APPENDICES

RFP-MQD-2014-005

APPENDIX A – Written Questions Format

Appendix A

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

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

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

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

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

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

APPENDIX B – Written Questions Format for Capitation Rates

Appendix B

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

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

APPENDIX C – RFP Interest Form

Notification to State Agency of Interest in Responding to an RFP

RFP Number and Title: ______________________________
Organization or Individual: ______________________________

Contact Person Information

First Name: ________________ Last Name: ________________
E-mail Address: ______________________________
Telephone: ______________________________
Fax Number: ______________________________

Mailing Address

Street Address or PO Box ______________________________

City ____________ State ____________ Zip Code ____________

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

APPENDIX D – Proposal Forms

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

STATE OF HAWAII

STATE PROCUREMENT OFFICE

PROPOSAL APPLICATION IDENTIFICATION FORM

STATE AGENCY ISSUING RFP: ______________________________

RFP NUMBER: ______________________________

RFP TITLE: ______________________________

Check one:

☐ Initial Proposal Application

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

1. APPLICANT INFORMATION

Legal Name:

Doing Business As:

Street Address:

Mailing Address:

Contact person for matters involving this application:

Name:

Title:

Phone Number:

Fax Number:

e-mail:

2. BUSINESS INFORMATION

Type of Business Entity *(check one)*:

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

☐ For-Profit Corporation ☐ Partnership

If applicable, state of incorporation and date incorporated:

State: Date:

3. PROPOSAL INFORMATION

Geographic area(s):

Target group(s):

4. FUNDING REQUEST

FY ________ ____________________ FY ________ ____________________

FY ________ ____________________ FY ________ ____________________

FY ________ ____________________ FY ________ ____________________

Grand Total ____________________

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

______________________________ ____________

Authorized Representative Signature *Date Signed*

____

Name and Title

STATE OF HAWAII

Department of Human Services

PROPOSAL LETTER

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

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

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

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

____

Authorized Applicant's Signature/Corporate Seal

Date

____

CERTIFICATION FOR CONTRACTS, GRANTS, LOANS AND COOPERATIVE AGREEMENTS

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

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

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

Applicant: ______________________________

Signature: ______________________________

Title: ______________________________

Date: ______________________________

DISCLOSURE STATEMENT (CMS REQUIRED)

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

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

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

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

§ 455.106
Disclosure by providers: Information on persons convicted of crimes.
(a) Information that must be disclosed. Before the Medicaid agency enters into or renews a provider agreement, or at any time upon written request by the Medicaid agency, the provider must disclose to the Medicaid agency the identity of any person who:
(1) Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and
(2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs.
(b) Notification to Inspector General. (1) The Medicaid agency must notify the Inspector General of the Department of any disclosures made under paragraph (a) of this section within 20 working days from the date it receives the information.
(2) The agency must also promptly notify the Inspector General of the Department of any action it takes on the provider's application for participation in the program.
(c) Denial or termination of provider participation. (1) The Medicaid agency may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the title XX Services Program.
(2) The Medicaid agency may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under paragraph (a) of this section.

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

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

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

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

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

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

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

3) As used in this section, "related party" means one that has the power to control or significantly influence the applicant, or one that is controlled or significantly influenced by the applicant. "Related parties" include, but are no t limited to agents, managing employees, persons with an ownership or controlling interest in the disclosing entity, 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 applicant's ability to meet Behavioral Health objectives. Related party transactions include transactions which are conducted in an arm's length manner or are not reflected *in* the accounting records at all (e.g., the provision of services without charge).

