

Amendment # 4  
 Issued on: November 15, 2007

For Requests for Proposals RFP-MQD-2008-006  
 QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

| # | RFP Section #   | RFP Language   | Amendment  |
|---|---|--|--|
| 1 | 10.400, 2 <sup>nd</sup> sentence<br><br>Use of Subcontractors | Sentence reads:<br><br>The project leader shall be an employee of the prime applicant and meet all the required experiences. | Sentence is amended to read:<br><br>The project leader shall be an employee of the prime applicant <del>and meet all the required experiences.</del>   |
| 2 | 20.100, Table<br><br>RFP Timeline                             |  | Table is amended by inserting between “Written Responses to Questions” and “Proposal Due Date” the following 2 items:<br><br><b>Submission of Questions on Amendments: November 19, 2007 at 10:00 a.m. (H.S.T.)</b><br><b>Written Responses to Questions on Amendments: November 23, 2007</b>  |
| 3 | 20.300<br><br>Submission of Written Questions                 |  | Section is amended by inserting at the end, the following paragraph:<br><br><b>Applicants may submit questions on any previously posted amendments ONLY. These question shall be in writing and submitted via e-mail or on diskette in Word 2003 format or lower, to the following mailing address or e-mail address:</b><br><br><p style="text-align: center;"><b>Ms. Lois Lee</b><br/> <b>C/O Ms. Dona Jean Watanabe</b><br/> <b>Med-QUEST Division (MQD) - Finance Office</b><br/> <b>1001 Kamokila Boulevard, Suite 317</b><br/> <b>Kapolei, Hawaii 96707-2005</b><br/> <b>Email Address: qexarfp@medicaid.dhs.state.hi.us</b></p> <b>The applicant shall use the format provided in Appendix N for the submission of questions.</b> |

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|   |   |   | <b>Applicants must submit written questions on the amendments by the time and date identified in Section 20.100. The DHS shall respond to the written questions on the amendments no later than 4:30 p.m. (H.S.T.) on the date identified in Section 20.100. No verbal responses shall be considered as official. The DHS shall not respond to any questions posed on issues that do not appear in any amendments.</b>  |
| 4 | 20.700, bulleted list<br><br>Documentation                |   | Bulleted list is amended to delete the following items: <ul style="list-style-type: none"> <li>• Current Quest Formulary</li> <li>• Information on the development of the QExA capitated rate ranges</li> </ul>   |
| 5 | 21.400 , last bullet<br><br>Disqualification of Applicant | Last bullet (as amended by Amendment #1) reads:<br><br>Failure to show proof of accreditation by National Committee for Quality Assurance (NCQA), American Accreditation HealthCare Commission/URAC, Accreditation Association for Ambulatory Health Care (AAAHC) or Joint Commission on Accreditation of HealthCare Associations (JCAHO) in any state in which the applicant is currently operating. | Last bullet is amended to read:<br><br>Failure to show proof of accreditation by National Committee for Quality Assurance (NCQA), American Accreditation HealthCare Commission/URAC, Accreditation Association for Ambulatory Health Care (AAAHC) or Joint Commission on Accreditation of HealthCare Associations (JCAHO) in any state in which the applicant <b>(including an affiliate company (as defined in Section 30.200) or a company with the same parent company as the applicant)</b> is currently operating. <b>Applicants not accredited but in the process of becoming accredited may submit proof that they are in the process.</b> |

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| 6 | 30.200, Action<br><br>Definitions & Acronyms | Last high level bullet in the definition reads: <ul style="list-style-type: none"> <li>• For a rural area member or for islands with only one health plan or limited providers, the denial of a member’s request to obtain services outside the network:                             <ul style="list-style-type: none"> <li>○ From any other provider (in terms of training, experience, and specialization) not available within the network;</li> <li>○ From a provider not part of a network that is the main source of a service to the member, provided that the provider is given the same opportunity to become a participating provider as other similar providers;</li> <li>○ Because the only health plan or provider does not provide the service because of moral or religious objections;</li> <li>○ Because the member’s provider determines that the member needs related services that would subject the member to unnecessary risk if received separately and not all related services are available within the network; and</li> <li>○ The State determines that other circumstances warrant out-of-network treatment.</li> </ul> </li> </ul> | Last high level bullet in the definition is amended to read: <ul style="list-style-type: none"> <li>• For a rural area member or for islands with only one health plan or limited providers, the denial of a member’s request to obtain services outside the network:                             <ul style="list-style-type: none"> <li>○ From any other provider (in terms of training, experience, and specialization) not available within the network;</li> <li>○ From a provider not part of a network that is the main source of a service to the member, provided that the provider is given the same opportunity to become a participating provider as other similar providers. <b>If the provider does not choose to join the network or does not meet the qualifications, the member is given a choice of participating providers and is transitioned to a participating provider within sixty (60) days;</b></li> <li>○ Because the only health plan or provider does not provide the service because of moral or religious objections;</li> <li>○ Because the member’s provider determines that the member needs related services that would subject the member to unnecessary risk if received separately and not all related services are available within the network; and</li> <li>○ The State determines that other circumstances warrant out-of-network treatment.</li> </ul> </li> </ul> |

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| 7 | 30.200<br><br>Definitions & Acronyms   |  | Section is amended to include the following:<br><br><b>Affiliate</b> – A business organization or entity that, directly or indirectly, is owned or controlled by the applicant, or owns or controls the applicant, or is under common ownership or control with the applicant.  |
|   | 30.200, Enrollee (Potential)<br><br>Definitions & Acronyms   | Definition reads:<br><br>An individual eligible for the QExA program who is subject to mandatory enrollment or may voluntarily elect to enroll in a MCO, who must make a choice on which plan to enroll into within a specified time designated by the DHS. See also Potential Members.  | Definition is amended to read:<br><br>An individual eligible for the QExA program <del>who is subject to mandatory enrollment or may voluntarily elect to enroll in a MCO,</del> who must make a choice on which plan to enroll into within a specified time designated by the DHS. See also Potential Members.   |
| 8 | 30.200<br>Expanded Adult Residential Care Home (E-ARCH), last sentence and bullets<br><br>Definitions & Acronyms | Definition reads:<br><br>There are two types of expanded care ARCHs in accordance with HRS § 321-1562: <ul style="list-style-type: none"> <li>• Type I – home consisting of six (6) or fewer residents with no more than two nursing facility level residents; and</li> <li>• Type II – home consisting of seven (7) or more residents with no more than twenty percent (20%) of the home’s licenses capacity as nursing level residents.</li> </ul> | Definition is amended to read:<br><br>There are two types of expanded care ARCHs in accordance with HRS § 321-15.62: <ul style="list-style-type: none"> <li>• Type I- home <del>consisting of six (6)</del> <b>allowing five</b> or fewer residents <b>provided that up to six residents may be allowed at the discretion of the department to live in a type I home</b>, with no more than two nursing facility level residents; and</li> <li>• Type II- home <del>consisting of seven (7)</del> <b>allowing six</b> or more residents with no more than twenty percent (20%) of the home’s licenses capacity as nursing <b>facility</b> level residents.</li> </ul> |

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| 9  | 30.200<br><br>Definitions & Acronyms  |  | Section is amended to include the following:<br><br><b>New Member</b> – a member (as defined in this Section) who has not been enrolled in the health plan during the prior sixty (60) day period.  |
| 10 | 30.200, Healthcare Professional<br><br>Definitions & Acronyms   | Definition reads:<br><br>A physician, podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, speech-language pathologist, audiologist, registered dietitian, licensed social worker, registered or licensed practical nurse, nurse practitioner, or any other licensed professional who meets the State requirements of a healthcare professional. | Definition is amended to read:<br><br>A physician, podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, speech-language pathologist, audiologist, registered dietitian, licensed social worker, registered or licensed practical nurse, nurse practitioner, or any other licensed <b>or certified</b> professional who meets the State requirements of a healthcare professional.   |
| 11 | 30.300, 4 <sup>th</sup> bullet under the 2 <sup>nd</sup> major bullet on p. 45<br><br>Program Population Descriptions | Bullet reads:<br><br>Developmental Disabilities and/or Mental Retardation (DD/MR) for ABD individuals of all ages who meet an ICF/MR LOC. The DHS will provide case management services and oversee 1915(c) HCBS and ICF/MR services for individuals with DD/MR.   | Bullet is amended to read:<br><br>Developmental Disabilities and/or Mental Retardation (DD/MR) for ABD individuals of all ages who meet an ICF/MR LOC. The <del>DHS</del> <b>DOH</b> will provide case management services and oversee 1915(c) HCBS and ICF/MR services for individuals with DD/MR.   |
| 12 | 30.520, 5 <sup>th</sup> paragraph<br><br>Enrollment Overview  | Paragraph reads:<br><br>Except as provided for in Sections 30.530, 30.540 and 30.560, the DHS or its designee will auto-assign any individual who does not select a health plan within fifteen (15) days. The DHS will make the auto-assignment according to the following algorithm.  | Paragraph is amended to read:<br><br>Except as provided for in Sections 30.530, 30.540 and 30.560, the DHS or its designee will auto-assign any individual who does not select a health plan within fifteen (15) days <b>of receipt of the enrollment letter. This fifteen (15) day period starts five (5) days after the date the DHS issues the enrollment letter to the member (the DHS assumes mail time of five (5) days).</b> The DHS will make the auto-assignment according to the following algorithm. |

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| 13 | 30.520, 2 <sup>nd</sup> and 3 <sup>rd</sup> series of bullets<br><br>Enrollment Overview | Language reads:<br><br>For enrollees in a long-term care residential facility: <ul style="list-style-type: none"> <li>• If the facility is in only one (1) health plan, the enrollee shall be assigned to that health plan provided that health plan has not exceeded the enrollment cap as described in Section 30.570;</li> <li>• If the facility is in more than one (1) health plan, and the enrollee has a relationship with a PCP that is in only one (1) health plan, the enrollee shall be assigned to that health plan provided that health plan has not exceeded the enrollment cap as described in Section 30.570;</li> <li>• If the facility is in more than one (1) health plan and the enrollee has a relationship with a PCP that is in more than one (1) health plan, the DHS shall make an auto-assignment to the health plan that did not receive the most recent auto-assigned individual, provided that health plan has not exceeded the enrollment cap as described in Section 30.570;</li> <li>• If the facility is in more than one (1) health plan and the enrollee does not have a relationship with any PCP, the DHS shall make an auto-assignment to the health plan that did not receive the most recent auto-assigned individual, provided that health plan has not exceeded the enrollment cap as described in Section 30.570.</li> </ul> For enrollees not in a long-term care residential facility: | Language is amended to read:<br><br>For enrollees in a long-term care residential facility: <ul style="list-style-type: none"> <li>• If the facility is in only one (1) health plan, the enrollee shall be assigned to that health plan provided that health plan has not exceeded the enrollment cap as described in Section 30.570;</li> <li>• If the facility is in more than one (1) health plan, and the enrollee has a relationship with a PCP that is in only one (1) health plan, the enrollee shall be assigned to that health plan provided that health plan has not exceeded the enrollment cap as described in Section 30.570;</li> <li>• If the facility is in more than one (1) health plan and the enrollee has a relationship with a PCP that is in more than one (1) health plan, the DHS shall make an <b>random</b> auto-assignment to the health plan that did not receive the most recent auto-assigned individual, provided that <b>the</b> health plan has not exceeded the enrollment cap as described in Section 30.570;</li> <li>• If the facility is in more than one (1) health plan and the enrollee does not have a relationship with any PCP, the DHS shall make an <b>random</b> auto-assignment to the health plan that did not receive the most recent auto-assigned individual, provided that <b>the</b> health plan has not exceeded the enrollment cap as described in Section 30.570.</li> </ul> For enrollees not in a long-term care residential facility: <ul style="list-style-type: none"> <li>• If the enrollee has a relationship with a PCP that is in</li> </ul> |

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|    |  | <ul style="list-style-type: none"> <li>• If the enrollee has a relationship with a PCP that is in only one (1) health plan, the enrollee shall be assigned to that health plan provided that health plan has not exceeded the enrollment cap as described in Section 30.570;</li> <li>• If the enrollee has a relationship with a PCP that is in more than one (1) health plan, the DHS shall make an auto-assignment to the health plan that did not receive the most recent auto-assigned individual, provided that health plan has not exceeded the enrollment cap as described in Section 30.570;</li> <li>• If the enrollee does not have a relationship with a PCP, the DHS shall make an auto-assignment to the health plan that did not receive the most recent auto-assigned individual, provided that health plan has not exceeded the enrollment cap as described in Section 30.570.</li> </ul> | <p>only one (1) health plan, the enrollee shall be assigned to that health plan provided that health plan has not exceeded the enrollment cap as described in Section 30.570;</p> <ul style="list-style-type: none"> <li>• If the enrollee has a relationship with a PCP that is in more than one (1) health plan, the DHS shall make an <b>random</b> auto-assignment to the health plan that did not receive the most recent auto-assigned individual, provided that <b>the</b> health plan has not exceeded the enrollment cap as described in Section 30.570;</li> <li>• If the enrollee does not have a relationship with a PCP, the DHS shall make an <b>random</b> auto-assignment to the health plan that did not receive the most recent auto-assigned individual, provided that <b>the</b> health plan has not exceeded the enrollment cap as described in Section 30.570.</li> </ul> |
| 14 | 30.520, last sentence<br><br>Enrollment Overview | Sentence reads:<br><br>If no members of a household have selected a health plan, the entire household shall be auto-assigned to the same health plan.  | Sentence is amended to read:<br><br>If no members of a household have selected a health plan, the <b>QExA eligible individuals in the entire</b> household shall be auto-assigned to the same health plan.  |
| 15 | 30.550, 1 <sup>st</sup> paragraph on p. 54       | Paragraph reads:<br><br>The DHS will process the health plan change request and enrollment in the new health plan will begin the first day of the month following the month in which the health plan change was requested.   | Paragraph is amended to read:<br><br>The DHS will process the health plan change request and enrollment in the new health plan will begin the first day of the month following the month in which the health plan change was requested. <b>Changes can be retroactive.</b>  |

