APPENDICES

RFP-MQD-2014-005

APPENDIX A – Written Questions Format

Appendix A

Written Questions Format for
QUEST Integration RFP
RFP-MQD-2014-005

Applicant Name	Date Submitted	Question #	RFP Section #	RFP Page #	Paragraph #	Question

Written Questions on Amendments
Format for
QUEST Integration RFP
RFP-MQD-2014-005

Applicant Name	Date Submitted	Question #	Amendment #	# (first column of list of amendments)	Question

Written Questions for
Clarification of Proposal Format for
QUEST Integration RFP
RFP-MQD-2014-005

Applicant Name	Date Submitted	Question #	Q&A Posting Date	Question # (related to Q&A)	Question

APPENDIX B – Written Questions Format for Capitation Rates

Appendix B

Written Questions Format for Capitation Rates
QUEST Integration RFP
RFP-MQD-2014-005

Applicant Name	Date Submitted	Question #	RFP Section #	RFP Page #	Paragraph #	Question

APPENDIX C – RFP Interest Form

Notification to State Agency of Interest in Responding to an RFP

RFP Number and Title: _____

Organization or Individual: _____

Contact Person Information

First Name: _____ Last Name: _____

E-mail Address: _____

Telephone: _____

Fax Number: _____

Mailing Address

Street Address or PO Box _____

City _____ State _____ Zip Code _____

Please provide to the agency contact person listed in the Request for Proposals (RFP).

APPENDIX D – Proposal Forms

SPO-H-200
Proposal Letter
Disclosure Statement
Insurance Requirements
Wage Certification
Provider Standards of Conduct

STATE OF HAWAII

STATE PROCUREMENT OFFICE

PROPOSAL APPLICATION IDENTIFICATION FORM

STATE AGENCY ISSUING RFP: _____

RFP NUMBER: _____

RFP TITLE: _____

Check one:

☐ Initial Proposal Application

☐ Final Revised Proposal (Completed Items _____ -_____ only)

1. APPLICANT INFORMATION

Legal Name:

Doing Business As:

Street Address:

Mailing Address:

Contact person for matters involving this application:
Name:

Title:

Phone Number:

Fax Number:

e-mail:

2. BUSINESS INFORMATION

Type of Business Entity *(check one)*:

☐ Non-Profit Corporation ☐ Limited Liability Company ☐ Sole Proprietorship

☐ For-Profit Corporation ☐ Partnership

If applicable, state of incorporation and date incorporated:

State: Date:

3. PROPOSAL INFORMATION

Geographic area(s):

Target group(s):

4. FUNDING REQUEST

FY _____ _____ FY _____ _____

FY _____ _____ FY _____ _____

FY _____ _____ FY _____ _____

Grand Total _____

I certify that the information provided above is to the best of my knowledge true and correct.

_____ _____

Authorized Representative Signature *Date Signed*

_____

Name and Title

STATE OF HAWAII

Department of Human Services

PROPOSAL LETTER

We propose to furnish and deliver any and all of the deliverables and services named in the attached Request for Proposals for behavioral health services. The administrative rates offered herein shall apply for the period of time stated in said RFP.

It is understood that this proposal constitutes an offer and when signed by the authorized State of Hawaii official will, with the RFP and any amendments thereto, constitute a valid and legal contract between the undersigned applicant and the State of Hawaii.

It is understood and agreed that we have read the State's specifications described in the RFP and that this proposal is made in accordance with the provisions of such specifications. By signing this proposal, we guarantee and certify that all items included in this proposal meet or exceed any and all such State specifications. We also affirm, by signing this proposal, that we have reviewed the reference materials in the State's documentation library and that we have used this documentation as a basis for submitting our firm fixed price cost proposal.

It also understood that failure to enter into the contract upon award shall result in forfeiture of the surety bond. We agree, if awarded the contract, to deliver goods or services which meet or exceed the specifications.

Authorized	Applicant's	Signature/Corporate	Seal
Date			

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 on 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 31 U.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.

Applicant: _____

Signature: _____

Title: _____

Date: _____

DISCLOSURE STATEMENT (CMS REQUIRED)

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.
(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 no t limited to agents, managing employees, persons with an ownership or controlling interest in the disclosing entity, a n d t h e i r i m m e d i a t e f a m i l i e s, 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.

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 agreeement.

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.

DISCLOSURE STATEMENT

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 applicant's ability to meet Behavioral Health 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 applicant. 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 applicant 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 on 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

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

DISCLOSURE STATEMENT

Provider 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 Provider, 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 Ombudsman Services.

Date Signed	Chief Executive Officer (Name and Title Typewritten)
Notarized	Signature

DISCLOSURE STATEMENT OWNERSHIP

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

For the period beginning: _____ and ending _____ Type

of Provider:

- o Staff — A Provider that delivers services through a group practice established to provide health services to Provider members; doctors are salaried,
- o Group — A Provider that contracts with a group practice to provide health services; the group is usually compensated on a capitation basis.
- o IPA — A Provider that contracts with an association of doctors from various settings (some solo practitioners, some groups) to provide health services.
- o Network — A Provider that contracts with two or more group practices to provide health services.

Type of Entity:

- ☐ Sole Proprietorship
- ☐ Partnership
- ☐ Corporation
- ☐ Governmental

- ☐ For-Profit
- ☐ Not-For-Profit
- ☐ Other (specify)
- ☐ _____

Appendix D

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.

Fill out all Applicable Sections. Indicate Not Applicable (N/A) for questions that do not apply. ADO forms will be rejected for any questions left blank. Please print or type.

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: DMS 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 c 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 <u>other disclosing entity</u> 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:

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 applicant.

Name	Address	Amount of Debt	Description of Security

Financial Reporting Guide Forms
Organization Structure and Financial Planning Form

1) If other than a government agency:
   a. When was your organization formed?

   b. If your organization is a corporation, attach a list of the names and addresses of the Board of Directors.

2) License/Certification
   a. Indicate all licenses and certifications (i.e., Federal HMO status or State certifications) your organization maintains. Use a separate sheet of paper using the following format:

Service Component	License/Requirement	Renewal Date

   b. Have any licenses been denied, revoked, or suspended?

   Yes _____ No _____ If yes, please explain:

3) Civil Rights Compliance Data

   Has any Federal or State agency ever made a finding of noncompliance with any relevant civil rights requirements with respect to your program?

   Yes _____ No _____ If yes, please explain:

4) Handicapped Assurance

   Does your organization provide assurance that no qualified handicapped person will be denied benefits of or excluded from participation in a program or activity because the applicant's facilities (including subcontractors) are inaccessible to or unusable by handicapped persons? (note: check with local zoning ordinances for handicapped requirements)

   Yes _____ If yes, briefly describe how such assurances are provided.
   No _____ If no, briefly describe how your organization is taking affirmative steps to provide assurance.

5) Prior Convictions

List all felony convictions of any key personnel (i.e., Chief Executive Officer, Applicant's Manager, Financial Officers, major stockholders or those with controlling interest, etc.). Failure to make full and complete disclosure shall result in the rejection of your proposal as unresponsive.

6) Federal Government Suspension/Exclusion

Has applicant been suspended or excluded from any federal government programs for any reason?

Yes _____ No _____ If yes, please explain:

Financial Planning Form

1) Is the applicants accounting system based on a cash, accrual, or modified method?
   a. Cash [ ]
   b. Accrual [ ]
   c. Modified [ ] Give brief explanation

2) Does the applicant prepare an annual financial statement?

   Yes _____ No _____ If yes, please explain:

3) Are interim financial statements prepared? Yes _____ No _____

   a. If yes, how often are they prepared? _____

   b. If yes, are footnotes and supplementary schedules an integral part of the statements?
      Yes _____ No _____

   c. If yes, are actuals analyzed and compared to budgeted amounts?
      Yes _____ No _____

   d. If yes, provide a copy of the latest statements including all necessary data to support your answers in (a) through (c) above.

4) Is the applicant audited by an independent accounting firm/accountant?

Yes _____ No _____

   a. If yes, how often are audits conducted? _____

   b. By whom are they conducted? _____

   c. Did this auditor perform that applicant's last audit?
      Yes _____ No _____
      If no, provide the name, address, and telephone number of the firm that performed the applicant's last audit.

d. Are management letters on internal controls issued by the accounting firm?

Yes _____ No _____

If yes, attach a copy of the management letter from the latest audit. This must be on the auditor's letterhead and the applicant, by its submission, certifies the letter is unaltered.

If no, the applicant shall provide a comprehensive description of internal control systems. The applicant is responsible for instituting adequate procedures against irregularities and improprieties and enforcing adherence to generally accepted accounting principles.

e. Do you have any uncorrected audit exceptions?

Yes _____ No _____

If yes, provide a copy of the auditor's management letter (see 4(d) of this form for instructions regarding submittal).

5) Does the applicant have an accounting manual?

Yes _____ No _____

If no, the applicant must explain, if it has proper accounting policies and procedures, and how it provides for the dissemination of such accounting policies and procedures within its organization and what controls exist to ensure the integrity of its financial information. The applicant agrees to furnish copies of such written accounting policies and procedures for inspection upon request from the DHS.

6) Does the applicant have a formal basis to allocate indirect costs reflected in your financial statement?

Yes _____ No _____

Explain principal allocation techniques used or to be used. Note the allocation base used for each type of cost allocated.

7) What types of liability insurance does the applicant have?

a. With what company(s)? _____

b. What is the amount of coverage for each type of insurance? _____

8) Provide a complete analysis of revenues and expenses by business segment (lines of business) and by geographic area (by county) for the applicant or its owner(s).

9) Are there any suits, judgments, tax deficiencies, or claims pending against the applicant?

Yes _____ No _____

Briefly describe each item and indicate probable amount.

10) Has the applicant or its owner(s) ever gone through bankruptcy?

Yes _____ No _____

If yes, when? _____

11) Do(es) the applicant's owner(s) intend to provide all necessary funds to make full and timely payments for liabilities (reported or not recognized)?

Yes _____ No _____

If yes, describe the dollar amount(s) and source(s) of all funding.

If no, briefly describe how your organization is taking affirmative steps to provide funding.

12) Does the applicant have a performance bonding mechanism in accordance with DHS rules?

Yes _____ No _____

If yes, provide the following information:

Amount of Bond $___
Term of Bond ____
Bonding Company ____
Restrictions on Bond ____

If no, describe how the applicant intends to provide a bond and/or security to meet established
DHS rules.

13) Does the applicant have a financial management system to account for incurred, but not reported liabilities?

Yes _____ No _____

If no, the applicant must describe in detail (and attach this description to this form) how it intends to manage, monitor and control IBNR's, The applicant, regardless of response (either yes or
no) must complete items "a" through "h" below.

a. Is your system capable of accurately forecasting all significant claims prior to receipt of all billing? Yes _____ No _____
b. How often are IBNRs projected? _____
_____
c. Identify all major data sources most often used.
d. Are data from open referrals and prior notifications used?
Yes _____ No _____ If so, how?
e. Are detailed written procedures maintained? Yes _____
No _____

f. Are IBNR amounts compared with actuals and adjusted when necessary?
Yes _____ No _____
g. Is the basis of periodic IBNR estimates well documented?
Yes _____ No _____
h. The applicant must provide a copy of their IBNR procedures and a summary of their IBNR practices. If these procedures do not adequately support any response to this item the applicant is cautioned to provide additional data.

Please identify the developer and name of any computerized IBNR system utilized. Indicate if it is administered by internal or external staff. If administered by external staff, state by whom, define how the applicant will control this function. Specify what other IBNR estimation methods will be used to test the accuracy of IBNR estimates, along with the primary system previously identified. (For the purposes of this item "administered" refers to either performing computer related operations or to providing direct supervision of staff operating a system).

14) Does the applicant have a full-time (100%) controller or chief financial officer?

Yes _____ No _____ If yes, enter name: _____

_____

15) Are the following items reported on the applicant's financial statements?

a. Medicare reimbursement Yes _____ No _____

_____

b. Other third-party recoveries Yes _____ No _____

_____

If no, explain why.

Controlling Interest Form

The applicant 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 applicant's proposal as unresponsive.

Name	Address	Owner or Controller	Has Controlling Interest? Yes	No

Background Check Information Form

The applicant 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 #	Date of Birth (Da/Mo/Yr)	Place of birth City/County/State

* If yes, provide all other names. Use a separate sheet if necessary.

** For each person listed:

a. Give addresses for the last ten years

b. Ever suspended from any Federal program for any reason?

Yes _____ No _____ If yes, please explain.

Operational Certification Submission Form

The applicant 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 rules or policies and procedures.

By signing below the applicant certifies that it shall at ail 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 applicant warrants that in the event DHS discovers, through an operational review, that the applicant has failed to maintain these operating procedures, the applicant will be subject to a non-refundable, non-waivable sanction in accordance with DHS Rules.

Signature Date

Grievance System Form

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

I hereby certify that _____
Applicant 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 applicant must have a grievance policy for recipients and providers which defines their rights regarding any adverse action by the applicant. 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

INSURANCE REQUIREMENTS CERTIFICATION

Proposals submitted in response to the RFP must include a Certificate of Liability Insurance (COLI) that meets the requirements of the RFP, summarized in the Checklist and sample Form Acord 25 attached hereto. The successful bidder will be required to provide an updated COLI upon contract award.

Time is of the essence in the execution and performance of the contract resulting from this RFP. Therefore, the Applicant must ensure that the COLI submitted with the proposal and, if applicable, the resulting contract, fully and timely complies with the insurance requirements of this RFP.

By signing below, the Applicant certifies that it has completed the attached Checklist and:

(Check and complete one)

☐ Applicant has included a current COLI with its proposal that fully meets the insurance coverage requirements contained in the RFP and in the attached Checklist.

☐ Applicant has included a current COLI with its proposal that meets the insurance coverage requirements contained in the RFP and in the attached Checklist and Form, *except for the following* (explain in detail):

_____

_____

_____

_____

_____

_____

If Applicant is awarded a contract, then Applicant certifies that the foregoing deficiencies will be corrected within five (5) business days after contract award.

_____

Name of Applicant

_____ _____

Authorized Representative Signature Date

_____

Print Name and Title

CERTIFICATE OF LIABILITY INSURANCE (COLI)
CHECKLIST & SAMPLE FORM (ACORD 25 Form (2009/09)[1])

This Checklist must accompany the completed COLI submitted with the proposal and subsequent contract. In the event of a conflict between this Checklist and the terms of the contract, the latter shall prevail.

If a requirement noted below is reflected in a current policy endorsement, a copy of the endorsement may be submitted in lieu of the statement on the COLI. Insurance requirements are subject to oversight by the State of Hawaii Department of Accounting and General Services, Risk Management Office.

NO.	CERTIFICATE OF INSURANCE LIABILITY REQUIRED ELEMENTS
(1)	THE DATE THE COLI ISSUED SHOULD NOT BE MORE THAN 15 DAYS FROM THE DATE OF ITS REQUEST. THE COLI SHOULD NOT BE ISSUED OVER 30 DAYS FROM THE DATE OF SUBMISSION.
(2)	THE NAME OF THE "INSURED" MUST MATCH THE NAME OF THE CONTRACTOR/PROVIDER.
(3)	THE INSURER MUST BE LICENSED TO DO BUSINESS IN THE STATE OF HAWAII OR MEET THE REQUIREMENTS OF SECTION 431:8-301, HAWAII REVISED STATUTES.
(4)	THE "COMMERCIAL GENERAL LIABILITY" COVERAGE SHOULD INDICATE COVERAGE ON A "PER OCCURRENCE" BASIS.
(5)	A "POLICY NUMBER" OR BINDER NUMBER SHOULD BE INDICATED.
(6)	THE "EFFECTIVE DATE" SHOULD BE NO LATER THAN THE CONTRACT DATE OR THE FIRST DATE THAT THE CONTRACTOR COMMENCES WORK FOR THE STATE.
(7)	THE "EXPIRATION DATE" SHOULD BE AFTER THE EFFECTIVE DATE OF THE AGREEMENT OR SUPPLEMENTAL AGREEMENT, AS APPLICABLE, AND BE MONITORED TO ENSURE THAT RENEWAL COLI ARE RECEIVED ON A TIMELY BASIS.
(8)	THE LIMITS OF LIABILITY FOR THE FOLLOWING TYPES OF COVERAGE SHOULD BE FOR AT LEAST AS MUCH AS REQUIRED BY THE CONTRACT, NORMALLY IN THE FOLLOWING AMOUNTS (CHECK CONTRACT LANGUAGE FOR SPECIFICS):

A. COMMERCIAL GENERAL LIABILITY
$1 MILLION PER OCCURRENCE, AND
$2 MILLION IN THE AGGREGATE

B. AUTOMOBILE – MAY BE COMBINED SINGLE LIMIT:
BODILY INJURY: $1 MILLION PER PERSON, $1 MILLION PER ACCIDENT
PROPERTY DAMAGE: $1 MILLION PER ACCIDENT

C. WORKERS COMPENSATION/EMPLOYERS LIABILITY (E.L.)
E.L. EACH ACCIDENT: $1 MILLION
E.L. DISEASE: $1 MILLION PER EMPLOYEE, $1 MILLION POLICY LIMIT
E.L. $1 MILLION AGGREGATE

[1] The Contractor should use the Acord form currently in use at the time of submission with the contract.

NO.	CERTIFICATE OF INSURANCE LIABILITY REQUIRED ELEMENTS
	D. PROFESSIONAL LIABILITY $1 MILLION PER CLAIM, AND $2 MILLION ANNUAL AGGREGATE
(9)	"ANY AUTO" COVERAGE IS REQUIRED, OR IF NOT MARKED, "HIRED AUTOS" AND "NON-OWNED AUTOS" SHOULD BE INDICATED. IF THERE ARE NO CORPORATE-OWNED AUTOS, THEN THE "HIRED & NON-OWNED AUTO" MAY BE ENDORSED TO THE COMMERCIAL GENERAL LIABILITY TO SATISFY THIS REQUIREMENT.
(10)	IF THE LIMITS OF LIABILITY SHOWN FOR GENERAL LIABILITY OR AUTOMOBILE LIABILITY ARE LESS THAN REQUIRED BY CONTRACT, THEN UMBRELLA LIABILITY WITH COMBINED LIMIT MAY SATISFY THE MINIMUM REQUIREMENT AND THE STATE LISTED AS "ADDITIONAL INSURED" ON THE UMBRELLA POLICY OR THE UMBRELLA POLICY IS NOTED AS "FOLLOW FORM" ON THE CERTIFICATE.
(11)	NOTE: THE STATE REQUIRES HIGHER LIMITS OF $1 MILLION, AS COMPARED TO THE BASIC LIMITS REQUIRED BY STATE LAW REGARDING WORKERS COMPENSATION COVERAGE.
(12)	THE REQUIRED "PROFESSIONAL LIABILITY" COVERAGE SHOULD BE INDICATED IN THIS SECTION.
(13)	THE "ADDL INSR" BOX SHOULD BE CHECKED TO INDICATE THAT THE STATE IS AN ADDITIONAL INSURED UNDER THE POLICY(IES), OR NOTED IN THE DESCRIPTION OF OPERATION BOX AT THE BOTTOM OF THE FORM.
(14)	THE "CERTIFICATE HOLDER" SHOULD BE THE NAME AND ADDRESS OF THE DEPARTMENT OF HUMAN SERVICES/MED-QUEST DIVISION, 1001 KAMOKILA BOULEVARD, SUITE 317, KAPOLEI, HAWAII 96707
(15)	THE COLI SHOULD BE SIGNED BY THE INSURANCE AGENT OR AN INSURANCE COMPANY REPRESENTATIVE.
	DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES BOX: THIS SECTION SHOULD CONTAIN THE FOLLOWING LANGUAGE: THE STATE OF HAWAII IS AN ADDITIONAL INSURED WITH RESPECT TO OPERATIONS PERFORMED FOR THE STATE OF HAWAII. ANY INSURANCE MAINTAINED BY THE STATE OF HAWAII SHALL APPLY IN EXCESS OF, AND NOT CONTRIBUTE WITH, INSURANCE PROVIDED BY THIS POLICY.

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) (1)

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME:
	PHONE (A/C, No, Ext): / FAX (A/C, No):
	E-MAIL ADDRESS:
	PRODUCER CUSTOMER ID #:

INSURED (2)	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A:	
	INSURER B: (3)	
	INSURER C:	
	INSURER D:	
	INSURER E:	
	INSURER F:	

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	(8) LIMITS	
	GENERAL LIABILITY	(13)		(5)	(6)	(7)	EACH OCCURRENCE	$
	COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
	CLAIMS-MADE ☐ OCCUR						MED EXP (Any one person)	$
	(4)						PERSONAL & ADV INJURY	$ (10)
							GENERAL AGGREGATE	$
	GEN'L AGGREGATE LIMIT APPLIES PER						PRODUCTS - COMP/OP AGG	$
	☐ POLICY ☐ PRO-JECT ☐ LOC							$
	AUTOMOBILE LIABILITY	(13)					COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO (9)						BODILY INJURY (Per person)	$
	ALL OWNED AUTOS						BODILY INJURY (Per accident)	$
	SCHEDULED AUTOS						PROPERTY DAMAGE (Per accident)	$ (10)
	HIRED AUTOS							$
	NON-OWNED AUTOS							$
	UMBRELLA LIAB ☐ OCCUR	(13)					EACH OCCURRENCE	$
	EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	DEDUCTIBLE							$ (10)
	RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N	N / A					WC STATU-TORY LIMITS / OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ (Mandatory in NH)						E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ (11)
	(12)						E.L. DISEASE - POLICY LIMIT	$

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

CERTIFICATE HOLDER

(14)

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

(15)

Wage Certification

Pursuant to Section 103-55, Hawaii Revised Statutes, I hereby certify that if awarded the contract In excess of $25,000, the services to be performed will be performed under the following conditions:

1. The services to be rendered shall be performed by employees paid as wages or salaries not less than wages paid to the public officers and employees for similar work, if similar positions are listed in the classification plan of the public sector.

2. All applicable laws of the Federal and State governments relating to worker's compensation, unemployment insurance, payment of wages, and safety will be fully complied with.

I understand that all payments required *by* Federal and Stale laws to be made by employers for the benefit of their employees are to be paid in addition to the base wages required by Section 103-55, HRS.

Applicant: _____

Signature: _____

Title: _____

Date: _____

CONTRACT NO. _____

PROVIDER'S
STANDARDS OF CONDUCT DECLARATION

For the purposes of this declaration:

"Agency" means and includes the State, the legislature and its committees, all executive departments, boards, commissions, committees, bureaus, offices; and all independent commissions and other establishments of the state government but excluding the courts.

"Controlling interest" means an interest in a business or other undertaking which is sufficient in fact to control, whether the interest is greater or less than fifty per cent (50%).

"Employee" means any nominated, appointed, or elected officer or employee of the State, including members of boards, commissions, and committees, and employees under contract to the State or of the constitutional convention, but excluding legislators, delegates to the constitutional convention, justices, and judges. (Section 84-3, HRS).

On behalf of:

_____
(Name of PROVIDER)

PROVIDER, the undersigned does declare as follows:

1. PROVIDER ☐ is* ☐ is not a legislator or an employee or a business in which a legislator or an employee has a controlling interest. (Section 84-15(a), HRS).

2. PROVIDER has not been represented or assisted personally in the matter by an individual who has been an employee of the agency awarding this Contract within the preceding two years and who participated while so employed in the matter with which the Contract is directly concerned. (Section 84-15(b), HRS).

3. PROVIDER has not been assisted or represented by a legislator or employee for a fee or other compensation to obtain this Contract and will not be assisted or represented by a legislator or employee for a fee or other compensation in the performance of this Contract, if the legislator or employee had been involved in the development or award of the Contract. (Section 84-14 (d), HRS).

4. PROVIDER has not been represented on matters related to this Contract, for a fee or other consideration by an individual who, within the past twelve (12) months, has been an agency employee, or in the case of the Legislature, a legislator, and participated while an employee or legislator on matters related to this Contract. (Sections 84-18(b) and (c), HRS).

PROVIDER understands that the Contract to which this document is attached is voidable on behalf of the STATE if this Contract was entered into in violation of any provision of chapter 84, Hawai'i Revised Statutes, commonly referred to as the Code of Ethics, including the provisions which are the source of the

* Reminder to agency: If the "is" block is checked and if the Contract involves goods or services of a value in excess of $10,000, the Contract may not be awarded unless the agency posts a notice of its intent to award it and files a copy of the notice with the State Ethics Commission. (Section 84-15(a), HRS).

declarations above. Additionally, any fee, compensation, gift, or profit received by any person as a result of a violation of the Code of Ethics may be recovered by the STATE.

PROVIDER

By _____
(Signature)

Print Name _____

Print Title _____

_____

Date _____

APPENDIX E – Risk Share Program

APPENDIX E
RISK SHARE PROGRAM

Objective of the Program: The State acknowledges that due to circumstances beyond the control of the MCOs and the State, the established capitation rates may not be appropriate for the services to be provided. Even with utilization data and experience serving enrollees, it is difficult for the plans and the State to accurately predict the actual performance or utilization of services by the enrolled population. It is possible that more recipients will utilize more services than estimated. Conversely, it is also possible that more recipients will utilize substantially less services than estimated.

