STATE OF HAWAII

Department of Human Services

REQUEST FOR PROPOSALS (RFP)

COMMUNITY CARE SERVICES PROGRAM (CCS) THAT PROVIDES BEHAVIORAL HEALTH SERVICES TO MEDICAID ELIGIBLE ADULTS WHO HAVE A SERIOUS MENTAL ILLNESS (SMI) OR SERIOUS AND PERSISTENT MENTAL ILLNESS (SPMI)

RFP–MQD–2021-010
APPENDICES

Med-QUEST Division
Health Coverage Services Branch

Appendix A

Written Questions Format
Community Care Services (CCS) Program RFP

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

CCS RFP Notice of Intent to Propose

RFP Number and Title: RFP-MQD-2021-010
Offeror Name: _____
Name and Title of the Authorized Individual: _____

Signature and Date: _____

List up to five (5) Offeror contact person(s) who can upload, revise or edit the Mandatory and Technical proposals in the DHS proposal designated electronic submission site. DHS will provide the submission site address to these five (5) staff no later than ten (10) calendar days before the proposal due date as described in Section 1.5.

	First Name, Last Name	Title	E-mail Address	Contact Phone Number
1				
2				
3				
4				
5				

Appendix C – Proposal Forms (14 documents)

(01) Proposal Application Identification Form (SPO-H 200)
(02) State of Hawaii DHS Proposal Letter
(03) Certification for Contracts, Grants, Loans and Cooperative Agreements Form
(04) Disclosure Statement (CMS Required)
(05) Disclosure Statement (Related Party Transactions and Attestation)
(06) Disclosure Statement (Ownership)
(07) Financial Reporting Guide Forms (Organization Structure and Financial Planning)
(08) Controlling Interest Form
(09) Background Check Information
(10) Operational Certification Submission Form
(11) Grievance System Form
(12) Insurance Requirements Certification Form
(13) Wage Certification Form
(14) Provider's Standards of Conduct Declaration

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 Proposal for the Community Care Services Program. 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 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, and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies , holding companies, and other entities controlled or managed by any of such entities or persons.

§ 455.101
Definitions.
Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

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 offerer'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 offerer. 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 offerer 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

BHO 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 BHO, 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 Behavioral Health Services.

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

DISCLOSURE STATEMENT
OWNERSHIP

BHO **Name,** BHO **No.:** _____

Address (City, State, Zip): _____

Telephone: _____

For the period beginning: _____ and ending _____ Type

of BHO:

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

Type of Entity;

Sole Proprietorship	For-Profit
Partnership	Not-For-Profit
Corporation	Other (specify}
Governmental	

455.104 Information on Ownership arid Control

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

Name	Address	Percent of Ownership Control

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

Name	Address	Percent of Ownership Control

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

Name	Address	Percent of Ownership Control

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

Name	Address	Percent of Ownership Control

455.105 Information Related to Business Transactions

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

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

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

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

455.106 Information on Persons Convicted of Crime

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

Name	Address	Title

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

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

Name/Title	Address

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

Name/Title	Address

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

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 offerer'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, BHO 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 offeror been suspended or excluded from any federal government programs for any reason?

Yes _____ No _____ If yes, please explain:

Financial Planning Form

1} Is the offerors accounting system based on a cash, accrual, or modified method?

a. Cash
b. Accrual
c. Modified Give brief explanation

2) Does the offeror prepare an annual financial statement?

Yes _____ No _____ Ifyes, 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 offeror 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 offeror's last audit?
Yes_____ No _____
Ifno, provide the name, address, and telephone number of the firm that performed the offeror'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 Jetter from the latest audit. This must be on the auditor's letterhead and the offerer, by its submission, certifies the letter is unaltered.

If no, the offerer shall provide a comprehensive description of internal control systems. The offerer 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 offerer have an accounting manual?
Yes_____ No _____

Ifno, the offerer 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 offerer agrees to furnish copies of such written accounting policies and_ procedures for inspection upon request from the DHS.

6) Does the offerer 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 offerer 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 offerer or its owner(s).

9) Are there any suits, judgements, tax deficiencies, or claims pending against the offeror?

Yes_____ No _____

Briefly describe each item and indicate probable amount.

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

Yes_____ No _____

Ifyes, when? _____

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

Yes_____ No _____

Ifyes, 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 offerer have a performance bonding mechanism in accordance with OHS rules?

Yes_____ No _____

Ifyes, provide the following information:

Amount of Bond $ _____

Term of Bond _____

Bonding Company _____

Restrictions on Bond _____

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

13) Does the offeror have a financial management system to account for incurred, but not reported liabilities?
Yes_____ No _ _ _ _ _ _ _ _

If no, the offeror must describe in detail (and attach this description to this form) how it intends to manage, monitor and control IBNR's, The offeror, 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 offeror 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 offeror 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 offeror 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 offeror have a full-time (100%} controller or chief financial officer?
Yes _____ No _____ If yes, enter name: ___
_____

15) re the following items reported on the offeror's financial statements?
a. Medicare reimbursement Yes _____ No _____
b. Other third-party recoveries Yes _____ No _____

If no, explain why.

Controlling Interest Form

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

Name	Address	Owner or Controller	Has Controlling Interest? Yes	No

Operational Certification Submission Form

The Offeror must complete the attached certification as documentation that it shall maintain Member Handbook, appointment procedures, referral procedures and other operating requirements in accordance with either DHS rules or policies and procedures.

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

_____

Signature Date

Grievance System Form

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

I hereby certify that _____
Offerer 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 OHS 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 offerer must have a grievance policy for recipients and providers which defines their rights regarding any adverse action by the offerer. 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 OHS and deficiencies are subject to sanction in accordance with OHS 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 Offeror 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 Offeror certifies that it has completed the attached Checklist and:

(Check and complete one)

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

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

_____

Name of Offeror

_____ _____

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 C:hecklist 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.I. EACH ACCIDENT: $1 MILLION
E.I. DISEASE: $1 MILLION PER EMPLOYEE, $1 MILLION POLICY LIMIT
E.I. $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.

ACORD

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	INSURER(S) AFFORDING COVERAGE	NAIC #
(2)	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 (4)						MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$ (10)
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
								$
	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.

Offeror: _____

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).

CONTRACT NO. _____

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 _____

AG Fonn 103F9 (10/08)

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

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

HOME ADDRESS _____ PHONE NO. _____

_____ CASE NO. _____

MAILING ADDRESS _____ CLIENT ID NO. _____

_____ SOCIAL SECURITY NUMBER _____

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

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

PRIMARY DIAGNOSIS _____ DSMIV CODE _____

SECONDARY DIAGNOSIS _____ DSMIV CODE _____

CURRENT MEDICAL CONDITIONS (Indicate, if none) _____

_____

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

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

Section below to be completed by MQD/CSO Evaluation Panel

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

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

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

Reason for denial/comments _____

_____

_____

Signature: _____

FOR ADULTS ONLY

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

I. MENTAL STATES

A. General:

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

B. Behavior:

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

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

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

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

F. Thought:

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

G. Perception – Hallucinations:

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

H. Reality Orientation:

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

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

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

FOR ADULTS ONLY

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

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

[ ] Medical/Physical

_____

_____

[ ] Family/Living

_____

_____

[ ] Interpersonal Relations

_____

_____

[ ] Role Performance

_____

_____

[ ] Socio-Legal

_____

_____

[ ] Self-Care/Basic Needs

_____

_____

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

Signed: _____ Date: _____

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

Reporting Psychiatrist/Psychologist Phone No.: _____

Signed: _____ Date: _____

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

INSTRUCTIONS
DHS 1157 (Rev. 04/14)

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

PURPOSE:

The DHS 1157, Referral for Serious Mental Illness (SMI) to the Community Care Services (CCS) Program, shall be initiated by the health plan or hospital when there is reason to believe that an applicant/beneficiary of medical assistance may meet the definition of SMI and would meet the criteria to receive services from CCS.

GENERAL INSTRUCTIONS:

The applicant/beneficiary's provider, with review and concurrence by the health plan medical director or attending physician, shall complete this form to refer an applicant/beneficiary for consideration for the CCS program and submit it along with pertinent medical records to the Med- QUEST Division/Clinical Standards Office (MQD/CSO). The MQD/CSO evaluation panel will complete the Section to be completed by MQD/CSO Evaluation Panel and make a determination for CCS referral based on the information provided in the Referral for SMI CCS packet.

SPECIFIC INSTRUCTIONS:

The DHS 1157 should be completed by the applicant/beneficiary's provider, with review and concurrence by the health plan medical director or attending physician.

The DHS 1157 page 1, the Mental States page 2, and the Functional Scales page 3, should be signed by the applicant/beneficiary's treating psychiatrist or psychologist. If the applicant/beneficiary does not have a treating psychiatrist or psychologist, then the treating medical provider for the applicant/beneficiary may sign where indicated on the form. Signature also required indicating review and concurrence by the health plan medical director or behavioral health specialist

Page 1:
Section A: To Be Completed By the Health Plan Medical Director or Attending Physician

1. Furnish the following identifying data: the applicant/beneficiary's name, gender, home address, mailing address, date of birth, age, phone number, DHS case No., client ID No., Social Security number, county and health plan.
2. Indicate the primary and secondary diagnosis along with any current medical conditions and DSMIV code. Qualifying diagnosis need to be present for over 12 months or expected to continue for 12 months.
3. Complete date of referral, name of primary care provider (PCP) and identify whether or not the PCP was informed of the referral.
4. Applicant/beneficiary is to initial acknowledgement of the statement to comply with the CCS program directions and understand that current provider(s) may change.
5. Applicant/beneficiary signature is required for the process to move forward.
6. Hospitalizations:
   Identify if the applicant/beneficiary is currently hospitalized and indicate the location. List all other hospitalizations by facility, location, date admitted, date discharged and diagnosis. Attach an extra sheet if more space is needed.

7. Medications:
List the routine psychiatric medications, as well as frequently used prn psychiatric medications identifying the medication strength, dosage, start date and end date

Outpatient therapists:
Provide a list of current and past mental health therapists, diagnosis, start and end dates of treatment. Attach an extra sheet if more space is needed.

Section B: To Be Completed By MQD/CSO Evaluation Panel

MQD medical director or behavioral health consultants will complete and sign this section indicating:

1. The date the Referral for CCS is evaluated;
2. If approved for CCS referral, the date of enrollment is indicated in this section and will be five business days after the date the CCS referral is approved.
3. Whether the applicant/beneficiary is approved for CCS referral or if additional information is needed;
4. Whether re-evaluation is required, if yes, date to be re-evaluated;
5. Reason for denial and any other comments.

Page 2
Section C: To Be Completed By the Health Plan Medical Director or Attending Physician

I. MENTAL STATES - Self-explanatory.

Page 3

II. FUNCTIONAL SCALES - Self-explanatory.

Section D: To Be Completed By the Health Plan Medical Director or Attending Physician

III. SUPPORTING DOCUMENTATION – Provide additional comprehensive information and assessments to assist in the evaluation of the criteria for CCS eligibility.

ELIGIBILITY CRITERIA

The beneficiary is eligible for CCS referral if A through E can be answered "Yes."

The applicant/beneficiary:

1. Is 18 years of age or older and is Medicaid eligible.
2. Is NOT successfully engaged in existing case management services, including AMHD Case management services.
3. Have been diagnosed as having one of the qualifying diagnoses (see attached).
4. Demonstrates the presence of the qualifying diagnosis for the last 12 months or is expected to demonstrate the qualifying diagnosis for the next 12 months.
5. Meets at least one of the criteria below that demonstrates instability and/or functional impairment:
    a. Clinical records demonstrate that the beneficiary is currently unstable under

current treatment and plan of care (e.g. multiple hospitalizations in the last year and currently unstable, substantial history of crises and currently unstable, consistently noncompliant with meds and follow-up, unengaged with providers, significant and consistent isolation, at risk for hospitalization, resource deficit causing instability).

b. The applicant/beneficiary's GAF scores, supported by submitted clinical records, currently is and have been consistently less than 50 over the past 6 months.

c. The applicant/beneficiary is under Adult Protective Services (APS) or requires intervention by housing or law enforcement officials. Supporting documentation exists in the medical record, such as a letter from APS or housing official.

