (QI)	
4. Reinsurance Receivable	
A. Billed	
B. Unbilled	
C. Advances	( )
D. Net Receivable	
5. Deferred Liability Receivable:	
A. Billed	
B. Unbilled	
C. Advances	( )
D. Net Receivable	
6. Non-QUEST Integration Programs	
A. Members' Dues	
B. Patient Services	
C. Third Party Payors	
D. Other	
E. Net Non-QUEST Integration Receivable	
7. Investment Income Receivable	
8. Amounts Due From Affiliates (Report #5)	
9. Risk Pool Receivable (Report #6)	
10. Risk Pool Receivable-non-QI	
11. Other Current Assets (Report #7)	
A. Inventory	
B. Prepaid Expenses	
12. TOTAL CURRENT ASSETS (Items 1 through 11)	
OTHER (Non-Current) ASSETS:	
13. General Performance Bond	
14. Bond Funds - non-QI Programs	
15. Ristricted Cash and Other Assets (Report #8)	
16. Long-Term Investments (Report #4)	
17. Amount Due from Affiliates (Report #5)	
18. Other Non-Current Assets (Report #7)	
19. TOTAL OTHER (Non-Current) ASSETS (Items 13 through 18)	
LAND, BUILDINGS and EQUIPMENT:	
20. Land	
21. Buildings	
22. Leasehold Improvements	
23. Furniture & Equipment	
24. Vehicles	
25. Construction in Progress	
26. Other	
27. Total Land, Buildings and Equipment (Items 20 through 26)	
28. Less Accumulated Depreciation and Amortization	( )
29. NET LAND, BUILDINGS and EQUIPMENT (Items 27 & 28)	
30. TOTAL ASSETS (Items 12, 19, and 29)	

STATEMENT AS OF _____ OF _____
(Quarter Ending) (Plan Name)

Plan Fiscal Year End _____

Report #1 - Balance Sheet (Continued)

LIABILITIES	CURRENT QUARTER
1. Accounts Payable and Other Accrued Expenses	
2. Accrued Administravie Expenses	
3. Capitation Payable (Providers)	
4. Medical Claims Payable (Report #9)	
5. Accrued Medical Incentive Pool	
6. Accrued Risk Pool Payable (Report #6)	
7. Current Portion of Long-Term Debt (Report #11)	
8. Amount Due to Affiliates (Report #5)	
9. Other Current Liabilities (Report #7)	
10. TOTAL CURRENT LIABILITIES (Items 1 through 9)	
OTHER LIABILITIES	
11. Long-term Debt Excluding Current Portion (Report #11)	
12. Amount Due to Affiliates (Report #5)	
13. Other Non-Current Liabilities (Report #7)	
14. TOTAL OTHER LIABILITIES (Items 11 through 13)	
15. TOTAL LIABILITIES (Items 10 through 14)	
EQUITY	
16. Preferred Stock (Par Value _____) (# of Shares Authorized, Issued and Outstanding)	
17. Common Stock (Par Value _____) (# of Shares Authorized, Issued and Outstanding)	
18. Treasury Stock (# of Shares)	( )
19. Additional Paid-in Capital	
20. Contributed Capital	
21. Retained Earnings/Fund Balance/Unrestricted Assets	
22. Restricted Assets	
23. TOTAL EQUITY (Items 16 through 22)	
24. TOTAL LIABILITY AND EQUITY (Items 15 and 23)	

STATEMENT AS OF _____ OF _____
(Quarter Ending) (Plan Name)

Plan Fiscal Year End _____

Report #2 - Statement of Revenue and Expenses

QUEST Integration □ **Consolidated Statement □**

		1		2	
	MEMBER MONTHS	CURRENT QUARTER		YEAR-TO-DATE	
REVENUES			PMPM		PMPM
1. Capitation/Premiums					
2. Reinsurance					
3. Fee-for-Service					
4. Third Party Liability Recoveries					
5. Investment Income					
6. Other Income (Specify)					
7. TOTAL REVENUES (Items 1 through 6)					
EXPENSES					
Inpatient Expenses:					
8. Hospital Inpatient Capitation					
9. Hospital Inpatient Fee-for-Service					
10. Hospital Risk Pool Expense Adjustment (Report #6)					
11. TOTAL INPATIENT (Items 8 through 10)					
Medical Reimbursement Expenses:					
12. Primary Care Physician Services (Report #12)					
13. Referral Physician Services (Report #12)					
14. Non-physician Services					
15. Physician Risk Pool Expense Adjustment (Report #6)					
16. TOTAL MEDICAL REIMBURSEMENT (Items 12 through 15)					
Outpatient Expenses:					
17. Emergency Services					
18. Outpatient Hospital Services					
19. Clinic Services					
20. Behavioral Health Services					
21. Other Outpatient Services					
22. Pharmacy					
23. Lab					
24. Radiology					
25. Therapeutic Services					
26. Risk Pool Expense Adjustment (Report #6)					
27. TOTAL OUTPATIENT (Items 17 through 26)					
Other Medical Expenses:					
28. Durable Medical Equipment/Supplies					
29. Transportation, Meals and Lodging					
30. Post Acute Care					
31. Translation Services					
32. Case Management/Care Coordination					
33. Other (Specify)					
34. Risk Pool Expense Adjustment (Report #6)					
35. TOTAL OTHER MEDICAL (Items 28 through 34)					
36. TOTAL MEDICAL EXPENSES (Items 11, 16, 27 and 35)					

STATEMENT AS OF _____ OF _____
(Quarter Ending) (Plan Name)

Plan Fiscal Year End _____

Report #2 - Statement of Revenue and Expenses (Continued)

QUEST Integration □ **Consolidated Statement □**

		1		2	
	MEMBER MONTHS	CURRENT QUARTER		YEAR-TO-DATE	
Administrative Expenses:			PMPM		PMPM
37. Compensation					
38. Data Processing					
39. Management Fees					
40. Insurance					
41. Interest Expense					
42. Occupancy (Rent/Utilities)					
43. Depreciation					
44. Medical Director Fees					
45. Other (Specify)					
46. TOTAL ADMINISTRATION (Items 37 through 45)					
47. TOTAL EXPENSE (Items 36 and 46)					
48. INCOME FROM OPERATIONS (Item 7 less Item 46)					
49. Non-operating Income (loss)					
50. INCOME (LOSS) BEFORE INCOME TAXES (Items 48 & 49)					
51. Income Taxes					
52. NET INCOME (LOSS) AFTER INCOME TAXES (Item 50 less Item 51)					

STATEMENT AS OF _____ OF _____
(Quarter Ending) (Plan Name)

Plan Fiscal Year End _____

Report #3 - Statement of Cash Flow
QUEST Integration □ Consolidated Statement □

	Current Quarter	YTD
1. Net Cash Provided from (Used in) Operating Activities		
2. Net Cash Provided from (Used in) Investing Activities		
3. Investment in Affiliated Company		
4. Purchase of Property and Equipment		
5. Other:		
6.		
7.		
8.		
9.		
10. Sub Total: Net Cash Provided from (used in) Investing Activities		
11. Net Cash Provided from (used in) Financing Activities		
12. Repayment of Long-Term Debt		
13. Proceeds from Short-Term Loans		
14. Other:		
15.		
16.		
17.		
18.		
19.		
20. Sub Total: Net Cash Provided from (used in) Financing Activities		
21. Net Change in Cash and Equivalents		
22. Beginning Cash Balance		
23. Ending Cash Balance *		

* Equals amount on Report #1, Assets, Line 1.

STATEMENT AS OF _____ OF _____
(Quarter Ending) (Plan Name)

Plan Fiscal Year End _____

Report #4 - Investments

(1) DESCRIPTION	(2) PAR VALUE (BONDS OR # SHARES (STOCK)	(3) PURCHASE DATE	(4) MATURITY DATE	(5) AVERAGE INTEREST RATE	(6) MARKET VALUE	(7) COST	(8) CARRYING VALUE	(9) SHORT-TERM*	(10) LONG-TERM**
STOCKS (ALL)									
TOTAL									
U.S. GOV'T SECURITIES									
TOTAL									
BONDS (NON-U.S. GOV'T)									
TOTAL									
OTHER (DESCRIBE)									
TOTAL									
GRAND TOTAL									

* Equals amount on Report #1 - Assets, Line 2.

** Equals amount on Report #1, Assets, Line 16.

STATEMENT AS OF _____ OF _____
(Quarter Ending) (Plan Name)

Plan Fiscal Year End _____

Report #6 - Risk Pool Analysis

	Current Period			Year-To-Date		
	$	Member Months	PMPM	$	Member Months	PMPM
Revenues Allocated to Risk Pool(s)						
Less Expenses Allocated to Risk Pools:						
Inpatient Expense						
Medical Reimbursement Expense						
Outpatient Expense						
Other Medical Expense						
Total Medical Expenses Allocated to Pools						
Change in Balance for Current Period Activity*						
Risk Pool Balances at the Beginning of the Period						
Adjustment to Beg of Period Risk Pool Balances						
Subtotal						
Less Risk Pool Distributions						
Undistributed Risk Pool Balance at Period End**						

* Equals the total of risk pool adjustments on Report #2, Lines 10, 15, 26 and 33.
** Equals the risk pool receivable/payable on Report #1, Assets, Line 9 or Liabilities, Line 6.

STATEMENT AS OF _____ OF _____
(Quarter Ending) (Plan Name)

Plan Fiscal Year End _____

Report #6A - Risk Pool Listing By Risk Pool (Quarterly)
Risk Pool Listing by Participant (Annual)

Participant	Prior Period Balance	Current Period Adj. +	(Distributions) Contributions*	Ending Balance **
TOTAL				

* Equals amount on Report #6, Less Risk Pool Distributions.

** Equals amount on Report #6, Undistributed Risk Pool Balance and Report #1 - Assets, Line 9 or Liabilities, Line 6.

STATEMENT AS OF _____ OF _____
(Quarter Ending) (Plan Name)

Plan Fiscal Year End _____

Report #7 - Other Assets and Liabilities

DESCRIPTION**	CURRENT	NON-CURRENT
Assets		
Other Receivables		
Deferred Income Taxes		
Deferred Finance Costs		
Other*		
Liabilities		
Other Payables		
Other*		
TOTALS		

* Include all items, in total, that are less than $50,000 individually.
** List all individual items greater than $50,000.

Equals amount on Report #1, Assets, Lines 11 and 18 and Liabilities, Lines 9 and 13.

STATEMENT AS OF _____ OF _____
(Quarter Ending) (Plan Name)

Plan Fiscal Year End _____

Report #8 - Restricted Case and Other Assets

DESCRIPTION OF ASSET (TYPE)	RESTRICTED PURPOSE	COST	MARKET VALUE	CARRYING VALUE*

* Total amount equals amount in Report #1, Assets, Line 15.