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| 16 | 30.550, last bullet on p. 54<br><br>90-Day Grace Period                             | Bullet reads:<br><br>A member has lost eligibility for a period of less than sixty (60) days, unless the period of ineligibility spans the annual plan change period in which case the member will have the ability to choose a new health plan or be re-enrolled in the previous health plan.  | Bullet is amended to read:<br><br>A member has lost eligibility for a period of sixty (60) days or less <del>than sixty (60) days</del> , unless the period of ineligibility spans the annual plan change period in which case the member will have the ability to choose a new health plan or be re-enrolled in the previous health plan.  |
| 17 | 30.570, 2 <sup>nd</sup> to last paragraph and bullets<br><br>Member Enrollment Caps | 2 <sup>nd</sup> to last paragraph and bullets read:<br><br>If a plan is capped, it will not be available for selection or auto-assignment until the next month.<br>There are two (2) exceptions to this policy:<br><br>1. Newborns who are eligible for QExA and born to QExA mothers enrolled in the capped plan will be enrolled with the mother; or<br>2. Members who have lost eligibility for a period of less than sixty (60) days may return to the capped plan. | 2 <sup>nd</sup> to last paragraph and bullets are amended to read:<br><br>If a plan is capped, it will not be available for selection or auto-assignment until the next month. There are <del>two (2)</del> <b>three (3)</b> exceptions to this policy:<br><br>1. Newborns who are eligible for QExA and born to QExA mothers enrolled in the capped plan will be enrolled with the mother; <del>or</del><br><b>2. Members enrolled in a health plan with a waiting list for HCBS or personal assistance services Level I may enroll in a capped plan with no waiting list for the necessary service(s); and</b><br>3. Members who have lost eligibility for a period of <del>less than sixty (60) days</del> <b>or less</b> may return to the capped plan. |
| 18 | 30.600, 2 <sup>nd</sup> paragraph and bulleted list<br><br>Disenrollment            | Section reads:<br><br>Appropriate reasons for disenrollment include, but are not limited to, the following:<br><ul style="list-style-type: none"> <li>• Member no longer qualifies based on the medical assistance eligibility criteria or voluntarily leaves the program;</li> <li>• Death of a member;</li> </ul>   | Section is amended to read:<br><br>Appropriate reasons for disenrollment include, but are not limited to, the following <b>related to program participation</b> :<br><ul style="list-style-type: none"> <li>• Member no longer qualifies based on the medical assistance eligibility criteria or voluntarily leaves the program;</li> </ul>   |

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|   |               | <ul style="list-style-type: none"> <li>• Incarceration of the member;</li> <li>• Member enters the Hawaii State Hospital;</li> <li>• Member becomes a PACE or Pre-Pace participant;</li> <li>• Member enters the State of Hawaii Organ and Transplant (SHOTT) program;</li> <li>• Member is in foster care and has been moved out-of-state by the DHS;</li> <li>• Member becomes a Medicare Special Savings Program recipient beneficiary;</li> <li>• Member provides false information with the intent of enrolling in the programs under false pretenses;</li> <li>• Member chooses another health plan during the annual plan change period and that health plan is not capped;</li> <li>• Member's long-term care residential facility is not in the health plan's provider network and is in the provider network of a different health plan (so long as that health plan is not capped);</li> <li>• Member's PCP is not in the health plan's provider network and is in the provider network of a different health plan (so long as that health plan is not capped); or</li> <li>• Member requests disenrollment for cause, at any time, due to:                         <ul style="list-style-type: none"> <li>○ An administrative appeal decision;</li> <li>○ Provisions in administrative rules or statutes;</li> <li>○ A legal decision;</li> <li>○ Relocation of the member to a service area where the health plan does not provide service;</li> </ul> </li> </ul> | <ul style="list-style-type: none"> <li>• Death of a member;</li> <li>• Incarceration of the member;</li> <li>• Member enters the Hawaii State Hospital;</li> <li>• Member becomes a PACE or Pre-Pace participant;</li> <li>• Member enters the State of Hawaii Organ and Transplant (SHOTT) program;</li> <li>• Member is in foster care and has been moved out-of-state by the DHS; <b>and</b></li> <li>• <del>Member becomes a Medicare Special Savings Program recipient beneficiary;</del></li> <li>• Member provides false information with the intent of enrolling in the programs under false pretenses.</li> </ul> <p><b>Additional appropriate reasons for disenrollment include, but are not limited to those related to the health plan:</b></p> <ul style="list-style-type: none"> <li>• <b>Member is enrolled in a health plan with a waiting list for HCBS or personal assistance services – Level I and the other health plan does not have a waiting list for the necessary service(s);</b></li> <li>• Member's long-term care residential facility is not in the health plan's provider network and is in the provider network of a different health plan (so long as that health plan is not capped);</li> <li>• Member's PCP is not in the health plan's provider network and is in the provider network of a different health plan (so long as that health plan is not capped); or</li> <li>• Member requests disenrollment for cause, at any time, due to:                         <ul style="list-style-type: none"> <li>○ An administrative appeal decision;</li> <li>○ Provisions in administrative rules or statutes;</li> </ul> </li> </ul> |

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|   |               | <ul style="list-style-type: none"> <li>○ An administrative decision for foster children which is the result of an agreement between the DHS, the child welfare service worker and the health plan involved;</li> <li>○ The health plan's refusal, because of moral or religious objections, to cover the service the member seeks as allowed for in Section 40.300;</li> <li>○ The member's need for related services (for example a cesarean section and a tubal ligation) to be performed at the same time and not all related services are available within the network and the member's PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk;</li> <li>○ Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's healthcare needs, lack of direct access to certified nurse midwives, pediatric nurse practitioners, family nurse practitioners, if available in the geographic area in which the member resides; or</li> <li>○ Lack of direct access to women's healthcare specialists for breast cancer screenings, pap smears and pelvic exams.</li> </ul> | <ul style="list-style-type: none"> <li>○ A legal decision;</li> <li>○ Relocation of the member to a service area where the health plan does not provide service;</li> <li>○ An administrative decision for foster children which is the result of an agreement between the DHS, the child welfare service worker and the health plan involved;</li> <li>○ The health plan's refusal, because of moral or religious objections, to cover the service the member seeks as allowed for in Section 40.300;</li> <li>○ The member's need for related services (for example a cesarean section and a tubal ligation) to be performed at the same time and not all related services are available within the network and the member's PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk;</li> <li>○ Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's healthcare needs, lack of direct access to certified nurse midwives, pediatric nurse practitioners, family nurse practitioners, if available in the geographic area in which the member resides; or</li> <li>○ Lack of direct access to women's healthcare specialists for breast cancer screenings, pap smears and pelvic exams.</li> </ul> |

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| 19 | 30.600, last paragraph on pg. 58<br><br>Disenrollment Responsibilities                                       | The last paragraph reads:<br><br>The effective date of all approved disenrollments will be no later than the first day of the second month in which the member or the health plan files the request. If the DHS fails to make a determination in that time frame, the disenrollment shall be considered approved. | The last paragraph is amended to read:<br><br>The effective date of all approved disenrollments will be no later than the first day of the second month <b>following the month</b> in which the member or the health plan files the request. If the DHS fails to make a determination in that time frame, the disenrollment shall be considered approved. |
| 20 | 30.730, 1 <sup>st</sup> paragraph<br><br>Dental Services   | The 1 <sup>st</sup> paragraph reads:<br><br>The DHS will provide dental services to health plan members under age twenty-one (21).  | The 1 <sup>st</sup> paragraph is amended to reads<br><br>The DHS will provide dental services to health plan members <del>under age twenty-one (21)</del> <b>through the month of their twenty-first (21<sup>st</sup>) birthday.</b>  |
| 21 | 30.920, last bullet on p. 64<br><br>Quality Assessment and Performance Improvement (QAPI) Program Monitoring | Bullet reads:<br><br>Health information systems;  | Bullet is amended to read:<br><br>Health plan information <b>technology and</b> systems;  |
| 22 | 30.930, 1 <sup>st</sup> bullet on p. 66, 1 <sup>st</sup> sentence<br><br>External Quality Review/ Monitoring | 1 <sup>st</sup> sentence of the bullet reads:<br><br>Administration and reporting the results of the CAHPS® 3.OH Consumer Survey.   | 1 <sup>st</sup> sentence of the bullet is amended to read:<br><br>Administration and reporting the results of the <b>most recent</b> CAHPS® <del>3-OH</del> Consumer Survey.  |

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| 23 | 31.100 last paragraph on p. 69<br><br>Information Technology                             | Last paragraph on p. 69 reads:<br><br>The MQD also operates the premium share billing system that administers the billing and collection of the members' share of their monthly premium rate when applicable.  | Last paragraph on p. 69 is deleted.   |
| 24 | 40.210, last paragraph on p. 73<br><br>General Provisions                                | Paragraph reads:<br><br>Annually, on the date identified in Section 51.310, the health plan shall provide to the DHS a Provider Network Development and Management Plan. In this plan, the health plan shall:  | Paragraph is amended to read:<br><br><b>The health plan shall have written policies and procedures for the selection and retention of providers. In addition,</b> annually, on the date identified in Section 51.310, the health plan shall provide to the DHS a Provider Network Development and Management Plan. In this plan, the health plan shall: |
| 25 | 40.500, bullet #17<br><br>Provider Contracts   | Bullet reads:<br><br>Require provider submission of complete and accurate encounter data on a monthly basis and any and all medical records to support encounter data upon request from the health plan with/without the specific consent of the member, DHS or its designee for the purpose of validating encounters; | Bullet is amended to read:<br><br>Require provider submission of complete and accurate encounter data on a monthly basis and any and all medical records to support encounter data upon request from the health plan <del>with</del> /without the specific consent of the member, DHS or its designee for the purpose of validating encounters;         |
| 26 | 40.500, bullet #40<br><br>Provider Contracts   | Bullet reads:<br><br>Require that the provider complies with all EPSDT requirements;   | Bullet is amended to read:<br><br>Require that the provider complies with all EPSDT requirements ( <b>if they will be providing EPSDT services</b> );   |
| 27 | 40.750.2, bullet #2 on p. 128<br><br>Primary and Acute Care Services – Behavioral Health | Bullet reads:<br><br>Prescribed drugs (excluding Clozaril or Clozapine) including medication management and patient counseling;  | Bullet is amended to read:<br><br>Prescribed drugs ( <del>excluding Clozaril or Clozapine</del> ) including medication management and patient counseling;   |

Amendment # 4  
Issued on: November 15, 2007

For Requests for Proposals RFP-MQD-2008-006  
QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

| #  | RFP Section #   | RFP Language  | Amendment  |
|----|---|---|--|
| 28 | 40.750.3.b., first sentence in first paragraph on p. 133<br><br>Adult Day Health                    | Sentence reads:<br><br>Adult day health refers to an organized day program of therapeutic, social, and health services provided to adults with physical, or mental impairments, or both which require nursing oversight or care in accordance with HAR §11-96.  | Sentence is amended to read:<br><br>Adult day health refers to an organized day program of therapeutic, social, and health services provided to adults with physical, or mental impairments, or both which require nursing oversight or care in accordance with HAR §11-96 <b>and HAR §11-94-5.</b>  |
| 29 | 40.750.3.r. second paragraph on p. 142<br><br>Residential Care Services                             | Paragraph reads:<br><br>Residential care is furnished: 1) in a Type I Expanded Adult Residential Care Home (EARCH) to a maximum of six (6) individuals, no more than three (3) of whom may be NF LOC; or 2) in a Type II EARCH, for seven (7) or more individuals, no more than twenty percent (20%) of the home's licensed capacity may be individuals meeting a NF LOC who receive these services in conjunction with residing in the home. | Paragraph is amended to read:<br><br>Residential care is furnished: 1) in a Type I Expanded Adult Residential Care Home (E-ARCH) <del>to a maximum of six (6) individuals,</del> <b>allowing five</b> or fewer residents <b>provided that up to six residents may be allowed at the discretion of the department to live in a type I home</b> with no more than <del>three (3)</del> two (2) of whom may be NF LOC; or 2) in a Type II E-ARCH, <del>for seven (7) or more individuals,</del> <b>allowing six</b> or more residents, no more than twenty percent (20%) of the home's licensed capacity may be individuals meeting a NF LOC who receive these services in conjunction with residing in the home. |
| 30 | 40.750.4, next to the last paragraph on p. 144<br><br>Expanded Personal Assistance Services Level I | Language reads:<br><br>As a point of reference, as of the posting date of this RFP (as specified in Section 20.100) approximately 1,200 persons received personal assistance services Level I in the State. Approximately 400 recipients are on the State's waiting list for personal assistance services Level I.  | Language is amended to read:<br><br>As a point of reference, as of <b>November, 14, 2007,</b> <del>the posting date of this RFP (as specified in Section 20.100)</del> <del>approximately 1,200 persons received personal assistance services Level I in the State.</del> <del>Approximately 400 recipients are on the State's waiting list for personal assistance services Level I.</del> <b>approximately 1,150 persons participate in the State funded Chore Services Program. Approximately 820 people are on the State's waiting list for the Chore Services Program. The State's waiting list is a list of people that have not been</b>  |

