

APPENDIX K – Health Professionals Counseling and Training

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

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

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

APPENDIX L – Service Coordinator Responsibilities and Ratios

**Appendix L
QUEST Integration Service Coordinator Responsibilities and Ratios**

	Children with SHCN	Adults with SHCN	HCBS (both "at risk" and institutional LOC)	Institutional LOC residing in an institutional setting	Self-Direction (both "at risk" and institutional LOC)	Optional Delegate to Provider (i.e., NF, CCMA, or hospital)
Identify members with Special Health Care Needs (SHCN) in accordance with Section 40.910.1 and 40.910.2	X	X				
Identify members requiring HCBS (both "at risk" and institutional LOC) and institutional LOC residing in an institutional setting			X	X		
Conduct initial health and functional assessment (HFA)	X	X	X	X	X	X
Develop service plan based upon the results of the HFA	X	X	X	X	X	X
Provide service coordination to support the PCP and other providers in the network in providing good medical care to members	X	X	X	X	X	
Coordinate a team of decision-makers to develop the service plan, including the PCP, other providers as appropriate, the member and others as determined by the member including family members, caregivers and significant others	X	X	X	X	X	

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Coordinating services with other providers and community programs such as Medicare, the DOH programs excluded from QI, other DHS programs such as Child Welfare Services and Adult Protective Services, Medicare Advantage plans, other health plan providers, Zero-To-Three, Healthy Start, DD/ID providers at DOH, CCS and CAMHD Programs to ensure continuity of care	X	X	X	X	X	
Monitor progress with EPSDT requirements	X		X (for children)	X (for children)	X (for children)	
Providing continuity of care when members are discharged from a hospital and prescribed medications that are normally prior authorized or not on the plan's formulary	X	X	X	X	X	

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Utilize compiled data received from member encounters to assure the services being provided meet member needs	X	X	X		X	
Facilitate access to services including community services	X	X	X	X	X	
Provide assistance to resolve any concerns about care delivery or providers	X	X	X	X	X	
Assisting members to maintain continuous Medicaid benefits, this includes identifying at risk members and ensuring continuity of care and services	X	X	X	X	X	X
Submit DHS 1148 to long-term eligibility unit			X	X	X	X (CCMA only)

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Individuals receiving HCBS who meet institutional LOC shall have access to both a nurse and social worker as their service coordinator(s). Both shall be present for the initial assessment and service plan development. The health plan may identify a primary service coordinator (either nurse or social worker) for future assessment and service plan updates based upon member needs (i.e., primarily medical or primarily social). However, members shall have access to both disciplines based upon their current or future needs.			X		X	
Update service plan with input from team of decision-makers	At a minimum, semi-annually	At a minimum, semi-annually	At a minimum, every 90 days	At a minimum, every 90 days	At a minimum, every 90 days	
Conduct functional level of care assessment using DHS form 1147, at a minimum annually			X	X	X	X

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Transfer functional level of care assessment results to State for nursing facility determination			X	X	X	X
Provide options counseling regarding institutional placement and HCB services alternatives			X	X	X	X
Assist members in transitioning to and from institutional setting/community placement			X	X		
Face-to-Face HFA Reassessment (including an assessment as to the need for a nursing facility evaluation)	At a minimum, semi-annually	At a minimum, semi-annually	At a minimum, every 90 days	At a minimum, every 90 days	At a minimum, every 90 days	X
Oversight and monitoring of the self-direction delivery process (including assistance in choosing providers, directing providers and provider background checks)					X	
Oversight and monitoring of the care delivery process			X	X	X	
Referral for SEBD/SMI Evaluation, if applicable	X	X	X	X	X	
Referral for preventive and restorative dental care	X		X (for children)	X (for children)	X (for children)	

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	Children with SHCN	Adults with SHCN	HCBS (both "at risk" and institutional LOC)	Institutional LOC residing in an institutional setting	Self-Direction (both "at risk" and institutional LOC)	Optional Delegate to Provider (i.e., NF, CCMA, or hospital)
Referral for termination from self-direction					X	
Service Coordinator Ratios and numbers needed	1:200	1:250	1:50	1:120	1:30	

APPENDIX M – DHS 1147

STATE OF HAWAII
Level of Care (LOC) Evaluation

1. PLEASE PRINT OR TYPE <input type="checkbox"/> Initial Request <input type="checkbox"/> Annual Review <input type="checkbox"/> Other review			
2. PATIENT NAME (Last, First, M.I.) _____		3. BIRTHDATE Month/Day/Year _____	4. SEX _____
		5. MEDICARE Part A <input type="checkbox"/> Yes <input type="checkbox"/> No Part B <input type="checkbox"/> Yes <input type="checkbox"/> No ID#: _____	
7. PRESENT ADDRESS: Present Address is <input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> NF <input type="checkbox"/> Care Home <input type="checkbox"/> EARCH <input type="checkbox"/> CCFH <input type="checkbox"/> Other: _____			6. MEDICAID ELIGIBLE? <input type="checkbox"/> Yes ID # _____ <input type="checkbox"/> No Date Applied _____
8. Medicaid Provider Number: (If applicable) _____			
9. ATTENDING PHYSICIAN/PRIMARY CARE PROVIDER (PCP) (Last Name, First Name, Middle Initial) _____ Phone : () _____ Fax: () _____			
10. RETURN FORM TO (SERVICE COORDINATOR/CONTACT PERSON): _____ MANAGED CARE PLAN NAME (IF APPLICABLE): _____ <input type="checkbox"/> VIA FAX (Print Fax Number Below) Phone () _____ Fax () _____ Email () _____			
11. REFERRAL INFORMATION (Completed by Referring Party)		12. ASSESSMENT INFORMATION (Completed by RN, Physician, PCP)	
A. SOURCE(S) OF INFORMATION <input type="checkbox"/> Client <input type="checkbox"/> Records <input type="checkbox"/> Other _____		A. ASSESSMENT DATE ____/____/____	
B. RESPONSIBLE PERSON Name _____ Last First MI Relationship _____ PHONE () _____ FAX () _____		B. ASSESSOR'S NAME Name _____ Last First MI Title _____ Signature _____ <input type="checkbox"/> Hard copy signature on file.	
C. Language <input type="checkbox"/> English <input type="checkbox"/> Other _____		PHONE: () _____ FAX: () _____ EMAIL: () _____	
13. REQUESTING LEVEL OF CARE			
CHECK ONE BOX: <input type="checkbox"/> Nursing Facility (ICF) <input type="checkbox"/> Nursing Facility (SNF) <input type="checkbox"/> Nursing Facility (HOSPICE) <input type="checkbox"/> Nursing Facility (Subacute I) <input type="checkbox"/> Nursing Facility (Subacute II) <input type="checkbox"/> Acute Waitlist (ICF) <input type="checkbox"/> Acute Waitlist (SNF) <input type="checkbox"/> Acute Waitlist (Subacute)		LEVEL OF CARE BEGIN and END DATES: _____ TO _____ LENGTH OF APPROVAL REQUESTED (CHECK ONE BOX): <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____	
14. MEDICAL NECESSITY / LEVEL OF CARE DETERMINATION – DO NOT COMPLETE			
LEVEL OF CARE APPROVAL: <input type="checkbox"/> Nursing Facility (ICF) <input type="checkbox"/> Nursing Facility (SNF) <input type="checkbox"/> Nursing Facility (HOSPICE) <input type="checkbox"/> Nursing Facility (Subacute I) <input type="checkbox"/> Nursing Facility (Subacute II) <input type="checkbox"/> Acute Waitlist (ICF) <input type="checkbox"/> Acute Waitlist (SNF) <input type="checkbox"/> Acute Waitlist (Subacute)		LEVEL OF CARE BEGIN AND END DATES: _____ TO _____ LENGTH OF APPROVAL (CHECK ONE BOX): <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____	
Comments: _____			
DEFERRED: <input type="checkbox"/> Current 1147 Version Needed <input type="checkbox"/> Missing Information			
<input type="checkbox"/> DOES NOT MEET LEVEL OF CARE REQUESTED <input type="checkbox"/> INCOMPLETE INFORMATION TO DETERMINE LEVEL OF CARE			
NOTE: THIS IS NOT AN AUTHORIZATION FOR PAYMENT OR APPROVAL OF CHARGES. PAYMENT BY THE MEDICAID PROGRAM IS CONTINGENT ON THE INDIVIDUAL BEING ELIGIBLE, THE SERVICES BEING COVERED BY MEDICAID AND THE PROVIDER BEING MEDICAID CERTIFIED AT THE TIME SERVICES ARE RENDERED. INDIVIDUAL'S ELIGIBILITY MUST BE VERIFIED BY THE PROVIDER AT THE TIME OF SERVICE.			
DHS REVIEWER'S / DESIGNEE'S SIGNATURE: _____			DATE: _____