If the referral to CCS does not provide sufficient information under A through E to make a determination, the referral will be sent back for more information, or the health plan or hospital will be contacted to provide additional information.

Upon Referral to CCS by the MQD, the applicant/beneficiary will be assessed by CCS. If the applicant/beneficiary does not meet or no longer meets the criteria for CCS admission, based on the initial evaluation, CCS will complete the DHS 1157 to indicate the reason for applicant/beneficiary not being recommended for either continued services or disenrollment from CCS. MQD will return the beneficiary referral back to the referring health plan or if applicant/beneficiary is still hospitalized, to the hospital.

Provisional Referral to CCS is made for individuals whose qualifying condition or duration of illness is uncertain because of co-existing substance abuse or medical condition. The criteria above should still be met. CCS will be made aware of the provisional status of the referral and the applicant/beneficiary must be re-evaluated by MQD using the DHS 1157 and reassessment completed by CCS at the timeframe indicated on the initial DHS 1157.

FILING INSTRUCTIONS:

In order for MQD CSO to perform an evaluation and determination, the supporting documentation must be adequate and complete. The following requirements must be included as part of the SMI CCS packet:

1. DHS 1157 'Referral for Serious Mental Illness (SMI) CCS Program page 1, page 2 "Mental States" and page 3 "Functional Scales";
2. Clinical notes within the past year outlining current plan of care and treatment;
3. Hospital admission and discharge notes within the past year, if applicable;
4. Psychiatric and/or psychosocial assessment within the past year; and
5. Global Assessment of Functioning (GAF) scores within the last six months, and highest within the last year, supported by clinical documentation.

The DHS 1157 form and supporting documentation may be faxed or mailed to the applicant's health plan for referral to the CCS Program with the exception of those providers who are allowed to fax directly to MQD at 808-692-8131

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.

CONTRACT NO. _____

GENERAL CONDITIONS FOR HEALTH & HUMAN SERVICES CONTRACTS
TABLE OF CONTENTS

CONTRACT NO. _____

STATE OF HAWAIʻI
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 Hawaiʻi ("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: _____

Hawaiʻi 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

APPENDIX F

Provider Letter of Intent

SAMPLE LETTER OF INTENT (LOI) TO ENTER INTO CONTRACT NEGOTIATIONS WITH [the offeror] FOR PROVISION OF BEHAVIORAL HEALTH SERVICES TO CCS MEMBERS

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 [offeror's name] for the provision of behavioral health services to Community Care Services (CCS) members. Signing this LOI does not obligate the provider to sign a contract with [offeror's name] for the provision of behavioral health services to CCS members.

[Offeror's name] is proposing to participate in the CCS program. The provider signing below is willing to enter into contract negotiations with [offeror's name], for the provision of behavioral health services to CCS members enrolled with [offeror's name] as indicated below.

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

NOTICE TO PROVIDERS:
This LOI will be used by the DHS in its bid evaluation and contract award process for the CCS RFP. You should only sign this LOI if you intend to enter into contract negotiations with (offeror's name) should they receive a contract award. If you are signing on behalf of a physician, please provide evidence of your authority to do so.

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

1. **PROVIDER'S SIGNATURE** _____
2. **DATE** _____
3. **PRINTED NAME OF SIGNER** _____
4. **TITLE OF SIGNER** _____
5. **PRINTED NAME OF PROVIDER** (IF DIFFERENT FROM SIGNER) _____

6. **OFFEROR REPRESENTATIVE'S SIGNATURE** _____
7. **DATE** _____
8. **PRINTED NAME OF SIGNER** _____

9. **TITLE OF SIGNER** _____

ADDITIONAL PROVIDER AND SERVICES INFORMATION FOR LOI BETWEEN PROVIDERS AND OFFERORS FOR PROVISION OF SERVICES TO CCS MEMBERS

1. MQD PROVIDER IDENTIFICATION NUMBER, if any _____

2. 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., behavioral health provider, case management agency, inpatient behavioral health hospital, outpatient behavioral health hospital, mental health rehabilitation, psychosocial rehabilitation, pharmacy, laboratory, crisis service, etc.) _____

9. SERVICE(S) TO BE PROVIDED TO CCS MEMBERS _____

_____

_____

_____

10. AREAS OF PROVIDER SPECIALTY, IF ANY _____

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

12. NAME OF HOSPITAL(S) WHERE PHYSICIAN HAS ADMITTING PRIVILEGES _____

_____

_____

Provider Listing

for Section 15.3.D.1

Provider Type (examples below)	Specialty	Island & City (examples below)	Provider Name (Last, First, Middle Initial)	Any group affiliations? If so, provide entity names.	Address	City	Zip Code	Ph. #	Accepting new CCS Members? (Y/N)	Any limit on # of CCS Members? (Y/N)	List cultural and linguistic capabilities	Physical disability accommodations in place? (Y/N)
Behavioral Health Specialist		Oahu, Honolulu										
Case Management		Oahu, Kapolei										
Inpatient behavioral health hospital		Maui, Kahului										
Hospital		Kauai, Kapaa										
Crisis Services: mobile crisis response		Hawaii Island, Hilo										
Therapist		Hawaii Island, Kona										

RISK SHARING MECHANISMS

RISK SHARE AND SETTLEMENT CORRIDORS

Risk mitigation for this program includes three separate mutually exclusive risk corridors described below. The global risk corridor described is global in that it covers all eligible services not covered elsewhere.

CASE MANAGEMENT RISK CORRIDOR

Sub-capitated case management payments are a large portion of the capitation rate for this program. These rates will be restructured for SFY 2024 to create performance incentives for the case management agencies. We included a preliminary estimate of what the resulting cost of this restructuring will be, but given the uncertainty around these rates, Med-QUEST is proposing a corridor around these payments. Assertive outreach is also included in the case management corridor as projected caseload is subject to more uncertainty due to the end of MOE.

The corridor includes sub-capitated case management payments and assertive outreach payments. The parameters of the corridor are:

- Med-QUEST will share 100% of gain/loss up to 7.5% loss
- Med-QUEST will share 50% of loss between 7.5% and 10% loss
- Med-QUEST will share 0% of loss above 10%

The BHO will provide detailed case management and assertive outreach payment data. Total applicable costs will be calculated as the sum of actual case management payments, including any incentives and rewards, made plus actual assertive outreach payments made. This does not include internal case management costs.

Total applicable revenue will be calculated using SFY 2024 enrollment based on eligibility data from Med-QUEST and the case management plus assertive outreach specific PMPMs loaded into the SFY 2024 rates ($392.32+$0.66=$392.98).

Gain/loss is equal to (total revenue – total cost) / (total revenue).

CIS RISK CORRIDOR

Community integration services have been provided by the CCS program for several years, however the memo *Community Integration Services (CIS) Implementation Guidelines: Overview, Member Eligibility, Service Delivery, Coordination, & Reimbursement* (CIS Memo) was issued in April 2021 with new guidance and requirements above the services provided historically. A separate CIS capitation rate was developed to fund the majority CIS services based on the guidance of the CIS Memo, however the adoption and administration of this benefit has been evolving and growing over time while providers and payers adjust to the new benefit and develop a better understanding of the service. As such, Med-QUEST is proposing to continue the CIS corridor that was introduced in SFY 2023 for SFY 2024.

The corridor applies to the separate CIS capitation rate outlined in Appendix 6. Revenue is net of premium tax and the administrative load assumed for rate development. Expenses include CIS specific services provided to CCS members that are not part of the typical CCS case management suite of services. Expenses must be paid as encounters to be considered valid.

The BHO will provide detailed CIS claim data. If there are BHO gains/losses, Med-QUEST would share equally in the gain/loss between 0% and 2.5%. Med-QUEST would recover/reimburse all gains/losses exceeding 2.5%. Premium tax and the administrative load assumed for rate development will be applied to positive or negative settlements. Settlements from this corridor will not impact the global CCS corridor.

The settlement will take place within one year after the end of the contract period.

GLOBAL RISK CORRIDOR

Med-QUEST is continuing the global corridor for SFY 2024 capitation rates. Under this program, Med-QUEST will share in significant differences between the revenue and the actual costs experienced by the BHO. The structure of the corridor is unchanged from SFY 2023.

The BHO will populate a template with aggregate financial data and supporting detail upon request.

Total revenue is the sum of all capitation payments made to the BHO for Medicaid eligible members during SFY 2024 excluding CIS and the incentive payment described in Section I.4.A. The behavioral health services portion of revenue is equal to total revenue net of case management (subcontracted payments, assertive outreach, and internal level 5 case manager salaries), administration expenses, and insurance premium tax assumed for SFY 2024 rate development; actual administrative expenses will not be included in the computation since the intent of the program is to adjust for unknown risk associated with providing the behavioral health services to the enrolled population Settlements from the CIS and case management corridor will not impact the global CCS corridor.

Total expenses include incurred claims as well as other benefit costs including sub-capitation net delegated administrative expenses. Expenses are net of pharmacy rebates and other recoveries. Expenses for case management and institutions for mental disease state funded expenses are not included.

The following formula will be used to determine the gain/loss:

Σ Behavioral health services portion of Total Revenue

Less: Σ Net behavioral health expenses (based on the actual incurred expenses for behavioral health services)

Equals: Net profit/loss (for the behavioral health services provided to the CCS population)

The net profit/loss divided by the Behavioral Health Services portion of Total Revenue will provide the percentage of the profit/loss which will be compared to the risk corridor established by Med-QUEST.

If there is a gain/loss exceeding 3%, Med-QUEST will share equally in the gain/loss between 3% and 5%. Med-QUEST will recover all gains/losses exceeding 5%.

The settlement will take place within one year after the end of the contract period.

Financial Responsibility Guideline for QI and CCS health plans

IP Facility:

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

OP Facility:

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

Professional:

- Based on specialty, either CCS or QI.

Supportive Housing Services (SHS):

- For eligible CCS members, CCS pays all SHS.

APPENDIX J
BUSINESS ASSOCIATE AGREEMENT

The State of Hawaii Department of Human Services (STATE) has determined that it is a Covered Entity or a Health Care Component of a Covered Entity under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA), as amended, and its implementing regulations at 45 CFR parts 160 and 164 (the HIPAA Rules).

The CONTRACTOR/PROVIDER (BUSINESS ASSOCIATE), under the CONTRACT will provide to STATE certain services described in the CONTRACT to which this Exhibit I is attached, and may have access to Protected Health Information (PHI) (as defined below) in fulfilling its responsibilities under the CONTRACT. To the extent BUSINESS ASSOCIATE needs to create, receive, maintain or transmit PHI to perform services under the CONTRACT, it will be acting as a Business Associate[1] of STATE and will be subject to the HIPAA Rules and the terms of this Business Associate Agreement (this Agreement).

In consideration of STATE's and BUSINESS ASSOCIATE's (collectively referred to as "the Parties") continuing obligations under the CONTRACT, and the provisions below, the Parties agree as follows:

1. DEFINITIONS.

Except for terms otherwise defined herein, and unless the context indicates otherwise, any capitalized terms used in this Agreement and the terms "person," "use," and "disclosure" shall have the same meaning as defined by the HIPAA Rules. An amendment to the HIPAA Rules that modifies any defined term, or which alters the regulatory citation for the definition, shall only be incorporated into this Agreement by written ratification of the Parties.