To address the unknown risk to the MCOs and the State, the DHS will implement a risk share program. All of the settlements are MCO specific (with the exception of the high risk newborn pool) and a MCO's settlement does not depend on the results of the program in aggregate.

We have included an excel template for each of these settlements. The templates are populated with an example to help illustrate the calculation of the settlements.

Note that service coordination costs are reported as healthcare services and not as administrative costs for this computation.

1 – Retroactive Settlement Corridor

Background: Some Medicaid members are retroactively enrolled with a MCO. During this retroactive enrollment period, a member may accrue claims prior to a MCO being aware of the member enrolling with the MCO. The MCO is financially responsible for these costs, but has no way to manage the member and their care during the retroactive enrollment period. To mitigate the MCO's risk during the retroactive period, the State introduced a retroactive settlement corridor in CY 2015.

Applies to the following:

1. Populations
    a. Family and Children and Expansion
    b. NOT applicable to the ABD program
2. MCOs
    a. All MCOs

Exclusions:

1. Revenue
    a. P4P Withhold Amounts Earned by MCOs
    b. Supplemental Payments
    c. Health Insurance Fee Revenue
    d. Premium Tax Revenue
    e. Pay for Performance Pool Revenue
    f. Administrative Load
2. Health Care Expenses
    a. Health Insurance Fee
    b. Pay for Performance Pool

Items needed from the MCOs:

1. Populated Retroactive Settlement Form
2. Detailed Retroactive Claims

Mechanics:

1. Retroactive periods are identified by the contract type Q.
2. This includes all high cost drug costs during the retroactive period
3. Costs for a member will be adjusted to be consistent with any pricing adjustments included in the rate development. Specifically, if there are unit cost issues with a plan such that repricing was required for the rate development material, that same repricing would be applied to the claims before application of the retroactive settlement.
4. Transition of Care
    a. If a retroactive member remains admitted in a facility after being assigned to a MCO then facility costs continue to be associated with the retroactive period.

   b. Costs will be excluded from the retroactive settlement and will be covered by the non-retroactive capitation rate after a transition of care occurs, based on the transition of care rules as included in the contract.
   c. This is consistent with how costs are transferred from one MCO to another when a member in a facility changes MCOs.
   d. Professional fees and enabling services (e.g. meals, transportation, and lodging) are considered prospective once the member is enrolled in the MCO. During the retroactive period these costs are associated with the retroactive settlement.
5. Assumed administrative load is as follows:
   a. Medicaid Expansion 10%
   b. Aged, Blind, and Disabled (ABD) 7.5%
   c. All other populations 10%
   d. Note that MCOs who do not participate on all islands will have administration reduced by 0.50% and 0.25% for non-ABD and ABD populations, respectively. The MCO specific administrative assumption will be used for that calculation.
6. During the retroactive period an enhanced premium (premiums are higher than for non-retroactive members of the same rate code) is paid on behalf of the enrollee.
7. This enhanced payment is paid for only during the retroactive period. All prospective periods of enrollment are paid at the standard capitation rates and are subject to the risk share program described below in "4 - Aggregate Gain/Loss Share."
8. If there are MCO-specific gains relative to the costs during the retroactive period included in the rates, the DHS would share equally in the gain between 0% and 2.5%.
   a. The DHS would recover all gains exceeding 2.5%. If there are MCO specific losses the DHS would share equally in the losses between 0% and 2.5%.
   b. DHS will reimburse all losses exceeding 2.5%.
9. The settlements will be calculated separately for each program for each MCO.

Timing:

1. Interim Settlement
   a. There will be an interim settlement two months after the end of the contract period.
2. Final Settlement
   a. The final settlement will take place one year after the end of the contract period.

TEMPLATE
State of Hawaii, Department of Human Services
Retroactive Settlement Calculation

	ABD	F&C	Expansion	Total
1. Member Months	NA	12,000	4,000	16,000
2. Revenue				
Total Retroactive Revenue(1)	NA	$ 1,950,000	$ 1,400,000	$ 3,350,000
P4P Withhold	NA	$ (30,000)	$ (20,000)	$ (50,000)
Supplemental Payments	NA	$ 45,000	$ 35,000	$ 80,000
Health Insurance Fee Revenue	NA	$ 45,000	$ 35,000	$ 80,000
Premium Tax Revenue	NA	$ 45,000	$ 35,000	$ 80,000
Pay for Performance Pool Revenue	NA	$ 45,000	$ 35,000	$ 80,000
Net Total Retroactive Revenue	NA	$ 1,800,000	$ 1,280,000	$ 3,080,000
Health Care Services Portion of Total Revenue %(2)	NA	90.0%	90.0%	90.0%
Health Care Services portion of Total Revenue $	NA	$ 1,620,000	$ 1,152,000	$ 2,772,000
3. Health Care Expense				
Retroactive Incurred Health Care Expenses	NA			
Hospital Facility		$ 601,500	$ 601,500	$ 1,203,000
Professional/Other		$ 300,750	$ 300,750	$ 601,500
Rx (Excluding High Cost Drugs)		$ 300,750	$ 300,750	$ 601,500
Other Benefit Costs Not Included Above	NA	$ 6,000	$ 3,000	$ 9,000
Other Supplemental Rx Rebates (Excluding High Cost Drugs)	NA	$ (6,000)	$ (3,000)	$ (9,000)
Retroactive High Cost Drug Expenses	NA	$ 4,000	$ 450,000	$ 454,000
Retroactive High Cost Drug Rebates	NA	$ (100)	$ (3,600)	$ (3,700)
Health Insurance Fee	NA	$ 45,000	$ 35,000	$ 80,000
Pay for Performance Pool	NA	$ 45,000	$ 35,000	$ 80,000
Total Retroactive Health Care Expenses	NA	$ 1,206,900	$ 1,649,400	$ 2,856,300
4. Settlement Calculations				
Net Gain/Loss	NA	$ 413,100	$ (497,400)	$ (84,300)
Calculated Gain/Loss Percentage	NA	25.50%	-43.18%	-3.04%
Below 2.50%	NA	2.50%	-2.50%	-2.50%
Excess of 2.50%	NA	23.00%	-40.68%	-0.54%
Plan Share of Gain/(Loss) < 2.50%	NA	$ 20,250	$ (14,400)	$ (34,650)
DHS Share of Gain/(Loss) < 2.50%	NA	$ 20,250	$ (14,400)	$ (34,650)
DHS Share of Gain/(Loss) > 2.50%	NA	$ 372,600	$ (468,600)	$ (15,000)

(1) - The revenue is net of the P4P amount withheld and does not include any P4P withhold amount earned by the health plan.

(2) - Note that health plans who do not participate on all islands will have administration reduced by 0.50% and 0.25% for non-ABD and ABD populations, respectively. The health plan specific administrative assumption will be used for that calculation.

2 – High Cost Drug Risk Corridor

Background: Some Medicaid members have conditions requiring very expensive drug treatments. These members are infrequent and not evenly distributed among the MCOs. To mitigate the MCO's risk, the State modified the existing drug corridor to include drugs that exceed $125,000 per member in CY 2019. High cost drugs include either 10-digit GPIs or J-code HCPCS in excess of $125,000 per member per code per year.

Applies to the following:

1. Populations
    a. All QUEST Integration programs
2. MCOs
    a. All MCOs

Exclusions:

1. Member Months
    a. Retroactive enrollment for Family and Children and Expansion populations
    b. Dual eligible enrollment for all populations
2. Health Care Expenses
    a. Retroactive drug claims
    b. Dual eligible member claims

Items needed from the MCOs:

1. Populated High Cost Drug Risk Corridor Settlement Form
2. Detailed High Cost Drug Claims

Mechanics:

1. This corridor is specific to drug costs (10-digit GPI based or J-code HCPCS based) exceeding $125,000 per member per drug during CY 2019.
2. The total drug costs considered for this corridor would be the total drug costs net of any retroactive drug costs included in the retroactive corridor. Supplemental rebates are included in the total costs.
3. For Family and Children and the Expansion populations, there is a retroactive settlement corridor in place. Drug costs incurred during a retroactive enrollment period are excluded for this settlement. For ABD, all drug costs are included in this settlement since there is no retroactive settlement corridor for the ABD population.
4. Table 9-1 summaries the high cost drug PMPM loaded into the 2019 rates. The actual costs from the MCOs will be compared to these costs for the final settlement calculation.
5. According to the "Affordable Care Act Medicaid Prescription Drug Rebate Provision" memo "Health plans are required to provide NDC information for all J code reimbursement." Consistent with this memo, to be an eligible claim in the high cost drug corridor for the CY 2019 rates, the claims must be an accepted claim with an NDC in the State's data warehouse

High Cost Drug Corridor PMPMs	
Program	**PMPM**
ABD - Medicaid Only	$33.13
QUEST – Family and Children	$5.83
Expansion	$4.15

1. For the gain/loss calculation, the net gain or loss percentage will be computed for each MCO separately.
    a. If there is MCO-specific gain/losses exceeding 3%, the DHS will share equally in the gain/loss between 3% and 6%.
    b. The DHS will recover/reimburse all gains/losses exceeding 6%.

Timing:

1. Interim Settlement
    a. There will be an interim settlement two months after the end of the period.
2. Final Settlement
    a. A final settlement will take place once the retroactive settlement corridor has been finalized.

TEMPLATE
State of Hawaii, Department of Human Services
High Cost Drug Risk Corridor Calculation

	ABD	F&C	Expansion	Rebate Percentage	Total
1. Member Months[1]					
ABD					140,000
Medicaid Only	140,000				
QUEST - Family		140,000			140,000
Expansion			40,000		40,000
Total Membership	140,000	140,000	40,000		320,000
2. Revenue					
Revenue for High Cost Drug PMPM					
ABD					
Medicaid Only	$ 33.13			-4.00%	$ 33.13
QUEST - Family		$ 4.15		-4.00%	$ 4.15
Expansion			$ 5.83	-4.00%	$ 5.83
High Cost Drug Subtotal	$ 4,638,200	$ 581,000	$ 233,200		$ 5,452,400
Assumed High Cost Drug Rebates	$ (185,528)	$ (23,240)	$ (9,328)		$ (218,096)
Total Revenue for High Cost Drugs	$ 4,452,672	$ 557,760	$ 223,872		$ 5,234,304
3. Health Care Expense					
High Cost Drug Costs (Including Retroactive High Cost Drugs)	$ 10,676,760	$ 630,000	$ 5,255,960		$ 16,562,720
Other Supplemental Rx Rebates (Excluding Retroactive Enrollment)	$ (213,535)	$ (12,600)	$ (105,119)		$ (331,254)
Retroactive High Cost Drug Claims	NA	$ 3,900	$ 446,400		$ 450,300
Total High Cost Drug Expenses	$ 10,463,225	$ 613,500	$ 4,704,441		$ 15,781,166
4. Settlement Calculations					
Net Gain/Loss	$ (6,010,553)	$ (55,740)	$ (4,480,569)		$ (10,546,862)
Calculated Gain/Loss Percentage	-134.99%	-9.99%	-2001.40%		-201.50%
Below 3.00%	-3.00%	-3.00%	-3.00%		-3.00%
Between 3.00% and 6.00%	-3.00%	-3.00%	-3.00%		-3.00%
Above 6.00%	-128.99%	-3.99%	-1995.40%		-195.50%
Plan Share of Gain/(Loss) < 3.00%	$ (133,580)	$ (16,733)	$ (6,716)		$ (157,029)
Plan Share of Gain/(Loss) 3.00% to 6.00%	$ (66,790)	$ (8,366)	$ (3,358)		$ (78,515)
DHS Share of Gain/(Loss) 3.00% to 6.00%	$ (66,790)	$ (8,366)	$ (3,358)		$ (78,515)
DHS Share of Gain/(Loss) > 6.00%	$ (5,743,392)	$ (22,274)	$ (4,467,136)		$ (10,232,803)

(1) - Excludes Retroactive Enrollment for Family and Children and Expansion populations.

3 – High Risk Newborn Risk Pool (HRNBP)

Background: In recent years, the State has become increasingly aware of the volatility of newborn costs and the resulting impact on MCO performance. In many of cases the MCOs are automatically assigned a newborn or a late-term pregnant mother, not enabling them to manage the care in order to reduce costs. In response to this concern, the State is including a High Risk Newborn Pool (HRNBP) to protect MCOs with high risk newborns. To mitigate the MCO's risk the State is introducing a risk pool in CY 2019.

Applies to the following:

1. Populations
    a. All QUEST Integration programs
2. MCOs
    a. All MCOs

Exclusions:

1. Membership
    a. Retroactively enrolled Family and Children newborns
    b. Dual Eligible ABD newborns
2. Health Care Expenses
    a. Retroactive High Cost Drug Claims
    b. High Cost Drug Claims
    c. Health Insurance Fee
    d. *Pay for Performance Pool*

Items needed from the MCOs:

1. Populated High Risk Newborn Form
2. Detailed High Risk Newborn Claims
3. Eligible high risk newborn IBNP assumptions and documentation

Mechanics:

1. Eligible Claims
    a. High risk newborns will be determined using TRICARE Diagnosis-Related Groups (DRGs) version consistent with the effective year of the risk pool. Eligible DRGs include neonates with a birthweight below 1,500 grams (612-613, and 631-635), and neonates above 1,500 grams with significant procedures and multiple major problems (636, 651, and 681). Only costs associated with these DRGs are eligible for the risk pool.
    b. Non-retroactively enrolled Family and Children newborns (defined as being in an 'Ages < 1' rate code) and all (both retroactive and non-retroactively enrolled) Non-Dual ABD newborns would be eligible.
    c. Eligible claims will be determined based on admission date. If a claim crosses between multiple years, the dollars will be included in the year corresponding to the admission date of the claim.
    d. To be an eligible claim for the HRBNP for the CY 2019 rates, the claims must be an accepted claim in the State's data warehouse.
2. The risk pool amount is based on a PMPM calculated using eligible claims in the base year multiplied by the current period's newborn member months.
3. To minimize cash flow issues, this risk pool amount will initially be allocated to each MCO on a PMPM basis based on their number of newborns from the Family and Children population during the rate setting period. This funding is not guaranteed revenue for each MCO but will instead be re-allocated to the appropriate MCOs once the high risk newborn settlement takes place after the rate setting period.
    a. This PMPM amount can be seen Appendix 1 in the "Newborn High Risk Pool" column.
4. The risk pool will be budget-neutral from the State's perspective, simply shifting money between MCOs based on which MCOs get a larger share of high risk newborns. The pool will be allocated between MCOs based on their actual costs for eligible newborns with eligible DRGs costs. An MCO's share of the pool will be the MCOs eligible costs / the sum of eligible costs across the entire QI program for the calendar year. Regardless of the actual high risk newborn claims paid out in CY 2019, the total amount paid out of the HRNBP will be no less than/greater than the amount loaded into the risk pool.
5. The settlements will be calculated in total across programs and MCOs.
6. IBNP for Open claims
    a. For claims that are still open when the final settlement is calculated, an MCO will be required to provide an Incurred-But-Not-Paid (IBNP) estimate for the remainder of the claim. MCOs must provide detailed documentation of IBNP assumptions.

b. Once reviewed and approved, IBNP estimates related to eligible claims will be included with eligible costs.

Timing:

1. Quarterly Updates
   a. The State will provide quarterly updates to the MCOs showing their current share of the pool relative to the rest of the QI program.
   b. These updates are informational only and no money will paid out with these updates.
2. Final Settlement
   a. A final settlement will take place once the retroactive and high cost drug risk corridor settlements have been finalized.

TEMPLATE		
State of Hawaii, Department of Human Services		
High Risk Newborn Pool Calculation		
	Individual MCO	**All MCOs(1)**
1. Member Months		
Newborn Member Months (Excluding Retroactive Enrollment)	20,000	100,000
2. Risk Pool Amount Eligible		
Base Year High Risk Newborn Pool Eligible Costs (Excluding High Cost Drugs and Retroactive Enrollment)		$ 24,876,552
Base Year Newborn Member Months		97,914
Base Year High Risk Newborn Pool Funding PMPM	$ 254.07	$ 254.07
Total High Risk Newborn Pool Funding Received	$ 5,081,329	$ 25,406,643
3. Risk Pool Distribution		
High Risk Newborn Pool Eligible Costs Paid (Excluding High Cost Drugs and Retroactive Enrollment)	$ 7,000,000	$ 21,000,000
High Risk Newborn Pool Eligible IBNP (Excluding High Cost Drugs and Retroactive Enrollment) (2)	$ 1,000,000	$ 3,500,000
Total High Risk Newborn Pool Eligible Costs (Excluding High Cost Drugs and Retroactive Enrollment)	$ 8,000,000	$ 24,500,000
Risk Pool Distribution Percentage	33%	
Total Risk Pool Revenue	$ 8,296,047	$ 25,406,643
4. Settlement Calculations		
Redistributed Revenue	$ 3,214,718	$ -
(1) Total High Risk Newborn Pool Eligible Costs won't be known until we receive forms from all the MCOs		
(2) MCOs must provide detailed documentation supporting IBNP assumptions.		

4 – Aggregate Gain/Loss Share

Background: There was concern relative to the gain-share program being one-sided. The program was changed in CY 2017 to provide two sided protection to the MCOs. Additionally, gains or losses are determined by MCO across all programs.

Applies to the following:

1. Populations
    a. All QUEST Integration programs
2. MCOs
    a. All MCOs

Exclusions:

1. Revenue
    a. P4P Withhold Amount Earned by MCOs
    b. Supplemental Payments
    c. Health Insurance Fee Revenue
    d. Premium Tax Revenue
    e. Pay for Performance Pool
    f. Retroactive Revenue
    g. High Cost Drug Revenue
    h. High Risk Newborn Revenue
    i. Administrative Load
2. MCO Expenses
    a. Retroactive High Cost Drug Claims
    b. High Cost Drug Claims
    c. High Risk Newborn Claims
    d. Health Insurance Fee
    e. *Pay for Performance Pool*

Items needed from the MCOs:

1. Populated Aggregate Settlement Form
2. Claim Lag Triangles

Mechanics:

1. Other risk protections will be accounted to ensure there is no overlapping of risk corridors. The other risk corridors include the retroactive enrollment corridor, high cost drug corridor, and the high risk newborn pool.
2. This will not be applied separately for each program, but in aggregate for all of managed care.
3. Costs for a member will be adjusted to be consistent with any pricing adjustments included in the rate development. Specifically, if there are unit cost issues with a plan such that repricing was required for the rate development material, that same repricing would be applied to the claims before application of the aggregate gain/loss share settlement.
4. Pass-through payments will be netted out of this calculation.
5. Assumed administrative load is as follows:
    a. Medicaid Expansion 10%
    b. Aged, Blind, and Disabled (ABD) 7.5%
    c. All other populations 10%
    d. Note that MCOs who do not participate on all islands will have administration reduced by 0.50% and 0.25% for non-ABD and ABD populations, respectively. The MCO specific administrative assumption will be used for that calculation.
6. For the gain/loss calculation, the net gain or loss percentage will be computed for each MCO separately.
    a. If there is MCO-specific gain/losses exceeding 3%, the DHS will share equally in the gain/loss between 3% and 5%.
    b. The DHS will recover/reimburse all gains/losses exceeding 5%.

Timing:

1. A single settlement will take place once the retroactive, high cost drug risk corridor, and high risk newborn pool settlements have been finalized.

TEMPLATE
State of Hawaii, Department of Human Services
Aggregate Gain Loss Share Calculation

	ABD[1]	F&C	Expansion	Total
1. Member Months (Excluding Retroactive Enrollment)	140,000	140,000	40,000	320,000
2. Revenue				
Total Revenue (Excluding Retroactive Enrollment)[2]	$ 28,500,000	$ 39,000,000	$ 28,000,000	95,500,000
High Cost Drug Revenue	$ 4,452,672	$ 557,760	$ 223,872	5,234,304
High Risk Newborn Revenue	$ -	$ 8,296,047	$ -	8,296,047
P4P Withhold (Excluding Retroactive Enrollment)	$ (2,000,000)	$ (300,000)	$ (200,000)	(2,500,000)
Supplement Payments (Excluding Retroactive Enrollment)	$ 300,000	$ 400,000	$ 300,000	$ 1,000,000
Health Insurance Fee Revenue (Excluding Retroactive Enrollment)	$ -	$ -	$ -	$ -
Premium Tax Revenue (Excluding Retroactive Enrollment)	$ 1,318,125	$ 1,803,750	$ 1,295,000	$ 4,416,875
Pay for Performance Pool Revenue (Excluding Retroactive Enrollment)	$ 692,016	$ 946,969	$ 679,875	$ 2,318,859
Net Total Revenue	$ 23,737,187	$ 27,295,475	$ 25,701,253	$ 76,733,915
Health Care Services Portion of Total Revenue %[3]	92.5%	90.0%	90.0%	90.8%
Health Care Services Portion of Total Revenue $	$ 21,956,898	$ 24,565,927	$ 23,131,128	69,653,953
3. Health Care Expense				
Incurred Claims (Excluding Retroactive Enrollment)	$ 28,300,000	$ 31,080,000	$ 22,950,000	$ 82,330,000
Hospital Facility	$ 6,150,000	$ 15,540,000	$ 11,475,000	$ 33,165,000
Professional/Other	$ 6,075,000	$ 7,770,000	$ 5,737,500	$ 19,582,500
Rx (Including High Cost Drugs)	$ 16,075,000	$ 7,770,000	$ 5,737,500	$ 29,582,500
Other Benefit Costs Not Included Above	$ 250,000	$ 250,000	$ 250,000	750,000
Other Supplemental Rx Rebates (Including High Cost Drugs, Excluding Retroactive Enrollment)	$ (250,000)	$ (250,000)	$ (250,000)	(750,000)
Health Insurance Fee (Excluding Retroactive Enrollment)	$ -	$ -	$ -	-
Pay for Performance Pool (Excluding Retroactive Enrollment)	$ 692,016	$ 946,969	$ 679,875	2,318,859
High Cost Drug Costs	$ 10,463,225	$ 613,500	$ 4,704,441	$ 15,781,166
High Risk Newborn Revenue	$ -	$ 8,296,047	$ -	8,296,047
Total Health Care Expenses	$ 17,836,775	$ 22,170,453	$ 18,245,559	58,252,788
4. Settlement Calculations				
Net Gain/Loss	$ 4,120,123	$ 2,395,474	$ 4,885,569	11,401,165
Calculated Gain/Loss Percentage	18.76%	9.75%	21.12%	16.37%
Below 3.00%	3.00%	3.00%	3.00%	3.00%
Between 3.00% and 5.00%	2.00%	2.00%	2.00%	2.00%
Above 5.00%	13.76%	4.75%	16.12%	11.37%
Plan Share of Gain/(Loss) < 3.00%	$ 658,707	$ 736,978	$ 693,934	$ 2,089,619
Plan Share of Gain/(Loss) 3.00% to 5.00%	$ 219,569	$ 245,659	$ 231,311	$ 696,540
DHS Share of Gain/(Loss) 3.00% to 5.00%	$ 219,569	$ 245,659	$ 231,311	$ 696,540
DHS Share of Gain/(Loss) > 5.00%	$ 3,022,278	$ 1,167,177	$ 3,729,012	$ 7,918,468

(1) - For the ABD population - all costs including retroactive costs should be included since there is not a separate retroactive enrollment for ABD.
(2) - The revenue is net of the P4P amount withheld and does not include any P4P withhold amount earned by the health plan.
(3) - Note that health plans who do not participate on all islands will have administration reduced by 0.50% and 0.25% for non-ABD and ABD populations, respectively
The health plan specific administrative assumption will be used for that calculation.

APPENDIX F – Dental Procedures which are the Responsibility of Health Plan

APPENDIX F
DENTAL PROCEDURES WHICH ARE THE RESPONSIBILITY OF THE HEALTH PLAN

HCPCS or CDT-5 Procedure Code*	Description
D/07340	Vestibuloplasty-ridge extension
D/07350	Vestibuloplasty-ridge extension (including soft tissue grafts, muscle reattachments, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)
	Excision of Tumors
D/07440	Excision of malignant tumor – lesion diameter up to 1.25 cm
D/07441	Excision of malignant tumor – lesion diameter over 1.25 cm
	Removal of Cysts and Neoplasms
D/07450	Removal of benign odontogenic cyst or tumor lesion diameter up to 1.25 cm
D/07451	Removal of benign odontogenic cyst or tumor lesion diameter over 1.25 cm
D/07460	Removal of benign non-odontogenic cyst or tumor lesion diameter up to 1.25 cm
D0/7461	Removal of benign non-odontogenic cyst or tumor lesion diameter over 1.25 cm
D/07465	Destruction of lesions by physical methods; electrosurgery, chemotherapy, cryotherapy or laser
	Excision of Bone Tissue
D/07471	Removal of lateral exostosis – mandible or maxilla
D/07472	Removal of torus palatinus
D/07473	Removal of torus mandibularis
D/07490	Radical resection of mandible or maxilla
	Surgical Incision
D/07511	Incision and drainage of abscess-intra oral soft-tissue-complicated
D/07520	Incision and drainage of abscess-extraoral soft tissue
D/07530	Removal of foreign body, skin, or subcutaneous areolar tissue
D/07540	Removal of reaction-producing foreign bodyies, musculoskeletal system
D/07550	Sequestrectomy for osteomyelitis
D/07560	Maxillary sinusotomy for removal of tooth fragment or foreign body
	Treatment of Fractures – Simple
D/07610	Maxilla – open reduction (teeth immobilized if present)
D/07620	Maxilla – closed reduction (teeth immobilized if present)
D/07630	Mandible – open reduction (teeth immobilized if present)
D/07640	Mandible closed reduction (teeth immobilized if present)

HCPS codes will be billed with the "zero" as the first character. CDT-5 codes will be billed with the "D" as the first character.