STATE OF HAWAII
 Level of Care (LOC) Evaluation

APPLICANT/CLIENT BACKGROUND INFORMATION (Please Type or Print)

1. NAME (Last, First, Middle Initial)	2. BIRTHDATE
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3. FUNCTIONAL STATUS RELATED TO HEALTH CONDITIONS
I. LIST SIGNIFICANT CURRENT DIAGNOSIS(ES):
 PRIMARY: _____

 SECONDARY: _____

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

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

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

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

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

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

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

XVI. ADDITIONAL INFORMATION CONCERNING PATIENT'S FUNCTIONAL STATUS:

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

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

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

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

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

XIV. TOTAL POINTS:
 Comatose = 30 points
 Total Points Indicated: _____

XV. MEDICATIONS/TREATMENTS:
 (List all Significant Medications, Dosage, Frequency, and mode)
 Attach additional sheet if necessary

	Administers Independently	Requires Supervision/ Monitoring	Requires Admin	PRNs Only Actual Freq
_____	[]	[]	[]	_____
_____	[]	[]	[]	_____
_____	[]	[]	[]	_____
_____	[]	[]	[]	_____
_____	[]	[]	[]	_____
_____	[]	[]	[]	_____

STATE OF HAWAII
Level of Care (LOC) Evaluation

APPLICANT/CLIENT BACKGROUND INFORMATION (Please Type or Print)

1. NAME (PRINT Last, First, Middle Initial)	2. BIRTHDATE
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XVII. SKILLED PROCEDURES: D = Daily Indicate number of times per day L = Less than once per day N = Not applicable / Never

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

XVIII. SOCIAL SITUATION:

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

B. If person has a home; caregiving support system is willing to provide/continue care. Yes No
Caregiver requires assistance? Yes No
Assistance required by Caregiver: _____

C. Caregiver name:
Name: _____ Relationship: _____
Last First MI
Address: _____ Phone: () _____ Fax () _____

XIX. COMMENTS ON NURSING REQUIREMENTS OR SOCIAL SITUATION:

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

PHYSICIAN'S SIGNATURE/PCP: _____ DATE: ____/____/____

Hard copy signature on file. This plan of care has been discussed with the MD/PCP.

Physician's/PCP Name (PRINT): _____

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

1. **Check the appropriate box for the evaluation:** Check type of request - initial, annual or other review, i.e. 3 month review to determine continued stay.
2. **Patient Name:** Self-explanatory
3. **Birthdate:** Self-explanatory
4. **Sex:** Indicate whether the patient is “M” for male or “F” for female.
5. **Medicare:** Check the appropriate box indicating whether patient has Medicare Part A and B and enter patient’s Medicare I.D. number, if eligible for either Part A or B.
6. **Medicaid Eligible:** Check “Yes” or “No” to indicate whether the patient is currently Medicaid eligible. Enter Medicaid I.D. number assigned by the Department of Human Services, if eligible. If the patient has applied for Medicaid but has not yet been deemed eligible, print or type in “pending” for I.D. # and print or type in date applied. Forms will be processed only if patient has a Medicaid number or has the date of the Medicaid application.
7. **Present Address:** Indicate patient’s present address, i.e. Home, Hospital, Nursing Facility (NF), Care Home, Extended Adult Residential Care Home (EARCH – Type I & Type II), Community Care Family Foster Home (CCFFH), or other.

Home: Patient is at his or her residential home or is homeless.

Hospital: Patient is currently residing in an Acute Care Hospital, i.e. waitlisted at an acute waitlisted level of care.

Nursing Facility (NF): Patient is currently residing in a nursing facility.

Care Home: Patient is currently residing in a care home – not at nursing facility level of care

Extended Adult Resident Care Home (EARCH): Patient is currently residing in a Department of Health or Shared Home with the Department of Human Services which include Patients at a care home and nursing facility level of care.

Community Care Foster Family Home (CCFFH): Patient is currently residing in a Department of Human Services Foster Home which includes Patients at a nursing facility level of care.

Other: Check this box if the patient’s present address is not listed above. Write in the description.

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

9. **Attending Physician/Primary Care Provider (PCP):** Enter the name of the attending physician or primary care provider, telephone and fax number.
10. **Return Form to:** Enter the name of the service coordinator or the contact person. Indicate the managed care plan name if applicable, telephone, fax number and email address of the person able to provide additional information about the patient.
11. **Referral Information:** Complete all sections for an initial request. Skip this section, if this is an annual or “other” review.
- A. **Source(s) of Information:** Identify the source(s) of patient information received.
 - B. **Responsible Person:** Provide the name, relationship, phone and fax numbers of the family member/personal agent who will be making decisions for the patient.
 - C. **Language:** Check the box of the primary language spoken by the patient. If checking “Other,” indicate the language spoken. Information is used to obtain interpreters.
12. **Assessment Information:** Complete all sections.
- A. **Assessment Date:** Indicate the date of the most current assessment.
 - B. **Assessor’s Name, Title, Signature, Phone and Fax Numbers:** A registered nurse (RN), physician or primary care provider must perform the assessment. Enter the name, title and telephone, fax number and email address of the assessor. The assessor must sign the form.
- Electronic submittal of form(s) will be accepted with the box checked that a signature of the RN, physician or primary care provider has signed a hard copy of this form and the hard copy of the form(s) can be found in the patient’s file.
13. **Requesting Level of Care:** Check service that is being requested. Indicate the begin and end date of the request. If hospice services have been elected by the patient AND the services will be provided in a nursing facility, attach the hospice election and physician verification form. Hospice services in other settings do not require an 1147 form.
- Indicate the length of approval requested. Check one box.
14. **Medical Necessity/Level of Care Determination:** Completed by DHS reviewer or designee. Leave Blank. DO NOT COMPLETE.