Amendment # 4  
 Issued on: November 15, 2007

For Requests for Proposals RFP-MQD-2008-006  
 QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

| #  | RFP Section #  | RFP Language   | Amendment   |
|----|--|--|---|
|    |  |  | <p>screened as <b>qualifying for Chore Services nor verified as eligible for Medicaid. The Chore Services Program is part of the broader personal assistance services Level I included in the QExA program. The State expects that annually no more than 1,600 and no fewer than 1,200 total QExA members will receive personal assistance services Level I. The State will provide health plan specific threshold data following Contract Award.</b></p> |
| 31 | 40.770<br><br>Self-Direction   |  | <p>Section is amended to include the following language after fourth paragraph:</p> <p><b>The budget for each member electing self-direction shall be sufficient to provide for the assessed service needs and to account for any necessary federal, State and local income and employment taxes and withholdings. The member is not obligated to provide health insurance benefits for his/her providers.</b></p>  |
| 32 | 40.770, first set of bullets, bullet # 6 on p. 150<br><br>Self-Direction | Bullet reads:<br><br>NOT be an activity that the family would ordinarily perform or is responsible to perform. | Bullet is amended to read:<br><br>NOT be an activity that the family would ordinarily perform or is responsible to perform. <b>The health plan will need to make this decision on a case by case basis and will need to consider the extent to which an individual who is the same age without a disability would need the requested level of care or assistance as the member with a disability.</b>   |

Amendment # 4  
 Issued on: November 15, 2007

For Requests for Proposals RFP-MQD-2008-006  
 QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

| #  | RFP Section #  | RFP Language   | Amendment  |
|----|--|--|--|
| 33 | 40.770, following 2 <sup>nd</sup> set of second set of bullets on p. 151<br><br>Self-Direction |  | Section is amended to include the following language after the bullets :<br><br><b>Members choosing to hire his/her family member may elect to forego bullets #1 and #2 above. However, a service agreement delineating the roles and responsibilities of both the member as the employer and the provider is still required.</b>  |
| 34 | 40.810, last paragraph on p. 157<br><br>Service Coordination System                            | Paragraph reads:<br><br>As part of its service coordination system policies and procedures, the health plan shall include information on established qualifications for service coordinators. At a minimum, service coordinators working with members who meet a NF LOC must meet all State certification and licensure requirements for a social worker, licensed nurse, or other healthcare professional with a minimum of three (3) years of relevant healthcare (preferably in long-term care) experience. | Paragraph is amended to read:<br><br>As part of its service coordination system policies and procedures, the health plan shall include information on established qualifications for service coordinators. At a minimum, service coordinators working with members who meet a NF LOC must meet all State certification and licensure requirements for a social worker, licensed nurse, or other healthcare professional with a minimum of <del>three</del> <b>one (1) year</b> of relevant healthcare (preferably in long-term care) experience. <b>Service coordinators for members working with non-NF LOC members must have, at a minimum, a high school diploma or GED equivalent and one (1) year of relevant healthcare (preferably in long-term care) experience.</b> |
| 35 | 40.820, last paragraph on p. 159<br><br>Assessments  | Paragraph reads:<br><br>The health plan shall offer the choice of institutional services or HCBS to members who meet the NF LOC when HCBS are available and are cost-neutral. The health plan shall document good faith efforts to establish a cost-neutral care plan in the community. The health plan must receive prior approval from the DHS or its designee prior to disapproving a request for HCBS.   | Paragraph is amended to read:<br><br>The health plan shall offer the choice of institutional services or HCBS to members who meet the NF LOC when HCBS are available and are cost-neutral. The health plan shall document good faith efforts <b>to establish cost-neutral care plans in the community.</b> The health plan must receive prior approval from the DHS or its designee prior to disapproving a request for HCBS.  |

Amendment # 4  
 Issued on: November 15, 2007

For Requests for Proposals RFP-MQD-2008-006  
 QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

| #  | RFP Section #  | RFP Language   | Amendment   |
|----|--|--|---|
| 36 | 40.820,<br>beginning at the second complete paragraph on pp. 160 through 161 (end of section)<br><br>Assessments | Language reads:<br><br>For members whose first day of enrollment into the health plan falls during the first ninety (90) days following Commencement of Delivery of Services as defined in Section 20.100, the service coordinator shall conduct the HFA and the LOC assessments (as needed) within the first ninety (90) days of enrollment into the health plan. The LOC assessment will remain in effect until expiration date. If the member has a change in condition which requires a revised LOC assessment under the State’s LOC assessment process, a revised LOC assessment will be required. For this ninety (90) day period, QExA health plans shall use the following triage strategy for conducting the HFA:<br><br><ul style="list-style-type: none"> <li>• Priority #1 – HCBS members with a care plan who have nurse delegation in place;</li> <li>• Priority #2 – HCBS members with a care plan without nurse delegation in place;</li> <li>• Priority #3 – members in a nursing facility; and</li> <li>• Priority #4 – members without a care plan in place.</li> </ul> If a member has a change in condition during the first ninety (90) days of enrollment into the health plan, the member shall be assessed to determine new service needs.<br><br>During this three (3) month period, prior to conducting a HFA and/or NF LOC assessment, the | Language is amended to read:<br><br>For <b>(1) all members whose first day of enrollment receiving HCBS and (2) all children under the age of twenty-one (21) whose first day of enrollment into the health plan falls during within the first <del>ninety (90)</del> seventy-five (75) days following the date of Commencement of Delivery of Services to Members</b> , as defined in Section 20.100, the service coordinator shall conduct <b>a face-to-face</b> HFA and the LOC (as needed) assessment within the first ninety (90) days <del>of following the date of Commencement of Services to Members, enrollment into the health plan.</del> The LOC assessment shall remain in effect until the expiration date. If the member has a change in condition which requires a revised LOC assessment under the State’s LOC assessment process, a revised LOC assessment will be required. <del>For this ninety (90) day period, QExA health plans shall use the following triage strategy for conducting the HFA:</del><br><br><ul style="list-style-type: none"> <li>• <del>Priority #1 – HCBS members with a care plan who have nurse delegation in place;</del></li> <li>• <del>Priority #2 – HCBS members with a care plan without nurse delegation in place;</del></li> <li>• <del>Priority #3 – members in a nursing facility; and</del></li> <li>• <del>Priority #4 – members without a care plan in place.</del></li> </ul> <b>During this seventy-five (75) day period, any member who is receiving HCBS or is under the age of twenty-one (21) and is identified by the health plan as having</b> |

Amendment # 4  
 Issued on: November 15, 2007

For Requests for Proposals RFP-MQD-2008-006  
 QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

| # | RFP Section # | RFP Language   | Amendment  |
|---|---------------|--|--|
|   |               | <p>health plan shall:</p> <ul style="list-style-type: none"> <li>• Ensure that members receive all medically necessary emergency services;</li> <li>• Ensure that members receive all medically necessary long-term care services, including both HCBS and institutional services;</li> <li>• Adhere to a member’s prescribed prior authorization for medically necessary services, including prescription drugs, or courses of treatment; and</li> <li>• Provide for the cost of care associated with a member transitioning to or from an institutional facility in accordance with the requirements prescribed in Section 40.800.</li> </ul> <p>For members enrolling after the transition enrollment period, the health plan shall complete a HFA and LOC assessment within fifteen (15) business days following enrollment.</p> <p>The health plan’s service coordinators shall conduct annual HFA and NF LOC re-assessments. For those members who meet a NF LOC, the health plan may substitute the NF LOC assessment for the HFA.</p> <p>For non-NF LOC members, at the member’s request, the HFA annual re-assessment may be conducted by telephone. Within ten (10) days the care coordinator shall follow-up a telephone reassessment with a face-to-face re-assessment when significant events occur in the life of a member, including but not limited to, the death of a caregiver, change in health status, change in</p> | <p><b>an emergency room (ER) visit, a hospital admission visit, or any change in condition shall have a face-to-face assessment conducted within fourteen (14) days of the event.</b></p> <p><b>Also during this seventy-five (75) day <del>three (3) month</del> period, prior to conducting a HFA and/or LOC assessment for any member who is receiving HCBS or is under the age of twenty-one (21), the health plan shall:</b></p> <ul style="list-style-type: none"> <li>• <b>Ensure that these members receive all medically necessary emergency services;</b></li> <li>• <b>Ensure that these members receive all medically necessary long-term care services, including both HCBS and institutional services;</b></li> <li>• <b>Adhere to a member’s prescribed prior authorization for medically necessary services, including prescription drugs, or courses of treatment; and</b></li> <li>• <b>Provide for the cost of care associated with a member transitioning to or from an institutional facility in accordance with the requirements prescribed in Section 40.800.</b></li> </ul> <p><b>For (1) all members living in a nursing facility and (2) all members without a care plan whose first day of enrollment into the health plan falls within the first one-hundred and sixty-five (165) days following the date of Commencement of Services to Members, as defined in Section 20.100, the service coordinator shall conduct a face-to-face HFA and the LOC (as needed)</b></p> |

Amendment # 4  
 Issued on: November 15, 2007

For Requests for Proposals RFP-MQD-2008-006  
 QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

| # | RFP Section # | RFP Language  | Amendment   |
|---|---------------|---|---|
|   |               | living arrangement, institutionalization and change in provider (if the provider change affects the care plan). | <p><b>assessment within the first one-hundred and eighty (180) days following the date of Commencement of Delivery of Services to Members. The LOC assessment shall remain in effect until the expiration date. If the member has a change in condition which requires a revised LOC assessment under the State's LOC assessment process, a revised LOC assessment will be required.</b></p> <p><del>If a member has a change in condition during the first ninety (90) days of enrollment into the health plan, the member shall be assessed to determine new service needs.</del></p> <p><b>During this one-hundred and sixty five (165) day period, any member who lives in a nursing facility or does not have a care plan and is identified by the health plan as having an emergency room (ER) visit, a hospital admission visit, or any change in condition shall have a face-to-face assessment conducted within fifteen (15) days of the event.</b></p> <p><b>Also during this one-hundred and sixty-five (165) <del>three (3) month</del> day period, prior to conducting a HFA and/or LOC assessment for any member living in a nursing facility or without a care plan, the health plan shall:</b></p> <ul style="list-style-type: none"> <li>• Ensure that members receive all medically necessary emergency services;</li> <li>• Ensure that members receive all medically necessary long-term care services, including both HCBS and institutional services;</li> <li>• Adhere to a member's prescribed prior authorization</li> </ul> |

Amendment # 4  
 Issued on: November 15, 2007

For Requests for Proposals RFP-MQD-2008-006

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

| # | RFP Section # | RFP Language | Amendment  |
|---|---------------|--------------|--|
|   |               |              | <p>for medically necessary services, including prescription drugs, or courses of treatment; and</p> <ul style="list-style-type: none"> <li>• Provide for the cost of care associated with a member transitioning to or from an institutional facility in accordance with the requirements prescribed in Section 40.800.</li> </ul> <p>For <b>children under the age of twenty-one (21) enrolling after the seventy-fifth (75th) day</b> <del>enrolling after the first one hundred and eighty (180) days following the date of Commencement of Services to Members transition enrollment period,</del> the health plan shall complete a HFA and LOC assessment within fifteen (15) business days following enrollment.</p> <p><b>For members living in a nursing facility or without a care plan enrolling after the one hundred sixty-fifth (165th) day</b> <del>enrolling after the first one hundred and eighty (180) days following the date of Commencement of Services to Members transition enrollment period,</del> the health plan shall complete a HFA and LOC assessment within fifteen (15) business days following enrollment.</p> <p>The health plan's service coordinators shall conduct annual HFA and NF LOC re-assessments. For those members who meet a NF LOC, the health plan may substitute the NF LOC assessment for the HFA.</p> <p>For non-NF LOC members, at the member's request, the HFA annual re-assessment may be conducted by telephone. Within ten (10) days the care coordinator shall follow-up a telephone re-assessment with a face-to-face reassessment when significant events occur in the life of a</p> |