HCPCS or CDT-5 Procedure Code*	Description
D/07650	Malar and/or zygomatic arch-open reduction
D/07660	Malar and/or zygomatic arch-closed reduction
D/07670	Aveolus – stabilization of teeth, open reduction, splinting
D/07680	Facial bones – complicated reduction with fixation and multiple surgical approaches
	Treatment of fractures – Compound
D/07710	Maxilla – open reduction
D/07720	Maxilla – closed reduction
D/07730	Mandible – open reduction
D/07740	Mandible – closed reduction
D/07750	Malar and/or zygomatic arch-open reduction
D/07760	Malar and/or zygomatic arch-closed reduction
D/07770	Alveolus – complicated reduction with fixation and multiple surgical approaches
D/07780	Facial bones – complicated reduction with fixation and multiple surgical approaches
	Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions
D/07810	Open reduction of dislocation
D/07820	Closed reduction of dislocation
D/07830	Manipulation under anesthesia
D/07840	Condylectomy
D/07850	Surgical disectomy, with/without implant
D/07852	Disc repair
D/07854	Synovectomy
D/07856	Myotomy
D/07858	Joint reconstruction
D/07860	Arthrotomy
D/07870	Arthrocentesis
D/07872	Arthroscopy – diagnosis, with or without biopsy
D/07873	Arthroscopy – surgical: lavage and lysis of adhesions
D/07874	Arthroscopy – surgical: disc repositioning and stabilization
D/07875	Arthroscopy – surgical: synovectomy
D/07876	Arthroscopy – surgical: discectomy
D/07877	Arthroscopy – surgical: dibridement
D/07880	Occlusal – orthotic device, by report
	Other Oral Surgery – Repair of Traumatic Wounds
D/07910	Suture of recent small wounds up to 5 cm
D/07911	Complicated suture up to 5 cm
D/07912	Complicated suture over 5 cm

HCPS codes will be billed with the "zero" as the first character. CDT-5 codes will be billed with the "D" as the first character.

HCPCS or CDT-5 Procedure Code*	Description
D/07920	Skin grafts (identify defect covered, location and type of graft)
	Other Repair Procedures
D/07940	Osteoplasty for orthognathic deformities
D/07941	Osteotomy – mandibular rami
D/07943	Osteotomy mandibular rami with bone graft; include obtaining the graft
D/07944	Osteotomy, segmented or subapical, per sextant or quadrant
D/07945	Osteotomy, body of mandible
D/07946	Le Fort I (maxilla –total)
D/07947	Le For I (maxilla – segmented)
D/07948	Le Fort II or Le Fort III – (osteoplasty of facial bones for midface hypoplasia retrusion) without bone graft)
D/07949	Le Fort II or Le Fort III – with bone graft
D/07950	Osseous, osteoperiosteal, periosteal, or cartilage graft of the mandible – autogenous or nonautogenous
D/07955	Repair of maxillofacial soft and hard tissue defects
D/07980	Sialolithotomy
D/07981	Excision of salivary gland, by report
D/07982	Closure of salivary fistula
D/07990	Emergency tracheotomy
D/07991	Coronoidectomy
D/07995	Synthetic graft – mandible or facial bones, by report
D/07996	Implant – mandible for augmentation purposes (excluding alveolar ridge), by report
D/07997	Appliance removal (not by dentist who replaced appliance), includes removal of archbar
D/07999	Unspecified oral surgery procedure, by report
	Adjunctive General Services
D/09220	General anesthesia – first 30 minutes (limitation: nitrous oxide for unruly children or highly apprehensive adults; attach report or note)
D/09221	General anesthesia – each additional 15 minutes
D/094220	Hospital calls (limitation: confinement must be approved; only under physician's request; no routine or follow-up visits)

HCPS codes will be billed with the "zero" as the first character. CDT-5 codes will be billed with the "D" as the first character.

APPENDIX G – Eligible Diagnosis for the Community Care Services

Eligible Diagnoses for the Community Care Services (CCS) Program

- Schizophrenic Disorders (295.1X, 295.2X, 295.3X, 295.6X, 295.9X)
- Schizoaffective Disorders (295.70)
- Delusional Disorders (297.1)
- Mood Disorders-Bipolar Disorders (296.0, 296.4X, 296.5X, 296.6X, 296.7, 296.89)
- Mood Disorders-Depressive Disorders (296.24, 296.33, 296.34)
- Substance Induced Psychosis (292.11, 292.12, 292.84)
- Post Traumatic Stress Disorder (PTSD) (309.81)

APPENDIX H – SEBD Program Services

SEBD SERVICES

The benefits of the **Support for Emotional and Behavioral Development** (SEBD) program include intensive mental health services provided through the State of Hawaii's Department of Health (DOH) Child and Adolescent Mental Health Division (CAMHD).

WHO IS ELIGIBLE?

A child, youth or adolescent who meets the following:

- Is age 3 through 20 years of age; and
- Has Hawaii QUEST or Medicaid Fee-For-Service insurance; and
- Has significant problems* with different areas of life such as home and school; and
- Has a qualifying primary DSM-IV Axis I diagnosis.

* Assessments and other information provided would be used to determine the extent of a child's emotional and behavioral needs.

WHAT ARE THE SERVICES?

Services may include any of the services listed below (and more) that are appropriate to the needs of the child.

- 24-Hour Crisis Mobile Outreach
- Intensive Case Management
- Psychosexual Assessment
- Intensive Home & Community Based Intervention
- Functional Family Therapy
- Multidimensional Treatment Foster Care
- Multisystemic Therapy
- Therapeutic Foster Home
- Respite Home
- Therapeutic Group Home
- Community Based Residential Programs
- Hospital Based Residential Services

WHO PROVIDES THE SERVICES?

The mental health professionals at CAMHD's conveniently located Family Guidance Centers will coordinate the intensive mental health services for the child.

WHERE DO I BEGIN?

Answer the following questions:

1. Would you like help with your child's emotional or behavioral problems?
2. Are you willing to have your child tested for these problems?
3. Is your child receiving Hawaii QUEST or Medicaid Fee-For-Service health insurance?

If you answered "YES" to all of the questions above, call the nearest Family Guidance Center and ask to speak with an SEBD Intake Coordinator. See the list at the back of this brochure.

Tell the Intake Coordinator that you would like to make an appointment to see if your child is able to get SEBD services.

WHO DECIDES THE ELIGIBILITY FOR SERVICES?

CAMHD's mental health professionals decide eligibility based upon information gathered.

FAMILY GUIDANCE CENTERS

Oahu

Central Oahu (Pearl City)
860 Fourth St 2nd Flr
Pearl City, HI 96782
808 453-5900
(Fax) 453-5940

Central Oahu (Kaneohe)
45-691 Keaahala Rd
Kaneohe, HI 96744
808 233-3770
(Fax) 233-5659

Leeward Oahu
601 Kamokila Blvd Suite 355
Kapolei, HI 96707
808 692-7700
(Fax) 692-7712

Honolulu
3627 Kilauea Ave Rm 401
Honolulu, HI 96816
808 733-9393
(Fax) 733-9377

Family Court Liaison Branch

42-477 Kalanianaole Hwy
Kailua, HI 96734
808 266-9922
(Fax) 266-9933

Maui

Maui (Wailuku)
270 Waiehu Beach Rd, Ste 213
Wailuku, HI 96793
808 243-1252
(Fax) 243-1254

Maui ((Lahaina)
1830 Honoapiilani Hwy
Lahaina, HI 96761
808 662-4045
(Fax) 661-5450

Molokai

65 Makaena Place
Kaunakakai, HI 96748
808 553-5067
(Fax) 553-9859

Lanai

c/o Lanai High & Elem School
555 Fraser Avenue
Lanai City, HI 96763
808 565-7915
(Fax) 565-7904

Hawaii

Hawaii (Hilo)
88 Kanoelehua, Ste A-204
Hilo, Hawaii 96720
808 933-0610
(Fax) 933-0558

Hawaii (Kona)
81-980 Haleki'i St Rm 101
Kealakekua, HI 96750
808 322-1541
(Fax) 322-1543

Hawaii (Waimea)
65-1230 Mamalahoa Hwy Suite A-11
Kamuela, HI 96743
808 887-8100
(Fax) 887-8113

Kauai

3-3204 Kuhio Hwy, Rm 104
Lihue, HI 96766
808 274-3883
(Fax) 274-3889

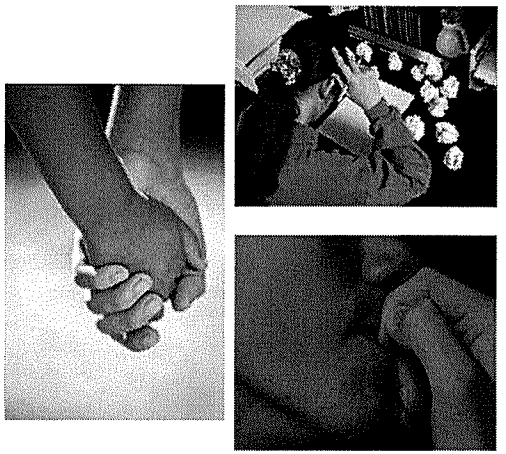
SEBD Behavioral Plan Assistant
(808) 733-9815 or
CAMHD's toll free number 1-800-294-5282
and ask for the SEBD BHP Office

STATE OF HAWAII
DEPARTMENT OF HEALTH
CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
3627 KILAUEA AVE RM 101
HONOLULU HAWAII 96816

Rev 10/10 (A7809)

DO YOU KNOW A CHILD WITH EMOTIONAL AND BEHAVIORAL CHALLENGES?

SUPPORT FOR EMOTIONAL AND BEHAVIORAL DEVELOPMENT



FOR CHILDREN AND ADOLESCENTS WHO HAVE HAWAII QUEST OR MEDICAID FEE-FOR-SERVICE HEALTH PLANS

APPENDIX I – ESPDT in the DD-ID Waiver

LINDA LINGLE
GOVERNOR

LILLIAN B. KOLLER, ESQ.
DIRECTOR

HENRY OLIVA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Health Care Services Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

July 21, 2010

MEMORANDUM

MEMO NOS.
ADMX-1015 (QExA)
ADM-NM-1001 (Non-Managed Care)

TO: QExA Health Plans
Department of Health/Developmentally Disabled/Mentally Retarded Waiver Program

FROM: Kenneth S. Fink, MD, MGA, MPH
Med-QUEST DivisionAdministrator

SUBJECT: EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

The State of Hawaii and the QUEST Expanded Access (QExA) health plans are committed to providing Early & Periodic Screening, Diagnosis, and Treatment (EPSDT) services to children less than twenty-one (21) years of age.

The addition of the QExA health plans and their service coordination create an opportunity to better coordinate care for their members who also receive services through the Medicaid home and community-based 1915c Developmentally Disabled/Mentally Retarded (DD/MR) waiver program.

This document will serve to clarify the services that the QExA health plans provide under EPSDT and services the DD/MR program provides under the waiver for joint QExA and DD/MR clients under the age of 21.

This guidance incorporates the projected EPSDT State Plan Amendment approval.

1. EPSDT Services provided by the QExA health plans

EPSDT services should meet the federal definition of early screening and diagnostic services to identify physical or mental defects as well as provision of health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered.

a. **Medically Necessary:** Only medically necessary services as defined in federal and state rules are covered under EPSDT by the health plans. The definition of medically necessary will follow the definition under HRS 432E-1.4 for medical necessity. A comprehensive nursing assessment must be performed and documented. The health plan Medical Director must review the request for any medically necessary services prior to any denial of requested services or reduction in existing services.

b. **Service Coordination:** The health plans will provide service coordination to coordinate the client's medical care. The Service Coordinators will coordinate any medically necessary services for which the health plan has responsibility to provide. These services may be requested by the DD/MR program or the client's physician(s)/family, or found through the health and functional assessments. Service Coordinators will perform regular health and functional assessments every twelve months and more frequently as needed, e.g., after hospitalization, change in condition or status. The Service Coordinator will provide a copy of the assessment to the Developmental Disabled Division (DDD) Case Manager if requested. They serve as the liaison between the health plan and the DDD Case Manager. See #3 for more information on coordination between the Service Coordinator and DDD Case Manager. See Attachment A entitled 'Role Delineation of DDD Targeted Case Manager and QExA Service Coordinator' for more information.

c. **Acute and Primary Care Services:** All medically necessary acute and primary care services, including EPSDT comprehensive exams and screenings, will be provided by the health plans. Attachment B includes a detailed list of primary and acute care services the health plans provide.

d. **Durable Medical Equipment (DME):** All durable medical supplies determined medically necessary will be covered by the health plan. DME supplies that are considered specialty items, which are not medically necessary, will not be covered by the health plan.

e. **Ancillary Services:** Speech, physical, or occupational therapy will be covered by the health plan when determined medically necessary and when effectiveness is documented as a result of the therapy/ies. Any therapy that is not effective in improving the client's condition or preventing the condition from worsening will not be covered.

f. **Skilled Nursing:** Any medically necessary skilled nursing services will be covered by the health plan. Requests for skilled nursing will be considered based on a comprehensive nursing assessment of the client in the context of medical necessity. The health plan's Medical Director must review any denial of skilled nursing requests,

including a reduction of previously approved skilled nursing hours. The definition of medically necessary will follow the HRS definition (see 1a above). The health plans may use Medicare's guidelines for home health skilled nursing (HIM11, Section 204.1A) as guidance in their medical necessity determinations. Any skilled nursing service, which a parent or caregiver usually provides and may be considered as respite, is not considered medically necessary and will not be covered by the health plans.

g. **Adverse Action:** Any adverse action (denial of service or decrease of service) will be reviewed by the health plan Medical Director. A Notice of Action must be sent by the health plans to the client and the requesting provider.

h. **Non-covered Services:** Based on federal and state definitions for EPSDT and medically necessary services, the following services shall not be covered by the QExA health plans for DD/MR clients under primary/acute care services or EPSDT. The DD/MR waiver program shall assess clients requesting these services and provide these services if meeting DD/MR waiver program policies. DD/MR waiver program shall not refer clients to QExA health plan to obtain a denial prior to assessing clients for provision of services.

   i. Respite care
   ii. Home and environmental modifications
   iii. Chore and personal care services
   iv. Supervision for stable clients to allow them to be maintained in their homes

2. Services provided by the DD/MR program

DD/MR services are provided above and beyond the medically necessary services provided by the QExA health plans. The DD/MR services support the goals of the 1915c waiver and assist in allowing the client to remain in the community.

a. **Coverage**: The DD/MR waiver program defines the coverage of the waiver services and the criteria for coverage. Attachment C includes a detailed list of all approved 1915c waiver services. All waiver services must be prior authorized and written into the participant's Individual Services Plan (ISP). Services are provided or adjusted by the DD/MR program in response to a comprehensive assessment or re-assessment and in accordance with the program's policies and procedures.

b. **Case Management:** The DDD Case Manager is the primary case manager for the client. The Case Manager is the point of contact for 1915c waiver services, coordinates such services for the client/family, conducts regular assessments, and generates an ISP for the client. For medical needs and primary care, the DDD Case Manager will work with the health plan Service Coordinator who will coordinate the medical services. See #3 for more information on coordination between the Service Coordinator and DDD Case Manager. See also attached table entitled 'Role Delineation of DDD Targeted Case Manager and QExA Service Coordinator'.

c. **Respite Care:** The DD/MR program covers any service that can be considered respite in accordance with program policies.

d. **Ancillary Services:** The DD/MR program covers on-going speech, physical, and occupational therapy, which are deemed not medically necessary and provided by the QExA health plans, in accordance with program policies.

e. **Home Modifications and Environmental Accessibility Adaptations:** The DD/MR program covers modifications to a home that meet requirements per DD/MR policy.

f. **Skilled and/or Private Duty Nursing:** The DD/MR program covers skilled nursing services according to DDD program policies and criteria. Requests for skilled nursing will be based on a skilled nursing assessment conducted by a DDD assigned nurse. Skilled nursing that is not covered by the health plan as medically necessary or that is considered respite may be covered by the DD/MR program to allow clients to be maintained in their homes, provided the request meets criteria and program guidelines.

g. **Chore and Personal Care:** The DD/MR program provides chore and personal care services in accordance with program policies to allow clients to be maintained in their homes.

h. **Supervision:** In the rare event that the DD/MR program provides supervision or monitoring for a stable client, this would be provided under and meet the criteria for PAB or Skilled Nursing in accordance with program policies to allow clients to be maintained in their homes.

i. **Other waiver services are provided by the DD/MR program** as described in the 1915c waiver application.

3. **Coordination between the QExA health plans and the DD/MR program is crucial for the clients and providers.**

Health plan Service Coordinators and DDD Case Managers must coordinate with each other to ensure seamless care for the client. The DD/MR Case Manager is the primary manager and ensures that there is good coordination with the QExA health plan as well as non-Medicaid entities. The health plan Service Coordinators are expected to attend the multidisciplinary ISP meetings that the DD/MR program conducts for the clients, if invited by the client. The health plan shall make available the client's health and functional assessment to the DD/MR Case Manager upon request. MQD will facilitate joint trainings for health plan Service Coordinators and DD/MR Case Managers to ensure that policies and procedures for coordination of care are understood and consistently implemented by everyone.

4. **Complicated clients should be jointly discussed among the medical directors of the health plan, MQD, and DDD as well as the QExA health plan Service Coordinators and DDD Case Managers.**

   Meetings will be scheduled to provide a regular time and place for these discussions. However, meetings may be scheduled more frequently with the appropriate health plan to discuss clients on a case-by-case basis.

5. **Dispute Resolution between QExA health plans and the DD/MR program.**

   In the event that a QExA health plan and the DD/MR program cannot agree on the coverage of services, a joint committee, composed of a clinical and an administrator representative from the QExA health plan, the DD/MR program, and MQD, will determine the delineation of covered services between the QExA health plan and the DD/MR program. The decision of this group will be the final decision regarding delineation of covered services. The committee will designate someone to clarify and document all decisions. All three parties will receive copies of the delineation for their records.

Attachment A

Role Delineation of Developmental Disabilities Division (DDD) Targeted Case Manager (TCM) and QUEST Expanded Access (QExA) Service Coordinator for member in the 1915(c) DD/MR waiver

Role	DD/MR Case Manager	QExA Service Coordinator	Information to share[1]
Coordination of services of client	• Primary case manager who coordinates service benefits for client • The DD/MR case manager is the primary person to help the client navigate the health care system • The DD/MR case manager may make referrals to other Medicaid programs including, but not limited to QExA, Dental Services, etc. • The DD/MR case manager is the liaison to other government programs other than Medicaid (i.e., Early Intervention, DOE, CAMHD, etc.) • Coordinates housing for DD Dom or Adult Foster Home, but refers requests for ICF/MR to MQD • For medical-related issues (i.e., physician, hospital, home health, etc.), the DD/MR case manager will refer the client to their QExA service coordinator • The DD/MR case manager can call on the service coordinator as one of their community resources to support coordination of services for their client	• The QExA service coordinator is responsible for coordinating the medical-related issues (i.e., physician, hospital, home health, medication, etc.) • QExA service coordinators will support the DD/MR case manager: ➢ Finding physicians or specialists ➢ Assuring that client has medically necessary DME or medical supplies ➢ Supporting client during a hospital discharge for new medications, home health, etc. • Acts as a health plan liaison to coordinate benefits with primary insurance to assure that client has medically necessary services to include medications • The QExA service coordinator is an adjunct to the DD/MR case manager to support the coordination of medically necessary services for their client • The QExA service coordinator is responsible for coordinating services for clients in an ICF/MR	• Change in condition/status/contact information with/for the client • Invite the service coordinator/case manager to any meeting that DD or the health plan attends (i.e., discharge planning meeting at hospital, meeting with provider/ family on complex cases)
Initial assessment	Performs the initial assessment prior to admission in the 1915(c) waiver on the 1150C	• Performs the initial health and functional assessment within 15 business days of enrollment into the QExA health plan • Does NOT perform an 1147 on DD clients	
Annual assessment	Performs the annual assessment no later than during the client's birthday month (starts three	• Performs annually based upon enrollment into the QExA health plan	Annual assessment date

[1] Note: All of the information listed in the "Information to Share" column should be shared between case manager and service coordinator except as identified

Role	DD/MR Case Manager	QExA Service Coordinator	Information to share[1]
	months prior to the month of birthday)	• Support DD/MR case manager in having client see their PCP for their annual physical • Note: if possible, coordinate timing of the face-to-face visit with DD's annual assessment • Does NOT perform an 1147 on DD clients	
Service/care plan development	• Develops Individualized Service Plan (ISP) with the circle of support that consists of a team of people that support the DD/MR waiver client • Updated annually, at a minimum • Recommend include QExA service coordinator in development • Based upon short and long-term goals of the client	• Develops within 15 business days of enrollment into the QExA health plan • Updated annually, at a minimum • Care plan is a broad roadmap of service delivery based upon medical needs	• Copy of ISP to service coordinator when updated • Copy of QExA care plan to DD case manager when updated
Setting/conducting meetings with participant/ member	• Sets up and conducts ISP meeting annually and as needed • Asks client if the QExA service coordinator can attend	Attends ISP meeting, if invited	
Approval of Services	Waiver approves services within guidelines developed for case managers, UR committee (URC) and Clinical Interdisciplinary Team (CIT): • Required by client to remain in the community instead of an institution • Must be benefit of the approved 1915(c) DD/MR waiver (Attachment A) • Services are home and community based (i.e., PAB, residential habilitation, adult day care, etc.)	Not a service coordinator responsibility. Health plan approves services that are: • Medically necessary • Coordinated with client's primary insurance • Part of the QExA primary and acute care benefit package (Attachment B)	DDD to Health Plan • Prior authorization (PA) for medically necessary services with copy of DDD nursing assessment attached, if applicable Health Plan to DDD • Approval of DME, medical supplies, or skilled nursing hours
Denial of Services	Waiver denies services within guidelines developed for case managers, URC and CIT: • Not needed by the client based upon guidelines developed by DDD	Not a service coordinator responsibility. Health plan denies services that are: • Not medically necessary • Should be covered by client's primary health	DDD to Health Plan • Any denial information from UR/CIT, if applicable

Role	DD/MR Case Manager	QExA Service Coordinator	Information to share[1]
	• Not part of 1915(c) benefit package	insurance • Not part of QExA primary and acute care benefit package	Health Plan to DDD • Any denial of DME, medical supplies, or skilled nursing hours • Denial of any item that DDD has requested
Grievances	• Works with client to try to resolve issues prior to becoming an official grievance • Refer to service coordinator if a QExA grievance includes medically necessary services and medical supplies	• Works with client to try to resolve issues prior to becoming an official grievance • Refer to DD/MR case manager if grievance is related to a DD/MR benefit	DDD to Health Plan • Any grievance resolution that involves the QExA health plan Health Plan to DDD • Any grievance resolution that involves the DD/MR waiver
Appeals	Supports DDD staff in development of response to appeal	Supports QExA health plan staff in development of response to appeal	Copy of appeal decisions DDD, health plan, MQD or Department of Insurance (DOI)[2]

Dispute Resolution between QExA health plans and the DD/MR program. In the event that a QExA health plan and the DD/MR program cannot agree on any of the information in this document, a joint committee, composed of a clinical and an administrator representative from the QExA health plan, the DD/MR program, and MQD, will determine the role delineation of the QExA health plan and the DD/MR program. The decision of this group will be the final decision regarding delineation of roles. The committee will designate someone to clarify and document all decisions. All three parties will receive copies of the delineation for their records.

[2] Use the contacts listed below for communication of information on appeals

Organization	Name	Phone	E-mail
DDD	Tracey Comeaux	453-6157	tracey.comeaux@doh.hawaii.gov
Evercare	Cherie Raymond	544-8822	cherie_raymond@uhc.com
'Ohana Health Plan	Greg Kono	675-7340	Gregory.Kono@wellcare.com

QUEST Expanded Access (QExA) Acute and Primary Care Services

- Acute inpatient hospital services for medical, surgical, psychiatric, and maternity/ newborn care;
- Cognitive rehabilitation services;
- Cornea transplants and bone graft services;
- Durable medical equipment and medical supplies;
- Emergency and Post Stabilization services;
- Family planning services;
- Home health services;
- Hospice services;
- Maternity services;
- Medical services related to dental needs;
- Other practitioner services;
- Outpatient hospital services;
- Physician services;
- Prescription drugs;
- Preventive services;
- Radiology/laboratory/other diagnostic services;
- Rehabilitation services;
- Sterilizations and hysterectomies;
- Transportation services;
- Urgent care services; and
- Vision services.