STATEMENT AS OF _____ OF _____
(Quarter Ending) (Plan Name)

Plan Fiscal Year End _____

Report #9 - Medical Claims Payable (RBUCs and IBNRs)

	Reported But Unpaid Claims (RBUCs)						
EXPENSE CATEGORY	1-30 DAYS	31-60 DAYS	61-90 DAYS	OVER 90 DAYS	TOTAL RBUCs	IBNR	TOTAL RBUCs & IBNRs
Inpatient							
Medical Reimbursement							
Outpatient							
Other Medical							
TOTAL MEDICAL CLAIMS PAYABLE*							

* Equals amount on Report #1, Liabilities, Line 4.

Report No. 10A

Claims Lag Report For
Inpatient Payments

Plan: _____ (QUARTER ENDED: _____) (Fiscal Year End: _____)

		QUARTER IN WHICH SERVICE PROVIDED							
(1) LINE	(2) QUARTER OF PAYMENT	(3) CURRENT	(4) 1ST PRIOR	(5) 2ND PRIOR	(6) 3RD PRIOR	(7) 4TH PRIOR	(8) 5TH PRIOR	(9) 6TH PRIOR	(10) TOTAL
1	CURRENT								
2	1ST PRIOR								
3	2ND PRIOR								
4	3RD PRIOR								
5	4TH PRIOR								
6	5TH PRIOR								
7	6TH PRIOR								
8	TOTALS								
9	EXPENSE REPORTED								
10	ACCRUAL ADJUSTMENT								
11	REMAINING LIABILITY*								

See instructions before completing schedule.

* The total amount must equal the total liability reported for hospitalization in Report #9 - Medical Claims Payable.

Row 9, Expense Reported, must equal the total inpatient expense (Report #2, Line 11) less risk pool adjustment (Report #2, Line 10) for the applicable quarter.

Report No. 10B

Claims Lag Report For
Medical Reimbursement Payments

Plan: _____ (QUARTER ENDED: _____) (Fiscal Year End: _____)

		QUARTER IN WHICH SERVICE PROVIDED							
(1) LINE	(2) QUARTER OF PAYMENT	(3) CURRENT	(4) 1ST PRIOR	(5) 2ND PRIOR	(6) 3RD PRIOR	(7) 4TH PRIOR	(8) 5TH PRIOR	(9) 6TH PRIOR	(10) TOTAL
1	CURRENT								
2	1ST PRIOR								
3	2ND PRIOR								
4	3RD PRIOR								
5	4TH PRIOR								
6	5TH PRIOR								
7	6TH PRIOR								
8	TOTALS								
9	EXPENSE REPORTED								
10	ACCRUAL ADJUSTMENT								
11	REMAINING LIABILITY*								

See instructions before completing schedule.

* This amount must equal the total liability reported for physician reimbursement in Report #9 - Medical Claims Payable.

Row 9, Expense Reported, must equal the total medical reimbursement expense (Report #2, Line 16) less risk pool adjustment (Report #2, Line 15) for the applicable quarter.

Report No. 10C

Claims Lag Report For
Outpatient Payments

Plan: _____ **(QUARTER ENDED:** _____**)** **(Fiscal Year End:** _____**)**

		QUARTER IN WHICH SERVICE PROVIDED							
(1) LINE	(2) QUARTER OF PAYMENT	(3) CURRENT	(4) 1ST PRIOR	(5) 2ND PRIOR	(6) 3RD PRIOR	(7) 4TH PRIOR	(8) 5TH PRIOR	(9) 6TH PRIOR	(10) TOTAL
1	CURRENT								
2	1ST PRIOR								
3	2ND PRIOR								
4	3RD PRIOR								
5	4TH PRIOR								
6	5TH PRIOR								
7	6TH PRIOR								
8	TOTALS								
9	EXPENSE REPORTED								
10	ACCRUAL ADJUSTMENT								
11	REMAINING LIABILITY*								

See instructions before completing schedule.

* This amount must equal the total liability reported for other medical in Report #9 - Medical Claims Payable.

Row 9, Expense Reported, must equal the total outpatient expense (Report #2, Line 27) less risk pool adjustment (Report #2, Line 26) for the applicable quarter.

Report No. 10D

Claims Lag Report For
Other Medical Payments

Plan: _____ (QUARTER ENDED: _____) (Fiscal Year End: _____)

		QUARTER IN WHICH SERVICE PROVIDED							
(1) LINE	(2) QUARTER OF PAYMENT	(3) CURRENT	(4) 1ST PRIOR	(5) 2ND PRIOR	(6) 3RD PRIOR	(7) 4TH PRIOR	(8) 5TH PRIOR	(9) 6TH PRIOR	(10) TOTAL
1	CURRENT								
2	1ST PRIOR								
3	2ND PRIOR								
4	3RD PRIOR								
5	4TH PRIOR								
6	5TH PRIOR								
7	6TH PRIOR								
8	TOTALS								
9	EXPENSE REPORTED								
10	ACCRUAL ADJUSTMENT								
11	REMAINING LIABILITY*								

See instructions before completing schedule.

* This amount must equal the total liability reported for other medical in Report #9 - Medical Claims Payable.

Row 9, Expense Reported, must equal the total other medical expense (Report #2, Line 34) less risk pool adjustment (Report #2, Line 33) for the applicable quarter.

STATEMENT AS OF _____ OF _____
(Quarter Ending) (Plan Name)

Plan Fiscal Year End _____

Report #11 - Long-Term Debt (Other Than Affiliates)

NAME OF LENDER	RATE	CURRENT*	LONG-TERM**	TOTAL	ACCRUED INTEREST
FINANCIAL INSTITUTIONS					
TOTAL FINANCIAL INSTITUTIONS					
OTHER LENDERS					
TOTAL OTHER LENDERS					
GRAND TOTALS					

* Equals amount on Report #1, Liabilities, Line 7.

** Equals amount on Report #1, Liabilities, Line 11.

STATEMENT AS OF _____ OF _____
(Quarter Ending) (Plan Name)

Plan Fiscal Year End _____

Report #12 - Physician Services (QUEST Integration only)

DESCRIPTION	CURRENT PERIOD	YEAR-TO-DATE
Primary Care Physician - Salary		
Primary Care Physician - Capitation		
Primary Care Physician - Fee-For-Service		
Primary Care Physician - Other		
TOTAL PRIMARY CARE PHYSICIAN SERVICES	*	
Referral Physician - Salary		
Referral Physician - Capitation		
Referral Physician - Fee-For-Service		
Referral Physician - Other		
TOTAL REFERRAL PHYSICIAN SERVICES	**	

* Equals the amount on Report #2, Line 12.

** Equals the amount on Report #2, Line 13.

STATEMENT AS OF _____ OF _____
(Quarter Ending) (Plan Name)

Plan Fiscal Year End _____

Report #13 - Related Party Transactions

Name of Related Party	Description of Transactions	Income or Receipts	Expense or Disbributions	Receivables	Payable
TOTALS					

QUEST Integration
FINANCIAL REPORTING GUIDE
MEDICAL PLAN

TABLE OF CONTENTS

SECTION NUMBER

1. GENERAL INFORMATION

This section discusses the following topics:

1.1 PURPOSE AND OBJECTIVE OF GUIDE

The purpose of the Financial Guide is to set forth the financial reporting requirements for the Hawaii QUEST Integration medical plans. The primary objective of the guide is to establish consistency and uniformity in reporting. The Department of Human Services (DHS) reserves the right to require certain monthly reporting when it is deemed appropriate by the Administration. Monthly reports are to be prepared using the quarterly reporting guidelines and instructions.

1.2 BACKGROUND

1.2.1 Centers for Medicare and Medicaid Services (CMS) regulations and DHS contractually require that medical plans furnish all information from the Plan's records relating to the performance of the contract. Certain financial and statistical data are outlined in the contract as minimum requirements. The QUEST Integration Program has developed a standard set of forms to be used to satisfy the quarterly financial reporting requirements, as well as guidelines and minimum reporting requirements for the annual audited financial statements.

1.2.2 In addition, DHS requires the Plan to demonstrate to the Administration that it has adequate financial reserves to carry out its contractual obligations. Each plan shall maintain financial records and may have an annual audit(s) performed by an authorized representative of DHS, the Hawaii State Auditor, the GAO, and/or the Comptroller of the United States. Each plan is required to provide the QUEST Integration Program with annual audited financial statements prepared by an independent certified public accountant.

1.2.3 DHS also reserves the right to require certain monthly reporting when it is deemed appropriate. When monthly reports are required, the quarterly reporting guidelines and instructions for the applicable forms are to be followed. Refer to section 1.3.3 of this guide for monthly reporting requirements and deadlines. Reports for the last month of a quarter are not required for monthly reporting. Reports for the last quarter are required in addition to the annual reports.

1.3 EFFECTIVE DATES AND REPORTING TIMEFRAMES

1.3.1 The provision and requirements of this guide are effective for fiscal quarters beginning on or after January 1, 2015. Amendments and/or updates to this guide may be issued by DHS from time to time as deemed necessary by DHS.

1.3.2 Monthly reporting, when required, is due within 45 days of each month end. Quarterly information is due within 45 days of each quarter end. Annual financial reports and disclosures are due within 120 days of the Plan's fiscal year end.

If a due date falls on a weekend or recognized State holiday, reports will be due the next business day.

1.3.3 FINANCIAL REPORTING REQUIREMENTS TABLE

Report Number	Description	Due Date
	MONTHLY (If Applicable)	
N/A	Certification Statement	45 days after month end
1	Balance Sheet	45 days after month end
2	Statement of Revenues and Expenses	45 days after month end
	QUARTERLY	
N/A	Certification Statement	45 days after quarter end
N/A	Listing of Changes to Plan Officers and Directors	45 days after quarter end
1	Balance Sheet	45 days after quarter end
2	Statement of Revenues and Expenses	45 days after quarter end
3	Statement of Cash Flow	45 days after quarter end
4	Investments	45 days after quarter end
5	Amounts Due From (To) Affiliates	45 days after quarter end
6	Risk Pool Analysis	45 days after quarter end
7	Other Assets and Liabilities	45 days after quarter end
8	Restricted Cash and Other Assets	45 days after quarter end
9	Medical Claims Payable (RBUCs and IBNRs)	45 days after quarter end
10	Claims Lag Reports	45 days after quarter end
11	Long-Term Debt (Other Than Affiliates)	45 days after quarter end
12	Physician Services	45 days after quarter end
13	Related Party Transactions	45 days after quarter end
	ANNUAL	
N/A	Final Annual Audit Report	120 days after year end
N/A	Final Management Letter	120 days after year end
N/A	Disclosure Statement	120 days after year end
N/A	Listing of Plan Officers and Directors	120 days after year end
N/A	Reconciliation – Annual Audit and Plan Year-to-Date Quarterly Financial Statements	120 days after year end

1.4 SANCTIONS

1.4.1 Failure to file with the QUEST Integration Program, ACCURATE, TIMELY and COMPLETE monthly (if applicable), quarterly and annual financial statements and disclosures may result in a penalty each day or portion thereof, until such statements are received by DHS. The penalty is $200.00 per day until the required reports are received by DHS.