Amendment # 4  
 Issued on: November 15, 2007

For Requests for Proposals RFP-MQD-2008-006  
 QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

| #  | RFP Section #                                      | RFP Language  | Amendment  |
|----|--|---|--|
|    |  |   | <p>member, including but not limited to, the death of a caregiver, change in health status, change in living arrangement, institutionalization and change in provider (if the provider change affects the care plan).</p> <p><b>As a part of the health plan’s HFA process, the State shall develop a process (including criteria) to determine a member’s eligibility for personal assistances services Level I. The process will be subject to annual evaluation by the State and or its designee.</b></p>   |
| 37 | 40.830, first paragraph on p. 163<br><br>Care Plan | <p>Paragraph reads:</p> <p>For members whose first day of enrollment into the health plan falls during the first three (3) months following Commencement of Delivery of Services as defined in Section 20.100, the health plan shall develop the care plan within the first 90 (ninety) days of enrollment into the plan, following the completion of the HFA. For members enrolling after this three (3) month period, the health plan shall complete the care plan within fifteen (15) business days following enrollment, following completion of the HFA.</p> | <p>Paragraph is amended to read as follows:</p> <p><b>For (1) all members receiving HCBS and (2) children under the age of twenty-one (21) whose first day of enrollment into the health plan falls within the first seventy-five (75) days following the date of Commencement of Services to Members, as defined in Section 20.100, the health plan shall develop the care plan within ninety (90) days following the date of Commencement of Services to Members identified in Section 20.100. The care plan shall be completed following completion of the HFA.</b></p> <p><b>For members under the age of twenty-one (21) enrolling after the seventy-fifth (75th) day following the date of Commencement of Services to Members, the health plan shall complete the care plan within fifteen (15) business days following enrollment. The care plan shall be completed following completion of the HFA.</b></p> |

Amendment # 4  
 Issued on: November 15, 2007

For Requests for Proposals RFP-MQD-2008-006

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

| #  | RFP Section #   | RFP Language  | Amendment   |
|----|---|---|---|
|    |   |   | <p><b>For (1) all members living in a nursing facility and (2) all members without a care plan whose first day of enrollment into the health plan falls within the first one-hundred and sixty-five (165) days following the date of Commencement of Services to Members identified in Section 20.100. The care plan shall be completed following completion of the HFA.</b></p> <p><del>For members whose first day of enrollment into the health plan falls during the first three (3) months following Commencement of Delivery of Services as defined in Section 20.100, the health plan shall develop the care plan within the first 90 (ninety) days of enrollment into the plan, following the completion of the HFA.</del></p> <p>For members <b>living in a nursing facility and without a care plan</b> enrolling after this three (3) month period <b>the one-hundred sixty-fifth (165th) day following the date of Commencement of Services to Members</b>, the health plan shall complete the care plan within fifteen (15) business days following enrollment. <b>The care plan shall be completed</b> following completion of the HFA.</p> |
| 38 | 40.910, 2 <sup>nd</sup> to last paragraph<br><br>Cultural Competency Plan | <p>Paragraph reads:</p> <p>The health plan shall provide to all in-network providers a summary of the cultural competency plan that includes a summary of information on how the provider may access the full cultural competency plan from the health plan at no charge to the provider.</p> | <p>Paragraph is amended to read:</p> <p>The health plan shall provide to all in-network providers a summary of the cultural competency plan <b>and information</b> on how the provider may access the full cultural competency plan (<b>either on-line or in hard copy</b>) from the health plan at no charge to the provider.</p>  |
| 39 | 40.920, p. 166<br><br>Disease Management                                  |   | <p>New paragraph is inserted after the first paragraph in the section. Language in the new paragraph shall read:</p> <p>The health plan may have a transition period for implementation of the disease management programs</p>  |

Amendment # 4  
 Issued on: November 15, 2007

For Requests for Proposals RFP-MQD-2008-006  
 QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

| #  | RFP Section #  | RFP Language   | Amendment  |
|----|--|--|--|
|    |  |  | <p>provided that the the programs are fully operational according to the following schedule:</p> <ul style="list-style-type: none"> <li>• First program – sixty (60) days following Commencement of Services;</li> <li>• Second program – one-hundred and twenty (120) days following Commencement of Services;</li> <li>• Third program – one hundred and eighty (180) days following Commencement of Services;</li> <li>• Fourth program – two hundred and forty (240) days following Commencement of Services.</li> </ul> <p>The health plan may choose the order in which each of the four (4) disease management programs is implemented.</p> |
| 40 | 40.950, last sentence of last paragraph before bullets, p. 171<br><br>Children’s Medical and Behavioral Health Services (EPSDT Services) | Sentence reads:<br><br>DOH and DOE will be responsible for providing the following services:   | Sentence is amended to read:<br><br>DOH <del>and DOE</del> will be responsible for providing the following services:   |
| 41 | 50.110, 2 <sup>nd</sup> bullet on p. 179<br><br>General Overview   | Bullet reads:<br><br>A health plan member number, which does not have to be the same as the Medicaid ID number which has been assigned by the DHS. | Section is amended to delete 2 <sup>nd</sup> bullet on p. 179.   |

Amendment # 4  
 Issued on: November 15, 2007

For Requests for Proposals RFP-MQD-2008-006  
 QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

| #  | RFP Section #  | RFP Language   | Amendment  |
|----|--|--|--|
| 42 | 50.130<br><br>PCP Selection  | Paragraph reads:<br><br>The health plan shall provide assistance in selecting a PCP and shall provide the member fifteen (15) days to select a PCP. This fifteen (15) day period shall not include mail time. If a PCP is not selected within fifteen (15) days, the health plan shall assign a PCP to the member based first on historical utilization and second on the geographic area in which the member resides. | Paragraph reads:<br><br>The health plan shall provide assistance in selecting a PCP and shall provide the member fifteen (15) days to select a PCP. This fifteen (15) day period shall not include mail time. <b>The standard number of days the health plan should use for mail time is five (5) days.</b> If a PCP is not selected within fifteen (15) days, the health plan shall assign a PCP to the member based first on historical utilization and second on the geographic area in which the member resides. |
| 43 | 50.220, 1 <sup>st</sup> paragraph<br><br>State of Hawaii Organ and Tissue Transplant Program (SHOTT) | Paragraph reads:<br><br>For all non-experimental, non-investigational covered transplants, except for cornea transplants and bone grafts, the health plan shall notify the member that he or she should submit a 1144 form to the MQD for authorization for an evaluation by SHOTT. The health plan shall provide assistance to the member as needed.  | Paragraph is amended to read:<br><br>For all non-experimental, non-investigational covered transplants, except for cornea transplants and bone grafts, <del>the health plan shall notify the member that he or she</del> the health plan shall <b>ensure that the provider</b> <del>should</del> submit an 1144 form to the MQD for authorization for an evaluation by SHOTT. <del>The health plan shall provide assistance to the member as needed.</del>   |
| 44 | 50.340, 8 <sup>th</sup> bullet on p. 190<br><br>Member Handbook Requirements                         | Bullet reads:<br><br>A notice stating that the health plan shall be liable only for those services authorized by the health plan.  | Bullet is amended to read:<br><br>A notice stating that the health plan shall be liable only for those services authorized by the health plan <b>(if it is a service requiring prior authorization).</b>   |

Amendment # 4  
 Issued on: November 15, 2007

For Requests for Proposals RFP-MQD-2008-006  
 QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

| #  | RFP Section #  | RFP Language   | Amendment  |
|----|--|--|--|
| 45 | 50.520, 3 <sup>rd</sup> paragraph<br><br>General Provisions                        | Paragraph reads:<br><br>The health plan shall execute processes to assess, plan, implement, evaluate and, as mandated, report quality management and performance improvement activities as specified in the Medicaid State Health Plan Manual, that adheres to the requirements prescribed in 42 CFR §438.240(a)(1) and (e)(2), including:   | Paragraph is amended to read:<br><br>The health plan shall execute processes to assess, plan, implement, evaluate and, as mandated, report quality management and performance improvement activities as specified <del>in</del> <b>by</b> the <del>Medicaid-State Health Plan Manual,</del> <b>and</b> that adheres to the requirements prescribed in 42 CFR §438.240(a)(1) and (e)(2), including:   |
| 46 | 50.520, 2 <sup>nd</sup> to last paragraph in the section<br><br>General Provisions | Paragraph reads:<br><br>The health plan shall have a process in place to monitor services provided in home and community-based settings. The process shall be a collaborative one that involves quality management and service coordinators. The health plan shall develop a process that, at a minimum, meets the requirements specified in the Medicaid State Health Plan Manual instructions. | Paragraph is amended to read:<br><br>The health plan shall have a process in place to monitor services provided in home and community-based settings. The process shall be a collaborative one that involves quality management and service coordinators. The health plan shall develop a process that, at a minimum, meets the requirements specified <del>in</del> <b>by</b> the <del>Medicaid-State Health Plan Manual instructions.</del>  |
| 47 | 50.520, last paragraph in the section<br><br>General Provisions                    | Paragraph reads:<br><br>The health plan shall submit a written Quality Assessment and Performance Improvement (QAPI) plan, an evaluation of the previous year's QAPI program, and Quarterly QAPI report that addresses its strategies for performance improvement and conducting the quality management activities described in this section.  | Paragraph is amended to read:<br><br>The health plan shall submit a written Quality Assessment and Performance Improvement (QAPI) <b>plan description</b> <del>and an evaluation of the previous year's QAPI program,</del> <del>and Quarterly QAPI report</del> that addresses its strategies for performance improvement and conducting the quality management activities described in this section. <b>In addition, the health plan shall submit an evaluation of the previous year's QAPI program.</b> |

Amendment # 4  
Issued on: November 15, 2007

For Requests for Proposals RFP-MQD-2008-006  
QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

| #  | RFP Section #  | RFP Language  | Amendment  |
|----|--|---|--|
| 48 | 50.540, 2 <sup>nd</sup> sentence of the last paragraph.<br><br>Performance Improvement Projects (PIPs) | Sentence reads:<br><br>In addition, the health plan shall submit its proposed PIPs no later than November 1 of each year and its PIP evaluations for the previous year to the DHS no later than April 1 of each year.   | Sentence is amended to read:<br><br>In addition, the health plan shall submit its proposed PIPs no later than <del>November 1</del> <b>October</b> 1 of each year and its PIP evaluations for the previous year to the DHS no later than April 1 of each year.   |
| 49 | 50.580, 1 <sup>st</sup> bullet<br><br>Medical Records Standards  | Bullet reads:<br><br><ul style="list-style-type: none"> <li>• Require that the medical record is maintained by the PCP;</li> </ul>  | Bullet is amended to read:<br><br>Require that the medical record is maintained by the <del>PCP</del> <b>provider</b> ;  |
| 50 | 50.580, 3 <sup>rd</sup> to last paragraph<br><br>Medical Records Standards                             | Sentence reads:<br><br>As part of its medical records standards, the health plan shall facilitate the transfer of the member's medical records (or copies) to the new PCP within seven (7) business days from receipt of request.   | Sentence is amended to read:<br><br>As part of its medical records standards, the health plan shall <b>ensure that providers</b> facilitate the transfer of the member's medical records (or copies) to the new PCP within seven (7) business days from receipt of request.  |
| 51 | 50.860, pp. 232-233<br><br>Notice of Action  | List reads:<br><br>The health plan shall mail the notice within the following time frames:<br><br><ul style="list-style-type: none"> <li>• For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) days prior to the date the adverse action is to start except: <ul style="list-style-type: none"> <li>○ By the date of action for the following reasons: <ul style="list-style-type: none"> <li>▪ The health plan has factual information confirming the death of a member;</li> <li>▪ The health plan receives a clear written statement signed by the member that he</li> </ul> </li> </ul> </li> </ul> | List is amended to read:<br><br>The health plan shall mail the notice within the following time frames:<br><br><ul style="list-style-type: none"> <li>• For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) days prior to the date the adverse action is to start except: <ul style="list-style-type: none"> <li>○ By the date of action for the following reasons: <ul style="list-style-type: none"> <li>▪ The health plan has factual information confirming the death of a member;</li> <li>▪ The health plan receives a clear written statement signed by the member that he or she no longer wishes services or gives</li> </ul> </li> </ul> </li> </ul> |

Amendment # 4  
 Issued on: November 15, 2007

For Requests for Proposals RFP-MQD-2008-006  
 QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

| # | RFP Section # | RFP Language  | Amendment  |
|---|---------------|---|--|
|   |               | <p>or she no longer wishes services or gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying that information;</p> <ul style="list-style-type: none"> <li>▪ The member has been admitted to an institution that makes him or her ineligible for further services;</li> <li>▪ The member's address is unknown and the post office returns health plan mail directed to the member indicating no forwarding address;</li> <li>▪ The member has been accepted for Medicaid services by another local jurisdiction;</li> <li>▪ The member's provider prescribes a change in the level of medical care;</li> <li>▪ There has been an adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989; or</li> <li>▪ In the case of adverse actions for nursing facility transfers, the safety or health of individuals in the facility would be endangered, the member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the member's urgent medical needs, or the member has not resided in the nursing facility for thirty (30) days.</li> </ul> <ul style="list-style-type: none"> <li>• The period of advanced notice is shortened to</li> </ul> | <p>information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying that information;</p> <ul style="list-style-type: none"> <li>▪ The member has been admitted to an institution that makes him or her ineligible for further services;</li> <li>▪ The member's address is unknown and the post office returns health plan mail directed to the member indicating no forwarding address;</li> <li>▪ The member has been accepted for Medicaid services by another local jurisdiction;</li> <li>▪ The member's provider prescribes a change in the level of medical care;</li> <li>▪ There has been an adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989; or</li> <li>▪ In the case of adverse actions for nursing facility transfers, the safety or health of individuals in the facility would be endangered, the member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the member's urgent medical needs, or the member has not resided in the nursing facility for thirty (30) days.</li> </ul> <ul style="list-style-type: none"> <li>○ The period of advanced notice is shortened to five (5) days if there is alleged fraud by the recipient and the facts have been verified, if possible, through secondary sources. <b>[Note,</b></li> </ul> |