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

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

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

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

Justification

____

____

____

____

____

____

____

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

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

Justification

____
____
____
____
____
____
____

DISCLOSURE STATEMENT

Provider NAME/NO. ____

DISCLOSURE STATEMENT FOR THE YEAR ENDED __________

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

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

DISCLOSURE STATEMENT OWNERSHIP

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

For the period beginning: ____________ and ending ____________ Type of Provider:

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

Type of Entity:

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

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

Appendix D

Annual Disclosure of Ownership (ADO) Instructions

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

<u>Indirect Ownership Interest</u> - 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.
<u>Ownership Interest</u> - means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

<u>Person with an Ownership or Control Interest</u> - means a person or corporation that:

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

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

<table>
<tr><td>11</td><td>List name of managing company, if not applicable enter N/A.</td></tr>
<tr><td>12</td><td>List names of the disclosing entities in which persons have ownership of other Medicare/Medicaid facilities.</td></tr>
<tr><td colspan="2"><u>Other Disclosing Entity</u> - means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Act. This includes:
• Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII).
• Any Medicare intermediary or carrier.
• Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health- related services for which it claims payment under any plan or program established under Title V or Title XX or the Act.</td></tr>
<tr><td>13</td><td>If entity engages with subcontractors (such as physical therapist, pharmacies, etc.,) which exceeds the lesser of $25,000 or 5% of applicant's operating expense, list subcontractor's name and address.</td></tr>
<tr><td colspan="2">Significant Business Transaction- means any business transaction or series of transactions that, during any one fiscal year, exceeds the lesser of $25,000 or 5% of applicant's operating expense.</td></tr>
<tr><td>14</td><td>List any significant business transactions between this provider and any wholly owned supplier, or between this provider and any subcontractor, during the previous 5-year period.</td></tr>
<tr><td>15</td><td>List name, SSN, address of any immediate family member who is authorized to prescribe drugs, medicine, devices or equipment.</td></tr>
<tr><td>16</td><td>List anyone disclosed in question #8 who has been convicted of a criminal offense related to the involvement of such persons or organizations in any problem established under Title 19 (Medicaid) or Title 20 (Social Services Block Grants) of the Social Security Act (SSA) or any criminal offense in this state or any other state. Please also indicate any HI Medicaid provider number(s) associated with individual or organization.</td></tr>
<tr><td>17</td><td>List any agent and/or managing employee who has been convicted of a criminal offense related to any program established under Title XVIII, XIX or XX of the SSA or any criminal offense in this state or any other state. Indicate any HI Medicaid provider number(s) associated with individual or organization.</td></tr>
<tr><td colspan="2"><u>Agent</u> - means any person who has been delegated the authority to obligate or act on behalf of a provider.
<u>Managing Employee</u> - 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.</td></tr>
<tr><td>18</td><td>List the name, title, FEIN/SSN, and business address of all managing employees as defined in 42 CFR 455.101.</td></tr>
<tr><td>19</td><td>List name, address and SSN/FEIN of each person with an ownership or control interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more.</td></tr>
<tr><td colspan="2"><u>Subcontractor</u> - means an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients, OR an individual, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or lease of real property) to obtain space, supplies, equipment or services provided under the Medicaid agreement.</td></tr>
</table>

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

Please return form to:

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

Annual Disclosure of Ownership (ADO)

THIS FORM IS REQUIRED BY FEDERAL AND STATE LAW AND REGULATION (42 CFR 455.101, 455.104, 455.105 AND 455.106 and HAR §17-1736-19).

Note: See the instructions of this form for definitions of underlined terms according to 42 CFR 455.101, 455.104, 455.105, and HAR §17-1736-19. ***All attachments must be labeled and reference to the question the attachment pertains.***

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

Name/Business Name:	SSN:	
Business Address:	FEIN:	DOB:
City:	State:	Zip

** If a corporate entity is disclosed in question #8 above, all business location(s) of this corporate entity must be disclosed. Please attach a sheet to disclose this information.