Breach[2] means the acquisition, access, use, or disclosure of PHI in a manner not permitted under the HIPAA Privacy Rule or as provided for by this Agreement, which compromises the security or privacy of the PHI.

An acquisition, access, use, or disclosure of PHI in a manner not permitted by the Privacy Rule is presumed to be a breach unless the BUSINESS ASSOCIATE demonstrates to the STATE's satisfaction that there is a low probability that the PHI has been compromised based on a risk assessment that identifies at least the following: (i) the nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification; (ii) the unauthorized person who used the PHI or to whom the disclosure was made; (iii) whether the PHI was actually acquired or viewed; and (iv) the extent to which the risk to the PHI has been mitigated.

[1] Business Associate is defined at 45 CFR §160.103
[2] Breach: 45 CFR §164.402.

Breach excludes:

A. Any unintentional acquisition, access or use of PHI by a Workforce member or person acting under the authority of the BUSINESS ASSOCIATE if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under the Privacy Rule.

B. Any inadvertent disclosure by a person who is authorized to access PHI at the BUSINESS ASSOCIATE to another person authorized to access PHI at the same BUSINESS ASSOCIATE, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under the Privacy Rule.

C. A disclosure of PHI where the BUSINESS ASSOCIATE has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

Designated Record Set means records, including but not limited to PHI maintained, collected, used, or disseminated by or for the STATE relating to (i) medical and billing records about Individuals maintained by or for a covered Health Care Provider, (ii) enrollment, Payment, claims adjudication, and case or medical management records systems maintained by or for a Health Plan, or (iii) that are used in whole or in part by the STATE to make decisions about Individuals.[3]

Electronic Protected Health Information (EPHI) means PHI that is transmitted by Electronic Media or maintained in Electronic Media.[4]

HIPAA Rules shall mean the Privacy, Security, Breach Notification, and Enforcement Rules in 45 CFR Parts 160 and 164.

Individual shall have the same meaning as defined in 45 CFR §160.103, and shall include a person who qualifies as a personal representative as provided by 45 CFR §164.502(g).

Privacy Rule means the HIPAA Standards for Privacy of Individually Identifiable Health Information found at 45 CFR part 160, and part 164, subparts A and E.

Protected Health Information (PHI) means any oral, paper or electronic information, data, documentation, and materials, including, but not limited to, demographic, medical, genetic, and financial information that is created or received by a Health Care Provider, Health Plan, Employer, or Health Care Clearinghouse, and relates to the past, present, or future physical or mental health or condition of an Individual; the provision of health care to an Individual; or the past, present, or future payment for the provision of health care to an Individual; and that identifies the Individual or with respect to which there is a reasonable basis to believe the information can be used to identify the Individual. For purposes of this Agreement, the term

[3] Designated Record Set: 45 CFR §164.501.
[4] Electronic Protected Health Information: 45 CFR §160.103

Protected Health Information is limited to the information created, maintained, received, or transmitted by BUSINESS ASSOCIATE on behalf of or from the STATE under the CONTRACT. Protected Health Information includes without limitation EPHI, and excludes education records under 20 U.S.C. §1232(g), employment records held by the STATE as an employer, and records regarding an Individual who has been deceased for more than 50 years.[5]

Security Incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system under 45 CFR §164.304.

Security Rule means the HIPAA Security Standards for the Protection of Electronic Protected Health Information found at 45 CFR part 160, and part 164, subpart C.

Unsecured Protected Health Information means protected health information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5.[6]

2. BUSINESS ASSOCIATE'S OBLIGATIONS.

BUSINESS ASSOCIATE agrees to:

a. Not use or disclose PHI other than as permitted or required by this Agreement or as Required by Law. In no event may BUSINESS ASSOCIATE use or further disclose PHI in a manner that would violate the Privacy Rule if done by the STATE, except as expressly provided in this Agreement and as required by 45 CFR §§ 164.502(a)(3), 164.502(a)(4) and 164.504(e)(2(ii)(A).

b. Implement appropriate safeguards, and comply, where applicable, with the Security Rule to ensure the confidentiality, integrity, and availability of all EPHI the BUSINESS ASSOCIATE creates, receives, maintains, or transmits on behalf of the STATE; protect against any reasonably anticipated threats or hazards to the security or integrity of such information; prevent uses or disclosures of such information other than as provided for by this Agreement or as Required by Law; and ensure compliance with the HIPAA Rules by BUSINESS ASSOCIATE's Workforce. [7] These safeguards include, but are not limited to:

(i) Administrative Safeguards. BUSINESS ASSOCIATE shall implement policies and procedures to prevent, detect, contain, and correct security violations, and reasonably preserve and protect the confidentiality, integrity

[5] Protected Health Information: 45 CFR §160.103
[6] 45 CFR §164.402.
[7] 45 CFR §164.306(a)

and availability of EPHI, and enforce those policies and procedures, including sanctions for anyone not found in compliance;

(ii) Physical Safeguards. BUSINESS ASSOCIATE shall implement appropriate physical safeguards to protect PHI, including, but not limited to, facility access, facility security, workstation use, workstation security, device and media controls, and disposal;[8]

(iii) Technical Safeguards. BUSINESS ASSOCIATE shall implement appropriate technical safeguards to protect PHI, including, but not limited to, access controls, authentication, and transmission security;[9] and

(iv) Security Awareness and Training. BUSINESS ASSOCIATE shall provide training to relevant workforce members, including management, on how to prevent the improper access, use, or disclosure of PHI; and update and repeat training on a regular basis.[10]

c. In accordance with 45 CFR §164.316, document the required policies and procedures and keep them current, and cooperate in good faith in response to any reasonable requests from STATE to discuss, review, inspect, and/or audit BUSINESS ASSOCIATE's safeguards. BUSINESS ASSOCIATE shall retain the documentation required for six (6) years from the date of its creation or the date when it last was in effect, whichever is later.[11]

d. Comply with the provisions found in 45 CFR §164.308 (a)(1) (ii)(A) and (B), requiring BUSINESS ASSOCIATE to conduct an accurate and thorough *risk analysis*, and to periodically update the risk analysis (no less than once every 3 years); and to implement *risk management* measures to reduce the risk and vulnerabilities to a reasonable and appropriate level to comply with 45 CFR §164.306(a).

e. As applicable only to the PHI BUSINESS ASSOCIATE receives from STATE, BUSINESS ASSOCIATE shall ensure that any subcontractor of BUSINESS ASSOCIATE that creates, receives, maintains, or transmits PHI on behalf of BUSINESS ASSOCIATE agrees in writing to the same restrictions, conditions, and requirements that apply to BUSINESS ASSOCIATE through this Agreement with respect to such PHI.[12]

f. Notify the STATE following discovery of any use or disclosure of PHI not permitted by this Agreement of which it becomes aware, or any Breach of Unsecured PHI.[13]

[8] 45 CFR §164.310
[9] 45 CFR §§ 164.310, 164.312
[10] 45 CFR §164.308(a)(5)
[11] 45 CFR §§164.306 – 164.316; 164.504(e)(2)(ii)(B)
[12] 45 CFR §§164.308(b), 164.314(a)(2), 164.502(e), 164.504(e)(2)(ii)(D)
[13] 45 CFR §§164.314(a)(2), 164.410(a), 164.504(e)(2)(ii)(C)

(i) BUSINESS ASSOCIATE shall immediately notify the STATE's HIPAA Privacy or Security Officer verbally.

(ii) BUSINESS ASSOCIATE shall subsequently notify the STATE's HIPAA Privacy or Security Officer in writing, without unreasonable delay, and in no case later than two (2) business days following discovery of the impermissible use or disclosure of PHI, or Breach of Unsecured PHI.

(iii) A Breach of Unsecured PHI shall be treated as discovered by the BUSINESS ASSOCIATE as of the first day on which such breach is known to the BUSINESS ASSOCIATE or, by exercising reasonable diligence, would have been known to the BUSINESS ASSOCIATE. BUSINESS ASSOCIATE shall be deemed to have knowledge of a Breach if the Breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the Breach, who is an employee, officer, or other agent of the BUSINESS ASSOCIATE.[14]

g. Take prompt corrective action to mitigate, to the extent practicable, any harmful effect that is known to BUSINESS ASSOCIATE of a Security Incident or a misuse or unauthorized disclosure of PHI by BUSINESS ASSOCIATE in violation of this Agreement, and any other action pertaining to such unauthorized disclosure required by applicable Federal and State laws and regulations. BUSINESS ASSOCIATE shall reasonably cooperate with the STATE's efforts to seek appropriate injunctive relief or otherwise prevent or curtail potential or actual Breaches, or to recover its PHI, including complying with a reasonable corrective action plan.[15]

h. Investigate such Breach and provide a written report of the investigation and resultant mitigation to STATE's HIPAA Privacy and/or Security Officer within thirty (30) calendar days of the discovery of the Breach.

i. Provide the following information with respect to a Breach of Unsecured PHI, to the extent possible, as the information becomes available, to the STATE's HIPAA Privacy or Security Officer:

(i) The identification of each Individual whose Unsecured PHI has been, or is reasonably believed by BUSINESS ASSOCIATE to have been accessed, acquired, used, or disclosed during the breach; and

(ii) Any other available information that the STATE is required to include in notification to the Individual under the HIPAA Rules, including, but not limited to the following:[16]

[14] 45 CFR §164.410(a)(2)
[15] 45 CFR §§164.308(a)(6)(ii); 164.530(f)
[16] 45 CFR §§164.404(c)(1), 164.408, 164.410(c)(1) and (2)

A. Contact information for Individuals who were or who may have been impacted by the HIPAA Breach (e.g., first and last name, mailing address, street address, phone number, and email address);

B. A brief description of the circumstances of the Breach, including the date of the Breach and date of discovery, if known;

C. A description of the types of Unsecured PHI involved in the Breach (such as whether the full name, social security number, date of birth, address, account number, diagnosis, disability and/or billing codes, or similar information was involved);

D. A brief description of what the BUSINESS ASSOCIATE has done or is doing to investigate the Breach, mitigate harm to the Individual(s) impacted by the Breach, and protect against future Breaches; and

E. Contact information for BUSINESS ASSOCIATE's liaison responsible for investigating the Breach and communicating information relating to the Breach to the STATE.

j. Promptly report to STATE's HIPAA Privacy and/or Security Officer any Security Incident of which BUSINESS ASSOCIATE becomes aware with respect to EPHI that is in the custody of BUSINESS ASSOCIATE, including breaches of Unsecured PHI as required by 45 CFR §164.410, by contacting the STATE's HIPAA Privacy and/or Security Officer.[17]

k. Implement reasonable and appropriate measures, including training, to ensure compliance with the requirements of this Agreement by Workforce members who assist in the performance of functions or activities on behalf of the STATE under this Agreement and use or disclose PHI, and discipline such Workforce members who intentionally violate any provisions of these special conditions, which may include termination of employment.[18]

l. Make its internal policies, procedures, books, and records relating to the use and disclosure of PHI received from or created or received by BUSINESS ASSOCIATE on behalf of the STATE available to the Secretary of Health and Human Services or to STATE if necessary or required to assess BUSINESS ASSOCIATE's or the STATE's compliance with the HIPAA Rules. BUSINESS ASSOCIATE shall promptly notify STATE of communications with the U.S. Department of Health and Human Services (HHS) regarding PHI provided by or created by STATE and shall provide STATE with copies of any information BUSINESS ASSOCIATE has made available to HHS under this paragraph.[19]

[17] 45 CFR §§164.314(a)(2), 164,410
[18] 45 CFR §§164.308(a), 164.530(b) and (e)
[19] 45 CFR §164.504(e)(2)(ii)(I)

m. Upon notice from STATE, accommodate any restriction to the use or disclosure of PHI and any request for confidential communications to which STATE has agreed in accordance with the Privacy Rule.[20]

n. Make available PHI held by BUSINESS ASSOCIATE, which the STATE has determined to be part of its Designated Record Set, to the STATE as necessary to satisfy the STATE's obligations to provide an Individual with access to their PHI under 45 CFR §164.524, in the time and manner designated by the STATE.[21]

o. Make available PHI held by BUSINESS ASSOCIATE, which the STATE has determined to be part of its Designated Record Set, for amendment, and incorporate any amendments to PHI that the STATE directs or agrees to in accordance with 45 CFR §164.526, upon request of the STATE or an Individual, subject to State law and BUSINESS ASSOCIATE policies regarding amending vital records.

p. Document disclosures of PHI made by BUSINESS ASSOCIATE, which are required to be accounted for under 45 CFR §164.528(a)(1), and make this information available as necessary to satisfy the STATE's obligation to provide an accounting of disclosures to an Individual within two (2) business days notice by the STATE of a request by an Individual of a request for an accounting of disclosures of PHI. If an Individual directly requests an accounting of disclosures of PHI from BUSINESS ASSOCIATE, BUSINESS ASSOCIATE shall notify STATE's HIPAA Privacy and/or Security Officer of the request within two (2) business days, and STATE shall either direct BUSINESS ASSOCIATE to provide the information directly to the Individual, or it shall direct that the information required for the accounting be forwarded to STATE for compilation and distribution to the Individual.[22]

q. Comply with any other requirements of the HIPAA Rules not expressly specified in this Agreement, as and to the extent that such requirements apply to Business Associates under the HIPAA Rules.

3. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE.

BUSINESS ASSOCIATE may, except as otherwise limited in this Agreement:

a. General Use and Disclosure: Create, receive, maintain or transmit PHI only for the purposes listed in the CONTRACT and this Agreement, provided that the use or disclosure would not violate the HIPAA Rules if done by the STATE or violate the Minimum Necessary requirements applicable to the STATE.[23]

b. Limited Use of PHI for BUSINESS ASSOCIATE's Benefit. Use PHI received by the BUSINESS ASSOCIATE in its capacity as the STATE's BUSINESS ASSOCIATE, if

[20] 45 CFR §164.522
[21] 45 CFR §§164.504(e)(2)(ii)(E), 164.524
[22] 45 CFR §§164.504(e)(2)(ii)(G) and (H), 164.528; HAR ch. 2-71, subch. 2.
[23] 45 CFR §§164.502(a) and (b), 164.504(e)(2)(i)

necessary, for the proper management and administration of the BUSINESS ASSOCIATE or to carry out the legal responsibilities of the BUSINESS ASSOCIATE. BUSINESS ASSOCIATE's proper management and administration does not include the use or disclosure of PHI by BUSINESS ASSOCIATE for Marketing purposes or for sale of PHI. [24]

c. Limited Disclosure of PHI for BUSINESS ASSOCIATE's Benefit. Disclose PHI for BUSINESS ASSOCIATE's proper management and administration or to carry out its legal responsibilities only if the disclosure is Required by Law, or BUSINESS ASSOCIATE obtains reasonable assurances from the person to whom PHI is disclosed that it will remain confidential and used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person, and the person notifies BUSINESS ASSOCIATE of any instances of which it is aware in which the confidentiality of PHI has been breached. [25]

d. Minimum Necessary. BUSINESS ASSOCIATE shall only request, use, and disclose the minimum amount of PHI necessary to accomplish the purpose of the request, use, or disclosure.[26]

e. Data Aggregation. Use PHI to provide Data Aggregation services relating to the STATE's Health Care Operations as permitted by 45 CFR §164.504(e)(2)(i)(B).

f. Disclosures by Whistleblowers: Disclose PHI to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR §164.502(j)(1).

4. STATE'S OBLIGATIONS.

a. STATE shall not request BUSINESS ASSOCIATE to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by STATE.

b. STATE shall not provide BUSINESS ASSOCIATE with more PHI than is minimally necessary for BUSINESS ASSOCIATE to provide the services under the CONTRACT and STATE shall provide any PHI needed by BUSINESS ASSOCIATE to perform under the CONTRACT only in accordance with the HIPAA Rules.

5. TERM AND TERMINATION.

a. This Agreement shall be effective as of the date of the CONTRACT or CONTRACT amendment to which this Agreement is attached, and shall terminate on the date the STATE terminates this Agreement or when all PHI is destroyed or returned to STATE.

b. In addition to any other remedies provided for by this Agreement or the CONTRACT, upon the STATE's knowledge of a material Breach by BUSINESS ASSOCIATE of this

[24] 45 CFR §§164.502(a)(5)(ii), 164.504(e)(2)(i)(A), 164.504(e)(4)(i), 164.508(a)(3) and (a)(4)
[25] 45 CFR §164.504(e)(4)(ii)
[26] 45 CFR §164.502(b)

Agreement, the BUSINESS ASSOCIATE authorizes the STATE to do any one or more of the following, upon written notice to BUSINESS ASSOCIATE describing the violation and the action it intends to take:

(i) Exercise any of its rights to reports, access and inspection under this Agreement or the CONTRACT;

(ii) Require BUSINESS ASSOCIATE to submit a plan of monitoring and reporting, as STATE may determine necessary to maintain compliance with this Agreement;

(iii) Provide BUSINESS ASSOCIATE with a reasonable period of time to cure the Breach, given the nature and impact of the Breach; or

(iv) Immediately terminate this Agreement if BUSINESS ASSOCIATE has breached a material term of this Agreement and sufficient mitigation is not possible.[27]

c. Effect of Termination.[28]

(i) Upon any termination of this Agreement, until notified otherwise by the STATE, BUSINESS ASSOCIATE shall extend all protections, limitations, requirements and other provisions of this Agreement to all PHI received from or on behalf of STATE or created or received by BUSINESS ASSOCIATE on behalf of the STATE, and all EPHI created, received, maintained or transmitted by BUSINESS ASSOCIATE on behalf of the STATE.

(ii) Except as otherwise provided in subsection 5(c)(iii) below, upon termination of this Agreement for any reason, BUSINESS ASSOCIATE shall, at the STATE's option, return or destroy all PHI received from the STATE, or created or received by the BUSINESS ASSOCIATE on behalf of the STATE, that the BUSINESS ASSOCIATE still maintains in any form, and BUSINESS ASSOCIATE shall retain no copies of the information. This provision shall also apply to PHI that is in the possession of subcontractors or agents of BUSINESS ASSOCIATE. BUSINESS ASSOCIATE shall notify the STATE in writing of any and all conditions that make return or destruction of such information not feasible and shall provide STATE with any requested information related to the STATE's determination as to whether the return or destruction of such information is feasible.

(iii) If the STATE determines that returning or destroying any or all PHI is not feasible or opts not to require the return or destruction of such information, the protections of this Agreement shall continue to apply to such PHI, and BUSINESS ASSOCIATE shall limit further uses and disclosures of PHI to those purposes that make the return or destruction infeasible, for so long as BUSINESS ASSOCIATE maintains such PHI. STATE hereby acknowledges and agrees that

[27] 45 CFR §164.504(e)(2)(iii)
[28] 45 CFR §164.504(e)(2)(ii)(J)

infeasibility includes BUSINESS ASSOCIATE's need to retain PHI for purposes of complying with its work product documentation standards.

6. MISCELLANEOUS.

a. Amendment. BUSINESS ASSOCIATE and the STATE agree to take such action as is necessary to amend this Agreement from time to time for compliance with the requirements of the HIPAA Rules and any other applicable law.

b. Interpretation. In the event that any terms of this Agreement are inconsistent with the terms of the CONTRACT, then the terms of this Agreement shall control. In the event of an inconsistency between the provisions of this Agreement and mandatory provisions of the HIPAA Rules, as amended, the HIPAA Rules shall control. Where provisions of this Agreement are different than those mandated in the HIPAA Rules, but are nonetheless permitted by the HIPAA Rules, the provisions of this Agreement shall control. Any ambiguity in this Agreement shall be resolved to permit STATE to comply with the HIPAA Rules. Notwithstanding the foregoing, nothing in this Agreement shall be interpreted to supersede any federal or State law or regulation related to confidentiality of health information or vital record information that is more stringent than the HIPAA Rules.

c. Indemnification. BUSINESS ASSOCIATE shall defend, indemnify, and hold harmless the STATE and STATE's officers, employees, agents, contractors and subcontractors to the extent required under the Contract for incidents that are caused by or arise out of a Breach or failure to comply with any provision of this Agreement or the HIPAA Rules by BSUSINESS Associates or any of BUSINESS ASSOCIATE's officers, employees, agents, contractors or subcontractors.

d. Costs Related to Breach. BUSINESS ASSOCIATE shall be responsible for any and all costs incurred by the STATE as a result of any Breach of PHI by BUSINESS ASSOCIATE, its officers, directors, employees, contractors, or agents, or by a third party to which the BUSINESS ASSOCIATE disclosed PHI under this Agreement, including but not limited to notification of individuals or their representatives of a Breach of Unsecured PHI,[29] and the cost of mitigating any harmful effect of the Breach.[30]

e. Response to Subpoenas. In the event BUSINESS ASSOCIATE receives a subpoena or similar notice or request from any judicial, administrative, or other party which would require the production of PHI received from, or created for, the STATE, BUSINESS ASSOCIATE shall promptly forward a copy of such subpoena, notice or request to the STATE to afford the STATE the opportunity to timely respond to the demand for its PHI as the STATE determines appropriate according to its State and federal obligations.

[29] 45 CFR Part 164, Subpart D
[30] 45 CFR §164.530(f)

f. Survival. The respective rights and obligations of STATE and BUSINESS ASSOCIATE under sections 5.c., Effect of Termination, 6.c., Indemnification, and 6.d., Costs Related to Breach, shall survive the termination of this Agreement.

g. Notices: Whenever written notice is required by one party to the other under this Agreement, it should be mailed, faxed, or e-mailed to the appropriate address noted below. If notice is sent by e-mail, then a confirming written notice should be sent by mail or fax within two (2) business days after the date of the e-mail. The sender of any written notice required under this Agreement is responsible for confirming receipt by the recipient.

STATE:	**BUSINESS ASSOCIATE:**
DHS Information Security / HIPAA Compliance Manager P.O. Box 700190 Kapolei, Hawaii 96709-0190 Fax: (808) 692-8173 Email: LYong@dhs.hawaii.gov	_____ _____ _____ Fax: (_____) _____ Email: _____

IN WITNESS WHEREOF, the Parties have executed this Agreement effective as of the date and year first written above.

BUSINESS ASSOCIATE

Dated: _____ By _____

Representative

DEPARTMENT OF HUMAN SERVICES, STATE OF HAWAII

Dated: _____ By _____

Director

STAFFING CHANGE NOTIFICATION FORM

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

1. Date Notification Form is submitted to MQD:

2. Date Health Plan has knowledge of the subject staffing change:
(For example: the date of the employee's resignation letter; the date of the decision to terminate an employee; the date an applicant accepts the offer of employment; or the date an employee receives the promotion to a new position.)

3. ☐ QI ☐ CCS ☐ Other

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

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

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

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

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

Name:
FTE:
Phone:
Email:

8.

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

9. Describe the staffing change:

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

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

Name:
Position Title:
Phone:
Email:

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

STAFFING CHANGE NOTIFICATION FORM (10/20)

INSTRUCTIONS

PURPOSE:

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

FORM INSTRUCTIONS:

1. Date Notification Form is submitted to MQD

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

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

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

3. ☐ QI ☐ CCS ☐ Other

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

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

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

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

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

6. Name of person *exiting* the above position

Enter the name of the person leaving the subject position.

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

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

8.

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

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

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

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

9. Describe the staffing change

In the space provided, briefly describe the staffing change.