Amendment # 4  
Issued on: November 15, 2007

For Requests for Proposals RFP-MQD-2008-006  
QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

| #  | RFP Section #   | RFP Language   | Amendment  |
|----|---|--|--|
|    |   | five (5) days if there is alleged fraud by the recipient and the facts have been verified, if possible, through secondary sources.   | <b>bullet has been indented so it appears under the “For Termination, suspension, or reduction bullet.” It is now a level 2 bullet, not a level 1 bullet.]</b>   |
| 52 | 51.110, 1 <sup>st</sup> paragraph<br><br>General Requirements | Paragraph reads:<br><br>The health plan shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities. The health plan shall have a compliance officer and sufficient staffing (as required in Section 51.210) and resources to investigate unusual incidents and develop and implement corrective action plans to assist the health plan in preventing and detecting potential fraud and abuse activities. The health plan’s fraud and abuse activities shall comply with the program integrity requirements outlined in 42 CFR 438.608. | Paragraph is amended to read:<br><br>The health plan shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities. <b>In addition, as part of these internal controls and policies and procedures, the health plan shall have ways to verify services were actually provided.</b> The health plan shall have a compliance officer and sufficient staffing (as required in Section 51.210) and resources to investigate unusual incidents and develop and implement corrective action plans to assist the health plan in preventing and detecting potential fraud and abuse activities. The health plan’s fraud and abuse activities shall comply with the program integrity requirements outlined in 42 CFR 438.608. |
| 53 | 51.130, bullet list<br><br>Compliance Plan                    |  | Bulleted list is amended to insert, between the 6 <sup>th</sup> and 7 <sup>th</sup> bullet, the following:<br><br><ul style="list-style-type: none"> <li>• Ensure the enforcement of standards through well-publicized disciplinary guidelines;</li> </ul>   |
| 54 | 51.220, 4th paragraph on p. 244.<br><br>Specific Descriptions | Paragraph reads:<br><br>The health plan shall have a service coordination manager who is a registered nurse (may have additional training, e.g., advanced practice nurse practitioner) and is responsible for all service coordination activities and oversees the hiring, training and work of all health plan service coordinators.  | Paragraph is amended to read:<br><br>The health plan shall have a service coordination manager who is a registered nurse (may have additional training, e.g., advanced practice nurse practitioner) <b>or a Masters Degree Social Worker who is licensed with a minimum of two (2) years of medical experience (i.e., acute care hospital or long-term care facility)</b> and is responsible for   |

Amendment # 4  
Issued on: November 15, 2007

For Requests for Proposals RFP-MQD-2008-006  
QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

| #  | RFP Section #  | RFP Language  | Amendment   |
|----|--|---|---|
|    |  |   | all service coordination activities and oversees the hiring, training and work of all health plan service coordinators.   |
| 55 | 51.220, 2 <sup>nd</sup> sentence, last paragraph on p. 244.<br><br>Specific Descriptions | Sentence reads:<br><br>This person shall oversee all activities related to prior authorizations and concurrent and post-payment reviews.  | Sentence is amended to read:<br><br>This person shall oversee all activities related to prior authorizations and concurrent and post-payment reviews, <b>to include UM line.</b>  |
| 56 | 51.220, 3 <sup>rd</sup> paragraph on p. 245.<br><br>Specific Descriptions                | Paragraph reads:<br><br>The health plan shall have a provider services manager who is responsible for the UM line, provider network activities and provider education. The person shall oversee the hiring, training and work of all line personnel performing member services functions. | Paragraph is amended to read:<br><br>The health plan shall have a provider services manager who is responsible for the <del>UM line</del> , provider network activities and provider education. The person shall oversee the hiring, training and work of all line personnel performing <del>member</del> <b>provider</b> services functions. |
| 57 | 51.310, Table<br><br>Reporting Requirements  |   | Table is amended by inserting the following information for the Due Dates and Recipient for the QAPI Program, Performance Measures,:<br>Due Dates (column 4): <b>March 1, September 1</b><br>Recipient (column 5): <b>MSB</b>   |
| 58 | 51.610, Table<br><br>Required Review Documents   |   | Table is amended by inserting, between Cultural competency plan and EPSDT plan, the following:<br><br>1 <sup>st</sup> column: Disease management policies and procedures<br>2 <sup>nd</sup> column: 40.920<br>3 <sup>rd</sup> column: 90 days after Contract Award  |

Amendment # 4  
 Issued on: November 15, 2007

For Requests for Proposals RFP-MQD-2008-006  
 QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

| #  | RFP Section #  | RFP Language   | Amendment   |
|----|--|--|---|
| 59 | 51.610, Table<br><br>Required Review Documents   |  | Table is amended by inserting at the end:<br><br>1 <sup>st</sup> column: Proof of licensed in-house capacity to fulfill the function of Community Care Management Agencies (if proof of licensure not provided with the proposal)<br>2 <sup>nd</sup> column: 80.315.2<br>3 <sup>rd</sup> column: 90 days after Contract Award   |
| 60 | 60.220, 2 <sup>nd</sup> paragraph<br><br>Provider and Subcontractor Reimbursement                | Paragraph reads:<br><br>The health plan shall reimburse providers at rates comparable to the Medicaid FFS rates in place on the date of Contract Award identified in Section 20.100. | Paragraph is amended to read and new paragraph added that reads:<br><br>The health plan shall reimburse providers ( <b>except nursing facilities</b> ) at rates comparable to the Medicaid FFS rates in place on the date of Contract Award identified in Section 20.100.<br><br>The health plan shall reimburse nursing facilities utilizing an acuity-based system in accordance with HRS § 346-D-1.5. <b>The health plan shall reimburse nursing facilities the rates as of July 1, 2008 in accordance with HRS § 346-D-1.5.</b> |
| 61 | 60.220, 3 <sup>rd</sup> paragraph, last sentence<br><br>Provider and Subcontractor Reimbursement | Sentence reads:<br><br>The health plan shall report this information to the DHS quarterly and in the format required by the DHS.   | Sentence reads:<br><br>The health plan shall report this information to the DHS <del>quarterly</del> <b>annually</b> and in the format required by the DHS.   |
| 62 | 60.220, 6 <sup>th</sup> paragraph<br><br>Provider and Subcontractor Reimbursement                | Paragraph reads:<br><br>The health plan shall reimburse nursing facilities utilizing an acuity-based system in accordance with HRS § 346-D-1-5.                                      | Paragraph is deleted.   |

Amendment # 4  
Issued on: November 15, 2007

For Requests for Proposals RFP-MQD-2008-006  
QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

| #  | RFP Section #   | RFP Language  | Amendment  |
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| 63 | 70.110, 2 <sup>nd</sup> paragraph<br><br>Compliance with other Federal Laws     | Paragraph reads:<br><br>The health plan shall recognize mandatory standards and policies relating to energy efficiency which are contained in the State energy conservation plan issues in compliance with the Energy Policy and Conservation Act (Pub. L. 94-165).   | Paragraph is amended to read:<br><br><b>The health plan shall comply with all applicable standards, orders or requirements issued under section 306 of the Clean Air Act (42 USC 1857 (h)), section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR part 15).</b> The health plan shall recognize mandatory standards and policies relating to energy efficiency which are contained in the State energy conservation plan issues in compliance with the Energy Policy and Conservation Act (Pub. L. 94-165).   |
| 64 | 70.500, 4 <sup>th</sup> major bullet on p. 300<br><br>Subcontractor Requirement | Bullet reads:<br><br>Fulfill the requirements of 42 CFR § 438.6 that are appropriate to the service delegated under the subcontract;  | Bullet is amended to read:<br><br>Fulfill the requirements of 42 CFR § 438.6 that are appropriate to the service delegated under the subcontract;  |
| 65 | 80.220 G<br><br>Company Background Narrative                                    | Lettered item as amended by Amendment #1 reads:<br><br>A list of the states in which it is accredited by either National Committee for Quality Assurance (NCQA), American Accreditation Healthcare Commission/URAC, Accreditation Association for Ambulatory Health Care (AAAHC) or Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and indicate the accreditation status by product line. The applicant shall also list the states in which it has applied for accreditation by one (1) of the three (3) accrediting bodies listed and the status of the application(s) by product line; and | Lettered item is amended to read:<br><br>A list of the states in which it, <b>an affiliate company (as defined in Section 30.200), or a company with the same parent company as the applicant</b> is accredited by either National Committee for Quality Assurance (NCQA), American Accreditation Healthcare Commission/URAC, Accreditation Association for Ambulatory Health Care (AAAHC) or Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and indicate the accreditation status by product line. The applicant shall also list the states in which it has applied for accreditation by one (1) of the <del>three (3)</del> <b>four (4)</b> accrediting bodies listed and the status of the application(s) by product line; and |

Amendment # 4  
 Issued on: November 15, 2007

For Requests for Proposals RFP-MQD-2008-006  
 QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

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| 66 | 80.230   |   | Add bullet to read:<br><br>Insert the following bullet between D and E and renumber accordingly.<br>E. Disclosure Statement   |
| 67 | 80.230 N.<br><br>Attachment:<br>Other<br>Documentation | Item reads:<br><br>The Elimination of Barriers to Contracting Between FQHCs/RHC and Health Plans forms (if applicable) from both the health plan and all providers of any applicant that is owned or controlled by a provider or providers of health care services as defined in Section 72.400.  | Item is amended to read:<br><br>The Elimination of Barriers to Contracting Between FQHCs/RHCs and Health Plans form(s) <del>(if applicable) from both the health plan and all providers of any applicant that is owned or controlled by a provider or providers of health care services</del> <b>or an appropriate explanation of why these forms have not been attached. The first form, (with the Health Plan Name____) across the top shall be submitted by all applicants. The second form (with the Name of FQHC/RHC____) across the top shall be submitted by any FQHC or RHC that has an ownership or control interest in the applicant,</b> as defined in Section 72.400. |
| 68 | 80.230 Q.<br><br>Attachment:<br>Other<br>Documentation | Item reads:<br><br>The State and Federal Tax Clearance certificates as assurance that all federal and state tax liabilities have been paid and that there are no significant outstanding balances owing (a statement shall be included if certificates are not available at time of submission of proposal that the certificates will be submitted in compliance with Section 20.500.); and | Item is amended to read:<br><br>The State and Federal Tax Clearance certificates <b>from the prime applicant and, upon request from subcontractors,</b> as assurance that all federal and state tax liabilities have been paid and that there are no significant outstanding balances owing (a statement shall be included if certificates are not available at time of submission of proposal that the certificates will be submitted in compliance with Section 20.500.); and   |

Amendment # 4  
 Issued on: November 15, 2007

For Requests for Proposals RFP-MQD-2008-006  
 QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

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|----|--|---|--|
| 69 | 80.310 A.<br><br>Experience and References | Bullet reads:<br><br>A narrative of its experience providing services to Medicaid and Medicare populations in Hawaii and in other states.   | Bullet is amended to read:<br><br>A narrative of its experience providing services to Medicaid and Medicare populations in Hawaii and in other states. <b>As part of this narrative the applicant may include experience of an affiliated company, a company with the same parent company as the applicant, and any subcontractors who will be providing direct services.</b>  |
| 70 | 80.310 B.<br><br>Experience and References | Bullet reads:<br><br>A listing, in table format, of contacts for all Medicaid program clients (including those served by an affiliated company or a company with the same parent company as the applicant), past and present. This listing shall include the name, title, address, telephone number and e-mail address of the client and/or contract manager, the number of lives the applicant has or had broken down by the type of membership (e.g. TANF and TANF related, ABD), and the number of years the applicant has been providing or had provided services for that program; | Bullet is amended to read:<br><br>A listing, in table format, of contacts for all Medicaid program clients (including those served by an affiliated company, a company with the same parent company as the applicant, <b>and any subcontractors providing direct services</b> ), past and present. This listing shall include the name, title, address, telephone number and e-mail address of the client and/or contract manager, the number of lives the applicant has or had broken down by the type of membership (e.g. TANF and TANF related, ABD), and the number of years the applicant has been providing or had provided services for that program. <b>In the interest of space, if the applicant has ten (10) or more contacts for Medicaid programs which entail the provision of direct services, it is not necessary to include all contacts which do not entail direct service provision (e.g. administrative service arrangements);</b> |
| 71 | 80.310 C.<br>Experience and References     | Bullet reads:<br><br>Information on whether or not any contract (including those for an affiliate of the company or a company with the same parent company as the applicant) has been terminated or not renewed for non-performance   | Bullet is amended to read:<br><br>Information on <b>(1)</b> whether or not any contract (including those for an affiliate of the company, a company with the same parent company as the applicant); <b>or subcontractor providing direct services</b> ) has been terminated or not   |

