

APPENDIX O
SERVICES AND MISCELLANEOUS ITEMS
NOT COVERED BY THE HAWAII QUEST PROGRAM

1. Personal care items such as shampoos, toothpaste, toothbrushes, mouth washes, denture cleansers, shoes, slippers, clothing, laundry services, baby oil and powder, sanitary napkins, soaps, lip balm, band aids
2. Non-medical items such as books, telephones, beepers, radios, linens, clothing, television sets, computers, air conditioners, air purifiers, fans, household items or furnishings
3. Experimental and/or investigational services, procedures, drugs, devices, and treatments; drugs not approved by the FDA, brand name drugs except single source drugs and brand name drugs when required by statute required
4. Gender reassignment - all medical, surgical, and/or psychiatric services and drugs, including hormones, needed for changing the sex of an individual
5. In vitro fertilization, reversal of sterilization, artificial insemination, sperm banking procedures; procedures and drugs to treat infertility or enhance fertilization
6. Biofeedback, acupuncture, naturopathic services, faith healing, Christian Science services, hypnosis, massage treatment (by masseurs)
7. Obesity treatment, weight loss programs; food, food supplements including prepared formulas, health foods
8. Cosmetic surgery or treatment - cosmetic rhinoplasties, reconstructive, or plastic surgery to improve appearance and not bodily function, piercing of ears and other body areas, electrolysis, hair transplantation, reduction and augmentation mammoplasties, paniclectomies and other body sculpturing procedures, excision or destruction of benign skin or subcutaneous lesions without medical justification
9. Tuberculosis services when provided free to the general public
10. Hansen's Disease treatment or follow-up
11. Treatment of persons confined to public institutions
12. Penile and testicular prostheses and related services

13. Psychiatric care and treatment for sex and marriage problems, weight control, employment counseling, primal therapy, long term character analysis, marathon group therapy, and/or consortium
14. Routine foot care; treatment of flat feet
15. Swimming lessons, summer camp, gym membership and weight control classes and
16. Smoking cessation classes (medications for smoking cessation may be provided)
17. Stand-by services by stand-by physicians, telephone consultations, telephone calls, writing of prescriptions, stat charges
18. All medical and surgical procedures, therapies, supplies, drugs, equipment for the treatment of sexual dysfunction
19. Beds - lounge beds, bead beds, water beds, day beds; overbed tables, bed lifters, bed boards, bed side rails if not an integral part of a hospital bed
20. Topical application of oxygen
21. Contact lenses for cosmetic purposes; bifocal contact lenses
22. Oversized lenses, blended or progressive bifocal lenses, tinted or absorptive lenses (except for aphakia, albinism, glaucoma, medical photophobia), trifocal lenses (except as a specific job requirement), spare glasses
23. Orthoptic training
24. Physical exams for employment when the patient is self-employed or as a requirement for continuing employment (i.e. truck and taxi drivers' licensing, other physical exams as a requirement for continual employment by the State or Federal Government, or by private business)
25. Physical exams and immunizations for travel - domestic or foreign
26. Physical exams, psychological evaluations and/or immunizations as a requirement for Hawaii or other states' drivers' licenses or for the purpose of securing life and other insurance policies or plans.
27. Organ transplants not meeting the guidelines established by the Medicaid program and organ transplants not specifically identified as a Medicaid benefit.

**APPENDIX P
HAWAII'S EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)
PERIODIC SCREENING GUIDELINES**

Patient Name:	INFANCY										EARLY CHILDHOOD					LATE CHILDHOOD					ADOLESCENCE			
	1-30 DAYS	2 MOS	4 MOS	6 MOS	9 MOS	12 MOS	15 MOS	18 MOS	2 YRS	3 YRS	4 YRS	5 YRS	6 YRS	8 YRS	10 YRS	12 YRS	14 YRS	16 YRS	18 YRS	20 YRS				
Date of Birth:																								
Elements for Health Screening																								
Date of Assessment:																								
1. Initial/Interval Health History																								
2. Height																								
3. Weight																								
4. Head Circumference																								
5. Blood Pressure																								
6. Developmental/Behavioral Assessment																								
7. Vision Testing																								
8. Hearing/Language Testing																								
9. Audiogram																								
10. Physical Examination																								
11. Immunizations																								
12. Tuberculin Skin Testing																								
13. Lead Risk Assessment																								
14. Lead Level																								
15. Hemoglobin/Hematocrit																								
16. Other Lab Screens																								
17. Dental Screen/Referral																								
18. Fluoride																								
19. Health Education & Counseling																								
20. Completed By:																								

These are minimum guidelines. Providers should perform all non-shaded elements of the health screen for the appropriate age. If at any time other procedures, tests, etc., are medically indicated, the physician should perform them. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be updated at the earliest possible times.