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

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

10. *Interim Contact Employee* (if applicable)

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

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

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

SAMPLESTAFFING CHANGE NOTIFICATION FORM**SAMPLE**

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

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

2. **Date Health Plan has knowledge of the subject staffing change:** 10/14/20
(For example: the date of the employee's resignation letter; the date of the decision to terminate an employee; the date an applicant accepts the offer of employment; or the date an employee receives the promotion to a new position.)

3. ☒ QI ☐ CCS ☐ Other

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

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

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

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

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

8.
- **Does the *entering* person reside in the State of Hawaii?** ☒ Yes ☐ No
- **Does the *entering* person work in the State of Hawaii?** ☒ Yes ☐ No
- ****Submit to MQD, a current RESUME of the *entering* person, along with this Notification Form.** (This resume submission may not apply to the above position. Please refer to the RFP.)

9. **Describe the staffing change:**

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

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

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

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

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

APPENDIX L. REMEDIES FOR NON-PERFORMANCE OF CCS CONTRACT
This Appendix includes Contract non-performance for which DHS may assess Liquidated Damages.

No.	Non-performance of Contract	Liquidated Damages
	Readiness Reviews and Implementation Activities	
1.	Failure to meet readiness review requirements as set forth in Section 13, Readiness Review and Contract Implementation Activities, within timelines as set by the DHS, including non-submission of deliverables or submitting deliverables late, with inaccuracies or incomplete.	Up to $2,500.00 per day for each day of non-compliance or $5,000.00 per deliverable for non-submission, late, inaccurate, or incomplete deliverables.
2.	Failure to be operational by the agreed upon operational start date of the Contract, based on DHS determination as to when the Health Plan is considered to be fully operational.	Up to $5,000.00 per day for each day beyond the start date of the Contract that the Health Plan is not operational until the day that the Health Plan is fully operational as determined by DHS.
	Administration and Management	
3.	Failure to comply with licensure requirements, as set forth in Section 14.3, Licensing and Accreditation.	Up to $5,000.00 per day that Health Plan is not licensed or qualified as required by applicable state or local law.
4.	Violation of a subcontracting requirement as set forth in Section 14.4**,** Subcontractor Agreements, and other sections of the Contract as applicable.	Up to $5,000.00 per violation.

No.	Non-performance of Contract	Liquidated Damages
5.	Failure to comply with the Health Plan staffing requirements, as set forth in Section 11.0, Health Plan Personnel.	Up to $1,000.00 per day for each separate failure to comply, for the first thirty (30) days non-compliance. At its discretion, DHS may double this amount for each day after thirty (30) days for each specific instance that the Health Plan remains non-compliant.
6.	Failure to have appropriate staff member(s) attend meetings as requested and designated by DHS.	Up to $250.00 per appropriate staff person per meeting as requested by DHS.
7.	Failure of the Health Plan to respond to a Notice of Concern within three (3) business days of receipt or to provide a sufficient response as set forth in Section 14.20.D, Notice of Concern and Opportunity to Cure.	Up to $500.00 per day for each day until the response is received and $1,000.00 for failure to respond sufficiently to Notice of Concern.
8.	Failure of the Health Plan to submit a Corrective Action Plan within ten (10) business days following the date of the Written Deficiency Notice as set forth in Section 14.21.E, Corrective Action Plan.	Up to $1000.00 per day for each day until the Corrective Action Plan is received.
9.	Failure to timely implement and comply with an accepted Corrective Action Plan as set forth in Section 14.20.E, Corrective Action Plan.	Up to $500.00 per day for each day the Health Plan fails to comply with an accepted Corrective Action Plan as determined by DHS.
10.	For requests not otherwise specifically addressed in this Contract, failure to respond or to submit a complete or accurate written response to a Department's written request within the designated timeframe.	Up to $500.00 per day penalty until the response is received, complete or accurate, whichever is applicable.

No.	Non-performance of Contract	Liquidated Damages
11.	Failure to provide notice of any known or suspected conflicts of interest or criminal conviction disclosures, as set forth in Section 14.8, Conflict of Interest.	Up to $1,000.00 per day that disclosure is late.
	Financial Requirements and Reimbursement	
12.	Failure to submit accurate and complete information or respond to a Department request regarding Medical Loss Ratio Calculation within the requested timeframe and as defined in the Contract.	Up to $500.00 per day until the information or response is received
13.	Failure to seek, collect and/or report third party information, as set forth in Section 7.3, Third Party Liability.	Up to $5,000.00 per day.
	Information Systems	
18.	Failure of the Health Plan's MIS to meet all requirements in Section 10, Information Systems and Information Technology, at any given time during operations.	Up to $2,500.00 per day of non-compliance.

No.	Non-performance of Contract	Liquidated Damages
19.	Failure of the Health Plan to provide notice to the Department, as set forth in Section 10, Information Systems and Information Technology, at least 30 days prior to implementation of any significant system changes that may impact data integrity, including such changes as new Claims processing software, and new Claims processing vendors..	Up to $2,500.00 per day of non-compliance.
	Encounter Data	
20.	Failure to submit accurate, complete, and timely encounter data to MQD in accordance with the requirements and specifications defined by the State and included in the HPMMIS Health Plan Manual ("Health Plan Manual").	Timeliness: $1,000.00 per day late. Accuracy: Per Encounter File error fee of $500.00
21.	Failure of the Health Plan to submit encounter data in the required form or format (as required by the HPMMIS Health Plan Manual and the Hawaii Companion Guide) for one calendar month.	$10,000 per file.
22.	Failure of the Health Plan to submit the required attestation as required in Section 6.5. B, Health Plan Certification	Up to $5,000.00 per file and an additional penalty of $1,000.00 per each late day beyond the thirty (30) days of notification.
23.	Encounter records are not resubmitted within thirty (30) days of the date the record is returned, as set forth in the Contract.	Per Encounter File error fee of $1,000.00.

No.	Non-performance of Contract	Liquidated Damages
	Quality and Health Outcomes	
24.	Failure to submit quality measures including audited HEDIS and CAHPS results within required timeframes, as set forth in Section 5, Quality, Utilization Management, and Administrative Requirements.	Up to $1,000.00 per day for every day reports are late.
25.	Failure to timely submit appropriate PIPs to DHS as set forth in Section 6, Quality, Utilization Management, and Administrative Requirements.	Up to $1,000.00 per day beyond the due date for which an appropriate PIP is received.
	Utilization Management	
26.	Imposing arbitrary utilization guidelines, prior authorization restrictions, or other quantitative coverage limits on an Member as prohibited under the Contract or not in accordance with an approved policy.	Up to $5,000.00 per occurrence per Member.
	Member Services	
27.	Failure to obtain approval of Member materials, as set forth in the Contract.	$500.00 per day for each day that the Department determines the Health Plan has provided Member materials that have not been approved by the Department.
28.	Failure to comply with timeframes for providing Member materials to Members as set forth the Contract.	$250.00 per occurrence per Member.

No.	Non-performance of Contract	Liquidated Damages
29.	Engaging in prohibited marketing activities or discriminatory practices or failure to market statewide, as set forth in the Contract.	Up to $5,000.00 per occurrence.
30.	Failure of the Health Plan to issue written notice to Members upon PCP's notice of termination in the Health Plan's plan, as set forth in the Contract.	Up to $1,000.00 per occurrence.
	Complaints, Grievances and Appeals	
31.	Failure to resolve at least 50% of Member and provider complaints within required timeframes from the date the complaint, grievance or appeal is received.	Up to $250.00 per reporting period.
32.	Failure to maintain a Grievance or Appeal System as set forth in Section 9.5, Member Grievance and Appeals System.	Up to $500.00 per day the Health Plan is in default.
33.	Failure to resolve Member appeals and grievances within required timeframes as set forth in Section 9.5, Member Grievance and Appeals System.	Up to $5,000.00 per violation.
34.	Failure to provide a timely and content-compliant Notice of Adverse Benefit Determination in accordance with Section 9.5, Member Grievance and Appeals System.	Up to $500.00 per day the Health Plan is in default.

No.	Non-performance of Contract	Liquidated Damages
35.	Failure to comply with all orders and final decisions relating to claim disputes, grievances, appeals and/or State Fair Hearing as issued or as directed by DHS and as set forth in Section 9.5, Member Grievance and Appeals System.	Up to $5,000.00 per occurrence.
36.	Failure to comply with Transition of Care requirements as set forth in the Contract.	$100.00 per day, per Member and the value of the services the Health Plan failed to cover during the applicable transition of care period, as determined by DHS.
	Provider Services and Network	
37.	Failure to comply with requirements and timeframes to process credentialing as set forth in the Contract.	Up to $1,000.00 per incident.
38.	Failure to maintain provider agreements as set forth in the Contract.	Up to $1,000.00 per provider agreement found to be non-compliant.
	Covered Services	
39.	Failure to timely provide a covered service as required under this contract when determined by the Department that such failure results in actual harm to an Member or places an Member at risk of imminent harm.	Up to $5,000.00 per day for each incidence of non-compliance.
	Program Integrity	
40.	Failure to fully implement, enforce and monitor the Health Plan's compliance plan as set forth in Section 12.1.A.4, Administrative Requirements.	Up to $500.00 per day for each day of non-compliance.

No.	Non-performance of Contract	Liquidated Damages
41.	Failure to establish and maintain a special Investigative unit as described in Section 12.1.A.4, Administrative Requirements.	Up to $500.00 per day for each day of non-compliance.
42.	Failure to comply with other Fraud, Waste and Abuse provisions set forth in Section 12, Program Integrity.	Up to $500.00 per day for each day of non-compliance.
43.	Failure to respond to informational or reporting requests whether recurring or a onetime request from DHS, the OIG, the OAG, the MFCU or any other agent or contractor of DHS within the timeframe requested.	Up to $500 a day penalty until the information is received.
	Data, Reporting Requirements and Deliverables	
44.	Failure to provide a required report or deliverable set forth in Appendix K, (Reporting Inventory), in the required timeframe; for which submission is incomplete or incorrect; or failure to resolve identified reporting or deliverable errors within five (5) business days or other required timelines upon notification by DHS.	$250 per day until the violation is remedied.
	Confidentiality and Protected Health Information	

No.	Non-performance of Contract	Liquidated Damages
45.	Failure to ensure Member confidentiality in accordance with 45 CFR 160 and 45 CFR 164; and an incident of non-compliance will be assessed as per Member and/or per HIPAA regulatory violation, as set forth in Section 14.16, Confidentiality of Information.	Up to $2,500.00 for each breach.
46.	Failure to ensure that all Hawaii Medicaid data containing protected health information (PHI), as defined by HIPAA, is secured as set forth in Section 14.16, Confidentiality of Information.	Up to $500.00 per Member per occurrence, and if DHS deems credit monitoring and/or identity theft safeguards are needed to protect those Members whose PHI was placed at risk by the Health Plan's failure to comply with the terms of this Contract, the BHO shall be liable for all costs associated with the provision of such monitoring and/or safeguard services.
47.	Failure to seek express written approval from DHS prior to the use or disclosure of Member data or Hawaii Medicaid confidential information as set forth in Section 14.15, Confidentiality of Information.	Up to $1,000.00 per Member or per occurrence.
48.	Failure to timely report violations in the access, use and disclosure of PHI or timely report a security incident or timely make a notification of breach or notification of provisional breach.	$500.00 per Member per occurrence, not to exceed $10,000,000.00.