1. **Name:** Self-explanatory
2. **Birthdate:** Self-explanatory
3. **Functional Status Related to Health Conditions:** Complete all sections.
 - I. **List significant current diagnosis(es):** List the primary and secondary diagnosis(es) or medical conditions related to the patient's need for long-term care.
 - II. **Comatose:** If patient is comatose, check "Yes" box and go directly to Section XIV. If patient is not comatose, check "No" and complete rest of section.
 - III. **Vision/Hearing/Speech through XIII Dressing and Personal Grooming:** Select the description that best describes the patient's functioning.

Note: Make only one selection in all sections except VI. Mental Status/Behavior and IX. Mobility/Ambulation. For Mental Status/Behavior, make only one selection for orientation (items a through c). Aggressive and/or abusive and wandering may also be checked with the appropriate orientation. For Mobility/Ambulation, check a maximum of 2 for items b through e. If an individual is either mobile or unable to walk, no other selections can be made.
 - XIV. **Total Points:** Add the points from each section to obtain total. Comatose patients are assigned 30 points.
 - XV. **Medications/Treatments:** List the significant medications prescribed by a physician. They may be chronic and given on a fixed schedule (such as antihypertensives), or short term (such as antibiotics), or significant PRN medications (such as narcotics and sedatives). Do not list stool softeners, enemas, and other agents to treat constipation, acetaminophen, non-steroidal anti-inflammatory agents (NSAIDs) unless they are given at least daily. If a patient has more than significant medications than available lines, attach orders or treatment sheet.
 - XVI. **Additional Information Concerning Patient's Functional Status:** Use the space to provide additional information on the patient's functional status. This section may be used to identify the extent of the assistance (minimal, with assistance or total) that is required. Attach a separate sheet if more space is required. See attachment Functional Status related to Health Conditions on scoring this section.
 - XVII. **Skilled Procedures:** Check the particular skilled procedure(s) that the patient requires. If the care is daily (D), indicate the number of times per day that care is required. If care is less than once per day check "L". If the care is not applicable, check "N".

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

XVIII. Social Situation:

- A. **Person can return home:** Identify whether the patient can return home. The home can be a family member's (daughter, son, brother, sister, parents, etc.) home as well as the patient's own home. Check "NA" if the patient is already in a home environment. If the individual does not have a home, indicate whether the patient can be placed in a community setting. Check "NA" if the patient is already in a community setting.
- B. **Caregiving support:** If the patient has a home, identify whether the caregiving support is willing/able to provide care. If caregiver requires assistance, identify the assistance required.
- C. **Caregiver name.** Provide the caregiver's name, relationship, address, phone and fax numbers.

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

Physician Signature/PCP: Self-explanatory.

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

Date: Indicate the date of the physician or Primary Care Provider's signature.

Physician's/PCP Name: Self-explanatory.

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

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

APPENDIX N – DHS 1148 and DHS 1148B

MEDICAID ELIGIBILITY FOR LONG-TERM CARE (LTC) SERVICES

SECTION 1: DHS & HEALTH PLAN INFORMATION			
TO/FROM: _____			
DHS Unit/Health Plan/CMA	Contact Name	Date	
Phone Number	FAX Number	Email Address	
FROM/TO: _____			
DHS Unit/Health Plan/CMA	Contact Name	Date	
Phone Number	FAX Number	Email Address	
SECTION 2: APPLICANT/RECIPIENT INFORMATION (Completed by Health Plan/CMA)			
Enrollee/Applicant Name (Last, First, M.I.)		Enrollee ID No./SSN	Date of Birth
Case Name (If different from Enrollee/Applicant)	HAWI Case No.	Unit/Worker Code	
SECTION 3: LONG-TERM CARE SERVICES BEING REQUESTED (Completed by Health Plan/CMA)			
A. Individual is requesting which of these long-term care services:			
<input type="checkbox"/> Nursing Facility: _____			
	Facility Name	Date of Admission	Phone No.
<input type="checkbox"/> HCBS in a private home: _____			
	Date of Provision of Services		
<input type="checkbox"/> HCBS in a Community Care Foster Family Home:			
Name and Address of CCFH		Date of Admission	Phone No.
B. Effective date of approved DHS 1147: _____			
SECTION 4 DHS MEDICAID LONG-TERM CARE ELIGIBILITY DETERMINATION (Completed by DHS)			
A. <input type="checkbox"/> Eligible for LTC with Cost Share (Enrollment Fee) of \$ _____			
B. <input type="checkbox"/> Not eligible for LTC due to: <input type="checkbox"/> Transfer of assets <input type="checkbox"/> Excess home property			
C. <input type="checkbox"/> Medicaid eligibility denied/terminated effective: _____			
D. <input type="checkbox"/> Reported change does not affect Medicaid eligibility.			
SECTION 5: STATUS CHANGE OF A LONG TERM CARE ENROLLEE (Completed by Health Plan)			
A. <input type="checkbox"/> Enrollee no longer eligible for HCBS effective: _____ because:			
<input type="checkbox"/> Not at level of care <input type="checkbox"/> Community Setting Not Safe <input type="checkbox"/> HCBS providers not available			
B. <input type="checkbox"/> Enrollee receiving HCBS is admitted to a nursing facility:			
Nursing Facility Name		Date of Admission	
C. <input type="checkbox"/> Enrollee discharged from nursing facility and receiving HCBS services effective: _____			
<input type="checkbox"/> HCBS in a private home		<input type="checkbox"/> HCBS in a Community Care Foster Family Home:	
Name and Address Of CCFH		Phone	
C. <input type="checkbox"/> Enrollee no longer at NF level of care, discharged effective: _____ to:			
<input type="checkbox"/> Home <input type="checkbox"/> Care Home <input type="checkbox"/> Other: _____			
D. <input type="checkbox"/> OTHER: _____			

INSTRUCTIONS

DHS 1148 (06/09)

MEDICAID ELIGIBILITY FOR LONG-TERM CARE (LTC) SERVICES

PURPOSE:

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

USE and ROUTING

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

SECTION 1: DHS & HEALTH PLAN INFORMATION:

Completed by the referring party.

SECTION 2: APPLICANT/RECIPIENT INFORMATION:

Completed by referring party.