1.4.2 Whoever knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any statement or disclosure filed pursuant to this policy may be fined $100,000 for each determination.

1.4.3 DHS may refuse to enter into a contract and may suspend or terminate an existing contract if the Plan fails to disclose ownership or controlling information and related party transactions as required by DHS policy.

2. INSTRUCTIONS FOR THE COMPLETION OF FINANCIAL REPORTING FORMS

This section contains the *instructions* for completing items in the required quarterly reports that may deviate from GAAP or be specific to QUEST Integration.

2.1 GENERAL INSTRUCTIONS

The following are general instructions for completing the quarterly reports required of the medical plans. The primary objective of these instructions is to ensure that all required information is submitted and to promote uniformity in reporting.

2.1.1 Generally accepted accounting principles (GAAP) are to be followed in the preparation of all financial statements. All revenues and expenses must be reported using the accrual basis of accounting.

2.1.2 All quarterly reports are to be completed and submitted to the QUEST Integration Program within 45 days after the last day of the quarter. If monthly reports are required, reports are to be completed and submitted within 45 days after the last day of the month.

2.1.3 Line titles and columnar headings are generally self-explanatory. Specific instructions are provided for items about which there may be some question. Any entry for which no specific instructions are included should be made in accordance with GAAP.

2.1.4 Always utilize predefined categories or classifications before reporting an amount as "OTHER". For any material amounts included in the "OTHER" category, details and explanations are to be provided. For this purpose, material amounts are defined as comprising more than 5% of the total for each section. For example, items included in Other Income which account for more than 5% of total revenues should be separately identified and explained in a separate sheet or in the footnotes.

2.1.5 Prior period information should be reported in a consistent manner and using the same criteria established for completing the current period information. Where the necessary detail does not exist to adequately report prior period information, this fact should be disclosed in the footnotes to the reports. Prior period information reported in the current period should agree to the information previously reported. Any variances or discrepancies are to be explained.

2.1.6 Unanswered Questions and blank lines or schedules will not be considered properly completed. If no answers or entries are to be made, write "None", not applicable "N/A", or "-0-" to reflect zero balances in the space provided.

2.1.7 All amounts are to be reported in whole dollars only. Plans who wish to report amounts to the nearest thousand must request prior approval from the QUEST Integration Program.

2.1.8 If corrections need to be made to previously submitted reports, submit the corrected schedules with a cover letter explaining the corrections made and the impact of the corrections, if any, on the financial results for the quarter and year to date.

2.2 REPORT #1 – BALANCE SHEET

2.2.1 Provide the balance sheet for the required period. The balance sheet shall be the consolidated balance sheet for the entity related to the medical plan.

2.2.2 The balance sheet shall be prepared in accordance with GAAP.

2.2.3 ASSETS

LINE 3: CAPITATION RECEIVABLE

Include: Net amounts receivable from the QUEST Integration Program for capitation as of the balance sheet date.

Exclude: Reinsurance and Deferred Liability receivables which are to be included in Lines 4 and 5, respectively.

2.2.4 LIABILITIES AND PLAN EQUITY

LINE 3: CAPITATION PAYABLE (PROVIDERS)

Include: Net amounts owed to providers for monthly capitation.

Exclude: Capitation payable to the QUEST Integration Program for overpayments by QUEST Integration.

LINE 4: MEDICAL CLAIMS PAYABLE (DETAIL IN REPORT #9)

Include: Total reported but unpaid claims (RBUCs) and incurred but not reported claims (IBNRs). This liability relates to claims expense categories 8 through 27 in the Statement of Revenues and Expenses.

Exclude: Withhold and Risk Pool Payables.

2.3 REPORT #2 – STATEMENT OF REVENUES AND EXPENSES

2.3.1 Provide the Statement of Revenues and Expenses for the required period. A consolidated statement for the entity related to the medical plan shall be provided. A Separate Statements of Revenues and Expenses shall be provided for the QUEST Integration Program.

2.3.2 The Statement of Revenues and Expenses shall be prepared in accordance with GAAP.

2.3.3 All physician and non-physician services whether the services are provided in an inpatient setting, outpatient hospital setting, post acute setting, emergency room, outpatient setting, clinic or physician's office are to be included in the appropriate Medical Reimbursement Expense Line (Lines 12-14).

2.3.4 All services (excluding physician and non-physician services) provided in an inpatient setting, outpatient hospital setting, post acute setting or emergency room including ancillary and diagnostic services, therapeutic services, DME, supplies and medication are to be included in the appropriate line based on the primary service. For example, all services provided in an inpatient setting are to be included in Lines 8-9, all services provided in an emergency room are to be included in Line 17 and all services provided in an outpatient hospital setting are to be included in Line 18.

2.3.5 All outpatient services (excluding those provided in an emergency room and outpatient hospital setting as noted in 2.3.4) are to be included in the appropriate individual line item. For example, pharmaceuticals provided during a clinic visit should be recorded on Line 22 and the clinic visit recorded on Line 19.

2.3.6 EXPENSES

LINES 8-9: INPATIENT EXPENSES

Include: Inpatient acute rehabilitation and behavioral health stays. Include all related services for an inpatient stay as provided in 2.3.4.

Exclude: Post acute (SNF, ICF and subacute) and waitlisted stays which are to be included in Line 30.

LINE 13: REFERRAL PHYSICIAN SERVICES

Include: Non-primary care physician services including services provided by emergency room physicians and specialty care physicians.

LINE 14: NON-PHYSICIAN SERVICES

Include: Services provided by psychologists, nurse mid-wives, social workers, nurse practitioners and others who are able to individually bill for their services.

LINE 17: EMERGENCY SERVICES

Include: All emergency room services (including non-emergency visits) per 2.3.4 and the related transportation services (ambulance and emergency air transport).

Exclude: Emergency room physician services per 2.3.3 which are included in Referral Physician Services (Line 13).

LINE 18: OUTPATIENT HOSPITAL SERVICES

Include: All outpatient hospital services including ancillary and diagnostic services, therapeutic services, DME, supplies and medication per 2.3.4. Includes hemodialysis and outpatient oncology services provided in other than an emergency room or outpatient clinic.

Exclude: Physician services per 2.3.3.

LINE 19: CLINIC SERVICES

Include: Services provided in community health centers, urgent care clinics and other outpatient clinic settings.

Exclude: Services provided in outpatient hospital settings. Physician services per 2.3.3. Ancillary and diagnostic services, supplies and medications per 2.3.5.

LINE 20: BEHAVIORAL HEALTH SERVICES

Include: Outpatient behavioral health services including residential treatment, detoxification services and other services provided at a freestanding clinic or treatment center (i.e., Salvation Army).

Exclude: Services provided in an inpatient setting, outpatient hospital setting, physician or non-physician's office or emergency room should be recorded on the respective line (i.e., emergency room services on Line 17). Ancillary and diagnostic services, supplies and medications per 2.3.5.

LINE 21: OTHER OUTPATIENT SERVICES

Include: Services provided on an outpatient basis that do not belong in any other category based on the definitions provided.

Exclude: Ancillary and diagnostic services, supplies and medications per 2.3.5.

LINE 22: PHARMACY

Include: Pharmaceuticals dispensed on an outpatient basis, in a physician's office or by a retail pharmacy.

Exclude: Pharmaceuticals dispensed during inpatient, outpatient hospital, emergency room and post acute services per 2.3.4.

LINES 23 AND 24: LAB AND RADIOLOGY

Include: Services provided on an outpatient basis including services provided in a freestanding facility or clinic or in the physician's office.

Exclude: Services provided during inpatient, outpatient hospital, emergency room and post acute services per 2.3.4.

LINE 25: THERAPEUTIC SERVICES

Include: Services provided on an outpatient basis including services provided in a freestanding facility or clinic or in the physician's office. Services include physical, occupational, speech and audiology therapy.

Exclude: Services provided during inpatient, outpatient hospital, emergency room and post acute services per 2.3.4.

LINE 28: DURABLE MEDICAL EQUIPMENT/SUPPLIES

Include: All durable medical equipment issued in an outpatient setting. Includes, DME, eye glasses, hearing aids, etc.

Exclude: Items provided during inpatient, outpatient hospital, emergency room and post acute services per 2.3.4.

LINE 29: TRANSPORTAION, MEALS AND LODGING

Include: Costs for transportation, meals and lodging including cab fair, airfare, handicab and handivan services and bus passes.

Exclude: Emergency transportation such as ambulance and emergency air services which are included on Line 17.

LINE 30: POST ACUTE CARE

Include: SNF, ICF, hospice and home health services and waitlisted stays. Include the ancillary and diagnostic services, therapeutic services, DME, supplies and medication per 2.3.4.

LINE 32: CASE MANAGEMENT/CARE COORDINATION

Include: Case management/care coordination services provided by plan staff or contracted personnel to case manage, monitor, or coordinate services for patients. Only case management/care coordination services which can be directly attributed to a specific patient should be included here. Include

allocation of plan personnel and related expenses as well as purchased services and incentives which can be associated with ensuring patient care and/or disease management and compliance with preventive health.

Exclude: Services provided by plan staff or contracted personnel to develop or design plan program(s) for improving/maintaining health outcomes. Exclude development, printing and mailing costs for brochure and other mailing material. These costs are included and reported as administrative expenses.

2.4 REPORT #3 – STATEMENT OF CASH FLOW

2.4.1 Provide the Statement of Cash Flow for the required period. A consolidated statement for the entity related to the medical plan shall be provided. A separate Statement of Cash Flow shall also be provided for the Plan's Total QUEST Integration Program operations.

2.4.2 The Statement of Cash Flow shall be prepared in accordance with GAAP.

2.5 REPORT #4 - INVESTMENTS

List all investments other than investments in affiliates for the reporting period. Any disposal of investments should be shown as negative amounts.

2.6 REPORT #5 – AMOUNTS DUE FROM (TO) AFFILIATES

List current and non-current amounts due from (to) affiliates. If a due from and due (to) exists for the same affiliate, the amounts should not be netted together and should be reported as separate amounts. Current amounts shall not be netted with non-current amounts.

2.7 REPORT #6 – RISK POOL ANALYSIS

The purpose of this report is to monitor risk pool activity. All revenues and expenses allocated to the risk pool(s) shall be shown in this report along with risk pool adjustments and distributions.

2.7.1 Revenues Allocated to Risk Pool

All amounts allocated to the risk pool(s) from which claims are to be paid should be reported (capitation, reinsurance, and other revenue sources).

2.7.2 Expenses Allocated to Pool

The expenses recognized in the risk pool(s) should be reported by expense category. Include provider capitations paid out of the pool(s).

2.7.3 Change in the Balance for Current Period Activity

Then net amount of total allocations to the risk pool less total medical expenses allocated to the risk pool results in the net change from current period activity. This amount equals the total of risk pool adjustments on Report #2, Line 10, 16, 27, and 34.

2.7.4 Risk Pool Balances at the Beginning of the Period

The beginning risk pool balance should be the Undistributed Risk Pool Balance at Period End from the prior quarter Report #6, Risk Pool Analysis.