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

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

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

12.	List the names of any other disclosing entity in which person(s) listed on this application have ownership of other Medicare/Medicaid facilities. ☐ *Check here for N/A*	
Name:	Provider #, if applicable:	
Address:		
City:	State:	Zip:

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

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

15.	List the name, SSN, and address of any immediate family member who is authorized under Hawaii Law or any other states' professional boards to prescribe drugs, medicine, medical devices, or medical equipment. ☐ *Check here for N/A*		
Name(a)		Title:	
Address:		DOB:	SSN:
City:		State:	Zip:
Name(b)		Title:	
Address:		DOB:	SSN:
City:		State:	Zip:

16.	List the name of any individuals or organizations having direct or indirect ownership or controlling interest of 5% or more, who have been convicted of a criminal offense related to the involvement of such persons, or organizations in any program established under Title XVIII (Medicare), or Title XIX (Medicaid), or Title XX (Social Services Block Grants) of the Social Security Act or any criminal offense in this state or any other state since the inception of those programs. (Attach extra page if necessary.) If individual or organization is associated with a HI Medicaid provider number(s), please indicate below. (Attach extra page if necessary.) ☐ *Check here for N/A*
Name (a)/HI Medicaid Provider Number(s), if applicable:	
Name (b)/HI Medicaid Provider Number(s), if applicable:	

17.	List the name of any agent and/or managing employee of the disclosing entity who has been convicted of a criminal offense related to the involvement in any program established under Title XVIII, XIX, or XX, or XXI of the Social Security Act or any criminal offense in this state or any other state since the inception of those programs. (Attach extra page if necessary.) If individual or organization is associated with a HI Medicaid provider number(s), indicate below. (Attach extra page if necessary.) ☐ *Check here for N/A*
Name (a)/HI Medicaid Provider Number(s), if applicable:	
Name (b)/HI Medicaid Provider Number(s), if applicable:	

18.	List the name, title, FEIN/SSN, and business address of all managing employees below as defined in 42 CFR 455.101. ☐ *Check here for N/A* (Attach extra page if necessary listing same details below.)		
Name(a)		Title:	
Address:		DOB:	SSN:
City:		State:	Zip:
Name(b)		Title:	
Address:		DOB:	SSN:
City:		State:	Zip:

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

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

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

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

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

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

Name/Title	Address

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

Name	Address	Amount of Debt	Description of Security

Financial Reporting Guide Forms
Organization Structure and Financial Planning Form

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

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

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

   Service Component | License/Requirement | Renewal Date

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

   Yes ______________ No ___________ If yes, please explain:

3) Civil Rights Compliance Data

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

   Yes ______________ No ___________ If yes, please explain:

4) Handicapped Assurance

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

   Yes ________ If yes, briefly describe how such assurances are provided.

   No ________ If no, briefly describe how your organization is taking affirmative steps to provide assurance.

5) Prior Convictions

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

6) Federal Government Suspension/Exclusion

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

Yes ______________ No ___________ If yes, please explain:

Financial Planning Form

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

2) Does the applicant prepare an annual financial statement?

   Yes ________________ No ________________ If yes, please explain:

3) Are interim financial statements prepared? Yes ______________ No __________ ______

   a. If yes, how often are they prepared? ____ ________________

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

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

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

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

   Yes ________________ No ________________

   a. If yes, how often are audits conducted? ____ __________

   b. By whom are they conducted? ____ ______________________

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

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

Yes ____________ No ________________

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

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

e. Do you have any uncorrected audit exceptions?

Yes ____________ No ________________

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

5) Does the applicant have an accounting manual?

Yes ________________ No ________________

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

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

Yes ________________ No ________________

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

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

a. With what company(s)? ____

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

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

9) Are there any suits, judgments, tax deficiencies, or claims pending against the applicant?
Yes ________________ No ________________

Briefly describe each item and indicate probable amount.