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

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

SECTION 4: DHS MEDICAID LONG-TERM CARE ELIGIBILITY DETERMINATION

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

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

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

FILING INSTRUCTIONS

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

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

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

SECTION 1: REFERRAL

1. TO: _____
 QExA Health Plan Contact Name Date

2. FROM: _____
 HCSB/AAU Contact Name Date

Phone Number FAX Number Email Address

SECTION 2: ENROLLEE INFORMATION (Completed by DHS)

1. Enrollee Name: _____

2. ID Number: _____

3. Date of Enrollment: _____

4. Enrollee is requesting HCBS in the following setting:
 HCBS in a private home HCBS in a community care foster family home (CCFFH)

Name and Address of CCFFH Date of Admission Telephone Number

SECTION 3: HCBS ELIGIBILITY ASSESSMENT BY QExA HEALTH PLAN

1. Date of HCBS Assessment: _____

2. Enrollee eligible for HCBS: Date HCBS initiated: _____

3. Enrollee not eligible for HCBS because:
 Not at level of care
 The provision of HCBS is not cost-effective
 Enrollee's residence does not assure for the safety of the enrollee
 HCBS providers not available

4. COMMENTS: _____

INSTRUCTIONS

DHS 1148B (06/09)

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

PURPOSE:

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

ROUTING

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

SECTION 1: REFERRAL

Completed by HCSB/AAU after plan choice or assignment.

SECTION 2: ENROLLEE INFORMATION:

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

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

SECTION 3: HCBS ELIGIBILITY ASSESSMENT

This section to be completed by the QExA health plan.

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

FILING INSTRUCTIONS

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

APPENDIX O – EPSDT Information

LINDA LINGLE
GOVERNOR



LILLIAN B. KOLLER, ESQ.
DIRECTOR

HENRY OLIVA
DEPUTY DIRECTOR

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

January 8, 2010

MEMORANDUM

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

TO: Medicaid EPSDT Providers, QUEST and QExA Health Plans

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

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

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

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

SECTION A: EPSDT Form Changes and New Online Tool

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

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

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

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

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

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

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

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

SECTION B: EPSDT Requirements

- 1) Required elements for the EPSDT exam follow CMS and AAP/Bright Futures guidelines. The health plans will be working with providers to ensure that an EPSDT visit paid at the increased EPSDT rate meets the requirements for that visit.
- 2) Elements for the complete visit should be reported in the DHS 8015 form and supported by documentation in the medical record, including:
 - a. an initial or interval history
 - b. measurements
 - c. sensory screening
 - d. developmental assessments, including autism, with validated screening tools
 - e. TB risk assessments
 - f. lead risk assessments
 - g. psychosocial and behavioral assessments

- h. alcohol and drug use assessment for adolescents
 - i. STI and cervical dysplasia screening as appropriate
 - j. dyslipidemia screening as appropriate
 - k. complete physical exam
 - l. age appropriate surveillance
 - m. immunizations
 - n. procedures such as hemoglobin and lead level as appropriate
 - o. referral to a dental home
 - p. referrals to state or specialty services
 - q. care coordination assistance if needed
 - r. age appropriate anticipatory guidance.
- 3) The forms must be signed by the physician performing the exam or supervising the immunizations and screenings. By completing and signing the form, the provider is indicating that the history, physical exam, surveillance, screenings, immunizations, diagnoses, and treatments were performed and are documented in the medical record, as specified on the EPSDT form.
 - 4) The completed and signed EPSDT exam form submitted to a health plan or ACS, by a participating primary care provider for a QUEST or QExA health plan or an active Medicaid provider for FFS respectively, fulfills the State's auditing requirement for compliance with an EPSDT comprehensive periodic screening visit.
 - 5) The form may be copied or printed and used to supplement, but not substitute for, the medical record. However, there should be sufficient documentation in the medical record to support completion of the requirements for a comprehensive EPSDT exam. Results of screening tests and record of immunizations reported on DHS 8015/8016 as being performed must be kept in the medical record.
 - 6) The EPSDT exam is a comprehensive exam and viewed as a global service. Therefore, the treatment of any medical conditions discovered during the EPSDT exam is included in the exam.
 - 7) Care coordination assistance will be provided by the appropriate health plans for QUEST or QExA members and by Community Case Management Corporation (CCMC) for any Medicaid client requiring dental services. The health plans will call the providers and the client/family to coordinate the assistance that is identified. Phone numbers for the health plans and for CCMC are also listed on DHS 8015/8016.

SECTION C: EPSDT Billing Procedures

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

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

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- a. Attach the original completed and signed hard-copy DHS **8015** to the CMS 1500 claim, and mail to the appropriate health plan for QUEST or QExA members or to ACS for FFS clients. If the completed form is not attached to the claim, the claim cannot be processed as a comprehensive EPSDT visit; or
 - b. Submit electronically a completed and signed/finalized EPSDT exam through the EPSDT online tool prior to electronic submission of the claim. The health plans or MQD will match the completed electronic EPSDT form with the electronic claim.
 - c. Without a completed EPSDT form submitted in either hard-copy or electronic as described above, the claim cannot be processed as a comprehensive EPSDT exam and enhanced reimbursement will not be provided.
2. No other claim for an evaluation and management (E&M) service (99201-99255; 99304-99499) is submitted on the same day by the same provider for that patient. The EPSDT exam includes the diagnosis of abnormal conditions and appropriate treatment rendered by the EPSDT examining provider on the day of the EPSDT examination. For example, otitis media found during an EPSDT exam should be submitted with the appropriate EPSDT code; a separate claim line for an office visit for the diagnosis and treatment of otitis medica should NOT be submitted.
 3. An eligible code listed in **APPENDIX 1** is used.

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

1. Submission of a completed DHS **8016**
 - a. Attach the original completed and signed hard-copy DHS **8016** to the CMS 1500 claim, and mail to the appropriate health plan for QUEST or QExA members or to ACS for FFS clients. If the completed form is not attached to the claim, the claim cannot be processed as a comprehensive EPSDT visit; or
 - b. Submit electronically a completed and signed/finalized EPSDT exam through the EPSDT online tool prior to electronic submission of the claim. The health plans or MQD will match the completed electronic EPSDT form with the electronic claim.
 - c. Without a completed EPSDT form submitted in either hard-copy or electronic as described above, the claim cannot be processed as a comprehensive EPSDT exam and enhanced reimbursement will not be provided.
2. No more than two (2) follow-up visits for screening attempts will be reimbursed. For example, if on the dates of the first and second follow-up visit for an audiogram, the child was unable to comply, the provider should note this on the DHS 8016 forms and the visits will be reimbursed. However, if the child is unable to comply after the second visit, the provider should not schedule a third catch-up/follow-up visit. Instead, the audiogram should be attempted at the next EPSDT comprehensive visit.
3. An eligible code in **APPENDIX 2** is used.