2.7.5 Adjustment to Beginning of Period Risk Pool Balances

All changes to the prior period risk pool balance should be recorded (i.e., change in prior period accrual estimates).

2.7.6 Risk Pool Distributions

All risk pool distributions, for both prior and current year, are to be recorded. This amount should equal the ending balance in the (Distributions)/Contributions column on Report 6A, Risk Pool Listing by Participant.

2.7.7 Undistributed Risk Pool Balance at Period End

The risk pool payable (receivable) at the end of the period is calculated by adding (or subtracting) the current period activity to the balance at the beginning of the period, plus (minus) any adjustments to the prior period estimates, plus any contributions to or less distributions from the risk pool(s) balance.

2.7.8 Report 6A – Risk Pool Listing

On a quarterly basis, list all risk pools on this schedule. Include prior period risk pool balances along with any distributions to or contributions from these risk pools during the period. The ending balance for the total of all risk pools should tie to Report #6.

On an annual basis, list all participants in the risk pools on this schedule. Include their prior period risk pool balances along with any distributions to or contributions from those participants during the period. The ending balance for the total of all participants should tie to Report #6.

2.8 REPORT #7 – OTHER ASSETS AND LIABILITIES

Include all other assets and liabilities (current and non-current) in the appropriate columns provided. Include all individual assets and liabilities greater than $50,000 and list the total of others not individually greater than $50,000.

2.9 REPORT #8 – RESTRICTED CASH AND OTHER ASSETS

List all restricted cash and other restricted assets included in the Balance Sheet. Do not include amounts pledged to meet the QUEST Integration Program's performance bond requirement. If multiple securities are maintained in the same account and are of a similar nature, the data relating to that account can be listed in total on this schedule. Otherwise, assets are to be listed separately.

2.10 REPORT #9 – MEDICAL CLAIMS PAYABLE (RBUCs and IBNRs)

Reported but unpaid claims (RBUCs) are to be reported by the appropriate expense and aging categories. A claim becomes an RBUC the day it is received by the plan, not the day it is processed/adjudicated. The incurred but not reported (IBNR) claims should be reported in the second to last column by the appropriate category.

2.11 REPORT #10 – CLAIMS LAG REPORTS

Analyzing the accuracy of historical medical claims liability estimates is helpful in assessing the adequacy of current liabilities. The schedule provides the necessary information to make this analysis.

2.11.1 The instructions below apply to Report No. 10A, 10B, 10C and 10D.

The schedules are arranged with dates of service horizontally and quarter of payment vertically. Therefore, payments made during the current quarter for services rendered during the current quarter would be reported on line 1, column 3. While payments made during the current quarter for services rendered in prior quarters would be reported on line 1, columns 4 through 9. Do not include risk pool distributions as payments in this schedule. Do not record any amounts in the shaded areas.

2.11.2 Line 9, the expense reported for each category of service (inpatient, medical reimbursement, outpatient and other medical) in current and previous quarters should be recorded less risk pool adjustment expenses for the same quarters on line 9 in the appropriate column.

2.11.3 Line 10, accrual adjustment, represents any change in estimates made subsequent to the quarter for which expenses/liabilities were reported. Therefore, the total payments made (row 8) plus accrual adjustments (row 10) and remaining liability (row 11) must equal the expense reported (row 9) for each quarter.

2.11.4 Line 11, remaining liability, represents any remaining liability estimated for each quarter. The total of the remaining liability reported (row 11, column 10) must equal the total liability (by cost category) reported in Report #9 Medical Claims Payable.

2.12 REPORT #11 – LONG-TERM DEBT (OTHER THAN AFFILIATES)

List all loans, notes payable and capital lease obligations by lender as well as by current and long-term portions (exclude debt to affiliates, this is to be reported on Report No. 5 Amounts Due From (To) Affiliates). Also include interest rate and accrued interest in the spaces provided.

2.13 REPORT #12 – PHYSICIAN SERVICES

Report the detail of Primary Care Physician and Referral Physician expenses by the method of reimbursement (i.e., Salary, Capitation, Fee-For-Service, or Other). Do not report risk pool expenses in this schedule. If the "Other" category is used, provide a brief description of the reimbursement arrangement.

2.14 REPORT #13 – RELATED PARTY TRANSACTIONS

Report the **aggregate** amount of each transaction for the current reporting period involving any individual or entity that meets the definition/description of a related party (affiliate). "Related party" or "affiliate" may be defined as anyone who has the power to control or significantly influence the Plan or be controlled or significantly influenced by the Plan. Accordingly, subsidiaries, parent companies, sister companies and entities accounted for by the equity method are considered related parties, as are principal owners, board of director members, management and their immediate families, and other entities controlled or managed by any of the previously listed entities or persons. Related party transactions include all transactions between program contractors and such related parties, regardless of whether they are conducted in an arm's length manner or are not reflected in the accounting records (e.g., the provision of services without charge or guarantees of outstanding debt). Transactions with related parties may be in the normal course of business or may represent an irregular exchange of assets or services. In the normal course of business, there may be numerous routine and recurring transactions with related parties. Although each party may be appropriately pursuing its respective best interest, transactions between them must be disclosed and reviewed for reasonableness.

For example, report all hospitalization expenses at an affiliated hospital for the period, or all medical reimbursement expenses to plan owners, medical directors, and/or board members. Other non-service transactions should also be accounted for on this schedule, such as allocation of overhead, rent or management fees to related parties as well as any loans (to or from) and distribution (to or from) related parties.

All significant related party transactions not in the ordinary course of business, require prior approval by the QUEST Integration Program.

2.15 QUARTERLY FOOTNOTE REQUIREMENTS

The purpose of these footnote requirements is to supplement our understanding of financial statements and supplemental schedules. The following list represents minimum expected disclosures and is not intended to be all inclusive. Disclosures required by GAAP should also be included.

2.15.1 "Other" Amounts

Describe material amounts included in the "other" categories in Reports #1, #2 and #3.

2.15.2 Pledges/Assignments and Guarantees:

a. Describe any pledges, assignments, or collateralized assets.

b. Describe any guaranteed liabilities not disclosed on the balance sheet.

2.15.3 Related Parties:

Disclose transactions with related parties during the quarter including receivables from and/or payables to related parties. Since all related party balances will be captured in Reports #5 and #13 this footnote will serve to provide further detail on transactions and relationships.

2.15.4 Subcapitation:

Indicate the amounts paid under subcapitation arrangements from the plan to the providers:

	Quarter	Year-to-Date
Inpatient	$_____	$_____
Physician Services	$_____	$_____
Outpatient	$_____	$_____
Other Medical (Describe)	$_____	$_____
TOTAL	$_____	$_____

2.15.5 Prior Period Adjustments:

Disclose and describe any adjustments made to previously submitted financial statements including those adjustments that affect the current quarter's financial statements.

2.15.6 Claims Payable Analysis:

Explain large fluctuations in IBNR and RBUC balances from the prior quarter. Specifically, address changes in IBNRs of more than 10% (on an IBNR per member basis) and changes in RBUCs of more than 5% (on an RBUC per member basis).

2.15.7 Risk Pools:

Describe any changes in the risk sharing arrangements the Plan utilizes. Key components to be included are:

- Services covered by risk pool(s)
- Remaining liabilities or receivables from prior fiscal years
- Scheduled frequency of distributions
- Percent of revenues allocated to pool(s) (i.e., methodology of allocation)

2.15.8 Contingent Liabilities:

Give details of any malpractice or other claims made against the Plan as well as the status of the case, potential financial exposure, and most likely resolution.

3. QUARTERLY REPORTING FORMS

This section includes the forms to be completed by Plan management on a quarterly basis. Instructions on the completion of these quarterly reporting forms are included in Section 2.

CERTIFICATION STATEMENT

LISTING OF PLAN OFFICERS AND DIRECTORS

BASIC FINANCIAL STATEMENTS

REPORT #1	BALANCE SHEET – CONSOLIDATED
REPORT #2	STATEMENT OF REVENUE AND EXPENSES (CONSOLIDATED AND QUEST INTEGRATION)
REPORT #3	STATEMENT OF CASH FLOW (CONSOLIDATED AND QUEST INTEGRATION)

SUPPLEMENTARY SCHEDULES

REPORT #4	INVESTMENTS
REPORT #5	AMOUNTS DUE FROM (TO) AFFILIATES
REPORT #6	RISK POOL ANALYSIS
REPORT #6A	RISK POOL LISTING BY PARTICIPANT
REPORT #7	OTHER ASSETS AND LIABILITIES
REPORT #8	RESTRICTED CASH AND OTHER ASSETS
REPORT #9	MEDICAL CLAIMS PAYABLE (RBUCs AND IBNRs)
REPORT #10	CLAIMS LAG REPORTS (PARTS A, B, C, AND D)
REPORT #11	LONG-TERM DEBT (OTHER THAN AFFILIATES)
REPORT #12	PHYSICIAN SERVICES
REPORT #13	RELATED PARTY TRANSACTIONS

CERTIFICATION STATEMENT OF

_____

(Name of Plan)

TO THE

Hawaii QUEST Integration Program

FOR THE QUARTER ENDING

_____, 20_____

(Month and Day) (Year)

Name of Preparer _____

Title _____

Phone Number _____

I hereby attest that the information submitted in the reports herein is current, complete and accurate to the best of my knowledge. I understand that whoever knowingly and willfully makes or causes to be made a false statement or representation on the reports may be prosecuted under applicable state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate, or where the entity already participates, a termination of a Plan's agreement or contract with the Hawaii QUEST Integration Program.