HAWAII'S EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)
PERIODIC SCREENING GUIDELINES

- 1 Record in chart
- 2,3,4 Plot on NCHS grid
- 5 Blood Pressure Guidelines
- | <u>AGE</u> | <u>SYSTOLIC</u> | | <u>DIASTOLIC mmHg</u> | |
|------------|-----------------|------------|-----------------------|------------|
| | <u>50%</u> | <u>90%</u> | <u>50%</u> | <u>90%</u> |
| 3yo | 95 | 112 | 64 | 80 |
| 5yo | 97 | 115 | 65 | 84 |
| 10yo | 110 | 130 | 70 | 92 |
| 15yo | 116 | 130 | 70 | 95 |
- 6 Obtain relevant developmental/behavioral/school history; utilize age appropriate developmental screen (e.g., R-PDQ, ICMQ, CDI, DENVER II, ELM, HearKit, appraisal of young child--gross motor, fine motor, communication, self-help/self-care, socio-emotional, cognitive skill development; evaluation of school age child--attention skills, learning disability, peer relationships, psychological/psychiatric problems) and behavioral questionnaire/survey (e.g., Eyberg)
- 7 Vision Guidelines
- | <u>AGE</u> | <u>EXAM</u> |
|----------------------------|--|
| 2 weeks | appearance of eyes; red reflex |
| 2 months | appearance of eyes; red reflex
corneal light reflex; alignment; follow object |
| 4 months | corneal light reflex; alignment; follow object |
| 6 months | corneal light reflex; alignment; follow object
EOM: cover test |
| 9 months | EOM; cover test |
| 18 months | EOM; cover test |
| 4,6,8,10,12,14,16,18 years | visual acuity |
- 8 Hearing/Language Guidelines
- | <u>AGE</u> | <u>HEARING MILESTONES</u> |
|------------|---|
| Birth | responds to loud noises |
| 4-5 months | turns to sound source |
| 8 months | imitates parent's sounds |
| 12 months | understands simple phrases |
| | <u>SPEECH MILESTONES</u> |
| 2 years | spontaneous speech using 2-3 word phrases |
| 3 years | consistently uses beginning consonants
m,n,h,p,g,f,w |
| 4 years | readily understands with good grammar |
- 9 Perform audiogram testing or obtain results from alternate source, e.g. school. ENT 1,000; 2,000; 4,000 Hz at 20 DB both ears/25 DB to compensate for extraneous noise
- 10 Record in chart
- 11 Use most currently available recommendations of the Department of Health/Immunizations Practice Advisory Committee/Center for Disease Control/American Academy of Pediatrics
- 12 Test with Mantoux (PPD) preferred; but, Tine may be used up to 5 years. Any positive Tine must be followed up by the PPD. High risk (annual test): child born outside of US in developing country; child with medical condition which would increase TB risk (e.g., HIV, chemotherapy, diabetes, renal disease)
- 13 Perform verbal risk assessment
- 14 Blood Lead Level Guidelines
- | | |
|------------|---|
| Low risk: | 12 months, 24 months |
| High risk: | 6 months, then every 6 months until 2 consecutive levels are <10, then every year until 72 months |
- 15 Hemoglobin or Hematocrit for anemia screening
- 16 Other optional lab screen include: urinalysis/urine bacteria screen, sickle cell screen; G6PD screen
- 17 Perform oral exam: refer to dentist at 12 months and every 6 months thereafter
- 18 Prescribe supplemental fluoride therapy with or without multivitamins per recommendations American Academy of Pediatric Dentistry and the American Academy of Pediatrics; revised dosage schedule is pending
- 19 Provide age appropriate anticipatory guidance for general health, nutrition, development, safety, sexuality, parenting; may use American Academy of Pediatrics Guidelines for Health Supervision II (pending revision)

APPENDIX Q

INSTRUCTIONS DHS FORM 1147

LEVEL OF CARE (LOC) EVALUATION

Top of Form: Check the appropriate box for the evaluation – initial request for placement into either a nursing home or community-based program; annual review; or other review such as a review requested by the department’s contractor for evaluating and determining level of care.