APPENDIX 1: BILLING CODES FOR COMPREHENSIVE EPSDT EXAMS

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

APPENDIX 1, CONTINUED: BILLING CODES FOR COMPREHENSIVE EPSDT EXAMS

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

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

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

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

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

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

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

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

Appendix O

PATIENT INFORMATION																																			
Screen Date (MMDDYY)		Indicate the EPSDT periodic screening age being reported																		Sex															
																									M	F									
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>										
Name (Last, First, Middle Initial)										Medicaid/QUEST ID					Birthdate (MMDDYY)																				
										0 0																									
MEASUREMENTS																																			
For infants, head circumference and weight for length should be assessed and documented in the Medical record.																																			
Blood Pressure					Height (In)					Weight (Lbs)					BMI #		BMI %		BMI Reference – For Information Only																
																			Normal < 85%		Overweight 85%-94%		Obese ≥95%												
/																																			
IMMUNIZATIONS GIVEN TODAY AND STATUS																																			
HepB	<input type="radio"/>	PCV	<input type="radio"/>	MMR	<input type="radio"/>	Tdap	<input type="radio"/>	Immunization(s) Not Given																											
DTaP	<input type="radio"/>	Rotav	<input type="radio"/>	Varicella	<input type="radio"/>	MCV4/MPSV4	<input type="radio"/>	Immunizations up to date																	<input type="radio"/>										
IPV	<input type="radio"/>	Influenza	<input type="radio"/>	HepA	<input type="radio"/>	HPV	<input type="radio"/>	Catch Up Scheduled																	<input type="radio"/>										
Hib	<input type="radio"/>	Other (List)					<input type="radio"/>	Refused (List)																	<input type="radio"/>										
Comments:										Contraindicated (List)										<input type="radio"/>															
SCREENING DONE TODAY																																			
Vision Screening: Snellen, Allen, Tumbling Es, LEA Symbols 3y, 4y, 5y, 6y, 8y, 10y, 12y, 14y-16y, 18y										<input type="radio"/>	<input type="radio"/>	Blood Lead Level 9 - 12m, 2y (2 levels required by 2 years)										<input type="radio"/>													
Hearing Screening: Audiometry (20-25 db screen) 4y, 5y, 6y, 8y, 10y										<input type="radio"/>	<input type="radio"/>	Hgb/Hct 9m – 12m, Females-12y – 14y										<input type="radio"/>													
Developmental Screening *(see back) 9m, 18m, 24m - 36m (3 screenings required by 36 months)					PEDS: ≥ 2 predictive concerns = Abnormal					<input type="radio"/>	<input type="radio"/>	Comments for screenings not done:										<input type="radio"/>													
					ASQ: ≥ 1 domain falling below normal cut-offs = Abnormal					<input type="radio"/>	<input type="radio"/>											Y	N												
Autism Screening *(see back) 18m, 24m Fail = Abnormal					CHAT					<input type="radio"/>	<input type="radio"/>	Has the child seen a dentist within the past year?										<input type="radio"/>	<input type="radio"/>												
					M-CHAT					<input type="radio"/>	<input type="radio"/>											<input type="radio"/>	<input type="radio"/>												
					Other (list)					<input type="radio"/>	<input type="radio"/>											<input type="radio"/>	<input type="radio"/>												
As part of surveillance per the AAP/Bright Futures recommended periodicity (see back), the following should be done and documented in the medical record: TB risk assessments, lead risk assessment, psychosocial/behavioral assessments, and for adolescents- alcohol/drug use assessment, and as appropriate - dyslipidemia, STI, and cervical dysplasia screening.																																			
REFERRALS MADE TODAY																																			
By leaving this section blank, I am confirming that there are no referral needs.																																			
Already referred or receiving state or specialty services.					<input type="radio"/>	H-KISS					<input type="radio"/>	PHN					<input type="radio"/>	CAMHD					<input type="radio"/>	WIC					<input type="radio"/>						
Patient/parent refused.					<input type="radio"/>	PT/OT/Speech/Audiology					<input type="radio"/>	DOE					<input type="radio"/>	DDD					<input type="radio"/>	Child Welfare					<input type="radio"/>	Dentistry					<input type="radio"/>
Behavioral Health/Substance Abuse (List name & specialty)										<input type="radio"/>	Nutrition/Exercise (List name & specialty)										<input type="radio"/>														
Medical/Surgical/Developmental (List name & specialty)										<input type="radio"/>	Other(s) (List name & specialty)										<input type="radio"/>														
CARE COORDINATION ASSISTANCE NEEDED																																			
Please call patient's Health Plan for Care Coordination assistance if needed.																																			
No Care Coordination Needed					<input type="radio"/>	Managing medical condition and/or medications					<input type="radio"/>	Obtaining foreign/sign language translation					<input type="radio"/>	Obtaining dental care (If yes, call CCMC)					<input type="radio"/>	Scheduling/Keeping appointments					<input type="radio"/>						
Arranging transportation					<input type="radio"/>	Coordinating multiple appointments					<input type="radio"/>	Family needs assistance in following the POC					<input type="radio"/>	Obtaining specialty services					<input type="radio"/>	Other					<input type="radio"/>						
If assistance is needed, please provide parent's/ caregiver's telephone no. The health plan will call to facilitate coordination.										List additional information or other assistance needed:																									
PHONE NUMBERS																																			
Aloha Care					808-973-1650 (Oahu) 1-800-434-1002 (Toll Free)					Kaiser QUEST					808-432-5330 (Oahu) 1-800-651-2237 (Toll Free)					CCMC Dental Resource					808-486-8030 (Oahu) 1-866-486-8030 (Toll Free)										
HMSA QUEST					808-948-6486 (Oahu) 1-800-440-0640 (Toll Free)					Ohana Health Plan					1-888-846-4262					UnitedHealthcare					1-888-980-8728										
PROVIDER STATEMENT																																			
A complete EPSDT exam also includes a history (initial or interval), a physical exam, age appropriate surveillance and anticipatory guidance. By signing below, I confirm that these were performed and documented in the patient's medical record.																																			
Provider Name (Print)										Signature										NPI #															
For additional forms, contact ACS at 808-952-5570 (Oahu) or 800-235-4378 (Toll Free).																																			

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

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

Section: Patient Information

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

Section: Measurements

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

Section: Immunizations Given Today

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

Section: Screening Done Today

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

Section: Referrals Made Today (Leave the section blank if no referrals were made during this visit)

1. Fill in the appropriate circle(s).
2. List the program(s) and/or specialty(ies) as indicated. For medical/developmental specialties, please note the specialty and agency or individual to whom the referral was made.
3. If referrals are made, please list a current phone number for parental contact under the Care Coordination section, so that the health plan can follow-up on the referral.

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

Section: Care Coordination Assistance Needed

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

Section: Provider Statement

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

Surveillance, risk assessment, and anticipatory guidance should follow the AAP/Bright Futures recommended periodicity schedule and guidelines. The AAP/Bright Futures periodicity schedule and guidelines can be found at [http://brightfutures.aap.org/3rd Edition Guidelines and Pocket Guide.html](http://brightfutures.aap.org/3rd_Edition_Guidelines_and_Pocket_Guide.html)

Tuberculin Skin Test (TST) Risk Assessment & Recommendations for Infants, Children, and Adolescents (<http://aapredbook.aappublications.org>) (Bacille Calmette-Guérin immunization is not a contraindication to a TST.) (HIV = Human Immunodeficiency Virus; LTBI = Latent Tuberculosis Infection)

Children for whom immediate TST is indicated (Beginning as early as 3 months of age):

- Contacts of people with confirmed or suspected contagious tuberculosis (contact investigation)
- Children with radiographic or clinical findings suggesting tuberculosis disease
- Children immigrating from countries with endemic infection (eg, Asia, Middle East, Africa, Latin America, countries of the former Soviet Union) including international adoptees
- Children with travel histories to countries with endemic infection and substantial contact with indigenous people from such countries (If the child is well, the TST should be delayed for up to 10 weeks after return.)