_____ _____

Date Signed Chief Executive Officer/Chief Financial Officer
(Name and Title typewritten)

_____

Signature

STATEMENT AS OF _____ OF _____
(Quarter Ending) (Plan Name)

Listing of Changes to Plan Officers and Directors (Quarterly)
Listing of All Plan Officers and Directors (Annual)

Name, Title	Other Relationship to Plan	Type of Compensation (if applicable)

STATEMENT AS OF _____ OF _____
(Quarter Ending) (Plan Name)

Plan Fiscal Year End _____

Report #1 - Balance Sheet

CURRENT ASSETS	CURRENT QUARTER
1. Cash and Cash Equivalents (Report #3)	
2. Short-term Investments (Report #4)	
3. Capitation Receivable (QI)	
4. Reinsurance Receivable	
A. Billed	
B. Unbilled	
C. Advances	( )
D. Net Receivable	
5. Deferred Liability Receivable:	
A. Billed	
B. Unbilled	
C. Advances	( )
D. Net Receivable	
6. Non-QUEST Integration Programs	
A. Members' Dues	
B. Patient Services	
C. Third Party Payors	
D. Other	
E. Net Non-QUEST Integration Receivable	
7. Investment Income Receivable	
8. Amounts Due From Affiliates (Report #5)	
9. Risk Pool Receivable (Report #6)	
10. Risk Pool Receivable-non-QI	
11. Other Current Assets (Report #7)	
A. Inventory	
B. Prepaid Expenses	
12. TOTAL CURRENT ASSETS (Items 1 through 11)	
OTHER (Non-Current) ASSETS:	
13. General Performance Bond	
14. Bond Funds - non-QI Programs	
15. Ristricted Cash and Other Assets (Report #8)	
16. Long-Term Investments (Report #4)	
17. Amount Due from Affiliates (Report #5)	
18. Other Non-Current Assets (Report #7)	
19. TOTAL OTHER (Non-Current) ASSETS (Items 13 through 18)	
LAND, BUILDINGS and EQUIPMENT:	
20. Land	
21. Buildings	
22. Leasehold Improvements	
23. Furniture & Equipment	
24. Vehicles	
25. Construction in Progress	
26. Other	
27. Total Land, Buildings and Equipment (Items 20 through 26)	
28. Less Accumulated Depreciation and Amortization	( )
29. NET LAND, BUILDINGS and EQUIPMENT (Items 27 & 28)	
30. TOTAL ASSETS (Items 12, 19, and 29)	

STATEMENT AS OF _____ OF _____
(Quarter Ending) (Plan Name)

Plan Fiscal Year End _____

Report #1 - Balance Sheet (Continued)

LIABILITIES	CURRENT QUARTER
1. Accounts Payable and Other Accrued Expenses	
2. Accrued Administravie Expenses	
3. Capitation Payable (Providers)	
4. Medical Claims Payable (Report #9)	
5. Accrued Medical Incentive Pool	
6. Accrued Risk Pool Payable (Report #6)	
7. Current Portion of Long-Term Debt (Report #11)	
8. Amount Due to Affiliates (Report #5)	
9. Other Current Liabilities (Report #7)	
10. TOTAL CURRENT LIABILITIES (Items 1 through 9)	
OTHER LIABILITIES	
11. Long-term Debt Excluding Current Portion (Report #11)	
12. Amount Due to Affiliates (Report #5)	
13. Other Non-Current Liabilities (Report #7)	
14. TOTAL OTHER LIABILITIES (Items 11 through 13)	
15. TOTAL LIABILITIES (Items 10 through 14)	
EQUITY	
16. Preferred Stock (Par Value _____) (# of Shares Authorized, Issued and Outstanding)	
17. Common Stock (Par Value _____) (# of Shares Authorized, Issued and Outstanding)	
18. Treasury Stock (# of Shares)	( )
19. Additional Paid-in Capital	
20. Contributed Capital	
21. Retained Earnings/Fund Balance/Unrestricted Assets	
22. Restricted Assets	
23. TOTAL EQUITY (Items 16 through 22)	
24. TOTAL LIABILITY AND EQUITY (Items 15 and 23)	

STATEMENT AS OF _____ OF _____
(Quarter Ending) (Plan Name)

Plan Fiscal Year End _____

Report #2 - Statement of Revenue and Expenses

QUEST Integration □ **Consolidated Statement □**

		1		2	
	MEMBER MONTHS	CURRENT QUARTER		YEAR-TO-DATE	
REVENUES			PMPM		PMPM
1. Capitation/Premiums					
2. Reinsurance					
3. Fee-for-Service					
4. Third Party Liability Recoveries					
5. Investment Income					
6. Other Income (Specify)					
7. TOTAL REVENUES (Items 1 through 6)					
EXPENSES					
Inpatient Expenses:					
8. Hospital Inpatient Capitation					
9. Hospital Inpatient Fee-for-Service					
10. Hospital Risk Pool Expense Adjustment (Report #6)					
11. TOTAL INPATIENT (Items 8 through 10)					
Medical Reimbursement Expenses:					
12. Primary Care Physician Services (Report #12)					
13. Referral Physician Services (Report #12)					
14. Non-physician Services					
15. Physician Risk Pool Expense Adjustment (Report #6)					
16. TOTAL MEDICAL REIMBURSEMENT (Items 12 through 15)					
Outpatient Expenses:					
17. Emergency Services					
18. Outpatient Hospital Services					
19. Clinic Services					
20. Behavioral Health Services					
21. Other Outpatient Services					
22. Pharmacy					
23. Lab					
24. Radiology					
25. Therapeutic Services					
26. Risk Pool Expense Adjustment (Report #6)					
27. TOTAL OUTPATIENT (Items 17 through 26)					
Other Medical Expenses:					
28. Durable Medical Equipment/Supplies					
29. Transportation, Meals and Lodging					
30. Post Acute Care					
31. Translation Services					
32. Case Management/Care Coordination					
33. Other (Specify)					
34. Risk Pool Expense Adjustment (Report #6)					
35. TOTAL OTHER MEDICAL (Items 28 through 34)					
36. TOTAL MEDICAL EXPENSES (Items 11, 16, 27 and 35)					

STATEMENT AS OF _____ OF _____
(Quarter Ending) (Plan Name)

Plan Fiscal Year End _____

Report #2 - Statement of Revenue and Expenses (Continued)

QUEST Integration □ **Consolidated Statement □**

		1		2	
	MEMBER MONTHS	CURRENT QUARTER		YEAR-TO-DATE	
Administrative Expenses:			PMPM		PMPM
37. Compensation					
38. Data Processing					
39. Management Fees					
40. Insurance					
41. Interest Expense					
42. Occupancy (Rent/Utilities)					
43. Depreciation					
44. Medical Director Fees					
45. Other (Specify)					
46. TOTAL ADMINISTRATION (Items 37 through 45)					
47. TOTAL EXPENSE (Items 36 and 46)					
48. INCOME FROM OPERATIONS (Item 7 less Item 46)					
49. Non-operating Income (loss)					
50. INCOME (LOSS) BEFORE INCOME TAXES (Items 48 & 49)					
51. Income Taxes					
52. NET INCOME (LOSS) AFTER INCOME TAXES (Item 50 less Item 51)					

STATEMENT AS OF _____ OF _____
(Quarter Ending) (Plan Name)

Plan Fiscal Year End _____

Report #3 - Statement of Cash Flow
QUEST Integration □ Consolidated Statement □

	Current Quarter	YTD
1. Net Cash Provided from (Used in) Operating Activities		
2. Net Cash Provided from (Used in) Investing Activities		
3. Investment in Affiliated Company		
4. Purchase of Property and Equipment		
5. Other:		
6.		
7.		
8.		
9.		
10. Sub Total: Net Cash Provided from (used in) Investing Activities		
11. Net Cash Provided from (used in) Financing Activities		
12. Repayment of Long-Term Debt		
13. Proceeds from Short-Term Loans		
14. Other:		
15.		
16.		
17.		
18.		
19.		
20. Sub Total: Net Cash Provided from (used in) Financing Activities		
21. Net Change in Cash and Equivalents		
22. Beginning Cash Balance		
23. Ending Cash Balance *		

* Equals amount on Report #1, Assets, Line 1.

STATEMENT AS OF _____ OF _____
(Quarter Ending) (Plan Name)

Plan Fiscal Year End _____

Report #4 - Investments

1 DESCRIPTION	2 PAR VALUE (BONDS OR # SHARES (STOCK)	3 PURCHASE DATE	4 MATURITY DATE	5 AVERAGE INTEREST RATE	6 MARKET VALUE	7 COST	8 CARRYING VALUE	9 SHORT-TERM*	10 LONG-TERM**
STOCKS (ALL)									
TOTAL									
U.S. GOV'T SECURITIES									
TOTAL									
BONDS (NON-U.S. GOV'T)									
TOTAL									
OTHER (DESCRIBE)									
TOTAL									
GRAND TOTAL									

* Equals amount on Report #1 - Assets, Line 2.
** Equals amount on Report #1, Assets, Line 16.

STATEMENT AS OF _____ OF _____
(Quarter Ending) (Plan Name)

Plan Fiscal Year End _____

Report #5 - Amounts Due From (To) Affiliates

COMPANY/AFFILIATE	DESCRIPTION OF AFFILIATION	AMOUNT DUE FROM (TO) CURRENT	AMOUNT DUE FROM (TO) NON-CURRENT
TOTALS		*	**

* Equals amounts on Report #1, Assets, Line 8 or Liabilities, Line 8.
** Equals amounts on Report #1, Assets, Line 17 or Liabilities, Line 12.

NOTE: All loans, disbursements or other transfer of funds to affiliates must be approved (in writing) by the QI Program.

STATEMENT AS OF _____ OF _____
(Quarter Ending) (Plan Name)

Plan Fiscal Year End _____

Report #6 - Risk Pool Analysis

	Current Period			Year-To-Date		
	$	Member Months	PMPM	$	Member Months	PMPM
Revenues Allocated to Risk Pool(s)						
Less Expenses Allocated to Risk Pools:						
Inpatient Expense						
Medical Reimbursement Expense						
Outpatient Expense						
Other Medical Expense						
Total Medical Expenses Allocated to Pools						
Change in Balance for Current Period Activity*						
Risk Pool Balances at the Beginning of the Period						
Adjustment to Beg of Period Risk Pool Balances						
Subtotal						
Less Risk Pool Distributions						
Undistributed Risk Pool Balance at Period End**						

* Equals the total of risk pool adjustments on Report #2, Lines 10, 15, 26 and 33.

** Equals the risk pool receivable/payable on Report #1, Assets, Line 9 or Liabilities, Line 6.

STATEMENT AS OF _____ OF _____
(Quarter Ending) (Plan Name)

Plan Fiscal Year End _____

Report #6A - Risk Pool Listing By Risk Pool (Quarterly)
Risk Pool Listing by Participant (Annual)

Participant	Prior Period Balance	Current Period Adj. +	(Distributions) Contributions*	Ending Balance **
TOTAL				

* Equals amount on Report #6, Less Risk Pool Distributions.

** Equals amount on Report #6, Undistributed Risk Pool Balance and Report #1 - Assets, Line 9 or Liabilities, Line 6.

STATEMENT AS OF _____ OF _____
(Quarter Ending) (Plan Name)

Plan Fiscal Year End _____

Report #7 - Other Assets and Liabilities

DESCRIPTION**	CURRENT	NON-CURRENT
Assets		
Other Receivables		
Deferred Income Taxes		
Deferred Finance Costs		
Other*		
Liabilities		
Other Payables		
Other*		
TOTALS		

* Include all items, in total, that are less than $50,000 individually.
** List all individual items greater than $50,000.

Equals amount on Report #1, Assets, Lines 11 and 18 and Liabilities, Lines 9 and 13.

STATEMENT AS OF _____ OF _____
(Quarter Ending) (Plan Name)

Plan Fiscal Year End _____

Report #8 - Restricted Case and Other Assets

DESCRIPTION OF ASSET (TYPE)	RESTRICTED PURPOSE	COST	MARKET VALUE	CARRYING VALUE*

* Total amount equals amount in Report #1, Assets, Line 15.