Attachment C

DD/MR waiver services in 1915(c) waiver

List of Services	Description of Services
Adult Day Health	Adult Day Health (ADH) services are full day (6 hours) or half day (3 to 6 hours) in a group setting to help individuals become more independent and involved in the community. Services may include skill development, pre-vocational training, and supports for an individual living in the community. Transportation to and from the ADH center, to the community during ADH time, and meals are included as part of ADH.
Assistive Technology	An item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is to increase, maintain, or improve functional capabilities of participants.
Chore	Services needed to maintain the home in a clean, sanitary and safe environment. These services are provided only when the individual or anyone else in the household, or other relatives, caregiver, landlord, community/volunteer agency, or third party payor is not capable or responsible for performing or financially providing for them.
DD/MR Emergency Services (outreach)	Immediate on-site support for situations in which the individual's presence in his/her home or program is at risk due to the display of challenging behaviors that occur with intensity, duration, and frequency that endangers his or her safety or the safety of others or results in the destruction of property.
DD/MR Emergency Services (respite)	Emergency out-of-home placement for individuals over the age of eighteen (18) years with potential for danger to self or others and their significant support systems due to the individual's challenging behaviors.
DD/MR Emergency Services (shelter)	Emergency out-of-home placement of individuals in need of intensive intervention in order to avoid institutionalization or more restrictive placement and for return to the current or a new living situation once stable.
Environmental Accessibility Adaptations	Physical adaptations to the individual's home, required by the individual's service plan, that is necessary to ensure the health, welfare, and safety of the individual or to enable the participant to function with greater independence in the home.
Personal Assistance/Habilitation (PAB)	A range of assistance or training to enable program individuals to accomplish tasks that they would

	normally do for themselves if they did not have a disability.
Personal Emergency Response System	PERS is an electronic device that enables waiver individuals to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility.
Respite	Services provided on a short-term basis to relieve the person normally providing the care. Respite may be furnished at various locations.
Residential Habilitation (RESHAB)	A service provided in a certified or licensed home for individuals with developmental disabilities. The service consists of supports over and beyond the room, board and supervision covered by SSI and SSP, commonly referred to as Level of Care or domiciliary care payment. It consists of supports to increase an individual's ability to be more independent in daily life.
Supported Employment	This service consists of intensive, ongoing supports that enable individuals, for whom competitive employment at or above minimum wage is unlikely, and who, because of their disabilities, need supports to perform in a regular work setting.
Skilled Nursing	Services within the scope of the State's Nurse Practice Act, provided by a registered professional nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in the State of Hawaii. If the skilled nursing service is medically necessary in accordance with guidelines provided by the MQD, it is not provided by the DD/MR waiver.
Specialized Medical Equipment and Supplies	Includes devices, controls or appliances, specified in the service plan, that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. If the specialized medical equipment or supply is medically necessary, it is not provided by the DD/MR waiver.
Transportation	This service enables individuals to gain access to waiver and other community services, activities, and resources specified in the Individual Service Plan (ISP). Transportation for medical service is not included.
Training and Consultation	Services for individuals who provide support, training, or supervision to individuals. For purposes of this service, individual is defined as any person, family member, neighbor, friend, or co-worker who provides care, training, guidance or support to the waiver

	participant. Training includes instruction about treatment regimens and other services included in the ISP and/or WAP, use of equipment specified in the service plan, and included updates as necessary to safely maintain the individual at home.
Vehicular Modifications	Adaptation to an automobile or van to accommodate the special needs of the individual as described in their service plan.

APPENDIX J – Covered Preventive Services for Adults and Children

APPENDIX J
COVERED PREVENTIVE SERVICES FOR ADULTS AND CHILDREN

The following is a listing of preventive services for which payments will be made by the health plan.

FOR ADULTS

The following are services for which payments will be made by the health plan as separate medical services, as components of separate medical services, or as components of the "evaluation and management" services rendered by the health plan's providers. The services and periodicity are adapted from the 1996 U.S. Preventive Services Task Force.

Screening

1. **Blood Pressure Measurement**
   Minimum: every single measurement, all ages and sexes
   Periodicity: every 2 years if normal
   (on basis of expert opinion) every 1 year or more frequently if abnormal

2. **Weight/Height Measurement**
   Minimum: all ages and sexes; single measurement
   Periodicity: (on basis of expert opinion) every 2 years

3. **Total Cholesterol Measurement**
   Minimum: females age 45-65; single measurement
   Males 35-65; single measurement
   Periodicity: every 5 years
   (there is insufficient evidence to recommend cholesterol measurement in younger adults with high cardiovascular disease risk factors or in older adults, however recommendation for screening may be made on other grounds. See U.S. Preventive Services Task Force. *Guide to Clinical Preventive Services, 2nd ed.* Baltimore: Wilkins & Wilkins, 1996)

4. **Breast Cancer Screening**
   Minimum: age 50 – 69 mammography alone or mammography and clinical breast exam (CBE)
   Periodicity: annual

   Minimum: age 40 – 49; although there is insufficient evidence to recommend either mammography alone or mammography and CBE, the American Cancer Society, the American College of OB/Gyn, and the American Academy of Family Physicians, recommend

mammography every 1-2 years and CBE every year. If done at this frequency, the health plan shall reimburse providers.

Minimum: age 70-72; although there is insufficient evidence to recommend mammography screening, the health plan shall reimburse providers for providing every 1-2 years

5. Cervical Cancer Screening

Minimum: pap test and pelvic exam; all sexually active women or age 18-65
Periodicity: annual, decreasing to every 3 years after 3 successive normal annual tests

Since it may be difficult to assess accurately if there have been 3 successive normal annual tests, annual pap tests will be reimbursed by the health plan.

6. Colorectal Cancer Screening

Minimum: age 50 or older; single sigmoidoscopy or annual fecal occult blood test (FOBT)
Periodicity: annual FOBT, sigmoidoscopy at age 50 and then every 10 years

7. Prostate Cancer Screening

Not recommended for routine screening.

If screening is to be performed, digital rectal exam and prostate specific antigen (PSA) for age 50-70 is best evaluated approach but should be preceded by objective information about the potential benefits and harms of early detection.

8. Rubella Serology or Vaccination History

Minimum: women of child bearing age

9. Tuberculin Skin Testing

Minimum: the current methodology, schedule and priority (immigrants, TB contacts, food handlers, health care and school workers, etc.) established by the DOH

10. Health Education and Counseling

a. Substance use, including alcohol
b. Diet and exercise
c. Injury prevention
d. Sexual behavior
e. Dental health
f. Family violence
g. Depression: there is insufficient evidence to recommend for or against the routine use of standardized questionnaires to screen for depression in asymptomatic patients
h. Results and implications of screening listed above

Immunizations

1. Tetanus-diphtheria (Td) booster
2. Rubella (or evidence of immunity) for women of child-bearing age
3. Hepatitis B in high risk groups—household and sexual contacts of HBsAg positive person

Chemoprophylaxis

1. Multivitamin with folic acid – pregnant women and women actively trying to become pregnant
2. Counsel all peri and post menopausal women about the potential benefits and risk of hormone prophylaxis

FOR THE HIGH RISK POPULATION

Required preventive interventions are those provided for adults and listed above **and** the following:

Risk Factor	Intervention
Low-income; immigrants; alcoholics; TB contacts	PPD
Certain chronic medical conditions; institutionalized persons	PPD; pneumococcal vaccine; influenza vaccine
Health care/lab workers	PPD; hepatitis B and hepatitis A influenza vaccine
Family h/o skin cancer; fair skin	Avoid sun exposure
Blood product recipients	HIV screen; hepatitis B vaccine
Susceptible to measles, mumps or varicella	MMR; varicella vaccine
Previous pregnancy with neural tube defect	Folic acid 4.0 mg
Injection of street drug use	RPR/VDRL; PPD; HIV screen; hepatitis B & A vaccines
High risk sexual behavior	STD screens; hepatitis B & A vaccines

FOR PREGNANT WOMEN

The following are services for which the health plan must reimburse providers as separate medical services, components of separate medical services or as components of the maternity (vaginal/Cesarean section delivery; prenatal care; postpartum care) benefit.

1. **Prenatal Laboratory Screening Tests**
   Including voluntary HIV testing and counseling and tests for alpha-fetoprotein, alone or in combination with other tests to screen for neural tube anomalies and chromosomal anomalies such as Down's syndrome. Prenatal laboratory screening tests covered include testing for gestational diabetes, rubella, GC, Chlamydia, pap

smear, Hepatitis B, blood typing and RH, urinalysis, complete blood count, etc. as currently recommended by the American College of Obstetrics and Gynecology (ACOG).

2. **Prenatal Visits**
Those meeting the periodicity and standards currently recommended by the ACOG.

3. **Health Education and Screening**
For conditions which could make a pregnancy "high-risk" such as smoking, alcohol and other substance abuse, depression, inadequate diet, psychosocial problems, signs of premature labor, other medical conditions, etc. and appropriate referrals including WIC and mental health providers. Other health education such as fetal development, breastfeeding, labor and delivery.

4. **Diagnosis of Premature Labor**

5. **Diagnostic Amniocentesis, Diagnostic Ultrasound, Fetal Stress and Non-Stress Testing**

6. **Prenatal Vitamins Including Folic Acid**

7. **Hospital Stays**
Up to 48 hours after vaginal delivery or 96 hours after Cesarean section delivery for health women with uncomplicated deliveries and postpartum stays following current guidelines of the American Academy of Pediatrics (AAP) or ACOG.

FOR CHILDREN

The following are services for which the health plan shall reimburse providers as separate medical services, as components of separate medical services, or as components of the EPSDT comprehensive evaluation.

1. **Newborn Screening**
Includes newborn hearing assessment, newborn laboratory screening—phenylketonuria, hypothyroidism, and other metabolic diseases as specified by the Department of Health (DOH) and currently in effect

2. **Hospital Stays for Normal, Term, Healthy Newborns**
Up to 48 hours after normal vaginal delivery or up to 96 hours after cesarean section delivery following current guidelines of the AAP and ACOG.

3. **Other Age Appropriate Laboratory Screening Tests**
Includes those currently in effect as recommended by the AAP, the Centers for Disease Control (CDC), and/or required by the Centers for Medicare & Medicaid

Services (CMS) for Medicaid recipients (for example, hemoglobin/hematocrit, blood lead level).

4. **Screening to Assess Health Status**
Includes age appropriate general physical and mental health, growth, development, and nutritional status. The periodicity schedule follows the AAP's Guidelines for Health Supervision currently in effect. Included, but not limited to the following:

   a. Initial/interval health history
   b. Height/weight/head circumference
   c. Blood pressure
   d. Developmental assessment using the Denver Developmental Screening Test of Developmental Inventory (MCDI), or any other acceptable method for developmental screening
   e. Behavioral assessment (including screening for substance abuse for ages 12+)
   f. Vision testing
   g. Hearing/language testing; audiometry
   h. Physical examination

5. **Tuberculin Skin Testing**
Using the method recommended by the DOH, following a schedule recommended by the Hawaii Chapter, AAP.

6. **Immunizations**
Following the standards and schedule of the Advisory Committee on Immunization Practices (ACIP) and the DOH currently in effect.

7. **Age Appropriate Dental Referral and Oral Fluoride**

8. **Age Appropriate Health Education**
Includes education to child and/or parent including dietary counseling, injury prevention, child maturation/development, behavior management, dental care, sexuality, family violence, STD, HIV, pregnancy, and depression. Provisions for children aged 12 years and older to be able to discuss sensitive issues alone with the provider or designated staff.

APPENDIX K – Health Professionals Counseling and Training

Appendix K
State Requirements for Health Care Professionals for Counseling and Training to include Mental Health Providers

Specialty	HRS	HAR (Dept. of Commerce and Consumer Affairs) http://hawaii.gov/dcca/main/hrs/	HAR (Dept. of Health) http://gen.doh.hawaii.gov/sites/har/admrules/default.aspx
Advanced Practice Registered Nurse	457 (8.5-8.8)	Title 16-89	
Audiologist	468E	Title 16-100	
Chiropractor	442	Title 16-76	
Dentist	448	Title 16-79	
Licensed Practical Nurse	457-8	Title 16-89	
Marriage and Family Therapist	451J	N/A	
Mental Health Counselor	453D		
Occupational Therapist	457G		
Optometrist	459	Title 16-92	
Physician/Psychiatrist	453	Title 16-85	
Physical Therapist	461J	Title 16-110	
Physician Assistant	453-5.3	Title 16-85, Subchapter 6	
Podiatrist	463E	Title 16-85, Subchapter 8	
Psychologist	465	Title 16-98	
Registered Dietitian	448-B	NA	Title 11-79
Registered Nurse	457	Title 16-89	
Speech-Language Pathologist	468E	Title 16-100	
Social Worker	467E	N/A	
Community Mental Health Center	334		Title 11-179
Mental Health and Substance Abuse Systems	334 and 321 (192-193)		Title 11-175
Special Treatment Facility	334-1		Title 11-98

Note: Respiratory Therapists must have passed the state-administered national examination and be either certified (CRT) or registered (RRT).

APPENDIX L – Service Coordinator Responsibilities and Ratios

Appendix L
QUEST Integration Service Coordinator Responsibilities and Ratios

	Children with SHCN	**Adults with SHCN**	**Members with CIS**	**HCBS (both "at risk" and institutional LOC)**	**Institutional LOC residing in an institutional setting**	**Self-Direction (both "at risk" and institutional LOC)**	**Dual Eligibles who do not have SHCN or receive LTSS**	**Optional Delegate to Provider (i.e., NF, CCMA, or hospital)**
Identify members with Special Health Care Needs (SHCN) in accordance with Section 40.910.1 and 40.910.2	X	X	X					
Identify members requiring HCBS (both "at risk" and institutional LOC) and institutional LOC residing in an institutional setting			X	X	X			
Identify members who are dual eligible without SHCN or receiving LTSS							X	
Conduct initial health and functional assessment (HFA)	X	X	X	X	X	X	X	X

Appendix L
QUEST Integration Service Coordinator Responsibilities and Ratios

	Children with SHCN	**Adults with SHCN**	**Members with CIS**	**HCBS (both "at risk" and institutional LOC)**	**Institutional LOC residing in an institutional setting**	**Self-Direction (both "at risk" and institutional LOC)**	**Dual Eligibles who do not have SHCN or receive LTSS**	**Optional Delegate to Provider (i.e., NF, CCMA, or hospital)**
Develop service plan based upon the results of the HFA	X	X	X	X	X	X	X	X
Provide service coordination to support the PCP and other providers in the network in providing good medical care to members	X	X	X	X	X	X	X	

Appendix L
QUEST Integration Service Coordinator Responsibilities and Ratios

	Children with SHCN	**Adults with SHCN**	**Members with CIS**	**HCBS (both "at risk" and institutional LOC)**	**Institutional LOC residing in an institutional setting**	**Self-Direction (both "at risk" and institutional LOC)**	**Dual Eligibles who do not have SHCN or receive LTSS**	**Optional Delegate to Provider (i.e., NF, CCMA, or hospital)**
Coordinate a team of decision-makers to develop the service plan, including the PCP, other providers as appropriate, the member and others as determined by the member including family members, caregivers and significant others	X	X	X (Includes a housing support and crisis plan)	X	X	X	X	

Appendix L
QUEST Integration Service Coordinator Responsibilities and Ratios

	Children with SHCN	**Adults with SHCN**	**Members with CIS**	**HCBS (both "at risk" and institutional LOC)**	**Institutional LOC residing in an institutional setting**	**Self-Direction (both "at risk" and institutional LOC)**	**Dual Eligibles who do not have SHCN or receive LTSS**	**Optional Delegate to Provider (i.e., NF, CCMA, or hospital)**
Coordinating services with other providers and community programs such as Medicare, the DOH programs excluded from QI, other DHS programs such as Child Welfare Services and Adult Protective Services, Medicare Advantage plans, other health plan providers, Zero-To-Three, Healthy Start, DD/ID providers at DOH, CCS and CAMHD Programs to ensure continuity of care	X	X	X	X	X	X	X	

Appendix L
QUEST Integration Service Coordinator Responsibilities and Ratios

	Children with SHCN	**Adults with SHCN**	**Members with CIS**	**HCBS (both "at risk" and institutional LOC)**	**Institutional LOC residing in an institutional setting**	**Self-Direction (both "at risk" and institutional LOC)**	**Dual Eligibles who do not have SHCN or receive LTSS**	**Optional Delegate to Provider (i.e., NF, CCMA, or hospital)**
Monitor progress with EPSDT requirements	X		X (for 18 up to 21 year olds)	X (for children)	X (for children)	X (for children)		
Providing continuity of care when members are discharged from a hospital and prescribed medications that are normally prior authorized or not on the plan's formulary	X	X	X	X	X	X	X	
Utilize compiled data received from member encounters to assure the services being provided meet member needs	X	X	X	X		X	X	

Appendix L
QUEST Integration Service Coordinator Responsibilities and Ratios

	Children with SHCN	**Adults with SHCN**	**Members with CIS**	**HCBS (both "at risk" and institutional LOC)**	**Institutional LOC residing in an institutional setting**	**Self-Direction (both "at risk" and institutional LOC)**	**Dual Eligibles who do not have SHCN or receive LTSS**	**Optional Delegate to Provider (i.e., NF, CCMA, or hospital)**
Facilitate access to services including community services	X	X	X	X	X	X	X	
Facilitate access to pre/tenancy services, this includes services to help find and apply for housing, training to be a good tenant and other supports for household management			X					
Provide assistance to resolve any concerns about care delivery or providers	X	X	X	X	X	X	X	

Appendix L
QUEST Integration Service Coordinator Responsibilities and Ratios

	Children with SHCN	**Adults with SHCN**	**Members with CIS**	**HCBS (both "at risk" and institutional LOC)**	**Institutional LOC residing in an institutional setting**	**Self-Direction (both "at risk" and institutional LOC)**	**Dual Eligibles who do not have SHCN or receive LTSS**	**Optional Delegate to Provider (i.e., NF, CCMA, or hospital)**
Assisting members to maintain continuous Medicaid benefits, this includes identifying at risk members and ensuring continuity of care and services	X	X	X	X	X	X	X	X
Submit DHS 1148 to long-term eligibility unit			X (institutional LOC only)	X (institutional LOC only)	X	X (institutional LOC only)		X (CCMA only)
Individuals receiving HCBS who meet institutional LOC shall have access to both a nurse and social worker as their service coordinator(s) except for those living in a			X	X		X		

Appendix L
QUEST Integration Service Coordinator Responsibilities and Ratios

	Children with SHCN	Adults with SHCN	Members with CIS	HCBS (both "at risk" and institutional LOC)	Institutional LOC residing in an institutional setting	Self-Direction (both "at risk" and institutional LOC)	Dual Eligibles who do not have SHCN or receive LTSS	Optional Delegate to Provider (i.e., NF, CCMA, or hospital)
residential setting such as CCFFH, E-ARCH, or ALF. Both shall be present for the initial assessment and service plan development. The health plan may identify a primary service coordinator (either nurse or social worker) for future assessment and service plan updates based upon member needs (i.e., primarily medical or primarily social). However, members shall have access to both disciplines based upon their								

Appendix L
QUEST Integration Service Coordinator Responsibilities and Ratios

	Children with SHCN	**Adults with SHCN**	**Members with CIS**	**HCBS (both "at risk" and institutional LOC)**	**Institutional LOC residing in an institutional setting**	**Self-Direction (both "at risk" and institutional LOC)**	**Dual Eligibles who do not have SHCN or receive LTSS**	**Optional Delegate to Provider (i.e., NF, CCMA, or hospital)**
current or future needs.								
Update service plan with input from team of decision-makers	At a minimum, semi-annually	At a minimum, semi-annually	At a minimum, every 90 days	At a minimum, every 90 days	At a minimum, semi-annually	At a minimum, every 90 days	At a minimum, annually	X
Update housing support and crisis plans			At a minimum, every 90 days					
Update service plan with input from team of decision-makers for those living in a residential setting such as CCFFH, E-ARCH, or ALF				At a minimum, semi-annually				X

Appendix L
QUEST Integration Service Coordinator Responsibilities and Ratios

	Children with SHCN	**Adults with SHCN**	**Members with CIS**	**HCBS (both "at risk" and institutional LOC)**	**Institutional LOC residing in an institutional setting**	**Self-Direction (both "at risk" and institutional LOC)**	**Dual Eligibles who do not have SHCN or receive LTSS**	**Optional Delegate to Provider (i.e., NF, CCMA, or hospital)**
Conduct functional level of care assessment using DHS form 1147, at a minimum annually			X (for at risk and institutional LOC)	X	X	X		X
Transfer functional level of care assessment results to State for nursing facility determination			X (for at risk and institutional LOC)	X	X	X		X
Provide options counseling regarding institutional placement and HCB services alternatives			X (for at risk and institutional LOC)	X	X	X		X

Appendix L
QUEST Integration Service Coordinator Responsibilities and Ratios

	Children with SHCN	**Adults with SHCN**	**Members with CIS**	**HCBS (both "at risk" and institutional LOC)**	**Institutional LOC residing in an institutional setting**	**Self-Direction (both "at risk" and institutional LOC)**	**Dual Eligibles who do not have SHCN or receive LTSS**	**Optional Delegate to Provider (i.e., NF, CCMA, or hospital)**
Assist members in transitioning to and from institutional setting/community placement			X	X	X			
Face-to-Face HFA Reassessment (including an assessment as to the need for a nursing facility evaluation)	At a minimum, semi-annually	At a minimum, semi-annually	At a minimum, every 90 days	At a minimum, every 90 days	At a minimum, semi-annually	At a minimum, every 90 days	At a minimum, annually	X
Face-to-Face HFA Reassessment for those living in a residential setting such as CCFFH, E-ARCH, or ALF				At a minimum, semi-annually				X

Appendix L
QUEST Integration Service Coordinator Responsibilities and Ratios

	Children with SHCN	**Adults with SHCN**	**Members with CIS**	**HCBS (both "at risk" and institutional LOC)**	**Institutional LOC residing in an institutional setting**	**Self-Direction (both "at risk" and institutional LOC)**	**Dual Eligibles who do not have SHCN or receive LTSS**	**Optional Delegate to Provider (i.e., NF, CCMA, or hospital)**
Oversight and monitoring of the self-direction delivery process (including assistance in choosing providers, directing providers and provider background checks)						X		
Oversight and monitoring of the care delivery process			X (for at risk and institutional LOC)	X	X	X		
Oversight and monitoring of the pre/tenancy services delivery process			X					

Appendix L
QUEST Integration Service Coordinator Responsibilities and Ratios

	Children with SHCN	**Adults with SHCN**	**Members with CIS**	**HCBS (both "at risk" and institutional LOC)**	**Institutional LOC residing in an institutional setting**	**Self-Direction (both "at risk" and institutional LOC)**	**Dual Eligibles who do not have SHCN or receive LTSS**	**Optional Delegate to Provider (i.e., NF, CCMA, or hospital)**
Referral for SEBD/SMI Evaluation, if applicable	X	X	X	X	X	X	X	
Referral for preventive and restorative dental care	X		X (for 18 up to 21year olds)	X (for children)	X (for children)	X (for children)		
Referral for termination from self-direction						X		
Service Coordinator Ratios and numbers needed	1:200	1:250	Pre-Tenancy 1:15 Tenancy 1:45	1:50	1:120	1:30	1:750	

APPENDIX M – DHS 1147

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

STATE OF HAWAII
Level of Care (LOC) Evaluation

HEALTH SERVICES ADVISORY GROUP, INC.
1440 Kapiolani Blvd., Suite 1110 Honolulu, HI 96814
Phone: (808) 440-6000 Fax: (808) 440-6009

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

2. PATIENT NAME (Last, First, M.I.)	3. BIRTHDATE Month/Day/Year	4. SEX	5. MEDICARE	6. MEDICAID ELIGIBLE?
			Part A ☐ Yes ☐ No Part B ☐ Yes ☐ No ID#:_____	☐ Yes ID # _____ ☐ No Date Applied _____

7. PRESENT ADDRESS: Present Address is ☐ Home ☐ Hospital ☐ NF ☐ Care Home ☐ EARCH ☐ CCFFH ☐ Other: _____

8. Medicaid Provider Number: (If applicable)

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

Phone : ( )_____ Fax: ( )_____

10. RETURN FORM TO (SERVICE COORDINATOR/CONTACT PERSON): _____

MANAGED CARE PLAN NAME (IF APPLICABLE): _____

[ ] VIA FAX (Print Fax Number Below)
Phone ( )_____ Fax ( ) _____ Email ( ) _____

11. REFERRAL INFORMATION (Completed by Referring Party)

A. SOURCE(S) OF INFORMATION
☐ Client ☐ Records ☐ Other _____

B. RESPONSIBLE PERSON
Name _____
Last First MI
Relationship _____
PHONE ( )_____ FAX ( ) _____

C. Language ☐ English ☐ Other _____

12. ASSESSMENT INFORMATION (Completed by RN, Physician, PCP)

A. ASSESSMENT DATE ____/____/____.

B. ASSESSOR'S NAME
Name _____
Last First MI
Title _____
Signature _____
☐ Hard copy signature on file.
PHONE: ( ) _____ FAX: ( ) _____
EMAIL: ( ) _____

13. REQUESTING LEVEL OF CARE

CHECK ONE BOX:

[ ] Nursing Facility (ICF)
[ ] Nursing Facility (SNF)
[ ] Nursing Facility (HOSPICE)
[ ] Nursing Facility (Subacute I)
[ ] Nursing Facility (Subacute II)
[ ] Acute Waitlist (ICF)
[ ] Acute Waitlist (SNF)
[ ] Acute Waitlist (Subacute)

LEVEL OF CARE BEGIN and END DATES: _____ TO _____

LENGTH OF APPROVAL REQUESTED (CHECK ONE BOX):

[ ] 1 month [ ] 3 months
[ ] 6 months [ ] 1 year
[ ] Other: _____

14. MEDICAL NECESSITY / LEVEL OF CARE DETERMINATION – DO NOT COMPLETE

LEVEL OF CARE APPROVAL:

[ ] Nursing Facility (ICF)
[ ] Nursing Facility (SNF)
[ ] Nursing Facility (HOSPICE)
[ ] Nursing Facility (Subacute I)
[ ] Nursing Facility (Subacute II)
[ ] Acute Waitlist (ICF)
[ ] Acute Waitlist (SNF)
[ ] Acute Waitlist (Subacute)

LEVEL OF CARE BEGIN AND END DATES: _____ TO _____

LENGTH OF APPROVAL (CHECK ONE BOX):

[ ] 1 month [ ] 3 months
[ ] 6 months [ ] 1 year
[ ] Other: _____

Comments: _____

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

[ ] DOES NOT MEET LEVEL OF CARE REQUESTED [ ] INCOMPLETE INFORMATION TO DETERMINE LEVEL OF CARE

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

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

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

STATE OF HAWAII
Level of Care (LOC) Evaluation

HEALTH SERVICES ADVISORY GROUP, INC.
1440 Kapiolani Blvd., Suite 1110 Honolulu, HI 96814
Phone: (808) 440-6000 Fax: (808) 440-6009

APPLICANT/CLIENT BACKGROUND INFORMATION (Please Type or Print)

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

3. FUNCTIONAL STATUS RELATED TO HEALTH CONDITIONS

I. LIST SIGNIFICANT CURRENT DIAGNOSIS(ES):

PRIMARY: _____

_____

SECONDARY: _____

_____

_____

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

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

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

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

VI. MENTAL STATUS / BEHAVIOR: (only one selection for orientation – items a through c. Aggressive and/or abusive and wandering may also be checked with appropriate orientation.)
[0] a. Oriented (mentally alert and aware of surroundings).
[1] b. Disoriented (partially or intermittently; requires supervision).
[2] c. Disoriented and/or disruptive.
[3] d. Aggressive and/or abusive.
[4] e. Wanders at [ ] Day [ ] Night [ ] Both, or in danger of self-inflicted harm or self-neglect.