Report #	Name	Report Category	Submission Frequency	Due Dates
1	Disclosure of Information on Annual Business Transactions	Administration, Finances, and Program Integrity	Annually	31-Oct
2	Encounter Data/Financial Summary Reconciliation	Administration, Finances, and Program Integrity	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
3	Fraud, Waste, and Abuse	Administration, Finances, and Program Integrity	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
4	Medical Loss Ratio	Administration, Finances, and Program Integrity	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
5	Overpayments	Administration, Finances, and Program Integrity	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
6	Prescription Drug Rebates	Administration, Finances, and Program Integrity	Monthly	The 15th of each month
7	BHO Financial	Administration, Finances, and Program Integrity	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
8	BHO Financial – Annual	Administration, Finances, and Program Integrity	Annually	31-Oct
9	Community Integration Services	Covered Benefits and Services	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
10	Behavioral Health Services Report	Covered Benefits and Services	Monthly	Last day of the month following the reporting month
11	Behavioral Health Services Report	Covered Benefits and Services	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
12	Case Management Services Report	Covered Benefits and Services	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
13	Call Center Report & Remote Monitoring	Member Services	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
14	Member Grievance and Appeals	Member Services	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
15	Provider Grievance and Claims	Provider Network/ Services	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
16	Provider Network Adequacy Verification	Provider Network/ Services	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
17	Suspensions, Terminations, and Program Integrity Education	Provider Network/ Services	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan

18	Timely Access	Provider Network/ Services	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
19	Value Driven Health Care	Provider Network/ Services	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
20	Accreditation Status	Quality	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
21	Performance Improvement Projects	Quality	Annually	1-Jul
22	QAPI Progress Report and Annual Plan Update	Quality	Annually	1-Jul
23	QAPI Quarterly Progress and Work Plan Update	Quality	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
24	Adverse Events	Utilization Management	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
25	Drug Utilization Review	Utilization Management	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
26	Mental Health and Substance Use Disorder Parity	Utilization Management	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
27	Over-Utilization and Under-Utilization of Services	Utilization Management	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
28	Prior Authorizations - Medical & Pharmacy	Utilization Management	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
29	Provider Preventable Conditions	Utilization Management	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan

Provider Contract Requirements

Community Care Services (CCS)

All contracts between providers and the BHO shall be in writing. The BHO's written provider contracts shall:

1. Specify covered populations and specifically cite the Community Care Services (CCS) program;
2. Specify covered services;
3. Specify rates of payment and applicable VBP arrangements;
4. Prohibit the provider from seeking payment from the Member for any covered services provided to the Member within the terms of the contract and require the provider to look solely to the BHO for compensation for services rendered, with the exception of cost sharing pursuant to the Hawaii Medicaid State Plan;
5. Prohibit the provider from imposing a no-show fee for CCS program Members who were scheduled to receive a CCS covered service;
6. Require the provider to cooperate with the BHO's quality improvement activities;
7. Require that providers meet all applicable state and federal regulations, including but not limited to all applicable HAR sections, and Medicaid requirements for licensing, certification and recertification;
8. Require the provider to cooperate with the BHO's utilization review and management activities;

9. Not prohibit a provider from discussing treatment or non-treatment options with Members that may not reflect the BHO's position or may not be covered by the BHO;
10. Not prohibit, or otherwise restrict, a provider from acting within the lawful scope of practice, from advising or advocating on behalf of a Member for the Member's health status, medical care, or treatment or non-treatment options, including any alternative treatments that might be self-administered;
11. Not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice from advocating on behalf of the Member to obtain necessary healthcare services in any grievance system or utilization review process, or individual authorization process;
12. Require providers to meet appointment waiting time standards pursuant to the terms of the RFP as described in Section 8.1.C;
13. Provide for continuity of treatment in the event a provider's participation terminates during the course of a Member's treatment by that provider except in the case of adverse reasons on the part of the provider;
14. Require that providers maintain the confidentiality of Member's information and records as required by law, including but not limited to privacy and security regulations adopted under HIPAA;
15. Keep any records necessary to disclose the extent of services the provider furnishes the Members;
16. Specify that CMS, the State Medicaid Fraud Control Unit, and DHS or its respective designee shall have the right to inspect, evaluate, and audit any pertinent books, financial records, medical records, lab results, documents, papers, and records of any provider involving financial transactions related to this contract and for the

monitoring of quality of care being rendered without the specific consent of the Member or the provider;

17. Require that provider comply with disclosure requirements identified in accordance with 42 CFR Part 455, Subpart B;
18. Require providers that are compensated by capitation payments to submit complete and accurate encounter data on a monthly basis and make available all medical records to support encounter data without the specific consent of the Member upon request from the BHO, DHS or its designee for the purpose of validating encounters;
19. Require provider to certify claim/encounter submissions to the plan as accurate and complete;
20. Require the provider to provide medical records or access to medical records to the BHO and DHS or its designee, upon request. Refusal to provide medical records, access to medical records or inability to produce the medical records to support the claim/encounter shall result in recovery of payment;
21. Include the definition and standards for medical necessity, pursuant to the definition in Section 3 of this RFP;
22. Specify acceptable billing and coding requirements;
23. Require that providers comply with the BHO's cultural competency requirements;
24. Require that the provider submit to the BHO any marketing materials developed and distributed by the provider related to the CCS program;
25. Require that the provider maintain the confidentiality of Members' information and records as required by the RFP and by federal and state law, including but not limited to:

a. The Administration Simplification (AS) provisions of HIPAA, Public Law 104-191 and the regulations promulgated thereunder, including but not limited to 45 CFR Parts 160, 162, and 164, if the provider is a covered entity under HIPAA;
b. 42 CFR Part 431 Subpart F;
c. Chapter 17-1702, HAR;
d. Section 346-10, HRS;
e. 42 CFR Part 2;
f. Section 334-5, HRS; and
g. Chapter 577A, HRS;

26. Require that providers comply with 42 CFR Part 434 and 42 CFR Section 438.6, if applicable;
27. Require that providers not employ or subcontract with individuals or entities whose owner, those with controlling interest, or managing employees are on any state or federal exclusion lists;
28. Prohibit providers from making referrals for designated health services to healthcare entities with which the provider or a Member of the provider's family has a financial relationship as defined in Section 3;
29. Require providers of transitioning Members to cooperate in all respects with the Members' prior providers to assure the best health outcomes for Members;
30. Require the provider to comply with corrective action plans initiated by the BHO or DHS;
31. Specify the provider's responsibilities regarding third party liability;
32. Require the provider to comply with the BHO's compliance plan including all fraud and abuse requirements and activities;

33. Require that providers accept Members for treatment, unless the provider applies to the BHO for a waiver of this requirement;
34. Require that the provider provide services without regard to race, color, creed, ancestry, sex, including gender identity or expression, sexual orientation, religion, health status, income status, or physical or mental disability;
35. Require that providers offer hours of operation that are no less than the hours of operation offered to commercial members or, if the provider has no commercial members, that the hours of operation are comparable to hours offered to recipients under Medicaid fee-for-service;
36. Require that providers offer access to interpretation services for Members that have a Limited English Proficiency (LEP) at no cost to the Member, and to document the offer and provision of interpreter services to the same extent as the BHO under the Contract;
37. Require that providers offer access to auxiliary aids and services at no cost for Members living with disabilities, and to document the offer and provision of auxiliary aids to the same extent as the BHO under the Contract;
38. Include a statement that DHS and the CCS Members shall bear no liability for the BHO's failure or refusal to pay valid claims of subcontractors or providers for covered services;
39. Include a statement that the provider shall accept BHO payment in full and cannot charge the patient for any cost of a BHO covered service whether or not the service was reimbursed by the BHO;
40. Include a statement that DHS and the CCS Members shall bear no liability for services provided to a Member for which DHS does not pay the BHO;

41. Include a statement that DHS and the CCS Members shall bear no liability for services provided to a Member for which the plan or DHS does not pay the individual or healthcare provider that furnishes the services under a contractual, referral, or other arrangement to the extent that the payments are in excess of the amount that the Member would owe if the BHO provided the services directly;
42. Require the provider to secure and maintain all necessary liability insurance and malpractice coverage as is necessary to protect CCS Members and the BHO;
43. Require the provider to secure and maintain automobile insurance when transporting Members, if applicable;
44. Require that the provider use the definition for emergency medical condition included in Section 3;
45. Require that the provider provides copies of medical records to requesting Members and allows them to be amended as specified in 45 CFR Part 164, HIPAA, or any other applicable federal or state law;
46. Require that the provider provide record access to any authorized DHS personnel or personnel contracted by DHS without Member authorization so long as the access to the records is required to perform the duties of the contract with DHS and to administer the CCS programs;
47. Require that the provider complies with BHO standards that provide DHS or its designee(s) prompt access to Members' medical records whether electronic or paper;
48. Require that the provider coordinate with the BHO in transferring medical records (or copies) when a Member changes providers;

49. Require that the provider comply with the advance directives requirements for hospitals, nursing facilities, providers of home and health care, hospices, and HMOs specified in 42 CFR Part 489, subpart I, and 42 CFR Section 417.436(d);
50. Require all Medicaid related records, be retained in accordance with 42 CFR Section 438.3(u) for a minimum of ten (10) years after the last date of entry in the records. For minors, records must be preserved and maintained during the period of minority plus a minimum of ten (10) years after the minor reaches the age of majority;
51. Require that the provider complies with all credentialing and re-credentialing activities;
52. Require that the provider refund any payment received from a resident or family member (in excess of share of cost) on behalf of the Member for the prior coverage period;
53. Require that the provider submit annual cost reports to DHS, if applicable;
54. Require that the provider comply with all requirements regarding when they may bill a Member or assess charges as described in Section 7.2.A;
55. Require that the provider is licensed in good standing in the State of Hawaii; and
56. Require provider to report capitation payments or other overpayments in excess of amounts specified in the contract within sixty (60) calendar days when identified.

Appendix O

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Section 42 C.F.R. § 438.6(c) Preprint – January 2021
STATE/TERRITORY ABBREVIATION: HI
CMS Provided State Directed Payment Identifier:

Section 438.6(c) Preprint

42 C.F.R. § 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D). Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).

Submit all state directed payment preprints for prior approval to: StateDirectedPayment@cms.hhs.gov.

SECTION I: DATE AND TIMING INFORMATION

1. Identify the State's managed care contract rating period(s) for which this payment arrangement will apply (for example, July 1, 2020 through June 30, 2021):
   July 1, 2022 - December 31, 2022
2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2021). *Note, this should be the start of the contract rating period unless this payment arrangement will begin during the rating period.* July 1, 2022
3. Identify the managed care program(s) to which this payment arrangement will apply:
   This payment arrangement will apply to all managed care programs, except for dual-eligible enrollees where Medicaid is not the primary paye
4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment: The State's new APR DRG inpatient payment methodology was designed to be budget neutral to actual aggregate managed care base payments ($0 payment change in aggregate); as such the estimated total dol
   a. Identify the estimated federal share of this state directed payment: $0
   b. Identify the estimated non-federal share of this state directed payment: $0

   Please note, the estimated total dollar amount and the estimated federal share should be described for the rating period in Question 1. If the State is seeking a multi-year approval (which is only an option for VBP/DSR payment arrangements (42 C.F.R. § 438.6(c)(1)(i)-(ii))), States should provide the estimates per rating period. For amendments, states should include the change from the total and federal share estimated in the previously approved preprint.
5. Is this the initial submission the State is seeking approval under 42 C.F.R. § 438.6(c) for this state directed payment arrangement? ☒ Yes ☐ No

6. If this is not the initial submission for this state directed payment, please indicate if:
   a. ☐ The State is seeking approval of an amendment to an already approved state directed payment.
   b. ☐ The State is seeking approval for a renewal of a state directed payment for a new rating period.
      i. If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted:

   c. Please identify the types of changes in this state directed payment that differ from what was previously approved.
      ☐ Payment Type Change
      ☐ Provider Type Change
      ☐ Quality Metric(s) / Benchmark(s) Change
      ☐ Other; please describe:

      ☐ No changes from previously approved preprint other than rating period(s).
7. ■ Please use the checkbox to provide an assurance that, in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(F), the payment arrangement is not renewed automatically.

SECTION II: TYPE OF STATE DIRECTED PAYMENT

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).