Amendment # 4  
 Issued on: November 15, 2007

For Requests for Proposals RFP-MQD-2008-006  
 QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

| #  | RFP Section #  | RFP Language  | Amendment   |
|----|--|---|---|
|    |  | or poor performance within the past five (5) years. In this instance include information on the details of termination or non-renewal.                  | renewed for non-performance or poor performance within the past five (5) years <b>and (2) whether the applicant (including an affiliate of the company, a company with the same parent company as the applicant or subcontractor providing direct services) failed to complete a full contract term or self-terminated mid-contract. Please include information on the details of termination, non-renewal, failure to complete a full contract term or self-termination.</b> |
| 72 | 80.310 D., 1 <sup>st</sup> sentence<br><br>Experience and References             | 1 <sup>st</sup> sentence of the bullet reads:<br><br>Its most recent EQRO evaluations from states in which it has previously or is currently operating. | 1 <sup>st</sup> sentence of the bullet is amended to read:<br><br>Its most recent EQRO evaluations from states in which it has previously or is currently operating. <b>The applicant shall also include EQRO evaluations of an affiliated company, a company with the same parent company as the applicant or any subcontractors.</b>  |
| 73 | 80.310 E., 1 <sup>st</sup> sentence<br><br>Experience and References             | 1 <sup>st</sup> sentence of the bullet reads:<br><br>EPSDT measures for the last twelve (12) month period.  | 1 <sup>st</sup> sentence of the bullet is amended to read:<br><br>EPSDT measures for the last twelve (12) month period. <b>The applicant shall also include EPSDT measures of an affiliated company or a company with the same parent company as the applicant.</b>   |
| 74 | 80.315.2, 5 <sup>th</sup> item in the table (Community Care Management Agencies) | Language reads:<br><br>Community Care Management Agencies or proof of licensed in-house capacity to fulfill the function.                               | Language is amended to read:<br><br>Community Care Management Agencies or proof of <del>licensed</del> in-house capacity to fulfill the function.   |
| 75 | 80.320, Heading<br><br>Provider Services   | Heading reads:<br><br>Provider Services (8 pages maximum not including attachments)   | Heading is amended to read:<br><br>Provider Services (8 pages maximum <del>not including attachments</del> )  |

Amendment # 4  
Issued on: November 15, 2007

For Requests for Proposals RFP-MQD-2008-006  
QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

| #  | RFP Section #   | RFP Language  | Amendment  |
|----|---|---|--|
| 76 | 80.335, 1 <sup>st</sup> paragraph<br><br>Other Services Narrative | Language reads:<br><br>The applicant shall describe in detail its proposed approach to disease management for at least one of the health conditions specified in Section 40.920. The description should include how the applicant will:   | Language is amended to read:<br><br>The applicant shall describe in detail its proposed approach to disease management for at least one of the health conditions specified in Section 40.920. <b>The description should include response shall describe how it will meet all requirements in Section 40.920, including but not limited to</b> how the applicant will:  |
| 77 | 80.345.2, D<br><br>Member Services                                | Language reads:<br><br>How it will monitor compliance with performance standards outlined in Section 50.555 and what it will do in the event they are not being met.  | Language is amended to read:<br><br>How it will monitor compliance with performance standards outlined in Section <b>50.380</b> and what it will do in the event they are not being met.   |
| 78 | 80.350.2, 2 <sup>nd</sup> sentence<br><br>QAPI                    | Language reads:<br><br>As part of this description, please include the following information:   | Language is amended to read:<br><br>As part of this description, please include, <b>at a minimum</b> , the following information:  |
| 79 | 80.350.3 B.<br><br>Performance Measures                           | Language reads:<br><br>Provide HEDIS measures for the last two (2), twelve (12) month periods for all Medicaid programs the applicant (or an affiliated company or a company with the same parent company as the applicant) was serving during that time period. Provide reference to population reporting on to include geographic location and member demographics. The applicant shall indicate which measures were validated by an EQRO and provide the EQRO validation reports. Note: the EQRO validation reports do not count towards the page limit. | Language is amended to read:<br><br>Provide HEDIS measures reports for the last two (2), twelve (12) month periods for all Medicaid programs the applicant (or an affiliated company or a company with the same parent company as the applicant) was serving during that time period. Provide reference to population reporting on to include geographic location and member demographics. The applicant shall indicate which measures were validated by an EQRO <b>or NCQA certified compliance auditor</b> and provide the <del>EQRO</del> validation reports. Note: <b>the HEDIS measures and the EQRO validation reports do not count towards the page limit but the HEDIS measures shall not exceed ten (10) pages.</b> |

Amendment # 4  
Issued on: November 15, 2007

For Requests for Proposals RFP-MQD-2008-006  
QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

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|----|---|---|--|
| 80 | 80.365.2,<br>Heading<br><br>General Administrative Requirements   | Heading reads:<br><br>General Administrative Requirements Narrative – Organization Charts and Narrative on Organization Charts  | Heading is amended to read:<br><br>General Administrative Requirements <b>Attachment and Narrative – Organization Charts (Attachment)</b> and Narrative on Organization Charts   |
| 81 | 80.365.3, 1 <sup>st</sup> sentence<br><br>General Administrative Requirements Narrative – Organization and Staffing Table | 1 <sup>st</sup> sentence reads:<br><br>In a table format, the applicant shall describe its current or proposed staffing that includes the number of full-time equivalents (FTEs) for all positions described in Section 51.310.   | 1 <sup>st</sup> sentence is amended to read:<br><br>In a table format, the applicant shall describe its current or proposed staffing that includes the number of full-time equivalents (FTEs) for all positions described in Section 51.3210.  |
| 82 | 80.370, Heading<br><br>Financial Responsibilities   | Heading reads:<br><br>Financial Responsibilities (6 pages maximum not including attachments)  | Heading is amended to read:<br><br>Financial Responsibilities (6 pages maximum <del>not including attachments</del> )  |
| 83 | 100.700 2 <sup>nd</sup> sentence of the 2 <sup>nd</sup> paragraph<br><br>Contract Award                                   | Sentence reads><br><br>If an awarded applicant requests to withdraw its bid from all or specified islands, without incurring penalties, it must be requested in writing to the MQD before the close of business (4:30 p.m. H.S.T.) on Contract Award date identified in Section 20.100. | Sentence is amended to read:<br><br>If an awarded applicant requests to withdraw its bid <del>from all or specified islands</del> , without incurring penalties, it must be requested in writing to the MQD before the close of business (4:30 p.m. H.S.T.) on Contract Award date identified in Section 20.100. |
| 84 | Appendix B  |   | Replace Appendix B amended by Amendment #2 with revised Appendix B below.  |
| 85 | Appendix L  |   | Replace Appendix L with revised Appendix L.  |
| 86 | Appendix N  |   | Insert Appendix N as included at the end of this document.   |
| 87 | Data Book   |   | Replace Data Book with amended version.  |

For Requests for Proposals RFP-MQD-2008-006  
QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals  
Who Are Aged, Blind or Disabled

**AMENDED**  
**APPENDIX B**  
**RISK SHARE PROGRAM**

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

To address the unknown risk to the health plans and the State, the DHS will implement a risk share program. The risk share program will be applied when there is an overall impact on the program such that there is a significant differential between the total funds provided to the plans for health care and the aggregate health care expenses of the plans. It is not intended to protect any one health plan from poor performance due to ineffective management of utilization, or the inability to negotiate effective and economical contracts. The risk share program cannot be activated by a single plan.

**Conceptual Framework:** Under the risk share program, the DHS will share in a significant difference between the capitated revenues and the actual costs experienced by the totality of the plans. Six (6) months following the end of the fiscal year (by December 31), using the financial reports provided by the participating health plans, a simple profit and loss statement will be developed for the health services portion of the QExA program. The health care services portion of the capitation revenues is assumed to be 93%. Actual administrative expenses will not be included in the computation since the intent of the program is to adjust for unknown risk associated with providing the health services to the enrolled population. Note that service coordination costs are reported as healthcare services and not as administrative costs for this computation.

Following the computation of the aggregate profit and loss statement, a net loss or gain percentage will be computed based upon the total capitations paid to the plans for health care. If the loss percentage is within a 5% risk corridor, there will be no loss sharing between the DHS and the health plans and the health plans will absorb all of the loss. If the aggregate loss is outside of this risk corridor, the DHS will share equally in the loss exceeding the risk corridor up to the risk share limit of \$5,000,000. If there is an aggregate gain exceeding 3%, the DHS will

Amendment # 4  
Issued on: November 15, 2007

For Requests for Proposals RFP-MQD-2008-006  
QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals  
Who Are Aged, Blind or Disabled  
share equally in the gain between 3% and 5%. The DHS will recover all gains  
exceeding 5%.

If there is to be risk sharing, each health plan would be compensated individually based on the number of eligible months. Using an example of a net loss of 7%, with the risk corridor at 5%, the 2% difference would be shared equally between the DHS and the health plans up to \$5,000,000. Since the DHS and the health plans share equally in the loss, the amount to be remitted back to the health plans is 1% of the total capitations paid to the health plans for health care. Only health plans experiencing an actual loss will benefit from the risk share program.

Similarly, if there is a net gain of 7%, there will be profit sharing for the 4% difference beyond the 3% corridor. The first 2% difference will be shared equally between the DHS and the plans. The second 2% will be returned to the State. Only health plans experiencing an actual gain above the 3% corridor will be required to reimburse the State.

The individual amounts to be remitted to the plans or to the State will be distributed based on eligible months. The following formula will be used to determine the aggregate gain/loss\*:

$\Sigma$ Total revenue (based on capitations paid to each plan for the health care portion)

Less:  $\Sigma$ Net health care expenses (based on the actual experience for health care)

Equals: Net profit/loss (for the health care services provided to QExA populations)

The net profit/loss divided by the total revenue will provide a percentage of the profit/loss which will be compared to the risk corridor established by the DHS.

\* The following definitions apply:

Total Revenue is the sum of all capitation payments made to each health plan during the fiscal year. The health care services portion is equal to Total Revenue times 93%

Net Health Care Expenses will be based on the actual service expenses less any reimbursements from third party reimbursements. The expenses will be taken from the financial reports provided by the health plans for the year ended June 30. DHS recognizes that the financial reports are due within 45 days from the

Amendment # 4  
 Issued on: November 15, 2007

For Requests for Proposals RFP-MQD-2008-006  
 QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals  
 Who Are Aged, Blind or Disabled

end of the reporting period and that some data may not be available at the time the reports are submitted. Therefore, prior to compiling the profit/loss statement for the risk share program, the plans will be requested to update their prior year's report for any adjustments. The report will be due to the DHS by January 15.

All net expenses for all health plans will be summed to determine the total net expenses for care.

**Examples:** The following examples illustrate how the Risk Share Program would be applied in aggregate and individually to the plans

Example 1: Aggregate Program Calculation for Loss

| Plan | Recipient Months | Capitation Paid (total) | Medical Portion % | Medical Portion \$ | Medical Expenses | Net Profit (Loss) | Gain (Loss) Percentage |
|------|------------------|-------------------------|-------------------|--------------------|------------------|-------------------|------------------------|
| A    | 205,200          | 102,600,000             | 93%               | 95,418,000         | 106,618,842      | -11,200,842       | -11.74%                |
| B    | 154,800          | 77,400,000              | 93%               | 71,982,000         | 79,122,150       | -7,140,150        | -9.92%                 |
|      | 360,000          | 180,000,000             |                   | 167,400,000        | 185,740,992      | -18,340,992       | -10.96%                |
|      |                  |                         |                   |                    |                  |                   |                        |

|  |                    |
|--|--------------------|
| Total Capitations Paid to the Plans for Care         | 167,400,000        |
| Total Expenses Related to Care                       | <u>185,740,992</u> |
| Net Loss   | 18,340,992         |
| Loss Percentage for the Program                      | 10.96%             |
| Risk corridor is 5%                                  | <u>-5.00%</u>      |
| % of loss to be shared equally between plans and DHS | 5.96%              |
| % to be returned to plans (50/50 share)              | 2.98%              |

Since in aggregate, the program experienced a loss greater than the 5% corridor, the risk share program will be implemented.

Example 2: Distribution to the Plans

The plans and DHS share equally in the loss over 5% (i.e., in this example 5.96%). The total amount to be returned to the plans is calculated based on 2.98% of the services portion of the capitations received by the plan experiencing

Amendment # 4  
 Issued on: November 15, 2007

For Requests for Proposals RFP-MQD-2008-006  
 QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals  
 Who Are Aged, Blind or Disabled

a loss ( $2.98\% \times \$167,400,000 = \$4,988,520$ ). A per capita amount to be returned can be calculated using the total amount to be returned divided by the total number of recipient months served by the plans experiencing a loss (which could be a single plan). In this example, the per capita amount would be \$13.857 per recipient month ( $\$4,988,520 / 360,000$ ). As long as the \$5,000,000 limit was not reached, the calculation would be computed as follows: Each plan with a loss will receive \$13.857 per recipient month. Plan A would receive \$2,843,456 ( $205,200 \times 13.857$ ); and Plan B would receive \$2,145,063 ( $154,800 \times 13.857$ ). A plan would not receive any payment from the Risk Share Program if it did not actually experience a loss.