VII. FEEDING/MEAL PREPARATION:
[0] a. Independent with or without an assistive device.
[1] b. Feeds self but needs help with meal preparation.
[2] c. Needs supervision or assistance with feeding.
[4] d. Is spoon / syringe / tube fed, does not participate.

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

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

X. BOWEL FUNCTION / CONTINENCE:
[0] a. Continent.
[1] b. Continent with cues.
[2] c. Incontinent (at least once daily).
[3] d. Incontinent (more than once daily, # of times _____).

XI. BLADDER FUNCTION / CONTINENCE:
[0] a. Continent.
[1] b. Continent with cues.
[2] c. Incontinent (at least once daily).
[3] d. Incontinent (more than once daily, # of times _____).

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

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

XIV. TOTAL POINTS:

Comatose = 30 points

Total Points Indicated: _____

XV. MEDICATIONS/TREATMENTS:

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

XVI. ADDITIONAL INFORMATION CONCERNING PATIENT'S FUNCTIONAL STATUS:

_____

_____

_____

_____

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

STATE OF HAWAII
Level of Care (LOC) Evaluation

HEALTH SERVICES ADVISORY GROUP, INC.
1440 Kapiolani Blvd., Suite 1110 Honolulu, HI 96814
Phone: (808) 440-6000 Fax: (808) 440-6009

APPLICANT/CLIENT BACKGROUND INFORMATION (Please Type or Print)

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

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

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

XVIII. SOCIAL SITUATION:

A. Person can return home ☐ Yes ☐ No ☐ N/A Community setting can be considered as an alternative to facility? ☐ Yes ☐ No ☐ N/A

B. If person has a home; caregiving support system is willing to provide/continue care. ☐ Yes ☐ No

Caregiver requires assistance? ☐ Yes ☐ No

Assistance required by Caregiver: _____ _____

C. Caregiver name:

Name: _____ Relationship: _____
Last First MI

Address: _____ Phone: (___) _____ Fax (___) _____

XIX. COMMENTS ON NURSING REQUIREMENTS OR SOCIAL SITUATION:

_____

_____

I HAVE REVIEWED AND AGREE WITH THE LEVEL OF CARE ASSESSMENT.

PHYSICIAN'S SIGNATURE/PCP: _____

☐ Hard copy signature on file. This plan of care has been discussed with the MD/PCP. **DATE:** ___/___/___

Physician's/PCP Name (PRINT): _____

Appendix M
INSTRUCTIONS
DHS FORM 1147
Rev. 01/09
LEVEL OF CARE (LOC) EVALUATION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13. ***Requesting Level of Care***: Check service that is being requested. Indicate the begin and end date of the request. If hospice services have been elected by the patient AND the services will be provided in a nursing facility, attach the hospice election and physician verification form. *Hospice services in other settings do not require an 1147 form.*

Indicate the length of approval requested. Check one box.

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

PAGE 2 AND 3– APPLICANT/PATIENT BACKGROUND INFORMATION

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

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

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

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

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

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

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

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

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

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

   XVII. **Skilled Procedures**: Check the particular skilled procedure(s) that the patient requires. If the care is daily (D), indicate the number of times per day that care is required. If care is less than once per day check "L". If the care is not applicable, check "N".

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

XVIII. **Social Situation**:

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

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

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

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

Physician Signature/PCP: Self-explanatory.

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

Date: Indicate the date of the physician or Primary Care Provider's signature.
Physician's/PCP Name: Self-explanatory.

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

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

APPENDIX N – DHS 1148 and DHS 1148B

MEDICAID ELIGIBILITY FOR LONG-TERM CARE (LTC) SERVICES

SECTION 1: DHS & HEALTH PLAN INFORMATION

TO/FROM: _____
DHS Unit/Health Plan/CMA | Contact Name | Date

_____
Phone Number | FAX Number | Email Address

FROM/TO: _____
DHS Unit/Health Plan/CMA | Contact Name | Date

_____
Phone Number | FAX Number | Email Address

SECTION 2: APPLICANT/RECIPIENT INFORMATION (Completed by Health Plan/CMA)

_____
Enrollee/Applicant Name (Last, First, M.I.) | Enrollee ID No./SSN | Date of Birth

_____
Case Name (If different from Enrollee/Applicant) | HAWI Case No. | Unit/Worker Code

SECTION 3: LONG-TERM CARE SERVICES BEING REQUESTED (Completed by Health Plan/CMA)

A. Individual is requesting which of these long-term care services:

☐ Nursing Facility: _____
Facility Name | Date of Admission | Phone No.

☐ HCBS in a private home: _____
Date of Provision of Services

☐ HCBS in a Community Care Foster Family Home:

_____
Name and Address of CCFFH | Date of Admission | Phone No.

B. Effective date of approved DHS 1147: _____

SECTION 4 DHS MEDICAID LONG-TERM CARE ELIGIBILITY DETERMINATION (Completed by DHS)

A. ☐ Eligible for LTC with Cost Share (Enrollment Fee) of $_____

B. ☐ Not eligible for LTC due to: ☐ Transfer of assets ☐ Excess home property

C. ☐ Medicaid eligibility denied/terminated effective: _____

D. ☐ Reported change does not affect Medicaid eligibility.

SECTION 5: STATUS CHANGE OF A LONG TERM CARE ENROLLEE (Completed by Health Plan)

A. ☐ Enrollee no longer eligible for HCBS effective: _____ because:
☐ Not at level of care ☐ Community Setting Not Safe ☐ HCBS providers not available

B. ☐ Enrollee receiving HCBS is admitted to a nursing facility:

_____
Nursing Facility Name | Date of Admission

C. ☐ Enrollee discharged from nursing facility and receiving HCBS services effective: _____
☐ HCBS in a private home ☐ HCBS in a Community Care Foster Family Home:

_____
Name and Address Of CCFFH | Phone

C. ☐ Enrollee no longer at NF level of care, discharged effective: _____ to:
☐ Home ☐ Care Home ☐ Other: _____

D. ☐ OTHER: _____

INSTRUCTIONS

DHS 1148 (06/09)

MEDICAID ELIGIBILITY FOR LONG-TERM CARE (LTC) SERVICES

PURPOSE:

The QExA Health Plans, case management agencies (CMA) shall use this form as a referral/feedback tool in the process to determine if a QExA enrollee or a Medicaid applicant is eligible to receive coverage of long-term care services. LTC services can be provided in a nursing facility or through home and community based services (HCBS). The Health Plans shall use this form to refer enrollees who require a LTC eligibility determination by DHS, or to report changes in the status of an enrollee who is receiving LTC services. The CMAs shall use this form to refer individuals who they are evaluating for placement in a CCFFH to MQD for a Medicaid eligibility determination. DHS will use this form to report the LTC eligibility status of enrollees to the Health Plans and CMAs.

USE and ROUTING

1. A CMA shall complete and rout this form to DHS to initiate Medicaid eligibility determination for coverage in a CCFFH.
2. A QExA health plan shall initiate this form when referring an enrollee to DHS to determine the enrollee's eligibility for LTC services (nursing facility or HCBS). If eligible for LTC, DHS shall change the capitation from P&A to HCBS.
3. A QExA health plan shall initiate this form when reporting changes for an enrollee receiving LTC services for whom they are receiving the HCBS or LTC capitation.

SECTION 1: DHS & HEALTH PLAN INFORMATION:

Completed by the referring party.

SECTION 2: APPLICANT/RECIPIENT INFORMATION:

Completed by referring party.

SECTION 3: REFERRAL FOR MEDICAID LONG-TERM CARE ELIGIBILITY DETERMINATION

- Completed by the CMA when referring an individual who they are placing in a CCFFH to DHS.
- Completed by the QExA Health Plan to identify the setting where LTC services are being requested.

SECTION 4: DHS MEDICAID LONG-TERM CARE ELIGIBILITY DETERMINATION

Completed by DHS eligibility staff to inform the Health Plan of the enrollee's eligible status for coverage of LTC services.

SECTION 5: CHANGE OF STATUS OF INDIVIDUAL RECEIVING LONG-TERM CARE SERVICES

Completed by the Heath Plan to report a change in the status of an enrollee for who the plan is receiving the HCBS or LTC capitation. The changes may basically involve, but not be limited to, enrollee not eligible for LTC, changes to the setting where LTC services are being provided, or a drop in the level of care that impact eligibility for LTC.

FILING INSTRUCTIONS

DHS shall send the response to DHS 1148 referral to health plan or CMA and file a copy in the case record.

ELIGIBILITY FOR HOME AND COMMUNITY BASED SERVICES IN THE INITIAL MONTH OF ENROLLMENT FOR MEDICALLY NEEDY AND §435.217 ENROLLEES

Certain Medicaid applicants require the provision of home and community based services (HCBS) to establish Medicaid eligibility. These applicants are medically needy or only eligible under the provisions of 42 C.F.R. §435.217. MQD has established Medicaid eligibility for these applicants on the basis that they are eligible for HCBS because they will be provided HCBS in the initial month of enrollment. MQD has enrolled the applicant in your health plan and you will be paid the HCBS capitation. You are required to assess the enrollee's eligibility for HCBS within seven calendar days of the initial enrollment. You must report to MQD the status of HCBS eligibility by the 12th day of the initial month of enrollment. MQD shall reassess Medicaid eligibility for enrollees who you determine are not eligible for HCBS.

SECTION 1: REFERRAL

1. **TO:** _____
   QExA Health Plan | Contact Name | Date
2. **FROM:** _____
   HCSB/AAU | Contact Name | Date

   _____
   Phone Number | FAX Number | Email Address

SECTION 2: ENROLLEE INFORMATION (Completed by DHS)

1. **Enrollee Name:** _____
2. **ID Number:** _____
3. **Date of Enrollment:** _____
4. **Enrollee is requesting HCBS in the following setting:**
   - ☐ **HCBS in a private home**
   - ☐ **HCBS in a community care foster family home (CCFFH)**

   _____
   Name and Address of CCFFH | Date of Admission | Telephone Number

SECTION 3: HCBS ELIGIBILITY ASSESSMENT BY QExA HEALTH PLAN

1. **Date of HCBS Assessment:** _____
2. ☐ **Enrollee eligible for HCBS: Date HCBS initiated:** _____
3. ☐ **Enrollee not eligible for HCBS because:**
   - ☐ **Not at level of care**
   - ☐ **The provision of HCBS is not cost-effective**
   - ☐ **Enrollee's residence does not assure for the safety of the enrollee**
   - ☐ **HCBS providers not available**
4. **COMMENTS:** _____

INSTRUCTIONS

DHS 1148B (06/09)

PROVISION OF HOME AND COMMUNITY BASED SERVICES IN THE INITIAL MONTH OF ENROLLMENT FOR MEDICALLY NEEDY AND §435.217 ENROLLEES

PURPOSE:

This form shall be used as a referral/feedback form between MQD Health Care Services Branch/Analysis and Accountability Utilization Unit (HCSB/AAU) and the QExA Health Plans to determine if medically needy and enrollees eligible under the provisions of 42 C.F.R. §435.217 are eligible to receive home and community based services (HCBS).

ROUTING

1. This form shall be initiated by HCSB/AAU and sent to the QExA health plan after a plan choice is made by the medically needy or §435.217 applicant.
2. The QExA health plan shall return the completed form to the HCSB/AAU by the 12th day of the initial month of enrollment.
3. The HCSB/AAU shall report HCBS eligibility status of the enrollee to the Eligibility Worker (via DHS 1148A).

SECTION 1: REFERRAL

Completed by HCSB/AAU after plan choice or assignment.

SECTION 2: ENROLLEE INFORMATION:

Completed with information provided by the EW on DHS 1148A.

1. Self-explanatory
2. Client ID Number
3. Date of enrollment
4. Enrollment Fee amount.
5. Indicate setting where HCBS is requested.

SECTION 3: HCBS ELIGIBILITY ASSESSMENT

This section to be completed by the QExA health plan.

1. Date of HCBS assessment
2. Completed if enrollee eligible for HCBS.
3. Completed if enrollee not eligible for HCBS.:

FILING INSTRUCTIONS

- EB staff shall file a copy in the case record.
- HCSB/AAU keep a copy for their records.

APPENDIX O – EPSDT Information

LINDA LINGLE
GOVERNOR

LILLIAN B. KOLLER, ESQ.
DIRECTOR

HENRY OLIVA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Clinical Standards Office
P. O. Box 700190
Kapolei, Hawaii 96709-0190

January 8, 2010

MEMORANDUM

MEMO #
ADM-1003
ADMX-1003
[Replaces ACS-0709]

TO: Medicaid EPSDT Providers, QUEST and QExA Health Plans

FROM: Kenneth S. Fink, MD, MGA, MPH KF
Med-QUEST Division Administrator

SUBJECT: EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) UPDATE

The Med-QUEST Division (MQD) issues this memo to inform providers of the changes occurring to the EPSDT forms and procedures. For any questions and clarifications on the content of this memorandum, please contact the MQD Clinical Standards Office at 808-692-8121. We encourage you to share this memo with all office staff involved with the EPSDT visit and submittal of EPSDT claims.

SECTION A: Form Changes and New Online Tool
SECTION B: Requirements
SECTION C: Billing Procedures
APPENDIX 1: Billing Codes for Comprehensive EPSDT Exams
APPENDIX 2: Billing Codes for Catch-Up/Follow-Up EPSDT Exams

SECTION A: EPSDT Form Changes and New Online Tool

1) **Revised DHS 8015 and 8016.** The EPSDT form has been updated to align with the most current recommendations and guidelines and in response to input from providers in the community. Please refer to the attached DHS 8015 and 8016. Effective April 1, 2010, the previous versions will no longer be accepted. The DHS 8015A has been eliminated.

   DHS 8015 continues to serve the purpose of guiding providers through the required components of an EPSDT exam, improving the quality of exams, and through the data

collected, providing a better understanding of the health and health needs of our Medicaid clients.

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

Forms may be obtained by calling ACS at 808-952-5570. Neighbor Island providers may call 1-800-235-4378 to obtain additional forms. The instructions for completing the form appear in detail on the back of the DHS 8015/8016.

2) **Online EPSDT.** An electronic version of the EPSDT form is now available online at https://hawaii.directaccessehr.com. Currently, this is the pilot site for training purposes. Effective March 1, 2010, providers will be able to enter data for an EPSDT exam online and submit this electronically. The online EPSDT also provides a database of previous vaccines, screenings, referrals, and other information, and it will provide prompts and alerts for services that are due. Providers are strongly encouraged to use the online EPSDT tool.

   Assistance in accessing electronic EPSDT system and obtaining a passcode, call ACS at 1-877-222-3218. Once in the system, training in how to complete the electronic form can be obtained from any QUEST or QExA health plan. Providers may begin electronic submission effective March 1, 2010.

3) **Collaborative Health Plan Trainings.** The QUEST and QExA health plans will conduct training for providers on the revised DHS 8015/8016 and the online EPSDT tool starting in January 2010. For training purposes, one health plan may represent other health plans with whom the provider is contracted. Training for the online tool will be provided jointly with ACS.

SECTION B: EPSDT Requirements

1) Required elemements for the EPSDT exam follow CMS and AAP/Bright Futures guidelines. The health plans will be working with providers to ensure that an EPSDT visit paid at the increased EPSDT rate meets the requirements for that visit.

2) Elements for the complete visit should be reported in the DHS 8015 form and supported by documentation in the medical record, including:
   - **a.** an initial or interval history
   - **b.** measurements
   - **c.** sensory screening
   - **d.** developmental assessments, including autism, with validated screening tools
   - **e.** TB risk assessments
   - **f.** lead risk assessments
   - **g.** psychosocial and behavioral assessments

h. alcohol and drug use assessment for adolescents
i. STI and cervical dysplasia screening as appropriate
j. dyslipidemia screening as appropriate
k. complete physical exam
l. age appropriate surveillance
m. immunizations
n. procedures such as hemoglobin and lead level as appropriate
o. referral to a dental home
p. referrals to state or specialty services
q. care coordination assistance if needed
r. age appropriate anticipatory guidance.

3) The forms must be signed by the physician performing the exam or supervising the immunizations and screenings. By completing and signing the form, the provider is indicating that the history, physical exam, surveillance, screenings, immunizations, diagnoses, and treatments were performed and are documented in the medical record, as specified on the EPSDT form.

4) The completed and signed EPSDT exam form submitted to a health plan or ACS, by a participating primary care provider for a QUEST or QExA health plan or an active Medicaid provider for FFS respectively, fulfills the State's auditing requirement for compliance with an EPSDT comprehensive periodic screening visit.

5) The form may be copied or printed and used to supplement, but not substitute for, the medical record. However, there should be sufficient documentation in the medical record to support completion of the requirements for a comprehensive EPSDT exam. Results of screening tests and record of immunizations reported on DHS 8015/8016 as being performed must be kept in the medical record.

6) The EPSDT exam is a comprehensive exam and viewed as a global service. Therefore, the treatment of any medical conditions discovered during the EPSDT exam is included in the exam.

7) Care coordination assistance will be provided by the appropriate health plans for QUEST or QExA members and by Community Case Management Corporation (CCMC) for any Medicaid client requiring dental services. The health plans will call the providers and the client/family to coordinate the assistance that is identified. Phone numbers for the health plans and for CCMC are also listed on DHS 8015/8016.

SECTION C: EPSDT Billing Procedures

The enhanced reimbursement ($120 for FFS in 2009*) **for comprehensive EPSDT exams** will apply under the following conditions:

1. Submission of a completed DHS **8015**

a. Attach the original completed and signed hard-copy DHS **8015** to the CMS 1500 claim, and mail to the appropriate health plan for QUEST or QExA members or to ACS for FFS clients. If the completed form is not attached to the claim, the claim cannot be processed as a comprehensive EPSDT visit; or
b. Submit electronically a completed and signed/finalized EPSDT exam through the EPSDT online tool prior to electronic submission of the claim. The health plans or MQD will match the completed electronic EPSDT form with the electronic claim.
c. Without a completed EPSDT form submitted in either hard-copy or electronic as described above, the claim cannot be processed as a comprehensive EPSDT exam and enhanced reimbursement will not be provided.

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

3. An eligible code listed in **APPENDIX 1** is used.

The enhanced reimbursement ($30 for FFS in 2009*) **for EPSDT catch-up/follow-up immunizations and screenings** will apply under the following conditions:

1. Submission of a completed DHS **8016**
   a. Attach the original completed and signed hard-copy DHS **8016** to the CMS 1500 claim, and mail to the appropriate health plan for QUEST or QExA members or to ACS for FFS clients. If the completed form is not attached to the claim, the claim cannot be processed as a comprehensive EPSDT visit; or
   b. Submit electronically a completed and signed/finalized EPSDT exam through the EPSDT online tool prior to electronic submission of the claim. The health plans or MQD will match the completed electronic EPSDT form with the electronic claim.
   c. Without a completed EPSDT form submitted in either hard-copy or electronic as described above, the claim cannot be processed as a comprehensive EPSDT exam and enhanced reimbursement will not be provided.

2. No more than two (2) follow-up visits for screening attempts will be reimbursed. For example, if on the dates of the first and second follow-up visit for an audiogram, the child was unable to comply, the provider should note this on the DHS 8016 forms and the visits will be reimbursed. However, if the child is unable to comply after the second visit, the provider should not schedule a third catch-up/follow-up visit. Instead, the audiogram should be attempted at the next EPSDT comprehensive visit.

3. An eligible code in **APPENDIX 2** is used.

APPENDIX 1: BILLING CODES FOR COMPREHENSIVE EPSDT EXAMS

Code	Modifier	Brief Description	Usage
New Patient			
99381	EP	Initial comprehensive preventive medicine E&M; infant less than 1 year of age	Initial EPSDT exam for a well infant, an infant with an acute illness, or an infant who is a child with special health care needs (CSHCN); less than 1 year of age. No other E&M can be billed for the same date of service.
99382	EP	Initial comprehensive preventive medicine E&M; age 1 through 4	Initial EPSDT exam for a well child, a child with an acute illness, or a CSHCN; age 1 through 4. No other E&M service can be billed for the same date of service.
99383	EP	Initial comprehensive preventive medicine E&M; age 5 through 11	Initial EPSDT exam for a well child, a child with an acute illness, or a CSHCN; age 5 through 11. No other E&M service can be billed for the same date of service.
99384	EP	Initial comprehensive preventive medicine E&M; age 12 through 17	Initial EPSDT exam for a well child, a child with an acute illness, or a CSHCN; age 12 through 17. No other E&M service can be billed for the same date of service.
99385	EP	Initial comprehensive preventive medicine E&M; age 18 through 20	Initial EPSDT exam for a well child, a child with an acute illness, or a CSHCN; age 18 through 20. No other E&M service can be billed for the same date of service.
Established Patient			
99391	EP	Periodic comprehensive preventive medicine E&M; infant less than 1 year of age	Periodic EPSDT exam for a well infant, an infant with an acute illness, or an infant who is a CSHCN; less than 1 year of age. No other E&M service can be billed for the same date of service.
99392	EP	Periodic comprehensive preventive medicine E&M; age 1 through 4	Periodic EPSDT exam for a well child, a child with an acute illness, or a CSHCN; age 1 through 4. No other E&M service can be billed for the same date of service.
99393	EP	Periodic comprehensive preventive medicine E&M; age 5-11	Periodic EPSDT exam for a well child, a child with an acute illness, or a CSHCN; age 5 through 11. No other E&M service can be billed for the same date of service.
99394	EP	Periodic comprehensive preventive medicine E&M; age 12-17	Periodic EPSDT exam for a well child, a child with an acute illness, or a CSHCN; age 12 through 17. No other E&M service can be billed for the same date of service.

APPENDIX 1, CONTINUED: BILLING CODES FOR COMPREHENSIVE EPSDT EXAMS

Code	Modifier	Brief Description	Usage
Established Patient			
99395	EP	Periodic comprehensive preventive medicine E&M; age 18-20	Periodic EPSDT exam for a well child, a child with an acute illness, or a CSHCN; age 18 through 20. No other E&M service can be billed for the same date of service.
99232	EP	Subsequent hospital care	Initial or periodic EPSDT exam for infant/child/youth performed during an inpatient acute hospital stay. At the time of evaluation, the infant, child, or youth may be well, have an acute illness, or be a CSHCN. No other E&M service can be billed for the same date of service.
99308	EP	Subsequent nursing facility care	Initial or periodic EPSDT exam for infant/child/youth performed during a nursing facility stay. At the time of evaluation, the infant, child, or youth may be well, have an acute illness, or be a CSHCN. No other E&M service can be billed for the same date of service.
99348	EP	Established patient home visit	Initial or periodic EPSDT exam for infant/child/youth performed in the child's home. At the time of evaluation, the infant, child, or youth may be well, have an acute illness, or be a CSHCN. No other E&M service can be billed for the same date of service. The child must be homebound/bedbound for medically appropriate reasons and the physician must be able to provide all age appropriate screening and surveillance in the home setting.
99460	EP	History and examination of a normal newborn infant (formerly code 99431)	Initial EPSDT exam of a normal infant one more or less of age in the hospital or birthing room. At the time of evaluation, the infant may be well, have an acute illness, or be a CSHCN. No other E&M service can be billed for the same date of service.
99461	EP	Normal newborn care in other than hospital or birthing room (formerly code 99432)	Initial EPSDT exam of a normal infant one more or less of age in a setting other than the hospital or birthing room. At the time of evaluation, the infant may be well, have an acute illness, or be a CSHCN. No other E&M service can be billed for the same date of service.