   Hawai'i's MCOs will use a new All Patient Refined Diagnosis Related Group (APR DRG) payment methodology for Medicaid fee-for-service (FFS) inpatient payment purposes for admissions, as approved by CMS in its state plan section 4.19a. Hawai'i's MCOs will have a mechanism to make a single case rate payment for similar services provided in a hospital inpatient stay. This program is predicated exclusively on utilization and delivery of services.

   a. ■ Please use the checkbox to provide an assurance that CMS has approved the federal authority for the Medicaid services linked to the services associated with the SDP (i.e., Medicaid State plan, 1115(a) demonstration, 1915(c) waiver, etc.).
   b. Please also provide a link to, or submit a copy of, the authority document(s) with initial submissions and at any time the authority document(s) has been renewed/revised/updated.

      The state plan amendment authority that defines this provider class is found here:
      https://medquest.hawaii.gov/content/dam/formsanddocuments/med-quest/hawaii-state-plan/SPA_21-0011_Public_Notice_05-21-21_and_Attachment_4_19-A_pg_1-4_CLEAN_Redline.pdf
      The state plan authority that defines this provider class is found here:
      https://humanservices.hawaii.gov/wp-content/uploads/2017/12/4.19-A-from-Attachment-4-Rev.-07.2017.pdf
      The 1115 waiver authority for these services can be found here:
      https://medquest.hawaii.gov/content/dam/formsanddocuments/med-quest/hawaii-state-plan/Hawaii_QUEST_ntegration_1115_Demonstration_Extension_Approval_Package.pdf

9. Please select the general type of state directed payment arrangement the State is seeking prior approval to implement. (Check all that apply and address the underlying questions for each category selected.)

a. ☐ **VALUE-BASED PAYMENTS / DELIVERY SYSTEM REFORM:** In accordance with 42 C.F.R. § 438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

If checked, please answer all questions in Subsection IIA.

b. ■ **FEE SCHEDULE REQUIREMENTS:** In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(B) through (D), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. **[Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).]**

If checked, please answer all questions in Subsection IIB.

SUBSECTION IIA: VALUE-BASED PAYMENTS (VBP) / DELIVERY SYSTEM REFORM (DSR):

This section must be completed for all state directed payments that are VBP or DSR. This section does not need to be completed for state directed payments that are fee schedule requirements.

10. Please check the type of VBP/DSR State directed payment the State is seeking prior approval for. *Check all that apply; if none are checked, proceed to Section III.*

- ☐ Quality Payment/Pay for Performance (Category 2 APM, or similar)
- ☐ Bundled Payment/Episode-Based Payment (Category 3 APM, or similar)
- ☐ Population-Based Payment/Accountable Care Organization (Category 4 APM, or similar)
- ☐ Multi-Payer Delivery System Reform
- ☐ Medicaid-Specific Delivery System Reform
- ☐ Performance Improvement Initiative
- ☐ Other Value-Based Purchasing Model

11. Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services. If "other" was checked above, identify the payment model. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., meet or exceed a performance benchmark on provider quality metrics).

12. In Table 1 below, identify the measure(s), baseline statistics, and targets that the State will tie to provider performance under this payment arrangement (provider performance measures). Please complete all boxes in the row. To the extent practicable, CMS encourages states to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures when applicable.

TABLE 1: Payment Arrangement Provider Performance Measures

Measure Name and NQF # (if applicable)	**Measure Steward/ Developer**[1]	**Baseline**[2] **Year**	**Baseline**[2] **Statistic**	**Performance Measurement Period**[3]	**Performance Target**	**Notes**[4]
Example: Percent of High-Risk Residents with Pressure Ulcers – Long Stay	*CMS*	*CY 2018*	*9.23%*	*Year 2*	*8%*	*Example notes*
a.						
b.						
c.						
d.						
e.						

1. Baseline data must be added after the first year of the payment arrangement
2. If state-developed, list State name for Steward/Developer.
3. If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment.
4. If the State is using an established measure and will deviate from the measure steward's measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here.

13. For the measures listed in Table 1 above, please provide the following information:

a. Please describe the methodology used to set the performance targets for each measure.

b. If multiple provider performance measures are involved in the payment arrangement, discuss if the provider must meet the performance target on each measure to receive payment or can providers receive a portion of the payment if they meet the performance target on some but not all measures?

c. For state-developed measures, please briefly describe how the measure was developed?

14. Is the State seeking a multi-year approval of the state directed payment arrangement?
☐ Yes ☐ No

a. If this payment arrangement is designed to be a multi-year effort, denote the State's managed care contract rating period(s) the State is seeking approval for.

b. If this payment arrangement is designed to be a multi-year effort and the State is **NOT** requesting a multi-year approval, describe how this application's payment arrangement fits into the larger multi-year effort and identify which year of the effort is addressed in this application.

15. Use the checkboxes below to make the following assurances:

a. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(A), the state directed payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified below) providing services under the contract related to the reform or improvement initiative.

b. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

c. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(C), the payment arrangement does not set the amount or frequency of the expenditures.

d. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:
This section must be completed for all state directed payments that are fee schedule requirements. This section does not need to be completed for state directed payments that are VBP or DSR.

16. Please check the type of state directed payment for which the State is seeking prior approval. *Check all that apply; if none are checked, proceed to Section III.*

a. ■ Minimum Fee Schedule for providers that provide a particular service under the contract *using rates other than State plan approved rates* [1] (42 C.F.R. § 438.6(c)(1)(iii)(B))

b. ■ Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))

c. ☐ Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

[1] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

17. If the State is seeking prior approval of a fee schedule (options a or b in Question 16):

a. Check the basis for the fee schedule selected above.

i. ☑ The State is proposing to use a fee schedule based on the **State-plan approved rates** as defined in 42 C.F.R. § 438.6(a). [2]

ii. ☐ The State is proposing to use a fee schedule based on the **Medicare or Medicare-equivalent rate**.

iii. ☐ The State is proposing to use a fee schedule based on an **alternative fee schedule established by the State**.

1. If the State is proposing an alternative fee schedule, please describe the alternative fee schedule (e.g., 80% of Medicaid State-plan approved rate)

b. Explain how the state determined this fee schedule requirement to be reasonable and appropriate.

The State believes the proposed state directed payment is reasonable and appropriate because the minimum and maximum fee schedules ensure budget neutrality to current Medicaid managed care base payments.

18. If using a maximum fee schedule (option b in Question 16), please answer the following additional questions:

a. ☑ Use the checkbox to provide the following assurance: In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

b. Describe the process for plans and providers to request an exemption if they are under contract obligations that result in the need to pay more than the maximum fee schedule.

The plans and the providers must submit a request for exemption if they are under contractual obligations that result in the need to pay more than the maximum fee schedule, for special arrangements such pay-for-performance or other alternative payment models. The contract, and contractual provisions, show why a plan and the provider needs to pay more than the maximum fee schedule must be submitted to the State. Additionally, the plan and the providers must submit a justification for why there is a need to pay more than the maximum fee schedule. The State will review the materials submitted by the plans and providers to make an informed determination of whether the contractual obligations resulting in a need to pay more than the maximum fee schedule will be approved as an exemption.

c. Indicate the number of exemptions to the requirement:

i. Expected in this contract rating period (estimate) 0

ii. Granted in past years of this payment arrangement 0

d. Describe how such exemptions will be considered in rate development.

The State will consider exemptions in rate development, for special arrangements such as pay-for-performance or other alternative payment models, by reviewing any contractual agreements that the State has from the plans and providers to determine the significance of potential maximum fee schedule exemptions.

[2] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:

a. Will the state require plans to pay a ☐ uniform dollar amount **or** a ☐ uniform percentage increase? (*Please select only one.*)

b. What is the magnitude of the increase (e.g., $4 per claim or 3% increase per claim?)

c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

20. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), identify the class or classes of providers that will participate in this payment arrangement by answering the following questions:

a. Please indicate which general class of providers would be affected by the state directed payment (check all that apply):

- ■ inpatient hospital service
- ☐ outpatient hospital service
- ☐ professional services at an academic medical center
- ☐ primary care services
- ☐ specialty physician services
- ☐ nursing facility services
- ☐ HCBS/personal care services
- ☐ behavioral health inpatient services
- ☐ behavioral health outpatient services
- ☐ dental services
- ☐ Other:

b. Please define the provider class(es) (if further narrowed from the general classe indicated above).

This applies to in-state general acute hospitals and children's hospitals as approved in in the State's recent SPA. Per the SPA, the APR DRG Payment methodology excludes Critical Access Hospitals, freestanding rehabilitation hospitals, freestanding psychiatric hospitals, long-term acute care hospitals military hospitals, Veterans Association hospitals, out-of-state hospitals, and State of Hawai`i Organ and Tissue Transplant (SHOTT) services.

c. Provide a justification for the provider class defined in Question 20b (e.g., the provider class is defined in the State Plan.) If the provider class is defined in the State Plan, please provide a link to or attach the applicable State Plan pages to the preprint submission. Provider classes cannot be defined to only include providers that provide intergovernmental transfers.

The provider class is defined in the state's recent approved SPA found here: https://medquest.hawaii.gov/content/dam/formsanddocuments/med-quest/hawaii-state-plan/SPA_21-0011_Public_Notice_05-21-21_and_Attachment_4_19-A_pg_1-4_CLEAN_Redline.pdf

21. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract.

The payment methodology does not vary by provider is and is predicated exclusively on utilization and delivery of services

22. For the services where payment is affected by the state directed payment, how will the state directed payment interact with the negotiated rate(s) between the plan and the provider? Will the state directed payment:

a. ☒ Replace the negotiated rate(s) between the plan(s) and provider(s).

b. ☐ Limit but not replace the negotiated rate(s) between the plans(s) and provider(s).

c. ☐ Require a payment be made in addition to the negotiated rate(s) between the plan(s) and provider(s).

23. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22), please provide an analysis in Table 2 showing the impact of the state directed payment on payment levels for each provider class. This provider payment analysis should be completed distinctly for each service type (e.g., inpatient hospital services, outpatient hospital services, etc.).

This should include an estimate of the base reimbursement rate the managed care plans pay to these providers as a percent of Medicare, or some other standardized measure, and the effect the increase from the state directed payment will have on total payment. *Ex: The average base payment level from plans to providers is 80% of Medicare and this SDP is expected to increase the total payment level from 80% to 100% of Medicare.*

TABLE 2: Provider Payment Analysis

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs
Ex: Rural Inpatient Hospital Services	*80%*	*20%*	*N/A*	*N/A*	*100%*
a. Hospital - Inpatient	44.00%	0.00%	18.30%		62.30%
b.	0.00%	0.00%	0.00%		0.00%
c.	0.00%	0.00%	0.00%		0.00%
d.	0.00%	0.00%	0.00%		0.00%
e.	0.00%	0.00%	0.00%		0.00%
f.	0.00%	0.00%	0.00%		0.00%
g.	0.00%	0.00%	0.00%		0.00%

24. Please indicate if the data provided in Table 2 above is in terms of a percentage of:

- **a.** ☐ Medicare payment/cost
- **b.** ☐ State-plan approved rates as defined in 42 C.F.R. § 438.6(a) *(Please note, this rate cannot include supplemental payments.)*
- **c.** ☒ Other; Please define: statewide average commercial rate (ACR) for Hawaii hospitals.

25. Does the State also require plans to pay any other state directed payments for providers eligible for the provider class described in Question 20b? ☒ Yes ☐ No

If yes, please provide information requested under the column "Other State Directed Payments" in Table 2.

26. Does the State also require plans to pay pass-through payments as defined in 42 C.F.R. § 438.6(a) to any of the providers eligible for any of the provider class(es) described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column "Pass-Through Payments" in Table 2.