STATEMENT AS OF _____ OF _____
(Quarter Ending) (Plan Name)

Plan Fiscal Year End _____

Report #9 - Medical Claims Payable (RBUCs and IBNRs)

	Reported But Unpaid Claims (RBUCs)						
EXPENSE CATEGORY	1-30 DAYS	31-60 DAYS	61-90 DAYS	OVER 90 DAYS	TOTAL RBUCs	IBNR	TOTAL RBUCs & IBNRs
Inpatient							
Medical Reimbursement							
Outpatient							
Other Medical							
TOTAL MEDICAL CLAIMS PAYABLE*							

* Equals amount on Report #1, Liabilities, Line 4.

Report No. 10A

Claims Lag Report For
Inpatient Payments

Plan: _____ (QUARTER ENDED: _____) (Fiscal Year End: _____)

		QUARTER IN WHICH SERVICE PROVIDED							
(1) LINE	(2) QUARTER OF PAYMENT	(3) CURRENT	(4) 1ST PRIOR	(5) 2ND PRIOR	(6) 3RD PRIOR	(7) 4TH PRIOR	(8) 5TH PRIOR	(9) 6TH PRIOR	(10) TOTAL
1	CURRENT								
2	1ST PRIOR								
3	2ND PRIOR								
4	3RD PRIOR								
5	4TH PRIOR								
6	5TH PRIOR								
7	6TH PRIOR								
8	TOTALS								
9	EXPENSE REPORTED								
10	ACCRUAL ADJUSTMENT								
11	REMAINING LIABILITY*								

See instructions before completing schedule.

* The total amount must equal the total liability reported for hospitalization in Report #9 - Medical Claims Payable.

Row 9, Expense Reported, must equal the total inpatient expense (Report #2, Line 11) less risk pool adjustment (Report #2, Line 10) for the applicable quarter.

Report No. 10B

Claims Lag Report For
Medical Reimbursement Payments

Plan: _____ (QUARTER ENDED: _____) (Fiscal Year End: _____)

		QUARTER IN WHICH SERVICE PROVIDED							
(1) LINE	(2) QUARTER OF PAYMENT	(3) CURRENT	(4) 1ST PRIOR	(5) 2ND PRIOR	(6) 3RD PRIOR	(7) 4TH PRIOR	(8) 5TH PRIOR	(9) 6TH PRIOR	(10) TOTAL
1	CURRENT								
2	1ST PRIOR								
3	2ND PRIOR								
4	3RD PRIOR								
5	4TH PRIOR								
6	5TH PRIOR								
7	6TH PRIOR								
8	TOTALS								
9	EXPENSE REPORTED								
10	ACCRUAL ADJUSTMENT								
11	REMAINING LIABILITY*								

See instructions before completing schedule.

* This amount must equal the total liability reported for physician reimbursement in Report #9 - Medical Claims Payable.

Row 9, Expense Reported, must equal the total medical reimbursement expense (Report #2, Line 16) less risk pool adjustment (Report #2, Line 15) for the applicable quarter.

Report No. 10C

Claims Lag Report For
Outpatient Payments

Plan: _____ (QUARTER ENDED: _____) (Fiscal Year End: _____)

		QUARTER IN WHICH SERVICE PROVIDED							
(1) LINE	(2) QUARTER OF PAYMENT	(3) CURRENT	(4) 1ST PRIOR	(5) 2ND PRIOR	(6) 3RD PRIOR	(7) 4TH PRIOR	(8) 5TH PRIOR	(9) 6TH PRIOR	(10) TOTAL
1	CURRENT								
2	1ST PRIOR								
3	2ND PRIOR								
4	3RD PRIOR								
5	4TH PRIOR								
6	5TH PRIOR								
7	6TH PRIOR								
8	TOTALS								
9	EXPENSE REPORTED								
10	ACCRUAL ADJUSTMENT								
11	REMAINING LIABILITY*								

See instructions before completing schedule.

* This amount must equal the total liability reported for other medical in Report #9 - Medical Claims Payable.

Row 9, Expense Reported, must equal the total outpatient expense (Report #2, Line 27) less risk pool adjustment (Report #2, Line 26) for the applicable quarter.

Report No. 10D

Claims Lag Report For
Other Medical Payments

Plan: _____ (QUARTER ENDED: _____) (Fiscal Year End: _____)

		QUARTER IN WHICH SERVICE PROVIDED							
(1) LINE	(2) QUARTER OF PAYMENT	(3) CURRENT	(4) 1ST PRIOR	(5) 2ND PRIOR	(6) 3RD PRIOR	(7) 4TH PRIOR	(8) 5TH PRIOR	(9) 6TH PRIOR	(10) TOTAL
1	CURRENT								
2	1ST PRIOR								
3	2ND PRIOR								
4	3RD PRIOR								
5	4TH PRIOR								
6	5TH PRIOR								
7	6TH PRIOR								
8	TOTALS								
9	EXPENSE REPORTED								
10	ACCRUAL ADJUSTMENT								
11	REMAINING LIABILITY*								

See instructions before completing schedule.

* This amount must equal the total liability reported for other medical in Report #9 - Medical Claims Payable.

Row 9, Expense Reported, must equal the total other medical expense (Report #2, Line 34) less risk pool adjustment (Report #2, Line 33) for the applicable quarter.

STATEMENT AS OF _____ OF _____
(Quarter Ending) (Plan Name)

Plan Fiscal Year End _____

Report #11 - Long-Term Debt (Other Than Affiliates)

NAME OF LENDER	RATE	CURRENT*	LONG-TERM**	TOTAL	ACCRUED INTEREST
FINANCIAL INSTITUTIONS					
TOTAL FINANCIAL INSTITUTIONS					
OTHER LENDERS					
TOTAL OTHER LENDERS					
GRAND TOTALS					

* Equals amount on Report #1, Liabilities, Line 7.

** Equals amount on Report #1, Liabilities, Line 11.

STATEMENT AS OF _____ OF _____
(Quarter Ending) (Plan Name)

Plan Fiscal Year End _____

Report #12 - Physician Services (QUEST Integration only)

DESCRIPTION	CURRENT PERIOD	YEAR-TO-DATE
Primary Care Physician - Salary		
Primary Care Physician - Capitation		
Primary Care Physician - Fee-For-Service		
Primary Care Physician - Other		
TOTAL PRIMARY CARE PHYSICIAN SERVICES	*	
Referral Physician - Salary		
Referral Physician - Capitation		
Referral Physician - Fee-For-Service		
Referral Physician - Other		
TOTAL REFERRAL PHYSICIAN SERVICES	**	

* Equals the amount on Report #2, Line 12.

** Equals the amount on Report #2, Line 13.

STATEMENT AS OF _____ OF _____
(Quarter Ending) (Plan Name)

Plan Fiscal Year End _____

Report #13 - Related Party Transactions

Name of Related Party	Description of Transactions	Income or Receipts	Expense or Disbributions	Receivables	Payable
TOTALS					

4. ANNUAL REPORTING REQUIREMENTS

This section presents the annual reporting requirements for the medical plans in the QUEST Integration Program.

4.1 GENERAL INFORMATION

4.2 REQUIRED STATEMENTS AND SUPPLEMENTAL SCHEDULES

4.3 MANAGEMENT LETTER

4.4 DISCLOSURE STATEMENT

4.5 RECONCILIATION

4.1 GENERAL INFORMATION

The medical plans in the QUEST Integration Program are required to submit certain financial reports and schedules on an annual basis to the QUEST Integration Program. See section 1.3.3 for the due dates of the annual reports.

4.2 REQUIRED STATEMENTS AND SUPPLEMENTAL SCHEDULES

In addition to the quarterly reports required at year end, the following audited financial statements accompanied by an independent certified public accountant's report must be provided.

- Balance Sheet
- Statements of Revenue and Expenses and Changes in Equity/Net Assets
- Statements of Cash Flow

4.3 MANAGEMENT LETTER

The final management letter provided by the independent certified public accountants shall be provided to DHS along with the required financial statements.

4.4 DISCLOSURE STATEMENT

An annual disclosure statement must be submitted to the QUEST Integration Program.

4.5 RECONCILIATION

In addition to the annual audited financial statements, a reconciliation of the Plan's final year-to-date quarterly statements to the annual audited statements must be submitted with the final audited statements.

DISCLOSURE STATEMENT (CMS REQUIRED)

DHS may refuse to enter into a contract and may suspend or terminate an existing contract, if the offeror fails to disclose ownership or controlling information and related party transaction as required by this policy.

Financial Disclosure requirements in accordance with 42 CFR 455.100 through 455.106 are:

455.104 Information on Ownership & Control

(1) The name and address of each person with an ownership or controlling interest in the disclosing entity.

(2) The name and address of each person with an ownership or controlling interest in any subcontractor in which the disclosing entity has direct or indirect ownership of five (5) percent or more.

(3) Names of persons named in (a) and (b) above who are related to another as spouse, parent, child or sibling of those individuals or organizations with an ownership or controlling interest.

(4) The names of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity also has an ownership or controlling interest.

455.105 Information Related to Business Transactions

(5) The ownership of any subcontractor with whom the offeror has had business transactions totaling more than $25,000 during the past 12-month period.

(6) Any significant business transactions between the offeror and any wholly owned supplier or between the offeror and any subcontractor during the past five-year period.

455.106 Information on Persons Convicted of Crimes

(7) Name of any person who has an ownership or controlling interest in the offeror, or is an agent or managing employee of the offeror, and has been convicted of a criminal offense related to that person’s involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

b) Additional information which must be disclosed to DHS is as follows:

(1) Names and addresses of the Board of Directors of the disclosing entity.

(2) Name, title and amount of compensation paid annually (including bonuses and stock participation) to the ten (10) highest management personnel.

(3) Names and addresses of creditors whose loans or mortgages are secured by a five (5) percent or more interest in the assets of the disclosing entity.

c) Additional Related Party Transactions which must be disclosed to DHS is as follows:

(1) Describe transactions between the disclosing entity and any related party in which a transaction or series or transactions during any one (1) fiscal year exceeds the lesser of $10,000 or two (2) percent of the total operating expenses of the disclosing entity. List property, goods, services, and facilities involved in detail. Note the dollar amounts or other consideration for each item and the date of the transaction(s). Also include justification of the transaction(s) as to the reasonableness, potential adverse impact on the fiscal soundness of the disclosing entity, and the nature and extent of any conflict of interest. This requirement includes, but is not limited to, the sale or exchange, or leasing of any property; and the furnishing for consideration of goods, services or facilities.

(2) Describe <u>all</u> transactions between the disclosing entity and any related party which includes the lending of money, extensions of credit or any investments in a related party. This type of transaction requires <u>advance</u> administrative review by the Director before being made.

(3) As used in this section, “related party” means one that has the power to control or significantly influence the offeror, or one that is controlled or significantly influenced by the offeror. “Related parties” include, but are not limited to, agents, managing employees, persons with an ownership or controlling interest in the disclosing entity, and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister

companies, holding companies, and other entities controlled or managed by any of such entities or persons.