APPENDIX 2: BILLING CODES FOR CATCH-UP/FOLLOW-UP EPSDT EXAMS

Code	Modifier	Brief Description	Usage
99211	EP	Established patient, office or outpatient evaluation and management that may not require the presence of a physician.	Immunization catch-up, repeat screening(s), and/or screening(s) not performed during an EPSDT exam visit that do NOT require the presence of a physician.
99212	EP	Established patient, office or outpatient evaluation and management, physician performed.	Immunization catch-up, repeat screening(s), screening(s) not performed during an EPSDT exam visit, follow-up of a referral and/or follow-up on a diagnosis or treatment that require a face to face assessment by the physician.

If an E&M service on a catch-up/follow-up visit requires more than a problem focused history and examination and straightforward decision making, the codes 99213-99215 with an EP modifier should be used. Medical records must justify this level of E&M service. A DHS 8016 must be attached to the claim.

Code	Modifier	FFS Rate as of 2009*
99213	EP	$36.31
99214	EP	$56.46
99215	EP	$83.57

*Reimbursement rates in this memo are specific to the FFS fee schedule as of 2009, which is subject to change. The current fee schedule should always be consulted. Please check with the QUEST and QExA health plans for specific health plan rates.

Hawaii Early And Periodic, Screening, Diagnosis, and Treatment (EPSDT) Exam

Appendix O

Please COMPLETELY fill in this form by supplying the requested information and filling in the appropriate ○

PATIENT INFORMATION

Screen Date (MMDDYY)	Indicate the EPSDT periodic screening age being reported																				Sex	
	14 d	30 d	2 m	4 m	6 m	9 m	12 m	15 m	18 m	2 y	3 y	4 y	5 y	6 y	8 y	10 y	12 y	14 y	16 y	18 y	20 y	M	F
	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Name (Last, First, Middle Initial)	Medicaid/QUEST ID	Birthdate (MMDDYY)
	0 0	

MEASUREMENTS

For infants, head circumference and weight for length should be assessed and documented in the Medical record.

Blood Pressure	Height (In)	Weight (Lbs)	BMI #	BMI %	BMI Reference – For Information Only		
/		.			Normal < 85%	Overweight 85%-94%	Obese ≥95%

IMMUNIZATIONS GIVEN TODAY AND STATUS

								Immunization(s) Not Given	
HepB	○	PCV	○	MMR	○	Tdap	○		
DTaP	○	Rotav	○	Varicella	○	MCV4/MPSV4	○	Immunizations up to date	○
IPV	○	Influenza	○	HepA	○	HPV	○	Catch Up Scheduled	○
Hib	○	Other (List)					○	Refused (List)	○
Comments:								Contraindicated (List)	○

SCREENING DONE TODAY

		Normal	Abnormal
Vision Screening: Snellen, Allen, Tumbling Es, LEA Symbols 3y, 4y, 5y, 6y, 8y, 10y, 12y, 14y-16y, 18y		○	○
Hearing Screening: Audiometry (20-25 db screen) 4y, 5y, 6y, 8y, 10y		○	○
Developmental Screening *(see back) 9m, 18m, 24m - 36m (3 screenings required by 36 months)	PEDS: ≥ 2 predictive concerns = Abnormal ASQ: ≥ 1 domain falling below normal cut-offs = Abnormal Other (list)	○	○
Autism Screening *(see back) 18m, 24m Fail = Abnormal	CHAT M-CHAT Other (list)	○	○

	Done
Blood Lead Level 9 - 12m, 2y (2 levels required by 2 years)	○
Hgb/Hct 9m – 12m, Females-12y – 14y	○
Comments for screenings not done:	

	Y	N
Has the child seen a dentist within the past year?	○	○

As part of surveillance per the AAP/Bright Futures recommended periodicity (see back), the following should be done and documented in the medical record: TB risk assessments, lead risk assessment, psychosocial/behavioral assessments, and for adolescents- alcohol/drug use assessment, and as appropriate - dyslipidemia, STI, and cervical dysplasia screening.

REFERRALS MADE TODAY

By leaving this section blank, I am confirming that there are no referral needs.

Already referred or receiving state or specialty services.	○	H-KISS	○	PHN	○	CAMHD	○	WIC	○		
Patient/parent refused.	○	PT/OT/Speech/Audiology	○	DOE	○	DDD	○	Child Welfare	○	Dentistry	○
Behavioral Health/Substance Abuse (List name & specialty)			○	Nutrition/Exercise (List name & specialty)							○
Medical/Surgical/Developmental (List name & specialty)			○	Other(s) (List name & specialty)							○

CARE COORDINATION ASSISTANCE NEEDED

Please call patient's Health Plan for Care Coordination assistance if needed.

No Care Coordination Needed	○	Managing medical condition and/or medications	○	Obtaining foreign/sign language translation	○	Obtaining dental care (If yes, call CCMC)	○	Scheduling/Keeping appointments	○
Arranging transportation	○	Coordinating multiple appointments	○	Family needs assistance in following the POC	○	Obtaining specialty services	○	Other	○

If assistance is needed, please provide parent's/ caregiver's telephone no. The health plan will call to facilitate coordination.	List additional information or other assistance needed:
-	

Phone Numbers					
Aloha Care	808-973-1650 (Oahu) 1-800-434-1002 (Toll Free)	Kaiser QUEST	808-432-5330 (Oahu) 1-800-651-2237 (Toll Free)	CCMC Dental Resource	808-486-8030 (Oahu) 1-866-486-8030 (Toll Free)
HMSA QUEST	808-948-6486 (Oahu) 1-800-440-0640 (Toll Free)	Ohana Health Plan	1-888-846-4262	UnitedHealthcare	1-888-980-8728

PROVIDER STATEMENT: A complete EPSDT exam also includes a history (initial or interval), a physical exam, age appropriate surveillance and anticipatory guidance. By signing below, I confirm that these were performed and documented in the patient's medical record.

Provider Name (Print)	Signature	NPI #

For additional forms, contact ACS at 808-952-5570 (Oahu) or 800-235-4378 (Toll Free).

DHS 8015 (01/10)

GENERAL INSTRUCTIONS FOR DHS 8015
Submit this form with your CMS 1500 claim form.

Appendix O

The following instructions detailing the completion of the Hawaii EPSDT DHS 8015 form can also be found on the Med-QUEST Division's website, www.med-quest.us, and in the Hawaii State Medicaid Provider Manual.

Complete the form using either **black** or **blue** ink. When indicated, fill in circles. **Do not (√) check, (×) cross, or (/) line through the circles.**

Section: Patient Information
1. Fill in date of screening visit (date should match date of service on CMS 1500 Claim form)
2. If the age of the patient on the date of the exam is **NOT** at the specific age listed in the column, indicate the EPSDT periodic screening age being reported. Usually, this is the age range immediately below the age of the child. E.g. If the child is 8 months and the child has not had a 6 month EPSDT exam, select 6 months. If the child is 8 months and has had a 6 month exam, an interperiodic exam can be done, with a 9 month EPSDT exam scheduled for a later date. If the child is 8 months but almost 9 months, and has had a 6 month exam, a 9 month EPSDT exam can be selected with subsequent visits prior to the 12 month visit billed as interperiodic exams.

Section: Measurements
1. Record height and weight in English using pounds and inches.
2. Calculate BMI and BMI% for children age **2 – 20 y/o**, using the CDC website BMI calculator (http://apps.nccd.cdc.gov/dnpabmi/).

Section: Immunizations Given Today
1. Fill in the circle(s) next to all of the immunizations given at visit. Indicate if immunizations are up to date, if catch-up is scheduled, if immunizations were refused, or if immunizations were contraindicated. This section should **NOT** be left blank.

Section: Screening Done Today
1. Record the results of the vision screening by filling in the appropriate circle. Use one or more of the listed validated vision screening tools.
2. Record the results of the audiometry testing by filling in the appropriate circle. A diagnostic audiologic assessment should also follow any positive hearing screens of newborns and children less than 4 years.
3. Record the results of the developmental screening, if done, by filling in the appropriate circle. It is recommended that either the PEDS or ASQ screening tool be used. Another validated screening tool recommended by the AAP may be used. A list of these may be found in the latest AAP policy on 'Identifying Infants and Young Children with Developmental Disorders in the Medical Home' (Table 1- General Developmental Screening Tools) that can be accessed through http://aappolicy.aappublications.org/cgi/content/full/pediatrics;118/1/405
4. Record the results of the autism screening, if done, by filling in the appropriate circle. It is recommended that either the CHAT or M-CHAT screening tool be used. Another validated screening tool recommended by the AAP may be used. A list of these may be found in the latest AAP policy on 'Identifying Infants and Young Children with Developmental Disorders in the Medical Home' (Table 1- Autism Screening Tools) that can be accessed through http://aappolicy.aappublications.org/cgi/content/full/pediatrics;118/1/405
5. Fill in the circle if a blood lead level was ordered. Blood lead levels are required at 9 – 12 months and 2 years of age. A blood lead level should be done at 3 – 6 years of age if a level has never been done or risk level changes.
6. Fill in the circle if an Hgb/Hct blood level was ordered. Follow EPSDT's recommended age(s) as listed.
7. Indicate if the child has seen a dentist. Y or N should be selected.
8. If no screenings were done, leave the section blank.

Section: Referrals Made Today (Leave the section black if no referrals were made during this visit)
1. Fill in the appropriate circle(s).
2. List the program(s) and/or specialty(ies) as indicated. For medical/developmental specialties, please note the specialty and agency or individual to whom the referral was made.
3. If referrals are made, please list a current phone number for parental contact under the Care Coordination section, so that the health plan can follow-up on the referral.

**Note: If specific services or programs are not known, refer patient to H-KISS, a DOH central referral agency for developmental early intervention services. If child is school age, refer to DOE. A referral may be made even prior to establishing a diagnosis.

Section: Care Coordination Assistance Needed
1. Fill in the appropriate circle(s) next to the assistance needed for the patient. If no care coordination is needed, indicate this by selecting 'no care coordination needed'.
2. Record the patient's/parent's/caregiver's contact phone number if assistance is needed. Refer patient/parent/caregiver to appropriate Health Plan if preferred.

Section: Provider Statement
1. To be considered complete, the provider signature **MUST** be filled out along with the provider's NPI #.

Surveillance, risk assessment, and anticipatory guidance should follow the AAP/Bright Futures recommended periodicity schedule and guidelines.
The AAP/Bright Futures periodicity schedule and guidelines can be found at http://brightfutures.aap.org/3rd_Edition_Guidelines_and_Pocket_Guide.html

Tuberculin Skin Test (TST) Risk Assessment & Recommendations for Infants, Children, and Adolescents (http://aapredbook.aappublications.org)
(Bacille Calmette-Gue´rin immunization is not a contraindication to a TST.) (HIV = Human Immunodeficiency Virus; LTBI = Latent Tuberculosis Infection)
Children for whom immediate TST is indicated (Beginning as early as 3 months of age):
- Contacts of people with confirmed or suspected contagious tuberculosis (contact investigation)
- Children with radiographic or clinical findings suggesting tuberculosis disease
- Children immigrating from countries with endemic infection (eg, Asia, Middle East, Africa, Latin America, countries of the former Soviet Union) including international adoptees
- Children with travel histories to countries with endemic infection and substantial contact with indigenous people from such countries (If the child is well, the TST should be delayed for up to 10 weeks after return.)

Children who should have annual TST:
- Children infected with HIV
- Incarcerated adolescents

Children at increased risk of progression of LTBI to tuberculosis disease: Children with other medical conditions, including diabetes mellitus, chronic renal failure, malnutrition, and congenital or acquired immunodeficiencies deserve special consideration. Without recent exposure, these people are not at increased risk of acquiring tuberculosis infection. Underlying immune deficiencies associated with these conditions theoretically would enhance the possibility for progression to severe disease. Initial histories of potential exposure to tuberculosis should be included for all of these patients. If these histories or local epidemiologic factors suggest a possibility of exposure, immediate and periodic TST should be considered. An initial TST should be performed before initiation of immunosuppressive therapy, including prolonged steroid administration, use of tumor necrosis factor-alpha antagonists, or immunosuppressive therapy in any child requiring these treatments.

Hawaii Early And Periodic, Screening, Diagnosis, and Treatment (EPSDT) IMMUNIZATION CATCH UP & FOLLOW-UP FORM

Please fill in this form by supplying the requested information and filling in the appropriate O for the areas covered by today's visit

The DHS 8016 form should be used to document the completion of any screening(s) and/or immunization(s) that were attempted and not done during a comprehensive EPSDT Screening visit (8015 document). In addition, the 8016 must be used to document any immunization or screening not captured on the 8015, or not associated with a comprehensive EPSDT screening visit.

PATIENT INFORMATION

Screen Date (MMDDYY)	Name (Last, First, Middle Initial)

Medicaid/QUEST ID	Birthdate (MMDDYY)	Sex
0 0		M O F O

IMMUNIZATIONS GIVEN TODAY AND STATUS

HepB	O	PCV	O	MMR	O	Tdap	O	DTaP	O	Rotav	O	Varicella	O	MCV4/MPSV4	O		
IPV	O	Influenza	O	HepA	O	HPV	O	Hib	O	Other (List)						O	

Comments:

SCREENING DONE TODAY

		Normal	Abnormal
Vision Screening: Snellen, Allen, Tumbling Es, LEA Symbols 3y, 4y, 5y, 6y, 8y, 10y, 12y, 14y-16y, 18y		O	O
Hearing Screening: Audiometry (20-25 db screen) 4y, 5y, 6y, 8y, 10y		O	O
Dev: PEDS/ASQ *(see back) 9m, 18m, 24m - 36m (3 screenings required by 36 months)	PEDS: ≥ 2 predictive concerns = Abnormal ASQ: ≥ 1 domain falling below normal cut-offs = Abnormal Other (list)	O	O
Autism: CHAT, M-CHAT *(see back) 18m, 24m	Fail = Abnormal Other (list)	O	O

REFERRALS MADE TODAY

By leaving this section blank, I am confirming that there are no referral needs.

Already referred or receiving state or specialty services.	O	H-KISS	O	PHN			O	CAMHD	O	WIC	O						
Patient/parent refused.	O	PT/OT/Speech/Audiology	O	DOE	O	DDD	O	Child Welfare	O	Dentistry	O						
Behavioral Health/Substance Abuse (List)			O	Nutrition/Exercise (List)							O						
Medical/Surgical/Developmental (List)			O	Other(s) (List)							O						

CARE COORDINATION ASSISTANCE NEEDED

Please call patient's Health Plan for Care Coordination assistance if needed.

Phone Numbers								
	AlohaCare	808-973-1650 (Oahu) 1-800-434-1002 (Toll Free)	Kaiser QUEST	808-432-5330 (Oahu) 1-800-651-2237 (Toll Free)	CCMC Dental Resource	808-486-8030 (Oahu) 1-866-486-8030 (Toll Free)
	HMSA QUEST	808-948-6486 (Oahu) 1-800-440-0640 (Toll Free)	Ohana Health Plan	1-888-846-4262	UnitedHealthcare	1-888-980-8728

Comments:

Provider Name (Print)	Signature	NPI #

For additional forms, contact ACS at 808-952-5570 (Oahu) or 800-235-4378 (Toll Free).

DHS 8016 (01/10)

Hawaii Early And Periodic, Screening, Diagnosis, and Treatment (EPSDT) IMMUNIZATION CATCH UP & FOLLOW-UP FORM

Please fill in this form by supplying the requested information and filling in the appropriate O for the areas covered by today's visit

GENERAL INSTRUCTIONS FOR DHS 8016
Submit this form with your CMS 1500 claim form.

The following instructions detailing the completion of the Hawaii EPSDT DHS 8016 form can also be found on the Med-QUEST Division's website, www.med-quest.us, and in the Hawaii State Medicaid Provider Manual.

This form is designed to be used by providers to enter immunization(s), screening(s), and/or referral(s) that was/were attempted or not done on during a previous comprehensive EPSDT screening visit and/or not entered onto the EPSDT DHS form 8015. In addition, the EPSDT DHS 8016 form **MUST** be used to document any immunization or screening not captured on the EPSDT DHS 8015 form, or not associated with a comprehensive EPSDT screening visit. Information should be completed only for those sections that were completed during this catch-up EPSDT visit.

Complete the form using either **black** or **blue** ink. When indicated, fill in circles. **Do not (√) check, (×) cross, or (/) line through the circles.**

Section: Patient Information
1. Fill in date of screening visit (date should match date of service on CMS 1500 Claim form)

Section: Immunizations Given Today (Leave the section black if no immunizations were given during this visit)
1. Fill in the circle(s) next to all of the immunizations given at visit.

Section: Screening Done Today
1. Record the results of the vision screening by filling in the appropriate circle. Use one or more of the listed validated vision screening tools.
2. Record the results of the audiometry testing by filling in the appropriate circle. A diagnostic audiologic assessment should also follow any positive hearing screens of newborns and children less than 4 years.
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5. If no screenings were done, leave the section blank.

Section: Referrals Made Today (Leave the section black if no referrals were made during this visit)
1. Fill in the appropriate circle(s).
2. List the program(s) and/or specialty(ies) as indicated. For medical/developmental specialties, please note the specialty and agency or individual to whom the referral was made.
3. If referrals are made, please list a current phone number for parental contact under the Care Coordination section, so that the health plan can follow-up on the referral.

**Note: If specific services or programs are not known, refer patient to H-KISS, a DOH central referral agency for developmental early intervention services. If child is school age, refer to DOE. A referral may be made even prior to establishing a diagnosis.

Section: Provider Statement
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Tuberculin Skin Test (TST) Risk Assessment & Recommendations for Infants, Children, and Adolescents (http://aapredbook.aappublications.org)
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- Children with travel histories to countries with endemic infection and substantial contact with indigenous people from such countries (If the child is well, the TST should be delayed for up to 10 weeks after return.)

Children who should have annual TST:
- Children infected with HIV
- Incarcerated adolescents

Children at increased risk of progression of LTBI to tuberculosis disease: Children with other medical conditions, including diabetes mellitus, chronic renal failure, malnutrition, and congenital or acquired immunodeficiencies deserve special consideration. Without recent exposure, these people are not at increased risk of acquiring tuberculosis infection. Underlying immune deficiencies associated with these conditions theoretically would enhance the possibility for progression to severe disease. Initial histories of potential exposure to tuberculosis should be included for all of these patients. If these histories or local epidemiologic factors suggest a possibility of exposure, immediate and periodic TST should be considered. An initial TST should be performed before initiation of immunosuppressive therapy, including prolonged steroid administration, use of tumor necrosis factor-alpha antagonists, or immunosuppressive therapy in any child requiring these treatments.

Appendix O

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Periodic Screening Guidelines

ELEMENTS OF REQUIRED HEALTH SCREENING	INFANCY							EARLY CHILDHOOD					LATE CHILDHOOD					ADOLESCENCE			
AGE	1-14 DAYS	1-15 DAYS	2 MOS	4 MOS	6 MOS	9 MOS	12 MOS	15 MOS	18 MOS	2 YRS	3 YRS	4 YRS	5 YRS	6 YRS	8 YRS	10 YRS	12 YRS	14 YRS	16 YRS	18 YRS	20 YRS
HISTORY																					
Initial/Interval																					
MEASUREMENTS																					
Length/Height and Weight																					
Head Circumference																					
Weight for Length																					
Body Mass Index																					
Blood Pressure																					
SENSORY SCREENING																					
Vision																		14-16 yrs			
Hearing/Language																					
Audiogram																					
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT																					
Developmental Screening																					
Autism Screening																					
Developmental Surveillance																					
Psychosocial/Behavioral Assessment																					
Alcohol and Drug Use Assessment																					
PHYSICAL EXAMINATION																					
PROCEDURES																					
Newborn Metabolic/Hemoglobin Screening																					
Immunization																					
Hematocrit or Hemoglobin						9-12 mos											females				
Lead Risk Assessment																					
Blood Lead Level Screening						9-12 mos															
Tuberculin Skin Test																					
Dyslipidemia Screening																				18-20 yrs	
STI Screening																					
Cervical Dysplasia Screening																					
ORAL HEALTH																					
ANTICIPATORY GUIDANCE																					

Required components to be performed for the age group

Risk Assessment to be performed, with appropriate action to follow, if positive

APPENDIX P – Financial Responsibility for Transition of Care

LINDA LINGLE
GOVERNOR

LILLIAN B. KOLLER, ESQ.
DIRECTOR

HENRY OLIVA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Health Care Services Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

June 7, 2010

MEMORANDUM

ACS/QUEST/QExA MEMO NOS.
ACS M10-04
ADM-1009
ADMX-1009

TO: Acute Care Hospitals
QUEST Health Plans
QExA Health Plans

FROM: Kenneth S. Fink, MD, MGA, MPH
Med-QUEST Division Administrator

SUBJECT: TRANSITION OF CARE – CLARIFICATION ON FINANCIAL RESPONSIBILITY ROLES

The Med-QUEST Division (MQD) is providing the following table to clarify financial responsibilities of MQD programs [QUEST, QUEST Expanded Access (QExA) and fee-for-service (FFS)] concerning transition of care relating to hospital, professional, and enabling services.

If you have any question(s), please contact Patti Bazin at 692-8083 or via e-mail at pbazin@medicaid.dhs.state.hi.us.

Attachment

TRANSITION OF CARE

PURPOSE:

To clarify financial responsibility roles of QUEST Health Plans, QUEST Expanded Access (QExA) Health Plans, and (MQD) Fee-For-Service (FFS) relating to hospital (H), professional (P), and enabling services (E).

DEFINITIONS:

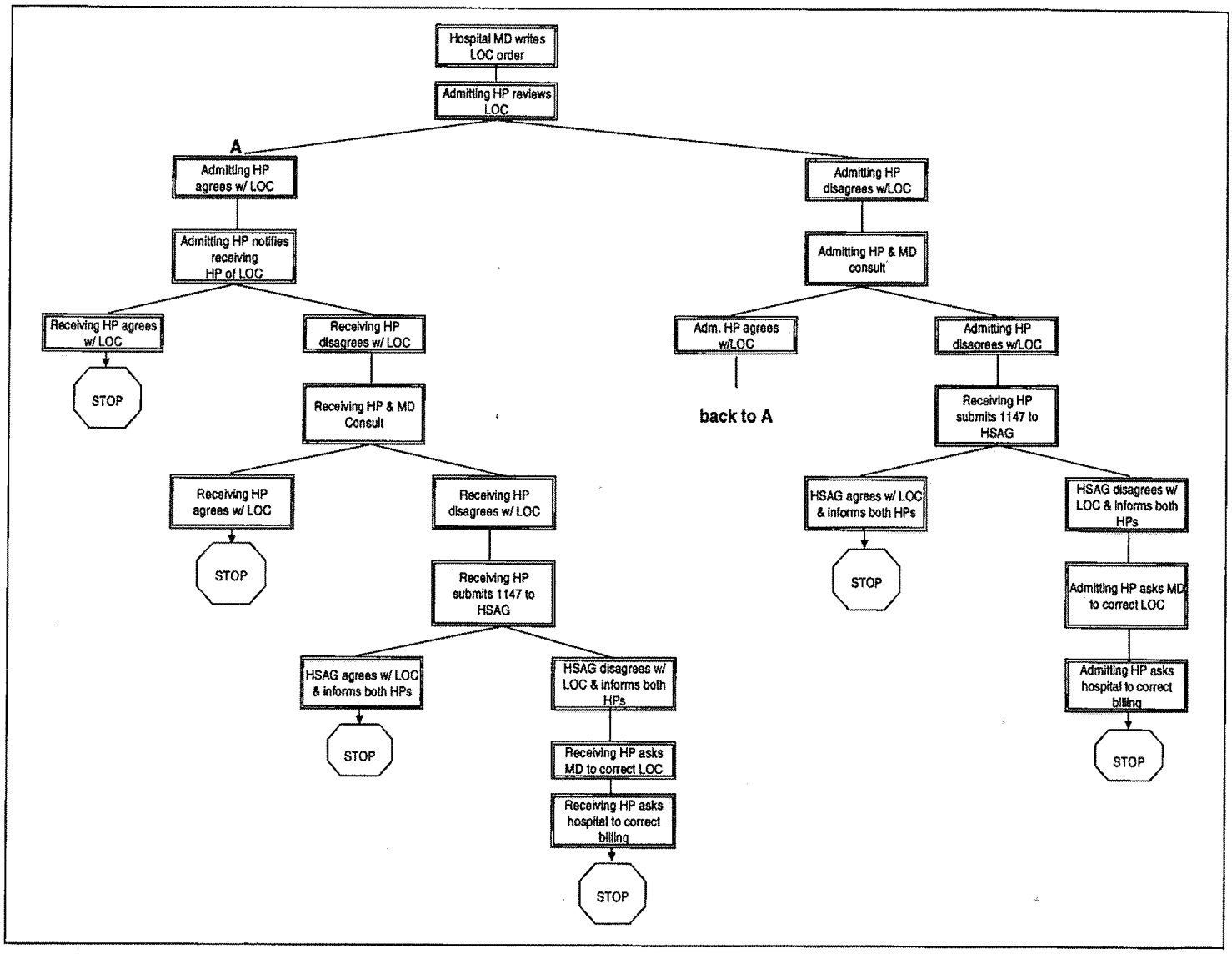
Hospital Services: Hospital services include medically necessary services for registered bed patients that are generally and customarily provided by licensed acute care general hospitals in the service area and prescribed, directed or authorized by the attending physician or other provider.
Professional Services: Professional services include services provided by physicians and any other outpatient hospital services. Examples may include medical supplies, equipment and drugs; diagnostic services; and therapeutic services including chemotherapy and radiation therapy.
Enabling Services: Enabling services include transportation (air or ground), lodging, meals, attendant/escort care, and any other services that may be needed.
Fee for Service (FFS) Window: The period of time after which a client is accepted into QUEST and before he/she is enrolled in a QUEST health plan is the FFS window. Also, any client who has less than one-month eligibility will be in FFS.
Transfer: A transfer to another facility (whether in state or out of state) is equivalent to a discharge from the original facility.
Level of Care Change: The first change from acute to less than acute level of care (sub-acute, waitlisted sub-acute, SNF, waitlisted SNF, ICF, waitlisted ICF).