Children who should have annual TST:

- Children infected with HIV
- Incarcerated adolescents

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

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

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

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

PATIENT INFORMATION

Screen Date (MMDDYY)					Name (Last, First, Middle Initial)											
Medicaid/QUEST ID										Birthdate (MMDDYY)					Sex	
0	0														M	F

IMMUNIZATIONS GIVEN TODAY AND STATUS

HepB	<input type="radio"/>	PCV	<input type="radio"/>	MMR	<input type="radio"/>	Tdap	<input type="radio"/>	DTaP	<input type="radio"/>	Rotav	<input type="radio"/>	Varicella	<input type="radio"/>	MCV4/MPSV4	<input type="radio"/>	
IPV	<input type="radio"/>	Influenza	<input type="radio"/>	HepA	<input type="radio"/>	HPV	<input type="radio"/>	Hib	<input type="radio"/>	Other (List)						<input type="radio"/>

Comments:

SCREENING DONE TODAY

Normal Abnormal

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

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

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

CARE COORDINATION ASSISTANCE NEEDED Please call patient's Health Plan for Care Coordination assistance if needed.

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

Provider Name (Print)	Signature	NPI #

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

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

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

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

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

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

Section: Patient Information

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

Section: Immunizations Given Today (Leave the section black if no immunizations were given during this visit)

1. Fill in the circle(s) next to all of the immunizations given at visit.

Section: Screening Done Today

1. Record the results of the vision screening by filling in the appropriate circle. Use one or more of the listed validated vision screening tools.
2. Record the results of the audiometry testing by filling in the appropriate circle. A diagnostic audiologic assessment should also follow any positive hearing screens of newborns and children less than 4 years.
3. Record the results of the developmental screening, if done, by filling in the appropriate circle. It is recommended that either the PEDS or ASQ screening tool be used. Another validated screening tool recommended by the AAP may be used. A list of these may be found in the latest AAP policy on 'Identifying Infants and Young Children with Developmental Disorders in the Medical Home' (Table 1- General Developmental Screening Tools) that can be accessed through <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;118/1/405>
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5. If no screenings were done, leave the section blank.

Section: Referrals Made Today (Leave the section black if no referrals were made during this visit)

1. Fill in the appropriate circle(s).
2. List the program(s) and/or specialty(ies) as indicated. For medical/developmental specialties, please note the specialty and agency or individual to whom the referral was made.
3. If referrals are made, please list a current phone number for parental contact under the Care Coordination section, so that the health plan can follow-up on the referral.

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

Section: Provider Statement

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

Surveillance, risk assessment, and anticipatory guidance should follow the AAP/Bright Futures recommended periodicity schedule and guidelines.

The AAP/Bright Futures periodicity schedule and guidelines can be found at http://brightfutures.aap.org/3rd_Edition_Guidelines_and_Pocket_Guide.html

Tuberculin Skin Test (TST) Risk Assessment & Recommendations for Infants, Children, and Adolescents (<http://aapredbook.aappublications.org>)

(Bacille Calmette-Guérin immunization is not a contraindication to a TST.) (HIV = Human Immunodeficiency Virus; LTBI = Latent Tuberculosis Infection)

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

Required components to be performed for the age group Risk Assessment to be performed, with appropriate action to follow, if positive

**APPENDIX P – Financial Responsibility for Transition of
Care**

LINDA LINGLE
GOVERNOR



LILLIAN B. KOLLER, ESQ.
DIRECTOR

HENRY OLIVA
DEPUTY DIRECTOR

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

June 7, 2010

MEMORANDUM

ACS/QUEST/QExA MEMO NOS.

ACS M10-04
ADM-1009
ADMX-1009

TO: Acute Care Hospitals
QUEST Health Plans
QExA Health Plans

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

SUBJECT: TRANSITION OF CARE – CLARIFICATION ON FINANCIAL
RESPONSIBILITY ROLES

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

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

Attachment

TRANSITION OF CARE

PURPOSE:

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

DEFINITIONS:

Hospital Services: Hospital services include medically necessary services for registered bed patients that are generally and customarily provided by licensed acute care general hospitals in the service area and prescribed, directed or authorized by the attending physician or other provider.

Professional Services: Professional services include services provided by physicians and any other outpatient hospital services. Examples may include medical supplies, equipment and drugs; diagnostic services; and therapeutic services including chemotherapy and radiation therapy.

Enabling Services: Enabling services include transportation (air or ground), lodging, meals, attendant/escort care, and any other services that may be needed.

Fee for Service (FFS) Window: The period of time after which a client is accepted into QUEST and before he/she is enrolled in a QUEST health plan is the FFS window. Also, any client who has less than one-month eligibility will be in FFS.

Transfer: A transfer to another facility (whether in state or out of state) is equivalent to a discharge from the original facility.

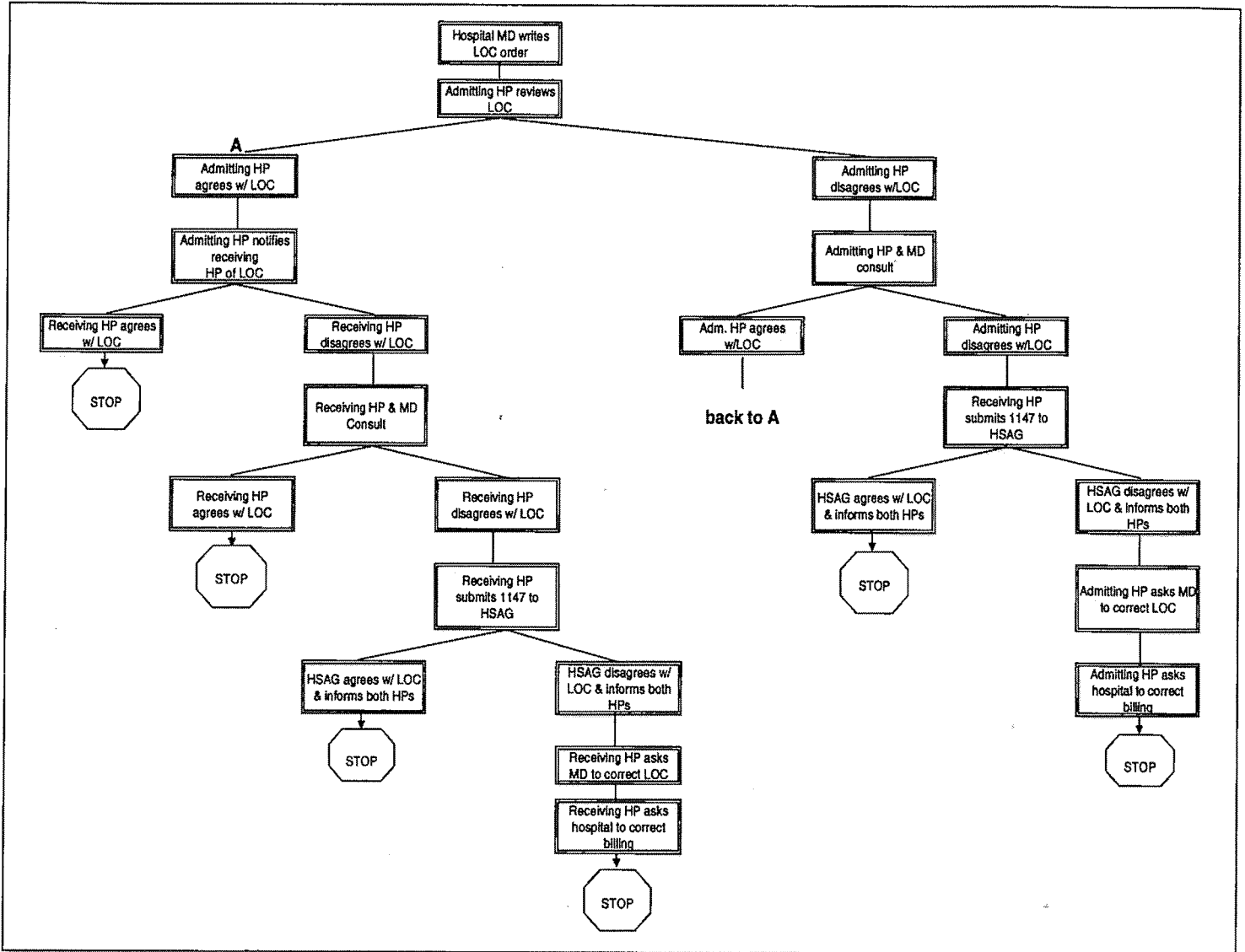
Level of Care Change: The first change from acute to less than acute level of care (sub-acute, waitlisted sub-acute, SNF, waitlisted SNF, ICF, waitlisted ICF).