42 CFR 455.101 DEFINITIONS

a) "Agent" means any person who has been delegated the authority to obligate or act on behalf of a provider.

b) "Convicted" means that a judgment of conviction has been entered by a Federal, State or local court, regardless of whether an appeal from that judgment is pending.

c) "Disclosing entity" means a QUEST Integration provider or health plan.

d) "Other disclosing entity" means any other QUEST Integration disclosing entity and any entity that does not participate in QUEST Integration but is required to disclose certain ownership and control information because of the participation in any of the programs established under Title V, XVIII or XX of the Social Security Act.
This includes:

(1) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII);

(2) Any Medicare intermediary or carrier; and

(3) Any entity that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XIX of the Social Security Act.

a) "Fiscal agent" means a contractor that processes or pays vendor claims on behalf of DHS.

b) "Group of practioners" means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

c) "Indirect ownership interest" means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

d) "Managing employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or

managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.

e) "Ownership interest" means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

f) "Person with an ownership or controlling interest" means a person or corporation that:

(1) Has an ownership interest totaling five (5) percent or more in a disclosing entity;

(2) Has an indirect ownership interest equal to five (5) percent or more in a disclosing entity;

(3) Has a combination of direct and indirect ownership interests equal to five (5) percent or more in a disclosing entity;

(4) Owns an interest of five (5) percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five (5) percent of the value of the property or assets of the disclosing entity;

(5) Is an officer or director of a disclosing entity that is organized as a corporation; or

(6) Is a partner in a disclosing entity that is organized as a partnership.

k) "Significant business transaction" means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and five (5) percent of an offeror's total operating expenses.

l) "Subcontractor" means:

(1) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or

(2) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the DHS agreement.

m) “Supplier” means an individual, agency, or organization from which a Provider purchases goods and services used in carrying out its responsibilities under its DHS contract (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

n) “Wholly owned subsidiary supplier” means a subsidiary or supplier whose total ownership interest is held by an offeror or by a person, persons, or other entity with an ownership or controlling interest in an offeror.

DISCLOSURE STATEMENT

PLAN NAME/NO. _____
DISCLOSURE STATEMENT FOR THE YEAR ENDED _____

I hereby attest that the information contained in the Disclosure Statement is current, complete and accurate to the best of my knowledge. I also attest that these reported transactions are reasonable, will not impact on the fiscal soundness of the Health Plan, and are without conflict of interest. I understand that whoever knowingly and willfully makes or causes to be made a false statement or representation on the statement may be prosecuted under applicable state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate in QUEST INTEGRATION.

_____ _____

Date Signed

Chief Executive Officer
(Name and Title Typewritten)

Notarized _____ _____

Signature

DISCLOSURE STATEMENT
OWNERSHIP

Health Plan Name, Plan No.: _____
Address (City, State, Zip): _____
Telephone: _____

For the period beginning: _____ and ending: _____

Type of Health Plan:

- o Staff – A health plan that delivers services through a group practice established to provide health services to health plan members; doctors are salaried.

- o Group – A health plan that contracts with a group practice to provide health services; the group is usually compensated on a capitation basis.

- o IPA – A health plan that contracts with an association of doctors from various settings (some solo practitioners, some groups) to provide health services.

- o Network – A health plan that contracts with two or more group practices to provide health services.

Type of Entity:

- o Sole Proprietorship
- o Partnership
- o Corporation
- o Governmental
- o For-Profit
- o Not-For-Profit
- o Other (Specify) _____

455.104 Information on Ownership and Control

a. List the names and addresses of any individuals or organizations with an ownership or controlling interest in the disclosing entity. "Ownership or control interest" means, with respect to the entity, an individual or organization who (A)(i) has a direct or indirect ownership interest of 5 per centum or more in the entity, or in the case of a nonprofit corporation, is a member; or (ii) is the owner of a whole or part interest in any mortgage, deed or trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets thereof, which whole or part interest is equal to or exceeds 5 per centum of the total property and assets of the entity; or (B) has the ability to appoint or is otherwise represented by an officer or director of the entity, if the entity is organized as a corporation; or (C) is a partner in the entity, if the entity is organized as a partnership.

Name	Address	Percent of Ownership of Control

b. List the names and addresses of any individuals or organizations with an ownership or controlling interest in any subcontractor in which the disclosing entity has direct or indirect ownership of five (5) percent or more.

Name	Address	Percent of Ownership of Control

c. Names of persons named in (a) and (b) above who are related to another as spouse, parent, child, or sibling of those individuals or organizations with an ownership or controlling interest.

d. List the names of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity also has an ownership or controlling interest.

455.105 Information related to Business Transactions

e. List the ownership of any subcontractor with whom the offeror has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request.

Describe Ownership of Subcontractors	Type of Business Transaction with Provider	Dollar Amount of Transaction

f. List any significant business transactions between the offeror and any wholly owned supplier or between the offeror and any subcontractor during the five-year period ending on the date of the request.

Describe Ownership of Subcontractors	Type of Business Transaction with Provider	Dollar Amount of Transaction

455.106 Information on Persons Convicted of Crime

g. List the names of any person who has ownership or controlling interest in the offeror, or is an agent or managing employee of the offeror and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs.

Name	Address	Title

2. Additional information which must be disclosed to DHS as follows:

a. List the names and addresses of the Board of Director of the Plan.

Name/Title	Address

b. Names and titles of the ten (10) highest paid management personnel including but not limited to the Chief Executive Officer, the Chief Financial Officer, Board of Chairman, Board of Secretary, and Board of Treasurer:

Name/Title	Address

c. List names and addresses of creditors whose loans or mortgages exceeding five percent (5) and are secured by the assets of the Health Plan.

Name	Address	Amount of Debt	Description of Security

DISCLOSURE STATEMENT

a. Instructions

DHS is concerned with monitoring the existence of related party transactions in order to determine if any significant conflicts of interest exist in the offeror's ability to meet QUEST Integration objectives. Related party transactions include transactions which are conducted in an arm's length manner or are not reflected in the accounting records at all (e.g., the provision of services without charge).

Transactions with related parties maybe in the normal course of business or they may represent something unusual for the offeror. In the normal course of business, there may be numerous routine and recurring transactions with parties that meet the definition of a related party. Although each party may be appropriately pursuing its respective best interests, this is usually not objectively determinable. In addition to transactions in the normal course of business, there may be transactions which are neither routine nor recurring and may be unusual in nature or in financial statement impact.

1) Describe transactions between the offeror and any related party in which a transaction or series of transactions during any one (1) fiscal year exceeds the lesser of $10,000 or two (2) percent of the total operating expenses of the disclosing entity. List property, goods, services and facilities in detail noting the dollar amounts or other consideration for each and the date of the transaction(s) including a justification as to the reasonableness of the transaction(s) and its potential adverse impact of the fiscal soundness of the disclosing entity.

a) The sale or exchange, or leasing of any property:

Description of Transaction(s)	Name of Related Party and Relationship	Dollar Amount for Reporting Period

Justification

b) The furnishing for consideration of goods, services or facilities:

Description of Transaction(s)	Name of Related Party and Relationship	Dollar Amount for Reporting Period

Justification

2) Describe all transactions between the disclosing entity and any related party which includes the lending of money, extensions of credit or any investments in a related party. This type of transaction requires advance administrative review by the Director before being made.

Description of Transaction(s)	Name of Related Party and Relationship	Dollar Amount for Reporting Period

Justification

CONTROLLING INTEREST FORM

The offeror must provide the name and address of any individual which owns or controls more than ten percent (10%) of stock or that has a controlling interest (i.e., ability to formulate, determine or veto business policy decisions, etc.). Failure to make full disclosure may result in rejection of the offeror's proposal as unresponsive.

NAME	ADDRESS	OWNER OR CONTROLLER	HAS CONTROLLING INTEREST YES	NO

BACKGROUND CHECK INFORMATION

The offeror must provide sufficient information concerning key personnel (i.e., Chief Executive Officer, Medical Director, Financial Officer, Consultants, Accountants, Attorneys, etc.) to enable DHS to conduct background checks. Failure to make full and complete disclosure may result in rejection of your proposal as unresponsive. Attach resumes for all individuals listed below.

NAME**	EVER KNOWN BY ANOTHER NAME* YES	NO	SOCIAL SECURITY ACCOUNT NUMBER	DATE OF BIRTH (DAY/MO/YR)	PLACE OF BIRTH CITY/COUNTRY /STATE

* If yes, provide all other names. Use a separate sheet if necessary.
** For each person listed:

a) Give addresses for the last 10 years.
b) Ever suspended from any federal program for any reason? (Yes/No) If yes, please explain.

OPERATIONAL CERTIFICATION SUBMISSION

The offeror must complete the attached certification as documentation that it shall maintain member handbook, appointment procedures, referral procedures and other operating requirements in accordance with either DHS rule(s) or policies and procedures.

By signing below the offeror certifies that it shall at all times during the term of this contract provide and maintain member handbook, appointment procedures, referral procedures, quality assurance program, utilization management program and other operating requirements in accordance with either DHS rule(s) or policies and procedures. The offeror warrants that in the event DHS discovers, through an operational review, that the offeror has failed to maintain these operating procedures, the offeror will be subject to a non-refundable, non-waivable sanction in accordance with DHS rules.

_____ _____

Signature Date

GRIEVANCE SYSTEM FORM

The offeror must complete the form below and submit with this proposal.

I hereby certify that _____
(Offeror Name)
will have in place on the commencement date of this contract a system for reviewing and adjudicating grievances by recipients and providers arising from this contract in accordance with DHS Rules and as set forth in the Request for Proposal.

I understand such a system must provide for prompt resolution of grievances and assure the participation of individuals with authority to require corrective action.

I further understand the offeror must have a grievance policy for recipients and providers which defines their rights regarding any adverse action by the offeror. The grievance policy shall be in writing and shall meet the minimum standards set forth in this Request for Proposal.

I further understand evaluation of the grievance procedure shall be conducted through documentation submission, monitoring, reporting, and on-site audit, if necessary, by DHS and deficiencies are subject to sanction in accordance with DHS rules.

Authorized Signature	Date
Printed Name	Title

CERTIFICATION FOR CONTRACTS, GRANTS, LOANS AND COOPERATIVE AGREEMENTS

1. The undersigned certifies, to the best of his or her knowledge and belief, that no Federal appropriated funds have been paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of Federal grant, the making of any Federal loan, the entering into of any cooperative Federal contract, grant, loan or cooperative agreement.

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan or cooperative agreement, the undersigned shall complete and submit "Disclosure Form to Report Lobbying" in accordance with its instructions.

3. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed under 31U.S.C §1352. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000.00 and not more than $100,000.00 for such failure.