The following rules apply in determining which entity (FFS, QUEST health plan, or QExA health plan) is responsible:

- **Eligibility for long-term care services and enrollment into managed care health plans** can be retroactively applied a maximum of 90 days from the date of application.
- **The FFS window applies only for QUEST**, not QExA. However, if a client deemed aged, blind, or disabled has less than one-month eligibility, he/she will be in FFS.
- **For QExA health plans, there is not a FFS window**. A QExA health plan is responsible for the client as soon as the client becomes eligible, which becomes the first day of enrollment in that health plan.
- **For acute inpatient hospitalizations**, the admitting health plan is responsible for hospital services from admission to discharge or to change in level of care, whichever comes first.
- **For professional services,** the health plan into which a client is enrolled on the date(s) the service was rendered is responsible, even if the client is in an acute inpatient hospital and enrollment is retroactively applied.
- **For enabling services,** the health plan into which a client is enrolled on the date(s) the service was rendered is responsible, including transportation, meals, lodging, and attendant care.
- **For clients sent out-of-state by the original health plan,** the original health plan is responsible for hospitalization from admission to change in level of care. The original health plan is also responsible for the transportation to get the client and attendant, if applicable, to the out-of-state services. If round trip tickets were purchased, the original health plan may bill the new responsible party for the return trip of the client and the client's attendant, if applicable. Otherwise, the health plan into which the client is enrolled becomes responsible for enabling services, including transportation, meals, and lodging. As round trip air fare is less costly than one-way fare, the health plans involved may share the cost of a round trip fare, rather than purchase one-way fares.
- **State of Hawaii Organ and Tissue Transplant (SHOTT) Program** covers clients approved as candidates by MQD for liver, lung, heart, small bowel, and kidney transplants (if Medicare does not cover the kidney transplant). The client will be disenrolled from QUEST, QExA, and FFS on the date of MQD approval and covered under the SHOTT program until at least one year post transplant.

LEVEL OF CARE RULES:

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



H=hospital, P=professional services, E=enabling services, LOC=level of care, OOS=out of state

Insurance Coverage Scenario	QUEST Responsibility	QExA Responsibility	FFS Responsibility	Comments
Acute Inpatient				
1) *QUEST health plan from admission to discharge.*	Covers H, P, and E from admission to discharge.			
2) *QExA health plan from admission to discharge.*		Covers H, P, and E from admission to discharge.		
3) *FFS admission to discharge.*			Covers H, P, and E from admission to discharge.	
4) *One QUEST health plan on admission switches to another QUEST health plan after admission.*	Admitting QUEST health plan covers H until LOC change and covers P and E once enrolled in the receiving QUEST health plan. Receiving QUEST health plan picks up H after LOC change and covers P and E once enrolled into the receiving health plan.			If the LOC remains acute for the entire hospitalization, the admitting QUEST health plan is responsible for H from admission to discharge.
5) *One QExA health plan on admission switches to another QExA health plan after admission.*		Admitting QExA health plan covers H until LOC change and covers P and E until enrolled in the receiving QExA health plan. Receiving QExA health plan picks up H after LOC change and covers P and E once enrolled into the receiving health plan.		If the LOC remains acute for the entire hospitalization, the admitting QExA health plan is responsible for H from admission to discharge.
6) *QUEST health plan on admission. Break in coverage. FFS window to discharge.*	Covers H, P, and E until eligibility ends.		Covers H, P, and E during FFS window.	If there is a break in QUEST health plan coverage and the client becomes eligible again, the client will enter the FFS window. If the LOC remains acute, FFS will be responsible from the

Insurance Coverage Scenario	QUEST Responsibility	QExA Responsibility	FFS Responsibility	Comments
				date QUEST health plan eligibility ends.
7) *QUEST health plan on admission. Change to QExA health plan after admission.*	Covers H until LOC change. Covers P and E until enrolled in a QExA health plan.	Covers P and E once enrolled in the QExA health plan. Covers H after LOC change.		If the LOC remains acute for the entire hospitalization, the admitting QUEST health plan is responsible for H from admission to discharge.
8) *FFS on admission. Change to QUEST health plan during admission.*	Covers P and E once enrolled in the QUEST health plan. Covers H after LOC change.		Covers H until LOC change. Covers P and E until enrolled in a QUEST health plan.	The FFS window applies to QUEST. If the LOC remains acute for the entire hospitalization, FFS is responsible for H from admission to discharge.
9) *FFS on admission. Change to QUEST health plan during admission. Client on SNF/ICF waitlist for 60 days. Change to QExA health plan at 61st day.*	Covers P and E once enrolled in the QUEST health plan. Covers H from LOC change through the 60th day of an SNF/ICF waitlist.	Covers H, P, and E once enrolled in the QExA health plan on the 61st day of waitlist.	Covers H until LOC change. Covers P and E until enrolled in a QUEST health plan.	The FFS window applies to QUEST.
10) *FFS on admission. Waitlisted SNF level of care while on FFS. Change to QUEST health plan.*	Covers P and E once enrolled in the QUEST health plan.		Covers H to discharge. Covers P and E until enrolled in a QUEST health plan.	
11) *FFS on admission. Change to QUEST health plan during admission. Patient goes through ADRC. Change to QExA health plan as per ADRC determination (1st day of the second month following receipt of completed ADRC packet).*	Covers P and E once enrolled in the QUEST health plan. Covers H after LOC change if this occurs during QUEST health plan.	Covers P and E once enrolled in the QExA health plan (on the 1st day of the second month following receipt of completed ADRC packet). Covers H after LOC change if this occurs during QExA health plan.	Covers H until LOC change. Covers P and E until enrolled in a QUEST health plan.	The FFS window applies to QUEST. If the LOC change occurs during FFS prior to change to a QUEST health plan or a QExA health plan, FFS would be responsible for H until discharge.

Insurance Coverage Scenario	QUEST Responsibility	QExA Responsibility	FFS Responsibility	Comments
12) *FFS on admission. Retroactive change to QExA health plan during admission.*		Covers H, P, and E from admission to discharge.		There is no FFS window in QExA.
13) *QExA health plan on admission. Eligibility lapses. FFS window. QUEST health plan before discharge and still QUEST health plan on discharge.*	Covers P and E once enrolled in the QUEST health plan. Covers H after LOC change.	Covers H, P, and E until eligibility ends.	Covers H, P, and E during FFS window prior to enrollment in a QUEST health plan. Continues to cover H until LOC change.	If the LOC remains acute for the entire hospitalization, QExA health plan is only responsible for H until the day eligibility ends. FFS is responsible for H from the date QExA health plan enrollment ends until discharge.
Transfer from acute to acute hospital in state				
14) *QUEST health plan on admission to first facility. QExA health plan before transfer/discharge to the second facility.*	Covers H during first hospitalization until transfer/discharge to second facility. Covers P and E until enrolled in a QExA health plan.	Covers P and E once enrolled in the QExA health plan during the first hospitalization. Responsible for transfer/transportation to the second facility. Covers H, P, and E at second hospital.		Transfer = discharge.
15) *QUEST health plan on admission to first facility. Break in eligibility. FFS window before transfer and during stay at second facility.*	Covers H during first hospitalization until eligibility ends. Covers P and E until eligibility ends.		Covers H, P, and E during FFS window. Responsible for transfer/transportation to the second facility. Covers H, P, and E at second hospital.	
Out of state (OOS) services				
16) *QUEST health plan authorizes OOS hospital services. Changes to QExA health plan during OOS hospital stay.*	Covers H until LOC change at OOS hospital. Covers P and E until enrolled in a QExA health plan.	Covers P and E once enrolled in the QExA health plan. Covers H after LOC change at OOS hospital.		If the QUEST health plan has round trip ticket(s), the QUEST health plan may bill the QExA health plan for the return ticket(s).

Insurance Coverage Scenario	QUEST Responsibility	QExA Responsibility	FFS Responsibility	Comments
17) *QUEST health plan authorizes OOS services. QUEST health plan during initial hospitalization through discharge from the hospital. Transfer to QExA health plan after discharge from the hospital while OOS (outpatient services, additional hospitalization).*	Covers H, P, and E for initial hospitalization.	Covers H, P, and E for additional hospitalizations. Covers P and E for outpatient services.		If QUEST health plan has round trip ticket(s), QUEST health plan may bill the QExA health plan for the return ticket(s).
18) *FFS authorizes OOS services. QUEST health plan before discharge.*	Covers P and E once enrolled in the QUEST health plan. Covers H after LOC change.		Covers H until LOC change. Covers P and E until enrolled in a QUEST health plan.	If FFS has round trip ticket(s), FFS may bill the QUEST health plan for the return ticket(s).
19) *FFS authorizes OOS services. QExA health plan before discharge.*		Covers H, P, and E once enrolled in the QExA health plan.		There is no FFS window in QExA. If FFS has round trip ticket(s) purchased prior to QExA implementation, FFS may bill QExA health plan for cost of return ticket(s).
Outpatient hospital, rehab and other services in state				
20) *QUEST health plan authorizes outpatient services. QExA health plan at the time of services.*		QExA health plan honors QUEST health plan's authorization for thirty (30) days or until an assessment is completed. Covers H, P, and E once enrolled in the QExA health plan.		
21) *QExA health plan authorizes services. Break in coverage. FFS at time of services.*			FFS honors QExA health plan's authorization. Covers H, P, and E once enrolled in FFS.	

Insurance Coverage Scenario	QUEST Responsibility	QExA Responsibility	FFS Responsibility	Comments
22) *Dental Services authorized by Cyrca. Client QUEST health plan, QExA health plan, or FFS at the time of the services.*	Covers H and P for hospital and anesthesia.	Covers H and P for hospital and anesthesia.	Covers H and P for hospital and anesthesia.	Dental services covered by Cyrca Dental. Anesthesiologist and hospital covered by the health plan effective at the time of procedure. Enabling services covered by Cyrca Dental.
SHOTT				
23) *QUEST health plan, QExA health plan, or FFS on admission. SHOTT before discharge and transplant.*	Covers H, P and E until enrolled into SHOTT	Covers H, P and E until enrolled into SHOTT.	Covers H, P and E until enrolled into SHOTT.	SHOTT covers H, P, E once enrolled into the SHOTT program.
24) *SHOTT on admission. Eligibility for SHOTT terminates during admission and enrolled in QUEST health plan, QExA health plan, or FFS.*	Covers P and E once enrolled in the QUEST health plan. Picks up H after LOC change.	Covers P and E once enrolled in the QExA health plan. Picks up H after LOC change.	Covers P and E once enrolled in FFS. Picks up H after LOC change.	SHOTT covers H from admission to LOC change. Client is disenrolled from SHOTT and enrolled into QUEST health plan, QExA health plan, or FFS on the 1st of the following month.

APPENDIX Q – Prior Authorization for Environmental Adaptability, Specialized Medical Equipment, and Monitoring Assistance

LINDA LINGLE
GOVERNOR

LILLIAN B. KOLLER
DIRECTOR

HENRY OLIVA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Health Care Services Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

June 29, 2010

MEMORANDUM

QExA Memo
ADMX-1013

TO: QExA Health Plans

FROM: Kenneth S. Fink, MD, MGA, MPH KF
Med-QUEST Division Administrator

SUBJECT: DHS POLICY GUIDANCE FOR ENVIRONMENTAL ACCESIBILITY ADAPTATIONS/HOME MODIFICATION, SPECIALIZED MEDICAL EQUIPMENT AND MOVING ASSISTANCE

This memo shall provide the Standard related to Environmental Accessibility Adaptations/ Home Modifications hereafter referred to as Environmental Accessibility Adaptations (EAA), Specialized Medical Equipment and Moving Assistance. The QUEST Expanded Access (QExA) health plans have no more than ninety (90) days, after one of these services has been approved through a health plan's prior authorization process, to implement the authorized service. As part of the implementation of this policy, both QExA health plans shall submit to the Med-QUEST Division (MQD) a list of all approved EAA, Specialized Medical Equipment, and Moving Assistance services that have not been completed. The health plans shall be required to comply with the specifications of this memo for all of the clients identified on this report. The format for submission to MQD is enclosed with this memorandum.

The QExA health plans shall submit a quarterly report to the MQD, as part of the HCBS report, that includes information identified on the "Summary of Authorization Approvals" format.

Section 40.750.3(h) defines Environmental Accessibility Adaptations as (emphasis added) "those physical adaptations to the home, required by the individual's care plan, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, **and** without which, the individual would require institutionalization."

Section 40.750.3(t) defines Specialized Medical Equipment and Supplies as "items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan."

Section 40.750.3(l) defines Moving Assistance as the packing and moving of belongings in rare instances when it is determined through an assessment by the Service Coordinator that an individual needs to relocate to a new home.

Environmental Accessibility Adaptations (EAA) Standard

EAA means items provided to give the member mobility, safety and independence in the home. The purpose of an EAA is to improve the member's quality of life with regard to health and safety and/or to delay or prevent institutionalization.

Environmental accessibility adaptations to a participant's home may include:

- Installation of ramps and grab-bars;
- Widening of doorways;
- Minimum modification of bathroom facilities;
- Installation of specialized electric and plumbing systems necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the member; and
- Installation of window air conditioners when it is necessary for the health and safety of the member.

Excluded adaptations are:

Adaptations that can be provided by the Division of Vocational Rehabilitation, the Department of Education, or by family or community resources;

- Adaptations or improvements to the member's home that are of general utility (to include materials above functional requirements) and are not of direct medical or remedial benefit to the member such as but not limited to carpeting, roof repair, or central air conditioning, etc.;
- Adaptations or improvements to the member's home that are required to meet the basic standards for compliance with state regulations for certification or licensure, or for compliance with the American Disabilities Act;
- Adaptations that add to the total square footage of the home; and
- Adaptations or improvements to the member's home when the participant is not reasonably expected to remain in the home at least 12 months.

All adaptations shall be provided by a licensed contractor in accordance with applicable state and county building codes, as appropriate.

The Service Coordinator shall ensure that the EAA is authorized and specified in the care plan. The Service Coordinator or other health plan representative shall:

1. Consult with a physical therapist, occupational therapist, and the Disability and Communication Access Board's architectural access committee, as appropriate, to determine the adequacy, appropriateness and specifications for the adaptations. Consultants should make a home visit and/or be provided photos of the area to be improved for review;
2. Sufficiently detail the scope of services to avoid confusion during construction. A clear definition of scope of services assures few to no change orders that increase the cost of provision of these services;
3. Ensure that the member and/or his/her family authorizes the approval of scope of services;
4. Obtain approval from the landlord, Hawaiian Homestead, etc., prior to any EAA if the home is a rental and/or on leasehold land (i.e., Hawaiian Homestead), if applicable;
5. Follow health plan procurement procedures to solicit quotations for purchases from licensed contractors for the completion of the adaptations;
6. Choose a licensed contractor based upon the quotations for purchases received and arrange for the work to be done. Materials used for the EAA should be the most practical and cost effective without jeopardizing quality. If the choice of licensed contractor is not the lowest quote, document the rational for not choosing the lowest quote;
7. Maintain documentation of the quotations for purchases information, the supplies purchased, and work performed in the member's record;
8. Record service cost in the member's record; and
9. Monitor installation/construction until completion.

Specialized Medical Equipment and Supplies (SME) Standard

Health plans' provision of specialized medical equipment and supplies includes responsibility for the purchase, rental, lease, warranty costs, cost of professional and technical services to assess the client for needed DME/SME, delivery, installation, training, maintenance, repairs, and removal of devices, controls, or appliances, specified in the care plan. SME shall enable individuals to increase and/or maintain their abilities to perform activities of daily living, or to perceive, control, participate in, or communicate with the environment in which they live.

All adaptations shall be provided by a retail, wholesale or DME/SME supplier that is an accredited organization licensed to do business in the State of Hawaii.

The Service Coordinator shall ensure that the SME is authorized and specified in the care plan. The Service Coordinator or other health plan representative shall:

1. Consult with a physical therapist or occupational therapist to determine the specifications for the equipment, if appropriate. Consultants should make a home visit for complex situations;
2. Follow health plan procurement procedures to solicit quotations for purchases from retail, wholesale and DME/SME suppliers for the specifications of the equipment;
3. Choose a retail, wholesale, or DME/SME supplier based upon the quotations for purchases received and arrange for the equipment;
4. Maintain documentation of the quotations for purchases information, the supplies purchased, and work performed in the member's record;
5. Record service cost in the member's record; and
6. Monitor process for obtaining equipment until completion.

Moving Assistance

The Service Coordinator shall ensure that the moving assistance is authorized and specified in the care plan. The Service Coordinator or other health plan representative shall:

1. Perform an assessment of the home and client to authorize the need for this service. Part of the assessment assures that the client's relocation is necessary to prevent a decline in functioning or that failure to relocate might lead to institutionalization;
2. Investigate all options to assure that the client moving to another location is the only option for the client and is medically necessary (i.e., a client who could previously walk, but now is in a wheelchair and is living on the third floor of an apartment building without an elevator) or is due to an unresolvable social situation (i.e., there is an infestation of pests that cannot be ameliorated by pest control);
3. Collaborate with other community organizations to assist the member in obtaining housing, as appropriate; and
4. Follow their health plan procurement procedures to solicit quotations for a mover who can perform the services adequately once the location to move is obtained.

Enclosure

Summary of Authorization Approvals
Health Plan:

Last Name	First Name	Medicaid ID #	Service Approved (EAA/ SME/ Moving Assistance)	Date of Approval	Anticipated Date of Completion	Summary of status of implementation

APPENDIX R – Health Care Acquired Conditions (HCAC)

HAC	CC/MCC (ICD-9-CM Code)
Foreign Object Retained After Surgery	998.4 (CC) 998.7 (CC)
Air Embolism	999.1 (MCC)
Blood Incompatibility	999.60 (CC) 999.61 (CC) 999.62 (CC) 999.63 (CC) 999.69 (CC)
Pressure Ulcer Stages III & IV	707.23 (MCC) 707.24 (MCC)
Falls and Trauma: - Fracture - Dislocation - Intracranial Injury - Crushing Injury - Burn - Electric Shock	Codes within these ranges on the CC/MCC list: 800-829 830-839 850-854 925-929 940-949 991-994
Catheter-Associated Urinary Tract Infection (UTI)	996.64 (CC) Also excludes the following from acting as a CC/MCC: 112.2 (CC) 590.10 (CC) 590.11 (MCC) 590.2 (MCC) 590.3 (CC) 590.80 (CC) 590.81 (CC) 595.0 (CC) 597.0 (CC) 599.0 (CC)
Vascular Catheter-Associated Infection	999.31 (CC)
Manifestations of Poor Glycemic Control	250.10-250.13 (MCC) 250.20-250.23 (MCC) 251.0 (CC) 249.10-249.11 (MCC) 249.20-249.21 (MCC)
Surgical Site Infections	
Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)	519.2 (MCC) And one of the following procedure codes: 36.10–36.19

HAC	CC/MCC (ICD-9-CM Code)
Surgical Site Infection Following Certain Orthopedic Procedures	996.67 (CC) 998.59 (CC) And one of the following procedure codes: 81.01-81.08, 81.23-81.24, 81.31-81.38, 81.83, 81.85
Surgical Site Infection Following Bariatric Surgery for Obesity	*Principal Diagnosis* – 278.01 998.59 (CC) And one of the following procedure codes: 44.38, 44.39, or 44.95
Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures	415.11 (MCC) 415.19 (MCC) 453.40-453.42 (CC) And one of the following procedure codes: 00.85-00.87, 81.51-81.52, or 81.54

APPENDIX S – Attorney General Forms

AG Form 103F1
General Conditions (AG Form 103F)

CONTRACT NO. _____

STATE OF HAWAI'I
CONTRACT FOR HEALTH AND HUMAN SERVICES: COMPETITIVE PURCHASE OF SERVICES

This Contract, executed on the respective dates indicated below, is effective as of

_____ □ _____, 20 _____ between the _____

_____,
(Name of the state department, agency board or commission)

_____

State of Hawai'i ("STATE"), by its _____
(Title of person signing for the STATE)

whose address is: _____

_____

_____

and _____,
(Name of PROVIDER)

("PROVIDER"), a _____,
(Legal form of PROVIDER i.e., Corporation, Limited Liability Company, etc.)

under the laws of the State of _____ whose business street address and taxpayer identification numbers are as follows:

Business street address:

_____

_____

_____

Mailing address if different than business street address:

_____

_____

_____

Federal employer identification number: _____

Hawai'i general excise tax number: _____

RECITALS

A. This Contract is for a competitive purchase of services (a "Competitive POS"), as defined in section 103F-402, Hawaii Revised Statutes ("HRS"), and chapter 3-143, Hawai'i Administrative Rules.

B. The STATE needs the health and human services described in this Contract and its attachments ("Required Services") and the PROVIDER agrees to provide the Required Services.

C. Money is available to fund this Contract pursuant to:

(1) _____,
(Identify state sources)

in the amount of _____, or
(state funding)

(2) _____,
(Identify federal sources)

in the amount of _____ □ _____, or both.
(federal funding)

D. The STATE is authorized to enter into this Contract pursuant to:

_____
(Legal authority for Contracts)

E. The undersigned representative of the PROVIDER represents, and the STATE relies upon such representation, that he or she has authority to sign this Contract by virtue of (check any or all that apply):

☐ corporate resolutions of the PROVIDER or other authorizing documents such as partnership resolutions;

☐ corporate by-laws of the PROVIDER, or other similar operating documents of the PROVIDER, such as a partnership contract or limited liability company operating contract;

☐ the PROVIDER is a sole proprietor and as such does not require any authorizing documents to sign this Contract;

☐ other evidence of authority to sign:

_____

F. The PROVIDER has provided a "Certificate of Insurance" to the STATE that shows to the satisfaction of the STATE that the PROVIDER has obtained liability insurance

which complies with paragraph 1.4 of the General Conditions of this Contract and with any relevant special condition of this Contract.

G. The PROVIDER produced, and the STATE inspected, a tax clearance certificate as required by section 103-53, HRS.

NOW, THEREFORE, in consideration of the promises contained in this Contract, the STATE and the PROVIDER agree as follows:

1. Scope of Services. The PROVIDER shall, in a proper and satisfactory manner as determined by the STATE, provide the Required Services set forth in Attachment "1" to this Contract, which is hereby made a part of this Contract, and the Request for Proposals ("RFP"), and the PROVIDER's Proposal, which are incorporated in this Contract by reference. In the event that there is a conflict among the terms of this Contract, and either the Proposal or the RFP, or both, then the terms of this Contract shall control.

2. Time of Performance. The PROVIDER shall provide the Required Services from _____□_____, 20 _____, to _____□_____, 20 _____, as set forth in Attachment "2" to this Contract, which is hereby made a part of this Contract.

3. Certificate of Exemption from Civil Service. The Certificate of Exemption from Civil Service is attached and made a part of this Contract.

4. Standards of Conduct Declaration. The Standards of Conduct Declaration of the PROVIDER is attached and made a part of this Contract.

5. General and Special Conditions. The General Conditions for Health and Human Services Contracts ("General Conditions") and any Special Conditions are attached hereto and made a part of this Contract. In the event of a conflict between the General Conditions and the Special Conditions, the Special Conditions shall control.

6. Notices. Any written notice required to be given by any party under this Contract shall be (a) delivered personally, or (b) sent by United States first class mail, postage prepaid.

Notice required to be given to the STATE shall be sent to:

_____

_____.

Notice to the PROVIDER shall be sent to the mailing address as indicated on page 1. A notice shall be deemed to have been received three (3) days after mailing or at the time of actual receipt, whichever is earlier. The PROVIDER is responsible for notifying the STATE in writing of any change of address.

IN VIEW OF THE ABOVE, the parties execute this Contract by their signatures below.