1. **Patient Name:** Self-explanatory
2. **Birthdate:** Self-explanatory
3. **Sex:** Self-explanatory
4. **Medicare:** Check the appropriate box indicating whether client has Medicare Part A and B and enter client’s Medicare I.D. number, if eligible for either Part A or B.
5. **Medicaid Eligible?:** Check “Yes” or “No” to indicate whether the client is currently Medicaid eligible. Enter Medicaid I.D. number assigned by the Department of Human Services, if eligible. If the patient has applied for Medicaid but has not yet been deemed eligible, write in “pending” for I.D.# and write in date applied.
6. **Present Address/Facility:** Identify facility name if patient is residing in a facility. If patient is at home, enter street address, city and zip code. Check appropriate box that best represents the patient’s “home.”
7. **Provider I.D. No.:** Enter the Medicaid Provider I.D. number.
8. **Attending Physician:** Enter the name of the attending physician, telephone and fax number.
9. **Contact Person:** Enter the name, telephone and fax numbers of the person able to provide additional information about the patient.
10. **Return Form:** Indicate how the form should be returned (i.e., fax or mail) and to whose attention. The form will NOT be mailed or faxed back with a cover sheet so information must be accurate.
11. **Referral Information:** Complete all sections for an initial request. If this is an annual or other review, skip this section.

- A. **Source(s) of Information:** Identify the source(s) of patient information received.
 - B. **Responsible Person:** Provide the name, relationship, phone and fax numbers of the family member/personal agent who will be making decisions for the patient.
 - C. **Language:** Check the box of the primary language spoken by the patient. If checking "Other," indicate the language spoken. Information is used to obtain interpreters.
12. **Assessment Information:** Complete all sections.
- A. **Assessment Date:** Date the most current assessment was completed.
 - B. **Assessor's Name, Title, Signature, Phone and Fax Numbers:** A registered nurse (RN) or physician must perform the assessment. Enter the name, title and telephone and fax numbers of the assessor. The assessor must sign the form.
13. **Requesting:** Enter expected placement date into the facility or community program. Check all services that are being requested. If hospice services has been elected by the patient AND the services will be provided in a nursing facility, attach the appropriate hospice election form. Hospice services in other settings do not require an 1147 form.

Applications for any Medicaid Home and Community-Based Services (HCBS) can be made at the same time as submittal of this form.

Indicate whether counseling on the HCBS option was provided and by whom. If counseling was not provided, provide brief explanation.

Independent Living (IL) services are available to provide information, referral for services, peer counseling and advocacy for the patient. Contact Hawaii Centers for Independent Living (HCIL) for brochures and other information that can be offered to the patient.

14. **Medical Necessity/Level of Care Action:** Completed by DHS or Designee. Leave Blank. DO NOT COMPLETE.

PAGE 2 AND 3– APPLICANT/CLIENT BACKGROUND INFORMATION

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

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

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

indicate whether the patient can be placed in a residential setting such as an Extended ARCH, assisted living facility or RACCP home.

- B. **Caregiving support:** If the patient has a home, identify whether the caregiving support is willing/able to provide care. If caregiver requires assistance, identify the assistance required.
 - C. **Caregiver name.** Provide the caregiver's name, relationship, address and phone numbers.
6. **Comments on Nursing Requirements or Social Situation:** Provide any additional information that would help explain the patient's nursing requirements or social situation.

Physician's Signature: Self-explanatory.

Date: Date that physician signs the form.

Physician's Name: Self-explanatory.