10) Has the applicant or its owner(s) ever gone through bankruptcy?
Yes ________________ No ________________

If yes, when? ____

11) Do(es) the applicant's owner(s) intend to provide all necessary funds to make full and timely payments for liabilities (reported or not recognized)?
Yes ________________ No ________________

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

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

12) Does the applicant have a performance bonding mechanism in accordance with DHS rules?
Yes ________________ No ________________

If yes, provide the following information:

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

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

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

Yes ________________ No ________________

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

no) must complete items "a" through "h" below.

a. Is your system capable of accurately forecasting all significant claims prior to receipt of all billing? Yes ________________ No ________________
b. How often are IBNRs projected? ________________________________
c. Identify all major data sources most often used.
d. Are data from open referrals and prior notifications used?
   Yes ____________ No ________________ If so, how?
e. Are detailed written procedures maintained? Yes ________________
   No ________________
f. Are IBNR amounts compared with actuals and adjusted when necessary?
   Yes ____________ No ________________
g. Is the basis of periodic IBNR estimates well documented?
   Yes ____________ No ________________
h. The applicant must provide a copy of their IBNR procedures and a summary of their IBNR practices. If these procedures do not adequately support any response to this item the applicant is cautioned to provide additional data.

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

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

Yes ________________ No ________________ If yes, enter name: ____

____

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

a. Medicare reimbursement Yes ________________ No ____ __________

b. Other third-party recoveries Yes ________________ No ____ __________

If no, explain why.

Controlling Interest Form

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

Name	Address	Owner or Controller	Has Controlling Interest? Yes	No

Background Check Information Form

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

Name**	Ever known by another name* Yes	No	Social Security Account #	Date of Birth (Da/Mo/Yr)	Place of birth City/County/State

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

a. Give addresses for the last ten years
b. Ever suspended from any Federal program for any reason?

Yes __________________ No __________________ If yes, please explain.

Operational Certification Submission Form

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

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

Signature Date

Grievance System Form

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

I hereby certify that ____

Applicant Name

will have in place on the commencement date of this contract a system for reviewing and adjudicating grievances by recipients and providers arising from this contract in accordance with DHS Rules and as set forth in the Request for Proposal.

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

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

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

____ ________________

Authorized Signature Date

____ ________________

Printed Name Title

INSURANCE REQUIREMENTS CERTIFICATION

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

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

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

(Check and complete one)

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

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

____

____

____

____

____

____

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

____

Name of Applicant

________________________________ ____________________

Authorized Representative Signature Date

____

Print Name and Title

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

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

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

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

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

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

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

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

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

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
(1)

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

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

PRODUCER	CONTACT NAME:	
	PHONE (A/C, No, Ext):	FAX (A/C, No):
	E-MAIL ADDRESS:	
	PRODUCER CUSTOMER ID #:	
INSURED	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)	LIMITS (8)	
	GENERAL LIABILITY ☐ COMMERCIAL GENERAL LIABILITY ☐ CLAIMS-MADE ☐ OCCUR (4) GEN'L AGGREGATE LIMIT APPLIES PER: ☐ POLICY ☐ PRO-JECT ☐ LOC	(13)		(5)	(6)	(7)	EACH OCCURRENCE	$
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$ (10)
							GENERAL AGGREGATE	$
							PRODUCTS - COMP/OP AGG	$
								$
	AUTOMOBILE LIABILITY ☐ ANY AUTO (9) ☐ ALL OWNED AUTOS ☐ SCHEDULED AUTOS ☐ HIRED AUTOS ☐ NON-OWNED AUTOS	(13)					COMBINED SINGLE LIMIT (Ea accident)	$
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$ (10)
								$
								$
	☐ UMBRELLA LIAB ☐ OCCUR ☐ EXCESS LIAB ☐ CLAIMS-MADE ☐ DEDUCTIBLE ☐ RETENTION $	(13)					EACH OCCURRENCE	$
							AGGREGATE	$
								$ (10)
								$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A					WC STATU-TORY LIMITS / OTH-ER	
							E.L. EACH ACCIDENT	$
							E.L. DISEASE - EA EMPLOYEE	$ (11)
							E.L. DISEASE - POLICY LIMIT	$
	(12)							