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

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

LEVEL OF CARE RULES:

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



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

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

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

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

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

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

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

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 Med-QUEST Division
 Health Care Services Branch
 P. O. Box 700190
 Kapolei, Hawaii 96709-0190

June 29, 2010

MEMORANDUM

QExA Memo
ADMX-1013

TO: QExA Health Plans

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

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

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

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

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

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

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

Environmental Accessibility Adaptations (EAA) Standard

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

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

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

Excluded adaptations are:

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

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

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

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

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

Specialized Medical Equipment and Supplies (SME) Standard

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

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

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

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

Moving Assistance

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

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

Enclosure

APPENDIX R – Health Care Acquired Conditions (HCAC)

Appendix R

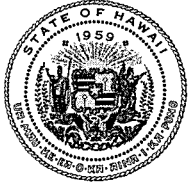
HAC	CC/MCC (ICD-9-CM Code)
Foreign Object Retained After Surgery	998.4 (CC) 998.7 (CC)
Air Embolism	999.1 (MCC)
Blood Incompatibility	999.60 (CC) 999.61 (CC) 999.62 (CC) 999.63 (CC) 999.69 (CC)
Pressure Ulcer Stages III & IV	707.23 (MCC) 707.24 (MCC)
Falls and Trauma: - Fracture - Dislocation - Intracranial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

Appendix R

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

APPENDIX S – Attorney General Forms

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



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

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

_____ , 20 _____ between the _____

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

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

whose address is: _____

and _____
(Name of PROVIDER)

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

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

Business street address:

Mailing address if different than business street address:

Federal employer identification number: _____

Hawai'i general excise tax number: _____

RECITALS

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

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

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

(1) _____,
(Identify state sources)

in the amount of _____, or
(state funding)

(2) _____,
(Identify federal sources)

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

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

(Legal authority for Contracts)

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

- corporate resolutions of the PROVIDER or other authorizing documents such as partnership resolutions;
- corporate by-laws of the PROVIDER, or other similar operating documents of the PROVIDER, such as a partnership contract or limited liability company operating contract;
- the PROVIDER is a sole proprietor and as such does not require any authorizing documents to sign this Contract;
- other evidence of authority to sign:

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

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

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

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

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

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

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

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

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

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

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

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

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

STATE

By _____
(Signature)

Print Name _____

Print Title _____

Date _____

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

By _____
(Signature)

Print Name _____

Print Title _____

Date _____

CONTRACT NO. _____

CORPORATE SEAL
(if available)

PROVIDER

By _____
(Signature)

Print Name _____

Print Title _____

Date _____

APPROVED AS TO FORM:

Deputy Attorney General

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GENERAL CONDITIONS FOR HEALTH & HUMAN SERVICES CONTRACTS

1. Representations and Conditions Precedent

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 1.6 Reporting Requirements. The PROVIDER shall submit a Final Project Report to the STATE containing the information specified in this Contract if applicable, or otherwise satisfactory to the STATE, documenting the PROVIDER's overall efforts toward meeting the requirements of this Contract, and listing expenditures actually incurred in the performance of this Contract. The PROVIDER shall return any unexpended funds to the STATE.
- 1.7 Conflicts of Interest. In addition to the Certification provided in the Standards of Conduct Declaration to this Contract, the PROVIDER represents that neither the PROVIDER nor any employee or agent of the PROVIDER, presently has any interest, and promises that no such interest, direct or indirect, shall be acquired, that would or might conflict in any manner or degree with the PROVIDER's performance under this Contract.

2. Documents and Files

2.1 Confidentiality of Material.

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

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

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

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

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

3. Relationship between Parties

- 3.1 Coordination of Services by the STATE. The STATE shall coordinate the services to be provided by the PROVIDER in order to complete the performance required in the Contract. The PROVIDER shall maintain communications with the STATE at all stages of the PROVIDER's work, and submit to the STATE for resolution any questions which may arise as to the performance of this Contract.
- 3.2 Subcontracts and Assignments. The PROVIDER may assign or subcontract any of the PROVIDER's duties, obligations, or interests under this Contract, but only if (i) the PROVIDER obtains the prior written consent of the STATE and (ii) the PROVIDER's assignee or subcontractor submits to the STATE a tax clearance certificate from the Director of Taxation, State of Hawai'i, and the Internal Revenue Service showing that all delinquent taxes, if any, levied or accrued under state law against the PROVIDER's assignee or subcontractor have been paid. Additionally, no assignment by the PROVIDER of the PROVIDER's right to compensation under this Contract shall be effective unless and until the assignment is approved by the Comptroller of the State of Hawai'i, as provided in section 40-58, HRS.
- 3.3 Change of Name. When the PROVIDER asks to change the name in which it holds this Contract, the STATE, shall, upon receipt of a document acceptable or satisfactory to the STATE indicating such change of name such as an amendment to the PROVIDER's articles of incorporation, enter into an amendment to this Contract with the PROVIDER to effect the change of name. Such amendment to this Contract changing the PROVIDER's name shall specifically indicate that no other terms and conditions of this Contract are thereby changed, unless the change of name amendment is incorporated with a modification or amendment to the Contract under paragraph 4.1 of these General Conditions.
- 3.4 Independent Contractor Status and Responsibilities, Including Tax Responsibilities.
- 3.4.1 Independent Contractor. In the performance of services required under this Contract, the PROVIDER is an "independent contractor," with the authority and responsibility to control and direct the performance and details of the work and services required under this Contract; however, the STATE shall have a general right to inspect work in progress to determine whether, in the STATE's opinion, the services are being performed by the PROVIDER in compliance with this Contract.
- 3.4.2 Contracts with Other Individuals and Entities. Unless otherwise provided by special condition, the STATE shall be free to contract with other individuals and entities to provide services similar to those performed by the Provider under this Contract, and the