STATE OF HAWAII
 Level of Care (LOC) Evaluation

Please Type Initial Request Annual Review Other review

1. PATIENT NAME (Last, First, M.I.)	2. BIRTHDATE Month/Day/Year / /	3. SEX	4. MEDICARE Part A <input type="checkbox"/> Yes <input type="checkbox"/> No Part B <input type="checkbox"/> Yes <input type="checkbox"/> No ID#:	5. MEDICAID ELIGIBLE? <input type="checkbox"/> Yes ID # <input type="checkbox"/> No Date Applied / /
6. PRESENT ADDRESS (Specify Facility Name When Applicable)			Present Address is <input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> NF <input type="checkbox"/> Care Home <input type="checkbox"/> Other	
8. ATTENDING PHYSICIAN (Last Name, First Name, Middle Initial) Phone: (808) Fax: (808)			7. PROVIDER I.D. NO.	
9. CONTACT PERSON (Last Name, First Name, AND Title) Phone: (808) Fax: (808)				
10. RETURN FORM TO: <input type="checkbox"/> VIA FAX (Type Fax Number Below) <input type="checkbox"/> BY MAIL (Type Address Below)				
Phone: (808) Fax: (808)			Mail:	
11. REFERRAL INFORMATION (Completed by Referring Party)			12. ASSESSMENT INFORMATION (Completed by RN or Physician)	
A. SOURCE(S) OF INFORMATION <input type="checkbox"/> Client <input type="checkbox"/> Records <input type="checkbox"/> Other			A. ASSESSMENT DATE / /	
B. RESPONSIBLE PERSON'S NAME (Last, First, M.I.) Name: Relationship: Phone: (808) Fax: (808)			B. ASSESSOR'S NAME (Last, First, M.I.) Name: Title: Signature _____ Phone: (808) Fax: (808)	
C. Language <input type="checkbox"/> English <input type="checkbox"/> Other				
13. REQUESTING (Check all that apply)				
Expected Placement Date: / /				
<input type="checkbox"/> Nursing Facility (NF) <input type="checkbox"/> Subacute I <input type="checkbox"/> Subacute II <input type="checkbox"/> SNF <input type="checkbox"/> ICF <input type="checkbox"/> Acute Waitlist <input type="checkbox"/> Subacute <input type="checkbox"/> SNF <input type="checkbox"/> ICF <input type="checkbox"/> Hospice - NF <input type="checkbox"/> Home & Community Based Services (HCBS) <input type="checkbox"/> NHWW <input type="checkbox"/> RACCP 1 <input type="checkbox"/> RACCP 2 <input type="checkbox"/> HCCP <input type="checkbox"/> PACE Program				
HCBS Option Counseling provided: <input type="checkbox"/> Yes <input type="checkbox"/> No If NO: explain: If YES, by whom: Name Title:				
Independent Living (IL) service/material provided: <input type="checkbox"/> Yes <input type="checkbox"/> No				
14. MEDICAL NECESSITY / LEVEL OF CARE ACTION - DO NOT COMPLETE				
LEVEL OF CARE APPROVAL:			EFFECTIVE DATE: _____	
<input type="checkbox"/> Subacute Level I <input type="checkbox"/> Subacute Level II <input type="checkbox"/> SNF <input type="checkbox"/> ICF <input type="checkbox"/> Acute Waitlisted Subacute <input type="checkbox"/> Acute Waitlisted SNF <input type="checkbox"/> Acute Waitlisted ICF <input type="checkbox"/> Hospice - NF			LENGTH OF APPROVAL: <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 1 year <input type="checkbox"/> Other - Specify: _____ to _____	
SETTING APPROVAL:				
<input type="checkbox"/> Home and Community-Based Services <input type="checkbox"/> Nursing Home Without Walls (NHWW) <input type="checkbox"/> Residential Alternatives Community Care Program (RACCP) Level 1 _____ Level 2 _____ <input type="checkbox"/> HIV Community Care Program (HCCP) <input type="checkbox"/> PACE Program			<input type="checkbox"/> Nursing Facility <input type="checkbox"/> Hospice - NF <input type="checkbox"/> Home <input type="checkbox"/> Extended Care ARCH <input type="checkbox"/> Other _____	
Comments: _____ _____ _____				
<input type="checkbox"/> DEFERRED: <input type="checkbox"/> New 1147 Needed. <input type="checkbox"/> Other. Reason: _____ <input type="checkbox"/> DENIED				
NOTE: THIS IS NOT AN AUTHORIZATION FOR PAYMENT OR APPROVAL OF CHARGES. PAYMENT BY THE MEDICAID PROGRAM IS CONTINGENT ON THE INDIVIDUAL BEING ELIGIBLE, THE SERVICES BEING COVERED BY MEDICAID AND THE PROVIDER BEING MEDICAID CERTIFIED AT THE TIME SERVICES ARE RENDERED. INDIVIDUAL'S ELIGIBILITY MUST BE VERIFIED BY THE PROVIDER AT THE TIME OF SERVICE.				
DHS REVIEWER'S / DESIGNEE'S SIGNATURE: _____ DATE: _____				

STATE OF HAWAII
 Level of Care (LOC) Evaluation

APPLICANT/CLIENT BACKGROUND INFORMATION (Please Type)

1. NAME (Last, First, Middle Initial)	2. BIRTHDATE / /
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3. **FUNCTIONAL STATUS RELATED TO HEALTH CONDITIONS**

I. **LIST SIGNIFICANT CURRENT DIAGNOSIS(ES):**

PRIMARY:

SECONDARY:

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

III. **VISION / HEARING / SPEECH:**

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

IV. **COMMUNICATION:**

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

V. **MEMORY:**

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

VI. **MENTAL STATUS/BEHAVIOR: (refer to instructions)**

- [0] a. Oriented (mentally alert and aware of surroundings).
- [1] b. Disoriented (partially or intermittently; requires supervision).
- [2] c. Disoriented and/or disruptive.
- [3] d. Aggressive and/or abusive.
- [4] e. Wanders at Day Night Both, or in danger of self-inflicted harm or self-neglect.