STATE

By _____
(Signature)

Print Name _____

Print Title _____

_____

Date _____

FUNDING AGENCY (to be signed by head of funding agency if other than the Contracting Agency)

By _____
(Signature)

Print Name _____

Print Title _____

_____

Date _____

CONTRACT NO. _____

CORPORATE SEAL
(if available)

PROVIDER

By _____
(Signature)

Print Name _____

Print Title _____

_____

Date _____

APPROVED AS TO FORM:

_____
Deputy Attorney General

CONTRACT NO. _____

GENERAL CONDITIONS FOR HEALTH & HUMAN SERVICES CONTRACTS
TABLE OF CONTENTS

GENERAL CONDITIONS FOR HEALTH & HUMAN SERVICES CONTRACTS

1. Representations and Conditions Precedent

1.1 Contract Subject to the Availability of State and Federal Funds.

1.1.1 State Funds. This Contract is, at all times, subject to the appropriation and allotment of state funds, and may be terminated without liability to either the PROVIDER or the STATE in the event that state funds are not appropriated or available.

1.1.2 Federal Funds. To the extent that this Contract is funded partly or wholly by federal funds, this Contract is subject to the availability of such federal funds. The portion of this Contract that is to be funded federally shall be deemed severable, and such federally funded portion may be terminated without liability to either the PROVIDER or the STATE in the event that federal funds are not available. In any case, this Contract shall not be construed to obligate the STATE to expend state funds to cover any shortfall created by the unavailability of anticipated federal funds.

1.2 Representations of the PROVIDER. As a necessary condition to the formation of this Contract, the PROVIDER makes the representations contained in this paragraph, and the STATE relies upon such representations as a material inducement to entering into this Contract.

1.2.1 Compliance with Laws. As of the date of this Contract, the PROVIDER complies with all federal, state, and county laws, ordinances, codes, rules, and regulations, as the same may be amended from time to time, that in any way affect the PROVIDER's performance of this Contract.

1.2.2 Licensing and Accreditation. As of the date of this Contract, the PROVIDER holds all licenses and accreditations required under applicable federal, state, and county laws, ordinances, codes, rules, and regulations to provide the Required Services under this Contract.

1.3 Compliance with Laws. The PROVIDER shall comply with all federal, state, and county laws, ordinances, codes, rules, and regulations, as the same may be amended from time to time, that in any way affect the PROVIDER's performance of this Contract, including but not limited to the laws specifically enumerated in this paragraph:

1.3.1 Smoking Policy. The PROVIDER shall implement and maintain a written smoking policy as required by Chapter 328K, Hawaii Revised Statutes (HRS), or its successor provision.

1.3.2 Drug Free Workplace. The PROVIDER shall implement and maintain a drug free workplace as required by the Drug Free Workplace Act of 1988.

1.3.3 Persons with Disabilities. The PROVIDER shall implement and maintain all practices, policies, and procedures required by federal, state, or county law, including but not limited to the Americans with Disabilities Act (42 U.S.C. §12101, et seq.), and the Rehabilitation Act (29 U.S.C.§701, et seq.).

1.3.4 Nondiscrimination. No person performing work under this Contract, including any subcontractor, employee, or agent of the PROVIDER, shall engage in any discrimination that is prohibited by any applicable federal, state, or county law.

1.4 Insurance Requirements. The PROVIDER shall obtain from a company authorized by law to issue such insurance in the State of Hawai'i commercial general liability insurance ("liability insurance") in an amount of at least TWO MILLION AND NO/100 DOLLARS ($2,000,000.00) coverage for bodily injury and property damage resulting from the PROVIDER's performance under this Contract. The PROVIDER shall maintain in effect this liability insurance until the STATE certifies that the PROVIDER's work under the Contract has been completed satisfactorily.

The liability insurance shall be primary and shall cover the insured for all work to be performed under the Contract, including changes, and all work performed incidental thereto or directly or indirectly connected therewith.

A certificate of the liability insurance shall be given to the STATE by the PROVIDER. The certificate shall provide that the STATE and its officers and employees are Additional Insureds. The certificate shall provide that the coverages being certified will not be cancelled or materially changed without giving the STATE at least 30 days prior written notice by registered mail.

Should the "liability insurance" coverages be cancelled before the PROVIDER's work under the Contract is certified by the STATE to have been completed satisfactorily, the PROVIDER shall immediately procure replacement insurance that complies in all respects with the requirements of this section.

Nothing in the insurance requirements of this Contract shall be construed as limiting the extent of PROVIDER's responsibility for payment of damages resulting from its operations under this Contract, including the PROVIDER's separate and independent duty to defend, indemnify, and hold the STATE and its officers and employees harmless pursuant to other provisions of this Contract.

1.5 Notice to Clients. Provided that the term of this Contract is at least one year in duration, within 180 days after the effective date of this Contract, the PROVIDER shall create written procedures for the orderly termination of services to any clients receiving the Required Services under this Contract, and for the transition to services supplied by another provider upon termination of this Contract, regardless of the circumstances of such termination. These procedures shall include, at

the minimum, timely notice to such clients of the termination of this Contract, and appropriate counseling.

1.6 Reporting Requirements. The PROVIDER shall submit a Final Project Report to the STATE containing the information specified in this Contract if applicable, or otherwise satisfactory to the STATE, documenting the PROVIDER's overall efforts toward meeting the requirements of this Contract, and listing expenditures actually incurred in the performance of this Contract. The PROVIDER shall return any unexpended funds to the STATE.

1.7 Conflicts of Interest. In addition to the Certification provided in the Standards of Conduct Declaration to this Contract, the PROVIDER represents that neither the PROVIDER nor any employee or agent of the PROVIDER, presently has any interest, and promises that no such interest, direct or indirect, shall be acquired, that would or might conflict in any manner or degree with the PROVIDER's performance under this Contract.

2. Documents and Files

2.1 Confidentiality of Material.

2.1.1 Proprietary or Confidential Information. All material given to or made available to the PROVIDER by virtue of this Contract that is identified as proprietary or confidential information shall be safeguarded by the PROVIDER and shall not be disclosed to any individual or organization without the prior written approval of the STATE.

2.1.2 Uniform Information Practices Act. All information, data, or other material provided by the PROVIDER to the STATE shall be subject to the Uniform Information Practices Act, chapter 92F, HRS, and any other applicable law concerning information practices or confidentiality.

2.2 Ownership Rights and Copyright. The STATE shall have complete ownership of all material, both finished and unfinished that is developed, prepared, assembled, or conceived by the PROVIDER pursuant to this Contract, and all such material shall be considered "works made for hire." All such material shall be delivered to the STATE upon expiration or termination of this Contract. The STATE, in its sole discretion, shall have the exclusive right to copyright any product, concept, or material developed, prepared, assembled, or conceived by the PROVIDER pursuant to this Contract.

2.3 Records Retention. The PROVIDER and any subcontractors shall maintain the books and records that relate to the Contract, and any cost or pricing data for three (3) years from the date of final payment under the Contract. In the event that any litigation, claim, investigation, audit, or other action involving the records retained under this provision arises, then such records shall be retained for three (3) years from the date of final payment, or the date of the resolution of the action, whichever occurs later. During the period that records are retained under this section, the

PROVIDER and any subcontractors shall allow the STATE free and unrestricted access to such records.

3. Relationship between Parties

3.1 Coordination of Services by the STATE. The STATE shall coordinate the services to be provided by the PROVIDER in order to complete the performance required in the Contract. The PROVIDER shall maintain communications with the STATE at all stages of the PROVIDER's work, and submit to the STATE for resolution any questions which may arise as to the performance of this Contract.

3.2 Subcontracts and Assignments. The PROVIDER may assign or subcontract any of the PROVIDER's duties, obligations, or interests under this Contract, but only if (i) the PROVIDER obtains the prior written consent of the STATE and (ii) the PROVIDER's assignee or subcontractor submits to the STATE a tax clearance certificate from the Director of Taxation, State of Hawai'i, and the Internal Revenue Service showing that all delinquent taxes, if any, levied or accrued under state law against the PROVIDER's assignee or subcontractor have been paid. Additionally, no assignment by the PROVIDER of the PROVIDER's right to compensation under this Contract shall be effective unless and until the assignment is approved by the Comptroller of the State of Hawai'i, as provided in section 40-58, HRS.

3.3 Change of Name. When the PROVIDER asks to change the name in which it holds this Contract, the STATE, shall, upon receipt of a document acceptable or satisfactory to the STATE indicating such change of name such as an amendment to the PROVIDER's articles of incorporation, enter into an amendment to this Contract with the PROVIDER to effect the change of name. Such amendment to this Contract changing the PROVIDER's name shall specifically indicate that no other terms and conditions of this Contract are thereby changed, unless the change of name amendment is incorporated with a modification or amendment to the Contract under paragraph 4.1 of these General Conditions.

3.4 Independent Contractor Status and Responsibilities, Including Tax Responsibilities.

3.4.1 Independent Contractor. In the performance of services required under this Contract, the PROVIDER is an "independent contractor," with the authority and responsibility to control and direct the performance and details of the work and services required under this Contract; however, the STATE shall have a general right to inspect work in progress to determine whether, in the STATE's opinion, the services are being performed by the PROVIDER in compliance with this Contract.

3.4.2 Contracts with Other Individuals and Entities. Unless otherwise provided by special condition, the STATE shall be free to contract with other individuals and entities to provide services similar to those performed by the Provider under this Contract, and the

PROVIDER shall be free to contract to provide services to other individuals or entities while under contract with the STATE.

3.4.3 PROVIDER's Employees and Agents. The PROVIDER and the PROVIDER's employees and agents are not by reason of this Contract, agents or employees of the State for any purpose. The PROVIDER and the PROVIDER's employees and agents shall not be entitled to claim or receive from the STATE any vacation, sick leave, retirement, workers' compensation, unemployment insurance, or other benefits provided to state employees. Unless specifically authorized in writing by the STATE, the PROVIDER and the PROVIDER's employees and agents are not authorized to speak on behalf and no statement or admission made by the PROVIDER or the PROVIDER's employees or agents shall be attributed to the STATE, unless specifically adopted by the STATE in writing.

3.4.4 PROVIDER's Responsibilites. The PROVIDER shall be responsible for the accuracy, completeness, and adequacy of the PROVIDER's performance under this Contract.

Furthermore, the PROVIDER intentionally, voluntarily, and knowingly assumes the sole and entire liability to the PROVIDER's employees and agents, and to any individual not a party to this Contract, for all loss, damage, or injury caused by the PROVIDER, or the PROVIDER's employees or agents in the course of their employment.

The PROVIDER shall be responsible for payment of all applicable federal, state, and county taxes and fees which may become due and owing by the PROVIDER by reason of this Contract, including but not limited to (i) income taxes, (ii) employment related fees, assessments, and taxes, and (iii) general excise taxes. The PROVIDER also is responsible for obtaining all licenses, permits, and certificates that may be required in order to perform this Contract.

The PROVIDER shall obtain a general excise tax license from the Department of Taxation, State of Hawai'i, in accordance with section 237-9, HRS, and shall comply with all requirements thereof. The PROVIDER shall obtain a tax clearance certificate from the Director of Taxation, State of Hawai'i, and the Internal Revenue Service showing that all delinquent taxes, if any, levied or accrued under state law against the PROVIDER have been paid and submit the same to the STATE prior to commencing any performance under this Contract. The PROVIDER shall also be solely responsible for meeting all requirements necessary to obtain the tax clearance certificate required for final payment under section 103-53, HRS, and these General Conditions.

The PROVIDER is responsible for securing all employee-related insurance coverage for the PROVIDER and the PROVIDER's employees and agents that is or may be required by law, and for payment of all premiums, costs, and other liabilities associated with securing the insurance coverage.

3.5 Personnel Requirements.

3.5.1 Personnel. The PROVIDER shall secure, at the PROVIDER's own expense, all personnel required to perform this Contract, unless otherwise provided in this Contract.

3.5.2 Requirements. The PROVIDER shall ensure that the PROVIDER's employees or agents are experienced and fully qualified to engage in the activities and perform the services required under this Contract, and that all applicable licensing and operating requirements imposed or required under federal, state, or county law, and all applicable accreditation and other standards of quality generally accepted in the field of the activities of such employees and agents are complied with and satisfied.

4. Modification and Termination of Contract

4.1 Modification of Contract.

4.1.1 In Writing. Any modification, alteration, amendment, change, or extension of any term, provision, or condition of this Contract permitted by this Contract shall be made by written amendment to this Contract, signed by the PROVIDER and the STATE.

4.1.2 No Oral Modification. No oral modification, alteration, amendment, change, or extension of any term, provision or condition of this Contract shall be permitted.

4.1.3 Tax Clearance. The STATE may, at its discretion, require the PROVIDER to submit to the STATE, prior to the STATE's approval of any modification, alteration, amendment, change, or extension of any term, provision, or condition of this Contract, a tax clearance from the Director of Taxation, State of Hawai'i, and the Internal Revenue Service showing that all delinquent taxes, if any, levied or accrued under state and federal law against the PROVIDER have been paid.

4.2 Termination in General. This Contract may be terminated in whole or in part because of a reduction of funds available to pay the PROVIDER, or when, in its sole discretion, the STATE determines (i) that there has been a change in the conditions upon which the need for the Required Services was based, or (ii) that the PROVIDER has failed to provide the Required Services adequately or satisfactorily, or (iii) that other good cause for the whole or partial termination of this Contract exists. Termination under this section shall be made by a written notice sent to the PROVIDER ten (10) working days prior to the termination date that includes a brief statement of the reason for the termination. If the Contract is terminated under this paragraph, the PROVIDER shall cooperate with the STATE to effect an orderly transition of services to clients.

4.3 Termination for Necessity or Convenience. If the STATE determines, in its sole discretion, that it is necessary or convenient, this Contract may be terminated in whole or in part at the option of the STATE upon ten (10) working days' written notice to the PROVIDER. If the STATE elects to terminate under this paragraph, the PROVIDER shall be entitled to reasonable payment as determined by the STATE for satisfactory services rendered under this Contract up to the time of termination. If the STATE elects to terminate under this section, the PROVIDER shall cooperate with the STATE to effect an orderly transition of services to clients.

4.4 Termination by PROVIDER. The PROVIDER may withdraw from this Contract after obtaining the written consent of the STATE. The STATE, upon the PROVIDER's withdrawal, shall determine whether payment is due to the PROVIDER, and the amount that is due. If the STATE consents to a termination under this paragraph, the PROVIDER shall cooperate with the STATE to effect an orderly transition of services to clients.

4.5 STATE's Right of Offset. The STATE may offset against any monies or other obligations that STATE owes to the PROVIDER under this Contract, any amounts owed to the State of Hawai'i by the PROVIDER under this Contract, or any other contract, or pursuant to any law or other obligation owed to the State of Hawai'i by the PROVIDER, including but not limited to the payment of any taxes or levies of any kind or nature. The STATE shall notify the PROVIDER in writing of any exercise of its right of offset and the nature and amount of such offset. For purposes of this paragraph, amounts owed to the State of Hawai'i shall not include debts or obligations which have been liquidated by contract with the PROVIDER, and that are covered by an installment payment or other settlement plan approved by the State of Hawai'i, provided, however, that the PROVIDER shall be entitled to such exclusion only to the extent that the PROVIDER is current, and in compliance with, and not delinquent on, any payments, obligations, or duties owed to the State of Hawai'i under such payment or other settlement plan.

5. Indemnification

5.1 Indemnification and Defense. The PROVIDER shall defend, indemnify, and hold harmless the State of Hawai'i, the contracting agency, and their officers, employees, and agents from and against any and all liability, loss, damage, cost, expense, including all attorneys' fees, claims, suits, and demands arising out of or in connection with the acts or omissions of the PROVIDER or the PROVIDER's employees, officers, agents, or subcontractors under this Contract. The provisions of this paragraph shall remain in full force and effect notwithstanding the expiration or early termination of this Contract.

5.2 Cost of Litigation. In case the STATE shall, without any fault on its part, be made a party to any litigation commenced by or against the PROVIDER in connection with this Contract, the PROVIDER shall pay any cost and expense incurred by or imposed on the STATE, including attorneys' fees.

6. Publicity

6.1 Acknowledgment of State Support. The PROVIDER shall, in all news releases, public statements, announcements, broadcasts, posters, programs, computer postings, and other printed, published, or electronically disseminated materials relating to the PROVIDER's performance under this Contract, acknowledge the support by the State of Hawai'i and the purchasing agency.

6.2 PROVIDER's Publicity Not Related to Contract. The PROVIDER shall not refer to the STATE, or any office, agency, or officer thereof, or any state employee, or to the services or goods, or both provided under this Contract, in any of the PROVIDER's publicity not related to the PROVIDER's performance under this Contract, including but not limited to commercial advertisements, recruiting materials, and solicitations for charitable donations.

7. Miscellaneous Provisions

7.1 Nondiscrimination. No person performing work under this Contract, including any subcontractor, employee, or agent of the PROVIDER, shall engage in any discrimination that is prohibited by any applicable federal, state, or county law.

7.2 Paragraph Headings. The paragraph headings appearing in this Contract have been inserted for the purpose of convenience and ready reference. They shall not be used to define, limit, or extend the scope or intent of the sections to which they pertain.

7.3 Antitrust Claims. The STATE and the PROVIDER recognize that in actual economic practice, overcharges resulting from antitrust violations are in fact usually borne by the purchaser. Therefore, the PROVIDER hereby assigns to the STATE any and all claims for overcharges as to goods and materials purchased in connection with this Contract, except as to overcharges which result from violations commencing after the price is established under this Contract and which are not passed on to the STATE under an escalation clause.

7.4 Governing Law. The validity of this Contract and any of its terms or provisions, as well as the rights and duties of the parties to this Contract, shall be governed by the laws of the State of Hawai'i. Any action at law or in equity to enforce or interpret the provisions of this Contract shall be brought in a state court of competent jurisdiction in Honolulu, Hawai'i.

7.5 Conflict between General Conditions and Procurement Rules. In the event of a conflict between the General Conditions and the Procurement Rules or a Procurement Directive, the Procurement Rules or any Procurement Directive in effect on the date this Contract became effective shall control and are hereby incorporated by reference.

7.6 Entire Contract. This Contract sets forth all of the contracts, conditions, understandings, promises, warranties, and representations between the STATE and the PROVIDER relative to this Contract. This Contract supersedes all prior agreements, conditions, understandings,

promises, warranties, and representations, which shall have no further force or effect. There are no contracts, conditions, understandings, promises, warranties, or representations, oral or written, express or implied, between the STATE and the PROVIDER other than as set forth or as referred to herein.

7.7 Severability. In the event that any provision of this Contract is declared invalid or unenforceable by a court, such invalidity or unenforceability shall not affect the validity or enforceability of the remaining terms of this Contract.

7.8 Waiver. The failure of the STATE to insist upon the strict compliance with any term, provision, or condition of this Contract shall not constitute or be deemed to constitute a waiver or relinquishment of the STATE's right to enforce the same in accordance with this Contract. The fact that the STATE specifically refers to one provision of the Procurement Rules or one section of the Hawai'i Revised Statutes, and does not include other provisions or statutory sections in this Contract shall not constitute a waiver or relinquishment of the STATE's rights or the PROVIDER's obligations under the Procurement Rules or statutes.

7.9 Execution in Counterparts. This Contract may be executed in several counterparts, each of which shall be regarded as an original and all of which shall constitute one instrument.

8. Confidentiality of Personal Information

8.1 Definitions.

8.1.1 Personal Information. "Personal Information" means an individual's first name or first initial and last name in combination with any one or more of the following data elements, when either name or data elements are not encrypted:

1) Social Security number;

2) Driver's license number or Hawaii identification card number; or

3) Account number, credit or debit card number, access code, or password that would permit access to an individual's financial information.

Personal information does not include publicly available information that is lawfully made available to the general public from federal, state, or local government records.

8.1.2 Technological Safeguards. "Technological safeguards" means the technology and the policy and procedures for use of the technology to protect and control access to personal information.

8.2 Confidentiality of Material.

8.2.1 Safeguarding of Material. All material given to or made available to the PROVIDER by the STATE by virtue of this Contract which is identified as personal information, shall be safeguarded by the PROVIDER and shall not be disclosed without the prior written approval of the STATE.

8.2.2 Retention, Use, or Disclosure. PROVIDER agrees not to retain, use, or disclose personal information for any purpose other than as permitted or required by this Contract.

8.2.3 Implementation of Technological Safeguards. PROVIDER agrees to implement appropriate "technological safeguards" that are acceptable to the STATE to reduce the risk of unauthorized access to personal information.

8.2.4 Reporting of Security Breaches. PROVIDER shall report to the STATE in a prompt and complete manner any security breaches involving personal information.

8.2.5 Mitigation of Harmful Effect. PROVIDER agrees to mitigate, to the extent practicable, any harmful effect that is known to PROVIDER because of a use or disclosure of personal information by PROVIDER in violation of the requirements of this paragraph.

8.2.6 Log of Disclosures. PROVIDER shall complete and retain a log of all disclosures made of personal information received from the STATE, or personal information created or received by PROVIDER on behalf of the STATE.

8.3 Security Awareness Training and Confidentiality Agreements.

8.3.1 Certification of Completed Training. PROVIDER certifies that all of its employees who will have access to the personal information have completed training on security awareness topics related to protecting personal information.

8.3.2 Certification of Confidentiality Agreements. PROVIDER certifies that confidentiality agreements have been signed by all of its employees who will have access to the personal information acknowledging that:

1) The personal information collected, used, or maintained by the PROVIDER will be treated as confidential;

2) Access to the personal information will be allowed only as necessary to perform the Contract; and

3) Use of the personal information will be restricted to uses consistent with the services subject to this Contract.

8.4 Termination for Cause. In addition to any other remedies provided for by this Contract, if the STATE learns of a material breach by PROVIDER of this paragraph by PROVIDER, the STATE may at its sole discretion:

1) Provide an opportunity for the PROVIDER to cure the breach or end the violation; or

2) Immediately terminate this Contract.

In either instance, the PROVIDER and the STATE shall follow chapter 487N, HRS, with respect to notification of a security breach of personal information.

8.5 Records Retention.

8.5.1 Destruction of Personal Information. Upon any termination of this Contract, PROVIDER shall, pursuant to chapter 487R, HRS, destroy all copies (paper or electronic form) of personal information received from the STATE.

8.5.2 Maintenance of Files, Books, Records. The PROVIDER and any subcontractors shall maintain the files, books, and records, that relate to the Contract, including any personal information created or received by the PROVIDER on behalf of the STATE, and any cost or pricing data, for three (3) years after the date of final payment under the Contract. The personal information shall continue to be confidential and shall not be disclosed without the prior written approval of the STATE. After the three (3) year retention period has ended, the files, books, and records that contain personal information shall be destroyed pursuant to chapter 487R, HRS.

APPENDIX T – LOI Form

APPENDIX T

SAMPLE LETTER OF INTENT (LOI) TO ENTER INTO CONTRACT NEGOTIATIONS WITH

[the applicant]
FOR PROVISION OF SERVICES TO QUEST INTEGRATION (QI) MEMBERS FOR HOME AND COMMUNITY BASED SERVICES (HCBS)

This letter is subject to verification by the Hawaii Department of Human Services (DHS). A provider should not sign this LOI unless he or she intends to enter into contract negotiations with [applicant's name] for the provision of home and community based services to QI members. Signing this LOI does not obligate the provider to sign a contract with [applicant's name] for the provision of services to QI members.

[Applicant's name] is proposing to participate in the QI program. The HCBS provider signing below is willing to enter into contract negotiations with [applicant's name], for the provision of home and community based services to QI members enrolled with [applicant's name] as indicated below.

This HCBS provider intends to sign a contract with [applicant's name] if [applicant's name] is awarded a QI contract **and** an acceptable agreement can be reached between the provider and [applicant's name].

NOTICE TO PROVIDERS:
This LOI will be used by the DHS in its proposal evaluation and contract award process for the QI RFP. You should only sign this LOI if you intend to enter into contract negotiations with (applicant's name) should they receive a contract award.

Do not return completed LOI to the DHS. Completed LOI needs to be returned to [applicant's name and address.]

1. **HCBS PROVIDER'S SIGNATURE** _____
2. **DATE** _____
3. **PRINTED NAME OF SIGNER** _____
4. **TITLE OF SIGNER** _____
5. **NAME OF AGENCY, IF APPLICABLE** _____
6. **APPLICANT REPRESENTATIVE'S SIGNATURE** _____
7. **DATE** _____
8. **PRINTED NAME OF SIGNER** _____
9. **TITLE OF SIGNER** _____

ADDITIONAL INFORMATION ABOUT HCBS PROVIDER FOR PROVISION OF SERVICES TO QI MEMBERS

1. MQD PROVIDER IDENTIFICATION NUMBER, if any _____

2. HCBS PROVIDER'S PRINTED NAME _____

3. ADDRESS (where services will be provided) _____
If services will be provided in more than one location, attach separate sheet with addresses. _____

_____

4. ZIP CODE _____
5. COUNTY _____
6. TELEPHONE _____
7. FAX _____

___Check here if additional service site information is attached.

8. PROVIDER TYPE (e.g., community care management agency, personal care agency, community care foster family home, expanded ARCH) _____

9. LANGUAGES SPOKEN BY THE PROVIDER (OTHER THAN ENGLISH) _____

_____

_____