Offeror: _____

Signature: _____

Title: _____

Date: _____

Department of Human Services
QUEST Integration (QI)

Financial Summary File

Federally Qualified Health Centers (FQHC)
Rural Health Clinics (RHC)

General Report Description	
Reimbursement for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) Services	
Purpose	Financial Summary Information for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) including incentive, capitation, administrative and fee for service payments. Submit one report to include all providers of this type. The data will be utilized to identify any supplemental payments that may be required of the Hawaii Department of Human Services to the in-network and out-of-network FQHC or RHC to ensure that the FQHC or RHC receives reimbursement for the services rendered to the MCO's members equal to the amount the provider is entitled to under the Benefits Improvements and Protection Act of 2000 (BIPA).
Preferred Submission Type	Excel .xls file
Comments	**Quarterly:** This financial summary data must be submitted by the MCO to DHS no later than 30 calendar days after the end of each quarter. **Annually:** This financial summary data must be submitted by the MCO to DHS no later than 150 calendar days after the end of each calendar year. The MCO should submit the data file for all FQHC/RHC providers as follows: Accumulate all data based on date of service. **For Fee-For-Service based payments**, information on all claims with service during the time period specified and paid as of the report run date. Paid claims are to include reversals, voids and or adjustments. Note: The sum of FFS payments (Data Element 13 and 14) must equal the respective detail claims/encounter data file. **For all capitation based payments**, information on all claims for services paid and encounters set to "final adjudication" during the time period specified on the report. All performance incentives (excluding dollars paid as capitation or fee-for-service reimbursement) which accrued or was paid during the reporting period. Total capitation payments made to the provider for the reporting period. Total administrative fees paid

Department of Human Services
QUEST Integration (QI)

Financial Summary File

Federally Qualified Health Centers (FQHC)
Rural Health Clinics (RHC)

Data Elements	
Include a header for each data element.	
1.) MCO ID	Insert the MCO identification number
2.) MCO Name	Insert the MCO Name
3.) Report Date	Indicate the date the report data was generated from the management information system.
4.) Provider Number	Insert the Medicaid Provider identification number on which the MCO is reporting.
5.) Provider Name	Indicate the name of the FQHC or RHC on which the MCO is reporting.
6.) Begin Period	Indicate the beginning date of the reporting period for which the MCO is submitting the report.
7.) End Period	Indicate the ending date of the reporting period for which the MCO is submitting the report.
8.) Count of FFS claims/encounters	Enter the count of Fee-For-Service paid claims/encounters.
9.) Count of CAP claims/encounters	Enter the count of Capitation paid claims/encounters.
10.) CAP Payments	Enter the capitated paid amount.
11.) Admin Fees	Enter the amount of paid administrative fees.
12.) Incentive Payments	Enter the total amount paid for incentives.
13.) Primary FFS Payments	Enter the Fee-For-Service paid amount for claims in which Medicaid was the primary payer.
14.) Secondary FFS Payments	Enter the Fee-For-Service paid amount for claims in which Medicaid was the secondary payer.
15.) Total Health Plan Payments	Enter the Sum of CAP Payments, Admin Fees, FFS Payments, and Incentive Payments.
16.) Third Party Liability	Enter the portion of the medical expense that a third party was responsible for.

Department of Human Services
QUEST Integration (QI)

Medicaid Primary Claim/Encounter Detail File

Federally Qualified Health Centers (FQHC) - Medicaid Primary
Rural Health Clinics (RHC) - Medicaid Primary

General Report Description	
Reimbursement for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) Medicaid Primary Services	
Purpose	Medicaid Primary Detail Claims and Encounter Services provided by Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). Submit one report per provider The data will be utilized to identify any supplemental payments that may be required of the Hawaii Department of Human Services to the in-network and out-of-network FQHC or RHC to ensure that the FQHC or RHC receives reimbursement for the services rendered to the MCO's members equal to the amount the provider is entitled to under the Benefits Improvements and Protection Act of 2000 (BIPA).
Preferred Submission Type	Excel .xls file
Comments	**Quarterly:** This financial summary data must be submitted by the MCO to DHS no later than 30 calendar days after the end of each quarter. **Annually:** This financial summary data must be submitted by the MCO to DHS no later than 150 calendar days after the end of each calendar year. The MCO should submit the data file for all FQHC/RHC providers as follows: **Include the line level detail of all claims in which Medicaid is the primary payer.** **For Fee-For-Service based payments**, information on all claims with service during the time period specified and paid as of the report run date. Paid claims are to include reversals, voids and or adjustments. **For all capitated based FQHC/RHC claims payments**, information on all claims for services paid and encounters set to "final adjudication" during the time period specified on the report.

Department of Human Services
QUEST Integration (QI)

Medicaid Primary Claim/Encounter Detail File

Federally Qualified Health Centers (FQHC) - Medicaid Primary
Rural Health Clinics (RHC) - Medicaid Primary

Data Elements	
Include a header for each data element.	
1.) Item No.	Consecutively number each member item for the report.
2.) MCO ID	Insert the MCO identification number
3.) MCO Name	Insert the MCO Name
4.) Report Date	Indicate the date the report data was generated from the management information system. Enter MM/DD/YYYY format.
5.) Billing Provider Number	Insert the Medicaid Provider identification number on which the MCO is reporting.
6.) Billing Provider Name	Insert the name of the billing FQHC/RHC on which the MCO is reporting.
7.) Rendering Provider Number	Insert the identification number of the rendering provider listed on the claim.
8.) Rendering Provider Name	Insert the name of the rendering provider listed on the claim.
9.) Begin Date	Indicate the beginning date of the claim/encounter. Enter MM/DD/YYYY format
10.) End Date	Indicate the ending date of the claim/encounter. Enter MM/DD/YYYY format
11.) Member First Name	Indicate the member's first name as listed on the referenced claim item.
12.) Member Last Name	Indicate the member's last name as listed on the referenced claim item.
13.) Member ID Number	Insert the member's Medicaid identification number that is associated with the reported claim. (report in a text field, so 9 digit number is reported)
14.) Patient Account Number	Identify the billing provider patient account number being submitted for the report.
15.) Claim Status	Identify the status of the claim (paid, denied, pending, reversal, void, adjustment, etc.)

Department of Human Services
QUEST Integration (QI)

Medicaid Primary Claim/Encounter Detail File

Federally Qualified Health Centers (FQHC) - Medicaid Primary
Rural Health Clinics (RHC) - Medicaid Primary

16.) Claim Number	Identify the claim identification number being submitted for the report.
17.) Claim Number Detail Line	Insert the numeric detail line number of the claim.
18.) Place of Service Code	Insert the place of service code.
19.) Procedure Code	Insert the procedure code as listed for the detail line number on the claim.
20.) Procedure Code Description	Insert the procedure code description for the detail line number on the claim.
21.) Diagnosis Code	Insert the diagnosis code as listed for the detail line number on the claim.
22.) Date Paid	Indicate the date the submitted claim was adjudicated as "paid". Enter MM/DD/YYYY format
23.) Billed Amount	Indicate the billed amont of the detail line number of the claim
24.) Co-Payment	Enter the portion of the medical expense that the member was responsible for.
25.) Third Party Liability	Enter the portion of the medical expense that a third party was responsible for.
26.) Paid Amount	Indicate the paid amount of the detail line number of the claim.

Department of Human Services
QUEST Integration (QI)

Medicaid Secondary Claim/Encounter Detail File

Federally Qualified Health Centers (FQHC) - Medicaid Secondary (Dual Eligibles)
Rural Health Clinics (RHC) - Medicaid Secondary (Dual Eligibles)

General Report Description	
Reimbursement for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) Medicaid Secondary Services	
Purpose	Medicaid Secondary Detail Claims and Encounter Services provided by Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). Submit one report per provider The data will be utilized to identify any supplemental payments that may be required of the Hawaii Department of Human Services to the in-network and out-of-network FQHC or RHC to ensure that the FQHC or RHC receives reimbursement for the services rendered to the MCO's members equal to the amount the provider is entitled to under the Benefits Improvements and Protection Act of 2000 (BIPA).
Preferred Submission Type	Excel .xls file
Comments	**Quarterly:** This financial summary data must be submitted by the MCO to DHS no later than 30 calendar days after the end of each quarter. **Annually:** This financial summary data must be submitted by the MCO to DHS no later than 150 calendar days after the end of each calendar year. The MCO should submit the data file for all FQHC/RHC providers as follows: **Include the line level detail of all claims in which Medicaid is the secondary payer.** **For Fee-For-Service based payments**, information on all claims with service during the time period specified and paid as of the report run date. Paid claims are to include reversals, voids and or adjustments. **For all capitated based FQHC/RHC claims payments**, information on all claims for services paid and encounters set to "final adjudication" during the time period specified on the report.

Department of Human Services
QUEST Integration (QI)

Medicaid Secondary Claim/Encounter Detail File

Federally Qualified Health Centers (FQHC) - Medicaid Secondary (Dual Eligibles)
Rural Health Clinics (RHC) - Medicaid Secondary (Dual Eligibles)

Data Elements	
Include a header for each data element.	
1.) Item No.	Consecutively number each member item for the report.
2.) MCO ID	Insert the MCO identification number
3.) MCO Name	Insert the MCO Name
4.) Report Date	Indicate the date the report data was generated from the management information system. Enter MM/DD/YYYY format.
5.) Billing Provider Number	Insert the Medicaid Provider identification number on which the MCO is reporting.
6.) Billing Provider Name	Insert the name of the billing FQHC/RHC on which the MCO is reporting.
7.) Rendering Provider Number	Insert the identification number of the rendering provider listed on the claim.
8.) Rendering Provider Name	Insert the name of the rendering provider listed on the claim.
9.) Begin Date	Indicate the beginning date of the claim/encounter. Enter MM/DD/YYYY format
10.) End Date	Indicate the ending date of the claim/encounter. Enter MM/DD/YYYY format
11.) Member First Name	Indicate the member's first name as listed on the referenced claim item.
12.) Member Last Name	Indicate the member's last name as listed on the referenced claim item.
13.) Member ID Number	Insert the member's Medicaid identification number that is associated with the reported claim. (report in a text field, so 9 digit number is reported)
14.) Patient Account Number	Identify the billing provider patient account number being submitted for the report.
15.) Claim Status	Identify the status of the claim (paid, denied, pending, reversal, void, adjustment, etc.)

Department of Human Services
QUEST Integration (QI)

Medicaid Secondary Claim/Encounter Detail File

Federally Qualified Health Centers (FQHC) - Medicaid Secondary (Dual Eligibles)
Rural Health Clinics (RHC) - Medicaid Secondary (Dual Eligibles)

16.) Claim Number	Identify the claim identification number being submitted for the report.
17.) Claim Number Detail Line	Insert the numeric detail line number of the claim.
18.) Place of Service Code	Insert the place of service code.
19.) Procedure Code	Insert the procedure code as listed for the detail line number on the claim.
20.) Procedure Code Description	Insert the procedure code description for the detail line number on the claim.
21.) Diagnosis Code	Insert the diagnosis code as listed for the detail line number on the claim.
22.) Date Paid	Indicate the date the submitted claim was adjudicated as "paid". Enter MM/DD/YYYY format
23.) Billed Amount	Indicate the billed amont of the detail line number of the claim
24.) Co-Payment	Enter the portion of the medical expense that the member was responsible for.
25.) Third Party Liability	Enter the portion of the medical expense that a third party was responsible for.
26.) Paid Amount	Indicate the paid amount of the detail line number of the claim.