27. Please describe the data sources and methodology used for the analysis provided in response to Question 23.

This directed payment arrangement is not a payment in addition to the negotiated rates. See other preprints for a description of their methodology.

28. Please describe the State's process for determining how the proposed state directed payment was appropriate and reasonable.

The State believes the proposed state directed payment is appropriate and reasonable because the minimum and maximum fee schedules ensure budget neutrality to current Medicaid managed care base payments

SECTION IV: INCORPORATION INTO MANAGED CARE CONTRACTS

29. States must adequately describe the contractual obligation for the state directed payment in the state's contract with the managed care plan(s) in accordance with 42 C.F.R. § 438.6(c). Has the state already submitted all contract action(s) to implement this state directed payment? ☒ Yes ☐ No

a. If yes:

i. What is/are the state-assigned identifier(s) of the contract actions provided to CMS?

Section 7.2.C.1.d.1 and Appendix N3 of the QI SC#2 contract action, that has an effective date of 7/1/2022.

ii. Please indicate where (page or section) the state directed payment is captured in the contract action(s).

b. If no, please estimate when the state will be submitting the contract actions for review.

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

Note: Provide responses to the questions below for the first rating period if seeking approval for multi-year approval.

30. Has/Have the actuarial rate certification(s) for the rating period for which this state directed payment applies been submitted to CMS? ☒ Yes ☐ No

a. If no, please estimate when the state will be submitting the actuarial rate certification(s) for review.

b. If yes, provide the following information in the table below for each of the actuarial rate certification review(s) that will include this state directed payment.

Table 3: Actuarial Rate Certification(s)

Control Name Provided by CMS (List each actuarial rate certification separately)	Date Submitted to CMS	Does the certification incorporate the SDP?	If so, indicate where the state directed payment is captured in the certification (page or section)
i. Hawaii_QuestIntegration_20220701-20221231	04/14/2022	Yes	In the section labeled "DOCUMENTATION OF NEW DIRECTED PAYMENTS"
ii. Hawaii_CCS_20220701-20230630	04/01/2022	Yes	In Section I.4.D
iii.			
iv.			
v.			

Please note, states and actuaries should consult the most recent Medicaid Managed Care Rate Development Guide for how to document state directed payments in actuarial rate certification(s). The actuary's certification must contain all of the information outlined; if all required documentation is not included, review of the certification will likely be delayed.)

c. If not currently captured in the State's actuarial certification submitted to CMS, note that the regulations at 42 C.F.R. § 438.7(b)(6) requires that all state directed payments are documented in the State's actuarial rate certification(s). CMS will not be able to approve the related contract action(s) until the rate certification(s) has/have been amended to account for all state directed payments. Please provide an estimate of when the State plans to submit an amendment to capture this information.

31. Describe how the State will/has incorporated this state directed payment arrangement in the applicable actuarial rate certification(s) (please select one of the options below):

- **a.** ☒ An adjustment applied in the development of the monthly base capitation rates paid to plans.
- **b.** ☐ Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.
- **c.** ☐ Other, please describe:

32. States should incorporate state directed payment arrangements into actuarial rate certification(s) as an adjustment applied in the development of the monthly base capitation rates paid to plans as this approach is consistent with the rate development requirements described in 42 C.F.R. § 438.5 and consistent with the nature of risk-based managed care. For state directed payments that are incorporated in another manner, particularly through separate payment terms, provide additional justification as to why this is necessary and what precludes the state from incorporating as an adjustment applied in the development of the monthly base capitation rates paid to managed care plans.

This section is not applicable because this directed payment arrangement applies an adjustment of the monthly base capitation rates paid to plans.

33. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with 42 C.F.R. § 438.4, the standards specified in 42 C.F.R. § 438.5, and generally accepted actuarial principles and practices.

SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

34. Describe the source of the non-federal share of the payment arrangement. Check all that apply:

- **a.** ☒ State general revenue
- **b.** ☐ Intergovernmental transfers (IGTs) from a State or local government entity
- **c.** ☐ Health Care-Related Provider tax(es) / assessment(s)
- **d.** ☐ Provider donation(s)
- **e.** ☐ Other, specify:

35. For any payment funded by **IGTs (option b in Question 34)**,

- **a.** Provide the following (respond to each column for all entities transferring funds). If there are more transferring entities than space in the table, please provide an attachment with the information requested in the table.

Table 4: IGT Transferring Entities

Name of Entities transferring funds (enter each on a separate line)	Operational nature of the Transferring Entity (State, County, City, Other)	Total Amounts Transferred by This Entity	Does the Transferring Entity have General Taxing Authority? (Yes or No)	Did the Transferring Entity receive appropriations? If not, put N/A. If yes, identify the level of appropriations	Is the Transferring Entity eligible for payment under this state directed payment? (Yes or No)
i.					
ii.					
iii.					
iv.					
v.					
vi.					
vii.					
viii.					
ix.					
x.					

b. ☐ Use the checkbox to provide an assurance that no state directed payments made under this payment arrangement funded by IGTs are dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

c. Provide information or documentation regarding any written agreements that exist between the State and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement. This should include any written agreements that may exist with healthcare providers to support and finance the non-federal share of the payment arrangement. Submit a copy of any written agreements described above.

36. For any state directed payments funded by **provider taxes/assessments (option c in Question 34)**,

a. Provide the following (respond to each column for all entries). If there are more entries than space in the table, please provide an attachment with the information requested in the table.

Table 5: Health Care-Related Provider Tax/Assessment(s)

Name of the Health Care-Related Provider Tax / Assessment (enter each on a separate line)	Identify the permissible class for this tax / assessment	Is the tax / assessment broad-based?	Is the tax / assessment uniform?	Is the tax / assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the "75/75" test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
i.						
ii.						
iii.						
iv.						
v.						

b. If the state has any waiver(s) of the broad-based and/or uniform requirements for any of the health care-related provider taxes/assessments, list the waiver(s) and its current status:

Table 6: Health Care-Related Provider Tax/Assessment Waivers

Name of the Health Care-Related Provider Tax/Assessment Waiver (enter each on a separate line)	Submission Date	Current Status (Under Review, Approved)	Approval Date
i.			
ii.			
iii.			
iv.			
v.			

37. For any state directed payments funded by **provider donations (option d in Question 34)**, please answer the following questions:

a. Is the donation bona-fide? ☐ Yes ☐ No

b. Does it contain a hold harmless arrangement to return all or any part of the donation to the donating entity, a related entity, or other provider furnishing the same health care items or services as the donating entity within the class?
☐ Yes ☐ No

38. ☑ **For all state directed payment arrangements**, use the checkbox to provide an assurance that in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

39. ■ Use the checkbox below to make the following assurance, "In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340."

40. Consistent with 42 C.F.R. § 438.340(d), States must post the final quality strategy online beginning July 1, 2018. Please provide:

a. A hyperlink to State's most recent quality strategy: https://medquest.hawaii.gov/en/resources/quality-strategy.html

b. The effective date of quality strategy. October 1, 2020

41. If the State is currently updating the quality strategy, please submit a draft version, and provide:

a. A target date for submission of the revised quality strategy (month and year):

b. Note any potential changes that might be made to the goals and objectives.

No changes anticipated.

Note: The State should submit the final version to CMS as soon as it is finalized. To be in compliance with 42 C.F.R. § 438.340(c)(2) the quality strategy must be updated no less than once every 3-years.

42. To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy. In the Table 7 below, identify the goal(s) and objective(s), as they appear in the Quality Strategy (include page numbers), this payment arrangement is expected to advance. If additional rows are required, please attach.

Table 7: Payment Arrangement Quality Strategy Goals and Objectives

Goal(s)	Objective(s)	Quality strategy page
Example: Improve care coordination for enrollees with behavioral health conditions	*Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15%*	*5*
a.		55
b.		53
c.		
d.		

43. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Table 7. If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and in terms of that of the multi-year payment arrangement.

This payment arrangement will allow Med-QUEST to establish standardized payment benchmarks, provide acuity measurement, promote equitability across providers, and incentivize the efficient delivery of care.

• For inpatient payment purposes, DRGs are a mechanism for making case rate payments for similar services provided in a hospital inpatient stay. By establishing a transparent, publicly available fee schedule, Med-QUEST will compare and evaluate reimbursement levels across inpatient services, hospitals, and MCOs; as well as control the rate of inpatient expenditure increases.

• DRGs are used both by payers and providers to classify hospital inpatient stays into clinically meaningful diagnostic groups. This provides Med-QUEST a basis for evaluating variation in service mix, cost structures, and patient outcomes (including readmissions) across hospitals and MCOs.

• For inpatient payment purposes, DRGs are a mechanism for making a standardized case rate payment for similar services provided in a hospital inpatient stay. This provides for an equitable payment for the same type of services across the delivery system, while also providing enhanced payment for the services with the highest levels of intensity.

• By establishing case rates for each DRG, a DRG prospective payment methodology incentivizes hospitals to avoid unnecessary lengths of stay and ancillary services during an inpatient service.

Together, these approaches are expected to achieve Med-QUEST's objectives of using aligned payment structures to enhance and incentivize quality and value of care (Objective 17) and decrease inappropriate care (Objective 15).

44. Please complete the following questions regarding having an evaluation plan to measure the degree to which the payment arrangement advances at least one of the goals and objectives of the State's quality strategy. To the extent practicable, CMS encourages States to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures, when applicable.

a. ■ In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(D), use the checkbox to assure the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340, and that the evaluation conducted will be *specific* to this payment arrangement. *Note:* States have flexibility in how the evaluation is conducted and may leverage existing resources, such as their 1115 demonstration evaluation if this payment arrangement is tied to an 1115 demonstration or their External Quality Review validation activities, as long as those evaluation or validation activities are ***specific*** to this payment arrangement and its impacts on health care quality and outcomes.

b. Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 42. For each measure the State intends to use in the evaluation of this payment arrangement, provide in Table 8 below: 1) the baseline year, 2) the baseline statistics, and 3) the performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives. Please attach the State's evaluation plan for this payment arrangement.

TABLE 8: Evaluation Measures, Baseline and Performance Targets

Measure Name and NQF # (if applicable)	Baseline Year	Baseline Statistic	Performance Target	Notes[1]
Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039	*CY 2019*	*34%*	*Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccination by 1 percentage point per year*	*Example notes*
i. Inpatient Utilization (IPU) – Total Inpatient Average Length of Stay (Total Population, excludes neonatal and mental health hospitalizations)	2021	6.73 days	≤ 5.40 days	Target set based on average national geometric mean length of stay by type of visit.
ii. Inpatient Utilization (IPU) – Total Maternity Average Length of Stay (Total Population)	2021	2.55 days	≤ 3.13 days	Target set based on average national geometric mean length of stay by type of visit.
iii. Inpatient Utilization (IPU) – Total Medicine Average Length of Stay (Total Population)	2021	5.69 days	≤ 4.28 days	Target set based on average national geometric mean length of stay by type of visit.
iv. Inpatient Utilization (IPU) – Total Surgery Average Length of Stay (Total Population) v. Plan All-Cause Readmissions (O/E Ratio, Total) – NQF# 1768	2021 2021	13.51 days 0.8594	≤ 6.91 days ≤ 0.8164	Target set based on average national geometric mean length of stay by type of visit. Target set based on a 1% annualized improvement over 5-years.

1. If the State will deviate from the measure specification, please describe here. If a State-specific measure will be used, please define the numerator and denominator here. Additionally, describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

c. If this is any year other than year 1 of a multi-year effort, describe (or attach) prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. Evaluation findings must include 1) historical data; 2) prior year(s) results data; 3) a description of the evaluation methodology; and 4) baseline and performance target information from the prior year(s) preprint(s) where applicable. If full evaluation findings from prior year(s) are not available, provide partial year(s) findings and an anticipated date for when CMS may expect to receive the full evaluation findings.

This is not applicable because this is year 1 of this payment arrangement