If the limit of \$5 million had been exceeded, each plan with a loss will receive a pro rata share of the \$5,000,000 based on the plan's recipient months. Plan A would receive \$2.85 million ( $57\% \times 5,000,000$ ); and Plan B would receive \$2.15 million ( $43\% \times 5,000,000$ ).

Example 3: Aggregate Calculation of Gain

If there is a net gain, the net gain percentage will be computed and distributed among the plans exceeding the 3% allowable gain.

| Plan | Recipient Months | Capitation Paid (total) | Medical Portion % | Medical Portion \$ | Medical Expenses | Net Profit (Loss) | Gain (Loss) Percentage |
|------|------------------|-------------------------|-------------------|--------------------|------------------|-------------------|------------------------|
| A    | 205,200          | 102,600,000             | 93%               | 95,418,000         | 92,142,598       | 3,275,402         | 3.43%                  |
| B    | 154,800          | 77,400,000              | 93%               | 71,982,000         | 66,404,401       | 5,577,599         | 7.75%                  |
|      | 360,000          | 180,000,000             |                   | 167,400,000        | 158,546,999      | 8,853,001         | 5.29%                  |

|  |                    |
|--|--------------------|
| Total Capitations Paid to the Plans for Care | 167,400,000        |
| Total Expenses Related to Care               | <u>158,546,999</u> |
| Net Gain                                     | 8,853,001          |

|                                 |       |
|---------------------------------|-------|
| Gain Percentage for the Program | 5.29% |
| Risk corridor is 3%             | 3.00% |

Since in aggregate, the program experienced a gain greater than the 3% corridor, the risk share program will be implemented.

Example 4: Plan Specific Calculations

The plans and DHS share equally in the gain between 3% and 5% and any gain at or over 5% is returned to the State. If a plan has a gain over 5%, the

Amendment # 4  
Issued on: November 15, 2007

For Requests for Proposals RFP-MQD-2008-006  
QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals  
Who Are Aged, Blind or Disabled

maximum amount that the plan will be allowed to retain will be 4%. The gain allocation would be applied only to plans which experienced a gain over 3%. In this example, Plan A had a gain of 3.43% and would return half of the gain in excess of 3%, or 0.215% ( $[3.43 - 3.00] / 2$ ). Plan A would retain \$3,069,299 and would return \$206,103 to DHS. Plan B had a gain of 7.75% and would be allowed to retain 4%. Plan B would retain \$2,879,280 and would return \$2,698,319 to DHS. If a plan has a gain of less than 3% or a loss, they would not make any payment to the state under the gain sharing provision.

Amendment # 4  
Issued on: November 15, 2007

For Requests for Proposals RFP-MQD-2008-006  
QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals  
Who Are Aged, Blind or Disabled

**Appendix N**  
**Written Questions on Amendments**  
**Format for QExA RFP**

| <b>Applicant Name</b> | <b>Date Submitted</b> | <b>Question #</b> | <b>Amendment #</b> | <b># (1<sup>st</sup> column on the Amendment documents)</b> | <b>Question</b> |
|-----------------------|-----------------------|-------------------|--------------------|---|-----------------|
|                       |                       |                   |                    |   |                 |
|                       |                       |                   |                    |   |                 |
|                       |                       |                   |                    |   |                 |
|                       |                       |                   |                    |   |                 |
|                       |                       |                   |                    |   |                 |

# Appendix L

State of Hawaii

STATE PROCUREMENT OFFICE

PROPOSAL APPLICATION IDENTIFICATION FORM

STATE AGENCY ISSUING RFP: \_\_\_\_\_

RFP#: \_\_\_\_\_

RFP TITLE: \_\_\_\_\_

Check one:

- Initial Proposal Application
- Final Revised Proposal (Completed Items \_\_\_\_\_ - \_\_\_\_\_ only)

1. APPLICANT INFORMATION:

Legal Name: \_\_\_\_\_

Doing Business As (if applicable): \_\_\_\_\_

Street Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

2. CONTACT PERSON FOR MATTERS INVOLVING THIS APPLICATION:

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

e-mail: \_\_\_\_\_

3. TYPE of BUSINESS ENTITY:

- Non-Profit Corporation
- For-Profit Corporation
- Limited Liability Company
- Sole Proprietorship
- Partnership

4. STATE OF INCORPORATION (if applicable)

Date of incorporation: \_\_\_\_\_

5. TAX IDENTIFICATION:

FEDERAL TAX ID #:

STATE TAX ID #:

6. GEOGRAPHIC AREA(S):

7. TARGET GROUP(S):

8. FUNDING REQUEST:

FY \_\_\_\_\_ \$ \_\_\_\_\_

FY \_\_\_\_\_ \$ \_\_\_\_\_

FY \_\_\_\_\_ \$ \_\_\_\_\_

FY \_\_\_\_\_ \$ \_\_\_\_\_

**Total** \$ \_\_\_\_\_

9. BUSINESS STATUS QUALIFICATION:

Applicant is registered with the State Procurement Office.

Applicant is not registered -- Form SPO-H-1 OOA and required documentation are attached.

Authorized Representative:

\_\_\_\_\_  
AUTHORIZED SIGNATURE

\_\_\_\_\_  
NAME & TITLE

\_\_\_\_\_  
DATE SIGNED

**STATE OF HAWAII**  
**Department of Human Services**  
**PROPOSAL LETTER**

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

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

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

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

\_\_\_\_\_  
Authorized Applicant's Signature/Corporate Seal

\_\_\_\_\_  
Date

**CERTIFICATION FOR CONTRACTS, GRANTS, LOANS AND  
COOPERATIVE AGREEMENTS**

1. The undersigned certifies, to the best of his or her knowledge and belief, that no Federal appropriated funds have been paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence on officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of Federal grant, the making of any Federal loan, the entering into of any cooperative Federal contract, grant, loan or cooperative agreement.
  
2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan or cooperative agreement, the undersigned shall complete and submit "Disclosure Form to Report Lobbying" in accordance with its instructions.
  
3. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed under 31 U.S.C. §1352. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000.00 and not more than \$100,000.00 for such failure.

Applicant: \_\_\_\_\_

Signature: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

## DISCLOSURE STATEMENT (CMS REQUIRED)

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

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

### 455.104 Information on Ownership & Control

- (1) The name and address of each person with an ownership or controlling interest in the disclosing entity.
- (2) The name and address of each person with an ownership or controlling interest in any subcontractor in which the disclosing entity has direct or indirect ownership of five (5) percent or more.
- (3) Names of persons named in (a) and (b) above who are related to another as spouse, parent, child or sibling of those individuals or organizations with an ownership or controlling interest.
- (4) The names of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity also has an ownership or controlling interest.

### 455.105 Information Related to Business Transactions

- (5) The ownership of any subcontractor with whom the applicant has had business transactions totaling more than \$25,000 during the past 12-month period.
- (6) Any significant business transactions between the applicant and any wholly owned supplier or between the applicant and any subcontractor during the past five-year period.

### 455.106 Information on Persons Convicted of Crimes

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

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

- (1) Names and addresses of the Board of Directors of the disclosing entity.
- (2) Name, title and amount of compensation paid annually (including bonuses and stock participation) to the ten (10) highest management personnel.
- (3) Names and addresses of creditors whose loans or mortgages are secured by a five (5) percent or more interest in the assets of the disclosing entity.

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

- (1) Describe transactions between the disclosing entity and any related party in which a transaction or series of transactions during any one (1) fiscal year exceeds the lesser of \$10,000 or two (2) percent of the total operating expenses of the disclosing entity. List property, goods, services, and facilities involved in detail. Note the dollar amounts or other consideration for each item and the date of the transaction(s). Also include justification of the transaction(s) as to the reasonableness, potential adverse impact on the fiscal soundness of the disclosing entity, and the nature and extent of any conflict of interest. This requirement includes, but is not limited to, the sale or exchange, or leasing of any property; and the furnishing for consideration of goods, services or facilities.
- (2) Describe all transactions between the disclosing entity and any related party which includes the lending of money, extensions of credit or any investments in a related party. This type of transaction requires advance administrative review by the Director before being made.
- (3) As used in this section, "related party" means one that has the power to control or significantly influence the applicant, or one that is controlled or significantly influenced by the applicant. "Related parties" include, but are not limited to, agents, managing employees, persons with an ownership or controlling interest in the disclosing entity, and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any of such entities or persons.

#### 42 CFR 456.101 DEFINITIONS

- a. "Agent" means any person who has been delegated the authority to obligate or act on behalf of a provider.
- b. "Convicted" means that a judgment of conviction, has been entered by a

Federal, State or local court, regardless of whether an appeal from that judgment is pending.

- c. "Disclosing entity" means a QExA provider or health plan.
- d. "Other disclosing entity" means any other QExA disclosing entity and any entity that does not participate in QExA but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Social Security Act.  
This includes:
  - (1) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII);
  - (2) Any Medicare intermediary or carrier; and
  - (3) Any entity that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XIX of the Social Security Act.
- e. "Fiscal agent" means a contractor that processes or pays vendor claims on behalf of DHS.
- f. "Group of practitioners" means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).
- g. "Indirect ownership interest" means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.
- h. "Managing employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.
- i. "Ownership interest" means the possession of equity in the capital, the stock, or the profits of the disclosing entity.
- j. "Person with an ownership or controlling interest means a person or corporation that:

- (1) Has an ownership interest totaling five (5) percent or more in a disclosing entity;
  - (2) Has an indirect ownership interest equal to five (5) percent or more in a disclosing entity;
  - (3) Has a combination of direct and indirect ownership interests equal to five (5) percent or more in a disclosing entity;
  - (4) Owns an interest of five (5) percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five (5) percent of the value of the property or assets of the disclosing entity;
  - (5) Is an officer or director of a disclosing entity that is organized as a corporation;  
or
  - (6) Is a partner in a disclosing entity that is organized as a partnership.
- k. "Significant business transaction" means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of \$25,000 and five (5) percent of an applicants total operating expenses.
- l. "Subcontractor" means:
- (1) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
  - (2) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the DHS agreement.
- m. "Supplier" means an individual, agency, or organization from which a Provider purchases goods and services used in carrying out its responsibilities under its NHS contract (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).
- n. "Wholly owned subsidiary supplier" means a subsidiary or supplier whose total ownership interest is held by an applicant or by a person, persons, or other entity with an ownership or controlling interest in an applicant.

**DISCLOSURE STATEMENT**

a. Instructions

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

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

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

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

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

Justification

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

| <u>Description of Transaction(s)</u> | <u>Name of Related Party and Relationship</u> | <u>Dollar Amount for Reporting Period</u> |
|--------------------------------------|---|---|
|--------------------------------------|---|---|

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Justification

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

| <u>Description of Transaction(s)</u> | <u>Name of Related Party and Relationship</u> | <u>Dollar Amount for Reporting Period</u> |
|--------------------------------------|---|---|
|--------------------------------------|---|---|

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Justification

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**DISCLOSURE STATEMENT**

PLAN NAME/NO. \_\_\_\_\_

DISCLOSURE STATEMENT FOR THE YEAR ENDED \_\_\_\_\_

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

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Chief Executive Officer (Name  
and Title Typewritten)

\_\_\_\_\_  
Notarized

\_\_\_\_\_  
Signature

**DISCLOSURE STATEMENT  
OWNERSHIP**

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

For the period beginning: \_\_\_\_\_ and ending \_\_\_\_\_

Type of Health Plan:

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

Type of Entity:

- |   |                                       |
|---|---------------------------------------|
| <input type="radio"/> Sole Proprietorship | <input type="radio"/> For-Profit      |
| <input type="radio"/> Partnership         | <input type="radio"/> Not-For-Profit  |
| <input type="radio"/> Corporation         | <input type="radio"/> Other (Specify) |
| <input type="radio"/> Governmental        | _____                                 |

455.104 Information on Ownership and Control

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

| <u>Name</u> | <u>Address</u> | <u>Percent of<br/>Ownership of Control</u> |
|-------------|----------------|--|
| _____       | _____          | _____                                      |
| _____       | _____          | _____                                      |
| _____       | _____          | _____                                      |
| _____       | _____          | _____                                      |

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

| <u>Name</u> | <u>Address</u> | <u>Percent of<br/>Ownership of Control</u> |
|-------------|----------------|--|
| _____       | _____          | _____                                      |
| _____       | _____          | _____                                      |
| _____       | _____          | _____                                      |
| _____       | _____          | _____                                      |

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

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455.105 Information Related to Business Transactions

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

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

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

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

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455.106 Information on Persons Convicted of Crime

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

Name

Address

Title

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

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

| <u>Name/Title</u> | <u>Address</u> |
|-------------------|----------------|
| <hr/>             | <hr/>          |

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

| Name/Title | Address |
|------------|---------|
| <hr/>      | <hr/>   |

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

| <u>Name</u> | <u>Address</u> | <u>Amount<br/>of Debt</u> | <u>Description<br/>of Security</u> |
|-------------|----------------|---------------------------|------------------------------------|
| _____       | _____          | _____                     | _____                              |
| _____       | _____          | _____                     | _____                              |
| _____       | _____          | _____                     | _____                              |
| _____       | _____          | _____                     | _____                              |
| _____       | _____          | _____                     | _____                              |
| _____       | _____          | _____                     | _____                              |
| _____       | _____          | _____                     | _____                              |
| _____       | _____          | _____                     | _____                              |
| _____       | _____          | _____                     | _____                              |
| _____       | _____          | _____                     | _____                              |

## FINANCIAL REPORTING GUIDE FORMS

### ORGANIZATION STRUCTURE AND FINANCIAL PLANNING FORM

1) If other than a government agency:

a) When was your organization formed?