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

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

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

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

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

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

3.5 Personnel Requirements.

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

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

4. Modification and Termination of Contract

4.1 Modification of Contract.

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

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

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

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

- 4.3 Termination for Necessity or Convenience. If the STATE determines, in its sole discretion, that it is necessary or convenient, this Contract may be terminated in whole or in part at the option of the STATE upon ten (10) working days' written notice to the PROVIDER. If the STATE elects to terminate under this paragraph, the PROVIDER shall be entitled to reasonable payment as determined by the STATE for satisfactory services rendered under this Contract up to the time of termination. If the STATE elects to terminate under this section, the PROVIDER shall cooperate with the STATE to effect an orderly transition of services to clients.
- 4.4 Termination by PROVIDER. The PROVIDER may withdraw from this Contract after obtaining the written consent of the STATE. The STATE, upon the PROVIDER's withdrawal, shall determine whether payment is due to the PROVIDER, and the amount that is due. If the STATE consents to a termination under this paragraph, the PROVIDER shall cooperate with the STATE to effect an orderly transition of services to clients.
- 4.5 STATE's Right of Offset. The STATE may offset against any monies or other obligations that STATE owes to the PROVIDER under this Contract, any amounts owed to the State of Hawai'i by the PROVIDER under this Contract, or any other contract, or pursuant to any law or other obligation owed to the State of Hawai'i by the PROVIDER, including but not limited to the payment of any taxes or levies of any kind or nature. The STATE shall notify the PROVIDER in writing of any exercise of its right of offset and the nature and amount of such offset. For purposes of this paragraph, amounts owed to the State of Hawai'i shall not include debts or obligations which have been liquidated by contract with the PROVIDER, and that are covered by an installment payment or other settlement plan approved by the State of Hawai'i, provided, however, that the PROVIDER shall be entitled to such exclusion only to the extent that the PROVIDER is current, and in compliance with, and not delinquent on, any payments, obligations, or duties owed to the State of Hawai'i under such payment or other settlement plan.

5. Indemnification

- 5.1 Indemnification and Defense. The PROVIDER shall defend, indemnify, and hold harmless the State of Hawai'i, the contracting agency, and their officers, employees, and agents from and against any and all liability, loss, damage, cost, expense, including all attorneys' fees, claims, suits, and demands arising out of or in connection with the acts or omissions of the PROVIDER or the PROVIDER's employees, officers, agents, or subcontractors under this Contract. The provisions of this paragraph shall remain in full force and effect notwithstanding the expiration or early termination of this Contract.
- 5.2 Cost of Litigation. In case the STATE shall, without any fault on its part, be made a party to any litigation commenced by or against the PROVIDER in connection with this Contract, the PROVIDER shall pay any cost and expense incurred by or imposed on the STATE, including attorneys' fees.

6. Publicity

- 6.1 Acknowledgment of State Support. The PROVIDER shall, in all news releases, public statements, announcements, broadcasts, posters, programs, computer postings, and other printed, published, or electronically disseminated materials relating to the PROVIDER's performance under this Contract, acknowledge the support by the State of Hawai'i and the purchasing agency.
- 6.2 PROVIDER's Publicity Not Related to Contract. The PROVIDER shall not refer to the STATE, or any office, agency, or officer thereof, or any state employee, or to the services or goods, or both provided under this Contract, in any of the PROVIDER's publicity not related to the PROVIDER's performance under this Contract, including but not limited to commercial advertisements, recruiting materials, and solicitations for charitable donations.

7. Miscellaneous Provisions

- 7.1 Nondiscrimination. No person performing work under this Contract, including any subcontractor, employee, or agent of the PROVIDER, shall engage in any discrimination that is prohibited by any applicable federal, state, or county law.
- 7.2 Paragraph Headings. The paragraph headings appearing in this Contract have been inserted for the purpose of convenience and ready reference. They shall not be used to define, limit, or extend the scope or intent of the sections to which they pertain.
- 7.3 Antitrust Claims. The STATE and the PROVIDER recognize that in actual economic practice, overcharges resulting from antitrust violations are in fact usually borne by the purchaser. Therefore, the PROVIDER hereby assigns to the STATE any and all claims for overcharges as to goods and materials purchased in connection with this Contract, except as to overcharges which result from violations commencing after the price is established under this Contract and which are not passed on to the STATE under an escalation clause.
- 7.4 Governing Law. The validity of this Contract and any of its terms or provisions, as well as the rights and duties of the parties to this Contract, shall be governed by the laws of the State of Hawai'i. Any action at law or in equity to enforce or interpret the provisions of this Contract shall be brought in a state court of competent jurisdiction in Honolulu, Hawai'i.
- 7.5 Conflict between General Conditions and Procurement Rules. In the event of a conflict between the General Conditions and the Procurement Rules or a Procurement Directive, the Procurement Rules or any Procurement Directive in effect on the date this Contract became effective shall control and are hereby incorporated by reference.
- 7.6 Entire Contract. This Contract sets forth all of the contracts, conditions, understandings, promises, warranties, and representations between the STATE and the PROVIDER relative to this Contract. This Contract supersedes all prior agreements, conditions, understandings,

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

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

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

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

8. Confidentiality of Personal Information

8.1 Definitions.

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

- 1) Social Security number;
- 2) Driver's license number or Hawaii identification card number; or
- 3) Account number, credit or debit card number, access code, or password that would permit access to an individual's financial information.

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

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

8.2 Confidentiality of Material.

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

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

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

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

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

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

8.3 Security Awareness Training and Confidentiality Agreements.

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

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

- 1) The personal information collected, used, or maintained by the PROVIDER will be treated as confidential;
- 2) Access to the personal information will be allowed only as necessary to perform the Contract; and
- 3) Use of the personal information will be restricted to uses consistent with the services subject to this Contract.

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

- 1) Provide an opportunity for the PROVIDER to cure the breach or end the violation; or
- 2) Immediately terminate this Contract.

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

8.5 Records Retention.

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

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

APPENDIX T – LOI Form

APPENDIX T

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

[the applicant]

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

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

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

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

NOTICE TO PROVIDERS:

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

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

1. HCBS PROVIDER'S SIGNATURE

2. DATE

3. PRINTED NAME OF SIGNER

4. TITLE OF SIGNER

5. NAME OF AGENCY, IF APPLICABLE

6. APPLICANT REPRESENTATIVE'S SIGNATURE

7. DATE

8. PRINTED NAME OF SIGNER

9. TITLE OF SIGNER

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

1. MQD PROVIDER IDENTIFICATION NUMBER, if any _____

2. HCBS PROVIDER'S PRINTED NAME _____

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

4. ZIP CODE _____

5. COUNTY _____

6. TELEPHONE _____

7. FAX _____

___ Check here if additional service site information is attached.

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

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