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

CERTIFICATE HOLDER	CANCELLATION
(14)	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)

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Wage Certification

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

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

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

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

Applicant: ____________________

Signature: ____________________

Title: ____________________

Date: ____________________

CONTRACT NO. ______________________

PROVIDER'S
STANDARDS OF CONDUCT DECLARATION

For the purposes of this declaration:

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

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

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

On behalf of:

____
(Name of PROVIDER)

PROVIDER, the undersigned does declare as follows:

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

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

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

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

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

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

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

PROVIDER

By ______________________________
(Signature)

Print Name ______________________________

Print Title ______________________________

____

Date ______________________________

APPENDIX E – Risk Share Program

Risk Share Program

This appendix shall be released on the date identified in Section 20.100.

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

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

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

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

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

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

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

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

APPENDIX G – Eligible Diagnosis for the Community Care Services

Eligible Diagnoses for the Community Care Services (CCS) Program

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

APPENDIX H – SEBD Program Services

SEBD SERVICES

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

WHO IS ELIGIBLE?

A child, youth or adolescent who meets the following:

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

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

WHAT ARE THE SERVICES?

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

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

WHO PROVIDES THE SERVICES?

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

WHERE DO I BEGIN?

Answer the following questions:

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

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

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

WHO DECIDES THE ELIGIBILITY FOR SERVICES?

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

FAMILY GUIDANCE CENTERS

Oahu

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

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

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

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

Family Court Liaison Branch

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

Maui

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

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

Molokai

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

Lanai

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

Hawaii

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

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

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

Kauai

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

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

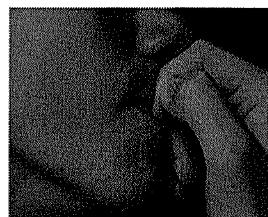
STATE OF HAWAII
DEPARTMENT OF HEALTH
CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
3627 KILAUEA AVE RM 101
HONOLULU HAWAII 96816

H-2

Rev 10/10 (A7809)

DO YOU KNOW A CHILD WITH EMOTIONAL AND BEHAVIORAL CHALLENGES?

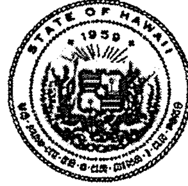
SUPPORT FOR EMOTIONAL AND BEHAVIORAL DEVELOPMENT



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

APPENDIX I – ESPDT in the DD-ID Waiver

LINDA LINGLE
GOVERNOR



LILLIAN B. KOLLER, ESQ.
DIRECTOR

HENRY OLIVA
DEPUTY DIRECTOR

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

July 21, 2010

MEMORANDUM

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

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

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

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

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

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

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

This guidance incorporates the projected EPSDT State Plan Amendment approval.

1. **EPSDT Services provided by the QExA health plans**

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

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

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

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

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

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

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

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

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

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

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

2. **Services provided by the DD/MR program**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attachment A

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

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

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

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

Attachment A

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

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

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

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

QUEST Expanded Access (QExA) Acute and Primary Care Services

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

Attachment C

DD/MR waiver services in 1915(c) waiver

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

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

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

APPENDIX J – Covered Preventive Services for Adults and Children

APPENDIX J
COVERED PREVENTIVE SERVICES FOR ADULTS AND CHILDREN

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

FOR ADULTS

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

Screening

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

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

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

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

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

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

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

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

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

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

7. **Prostate Cancer Screening**
Not recommended for routine screening.

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

8. **Rubella Serology or Vaccination History**
Minimum: women of child bearing age

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

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

Immunizations

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

Chemoprophylaxis

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

FOR THE HIGH RISK POPULATION

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

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

FOR PREGNANT WOMEN

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

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

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

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

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

4. **Diagnosis of Premature Labor**

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

6. **Prenatal Vitamins Including Folic Acid**

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

FOR CHILDREN

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

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

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

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

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

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

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

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

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

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

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