\_\_\_\_\_

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

2) License/Certification

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

| <u>SERVICE COMPONENT</u> | <u>LICENSE/REQUIREMENT</u> | <u>RENEWAL DATE</u> |
|--------------------------|----------------------------|---------------------|
|--------------------------|----------------------------|---------------------|

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

Yes \_\_\_\_\_

No \_\_\_\_ If yes, please explain:

3) Civil Rights Compliance Data

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

Yes \_\_\_\_\_

No \_\_\_\_ If yes, please explain:

4) Handicapped Assurance

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

(note: Check with Local Zoning ordinances for handicapped requirements.)

Yes \_\_\_\_\_ No

If yes, briefly describe how such assurance is provided.

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

6) Prior Convictions

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

6) Federal Government Suspension/Exclusion

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

Yes

No \_\_\_\_\_

if yes, please explain:

## FINANCIAL PLANNING FORM

1) Is the applicants accounting system based on a cash, accrual or modified method?

- (a) Cash [ ]
- (b) Accrual [ ]
- (c) Modified [ ] give brief explanation

2) Does the applicant prepare an annual financial statement?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, provide a copy of the latest report.

3) Are interim financial statements prepared? Yes \_\_\_\_\_ No \_\_\_\_\_

- a) If yes, how often are they prepared? \_\_\_\_\_
- b) If yes, are footnotes and supplementary schedules an integral part of the statements? Yes \_\_\_\_\_ No \_\_\_\_\_
- c) If yes, are actuals analyzed and compared to budgeted amounts? Yes \_\_\_\_\_ No \_\_\_\_\_
- d) If yes, provide a copy of the latest statements including all necessary data to support your answers in (a) through (c) above.

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

Yes \_\_\_\_\_ No \_\_\_\_\_

- a) If yes, how often are audits conducted? \_\_\_\_\_
- b) By whom are they conducted? \_\_\_\_\_
- c) Did this auditor perform the applicants last audit?

Yes \_\_\_\_\_ No \_\_\_\_\_

If no, provide the name, address and telephone number of the firm that performed the applicant's last audit.

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

Yes \_\_\_\_\_

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

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

e) Do you have any uncorrected audit exceptions? Yes \_\_\_\_\_

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

5) Does the applicant have an accounting manual? Yes \_\_\_\_\_ No \_\_\_\_\_

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

6) Does the applicant have a formal basis to allocate indirect costs reflected in your financial statement? Yes \_\_\_\_\_ No \_\_\_\_\_

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

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

(a) With what Company(s)? \_\_\_\_\_

(b) What is the amount of coverage for each type of insurance?  
\$ \_\_\_\_\_

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

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

Briefly describe each item and indicate probable amount

\$ \_\_\_\_\_

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

Yes \_\_\_\_\_ No \_\_\_\_\_

When? \_\_\_\_\_

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

Yes \_\_\_\_\_ No \_\_\_\_\_

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

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

12) Does the applicant have a performance bonding mechanism in accordance with DHS Rules? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes,

Amount of Bond: \$ \_\_\_\_\_

Term of Bond: \_\_\_\_\_ Term of Bond: \_\_\_\_\_

Bonding Company: \_\_\_\_\_

Restrictions on Bond: \_\_\_\_\_

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

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

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

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

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

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

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, Enter Name: \_\_\_\_\_

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

- a) Medicare Reimbursement Yes \_\_\_\_\_ No \_\_\_\_\_
- b) Other third-party recoveries Yes \_\_\_\_\_ No \_\_\_\_\_

If no, explain why.



## FINANCIAL PERFORMANCE FORM

The applicant must indicate its current status for each measure (based on their most recent audited financial statements below).

| FINANCIAL MEASURES  | APPLICANTS |             | TARGET VIABILITY CRITERIA                               |
|---|------------|-------------|---|
|   | (Audited)  | (Unaudited] |   |
| Working Capital Ratio   | _____      | _____       | At Least .90  |
| Equity per Enrollee   | _____      | _____       | At Least \$100  |
| Net Medical Costs as a % of Capitation Revenues                               | _____      | _____       | No More Than 93%(plans over 8,000 members)              |
| Administrative Costs (To include Contingencies) as a % of Capitation Revenues | _____      | _____       | No More Than 7%(small plans of 8,000 members and under) |
| Day Claims Outstanding  | _____      | _____       | No More Than 90 days (IBNRs)                            |
|   | _____      | _____       | No More Than 45 Days (RBUCS)                            |

\*Audited Current Status means measures developed from applicant audited financial statements for the most recently completed fiscal year. Unaudited Current Status means measures developed from the most recent year-to-date applicant internally prepared financial statements. All changes of more than 2% for working capital, \$10 for equity per enrollee, 3% for net medical cost. 2% for administrative cost, or 10 days for claims outstanding must be explained in written narrative and submitted as part of the applicant's response to this request for proposal.

A new applicant is to project these ratios based on its financial plan. Insert the projected ratios in the "Unaudited" column.

## CONTROLLING INTEREST FORM

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

| Name  | Address | Owner or Controller | Has controlling interest? |    |
|-------|---------|---------------------|---------------------------|----|
|       |         |                     | Yes                       | No |
| <hr/> |         |                     |                           |    |

## BACKGROUND CHECK INFORMATION FORM

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

| NAME** | EVER KNOWN BY<br>ANOTHER NAME* |    | SOCIAL SECURITY<br>ACCOUNT<br>NUMBER | DATE OF BIRTH<br>(DA/MO/YR) | PLACE OF<br>BIRTH<br>CITY/COUNTY<br>/STATE |
|--------|--------------------------------|----|--------------------------------------|-----------------------------|--|
|        | YES                            | NO |                                      |                             |  |

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

\*\*For each person listed:

- a) give addresses for the last 10 years
- b) Ever suspended from any federal program for any reason?

Yes       No       If yes, please explain.

## OPERATIONAL CERTIFICATION SUBMISSION FORM

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

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## GRIEVANCE SYSTEM FORM

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

I hereby certify that \_\_\_\_\_  
(Applicant Name)

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

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

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

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

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Title

INSURANCE

Applicant shall provide the following:

1. Commercial General Liability Insurance is provided by:

Insurance Company \_\_\_\_\_

Coverage \_\_\_\_\_

2. Reinsurance is provided by:

Insurance Company \_\_\_\_\_

Coverage \_\_\_\_\_

3. Other forms of insurance will be provided by:

Type: \_\_\_\_\_

Insurance Company \_\_\_\_\_

Coverage \_\_\_\_\_

Type: \_\_\_\_\_

Insurance Company \_\_\_\_\_

Coverage \_\_\_\_\_

Type: \_\_\_\_\_

Insurance Company \_\_\_\_\_

Coverage \_\_\_\_\_

Applicant: \_\_\_\_\_



## IMPORTANT

If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

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

## DISCLAIMER

The Certificate of Insurance on the reverse side of this form does not constitute a contract between the issuing insurer(s), authorized representative or producer, and the certificate holder, nor does it affirmatively or negatively amend, extend or alter the coverage afforded by the policies listed thereon.

**Elimination of Barriers to Contracting Between FQHC/RHCs and Health Plans**

Health Plan Name \_\_\_\_\_

1. Does the health plan assure that it will make payments for services to FQHCs and RHCs in its network that are no less than the level and amount of payment which the health plan would make for like services furnished by a provider which is not an FQHC or an RHC?.
  
2. Identify any FQHC or RHC that has an ownership or control interest in the health plan, as defined in Section 72.400 of RFP-MQD-2008-006.
  
3. Attach signed attestations from each entity (using the form provided in Appendix L) identified in paragraph 2 confirming that the identified entities have agreed to participate or will, if requested, participate in the network of any other health plan participating in the programs to provide services to eligible QExA members, so long as the requesting health plan has offered payment terms that comply with the requirements of Section 60.220 of RFP-MQD-2008-006.

---

Chief Executive Officer Name

---

Chief Executive Officer Signature

---

Date

**Elimination of Barriers to Contracting Between FQHC/RHCs and Health Plans**

Health Plan Name \_\_\_\_\_

1. Does the health plan assure that it will make payments for services to FQHCs and RHCs in Its network that are no less than the level and amount of payment which the health plan would make for like services furnished by a provider which is not an FQHC or an RHC?,
  
2. Identify any FQHC or RHC that has an ownership or control interest in the health plan, as defined in Section 72.400 of RFP-MQD-2008-006.
  
3. Attach signed attestations from each entity (using the form provided in Appendix Z) identified in paragraph 2 confirming that the identified entities have agreed to participate or will, if requested, participate in the network of any other health plan participating in the programs to provide services to eligible QExA members, so long as the requesting health plan has offered payment terms that comply with the requirements of Section 60.220 of RFP-MQD-2008-006,

---

Chief Executive Officer Name

---

Chief Executive Officer Signature

---

Date

**Elimination of Barriers to Contracting Between FQHC/RHCs and  
Health Plans**

Name of FQHC or RHC: \_\_\_\_\_

I hereby certify that I have read and understand the requirements of Section 72.400 of RFP-MQD-2008-006 and further certify that the above-named entity has agreed to participate or will, if requested, participate in the network of any health plan participating in the programs to provide services to eligible QExA members, so long as the requesting health plan has offered payment terms that comply with the requirements of Section 60.220 of RFP-MQD-2008-006. I further certify that I am authorized to make this attestation on behalf of the above-named entity.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title

**WAGE CERTIFICATION**

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

1. The services to be rendered shall be performed by employees paid as wages or salaries not less than wages paid to the public officers and employees for similar work, if similar positions are listed in the classification plan of the public sector. .
2. All applicable laws of the Federal and State governments relating to worker's compensation, unemployment insurance, payment of wages, and safety will be fully complied with.

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

Applicant: \_\_\_\_\_

Signature: \_\_\_\_\_

Title: \_\_\_\_\_

Dale: \_\_\_\_\_

**P R O V I D E R ' S  
STANDARDS OF CONDUCT DECLARATION**

For the purposes of this declaration:

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

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

"Employee" means any nominated, appointed, or elected officer or employee of the State, including members of boards, commissions, and committees, and *employees* under contract to the State or of the constitutional convention, but excluding legislators, delegates to the constitutional convention, justices, and *judges*. (Section 84.3, HAS).

On behalf of \_\_\_\_\_, PROVIDER, the undersigned does declare as follows:

PROVIDER  is  is not a legislator or an employee or a business in which a legislator or an employee has a controlling interest. (Section 84-3 5(a), HRS).

2. PROVIDER has not been represented or assisted personally in the matter *by an* individual who has been an employee of the agency awarding this Contract within the preceding two years and who participated while so employed in the matter with which the Contract is directly concerned. (Section 84-15(b),
3. PROVIDER has not been assisted or represented by a legislator or employee for a *fee* or other compensation to obtain this Contract and will not be assisted or represented by a legislator or employee for a *fee or* other compensation in the performance of this Contract, *if* the legislator or employee had been involved in the development or award of the Contract. (Section 84-14 (d), HRS).
4. PROVIDER has not been represented on matters related to this Contract, for a fee or other consideration by *an* individual who, within the past twelve (12) months, has been an *agency* employee, or in the case of the Legislature, a legislator, and participated while an employee or legislator on matters related to this Contract. (Sections 84-1 8(b) and (c), HRS).

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Reminder to agency: If the 1 block is checked and *if* the Contract involves goods or services of a value in *excess* of \$ 10,000, the Contract may not be awarded unless the agency posts a notice of *its* intent to award it and files a copy of the notice with *the* State Ethics Commission. (Section 84.15(a), HRS).

PROVIDER understands that the Contract to which this document is attached *is* avoidable on behalf of the STATE if this Contract was entered into in violation of any provision of chapter 84, Hawaii Revised Statutes, commonly referred to as the Code of Ethics, including the provisions which are the source *of* the declarations above. Additionally, any fee, compensation, gift, or profit received by any person *as a* result of a violation of the Code of Ethics may be recovered by the STATE.

DATED: Honolulu, Hawaii, \_\_\_\_\_

**PROVIDER**

By \_\_\_\_\_  
*(signature)*

Print Name \_\_\_\_\_

Print Title \_\_\_\_\_

Name of Provider \_\_\_\_\_

\_\_\_\_\_

Date \_\_\_\_\_