VII. **FEEDING/MEAL PREPARATION:**

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

VIII. **TRANSFERRING:**

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

XVI. **ADDITIONAL INFORMATION CONCERNING PATIENT'S FUNCTIONAL STATUS:**

Attach additional sheet if more space is needed.

IX. **MOBILITY / AMBULATION: (refer to instructions)**

- [0] a. Independently mobile with or without device
- [1] b. Ambulates with or without device but unsteady / subject to falls.
- [2] c. Able to walk/be mobile with minimal assistance
- [3] d. Able to walk/be mobile with one assist.
- [4] e. Able to walk/be mobile with more than one assist.
- [5] f. Unable to walk.

X. **BOWEL FUNCTION / CONTINENCE:**

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

XI. **BLADDER FUNCTION / CONTINENCE:**

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

XII. **BATHING:**

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

XIII. **DRESSING AND PERSONAL GROOMING:**

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

XIV. **TOTAL POINTS:**

Comatose = 30 points

Total Points Indicated:

XV. **MEDICATIONS/TREATMENTS:**

(List all Significant Medications, Dosage, Frequency, and mode)
 Attach additional sheet if necessary

	Administers Independently	Requires Supervision/ Monitoring	Requires Admin	PRNs Only Actual Freq
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

APPLICANT/CLIENT BACKGROUND INFORMATION (Please Type)

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

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

XVIII. SOCIAL SITUATION:

- A. Person can return home Yes No Residential setting can be considered as an alternative to facility? Yes No
- B. If person has a home, caregiving support system is willing to provide/continue care. Yes No
 Caregiver requires assistance? Yes No
 Assistance required by Caregiver:
- C. Caregiver name (PRINT Last, First, Middle Initial):
 Name: _____ Relationship: _____
 Address: _____ Phone: (808) _____ Fax: (808) _____

XIX. COMMENTS ON NURSING REQUIREMENTS OR SOCIAL SITUATION:

I HAVE REVIEWED AND AGREE WITH THE LEVEL OF CARE ASSESSMENT, ANTICIPATED PLACEMENT DATE AND REQUESTED PLACEMENT OF THE PATIENT.

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

Physician's Name (TYPE): _____

APPENDIX R
EVALUATION PROCESS FOR DETERMINATION OF ELIGIBILITY FOR THE
BEHAVIORAL HEALTH MANAGED CARE (BHMC) PLAN FOR SERIOUSLY
MENTALLY ILL (SMI) ADULTS OR SERIOUSLY EMOTIONALLY DISTURBED (SED)
CHILDREN

1) **INPATIENTS**

a) Individuals on Oahu

If, after reviewing relevant clinical information, the QUEST plan or referring fee-for-service provider determines that a member meets the criteria for a Serious Mental Illness (SMI) or Seriously Emotionally Disturbed (SED), they should complete and fax to the MQD the referral form entitled Referral for Serious Mental Illness. This form is self-explanatory, must be completed entirely, and should be submitted at least two (2) working days before anticipated discharge to:

Medical Standards Branch (MSB)/MQD
ATTENTION: SMI Determinations
Fax #: 692-8131

If the patient is discharged in advance of his/her projected discharge date, please inform the MQD Psychiatric Consultant at 692-8115 and use the process described under "OUTPATIENTS."

b) Individuals on Neighbor Islands

Use the process described under "OUTPATIENTS".

2) **OUTPATIENTS** - The QUEST plans or referring provider should mail or fax to the MQD, the "Referral for SMI/SED" form, the forms for the assessment of Mental States and Functional Scales. In addition, to expedite the processing of SMI/SED referrals, it is asked that as much of the following information, as possible, be included:

- a) Personal history, family history, social history and history of drug use.
- b) Mental health history and educational history.
- c) History of past hospitalizations and other prior psychiatric care.
- d) Local hospital admission and discharge summaries (including medical and psychiatric histories and physical examinations).
- e) Most current psychiatric and psychological assessments to include pertinent history, behavioral observation and presentation, diagnostic impression, reports of psychological/psychiatric testing, Global Assessment of Functioning (GAF) scores and substance abuse information using ASAM placement criteria (if applicable).

- f) Pre-signed option letters for patients who are or have Medicaid or Medicaid/Medicare insurance. (Note: Patients having Medicare only, are not eligible for SMI services.)
- 3) For QUEST plans, the MQD expects that the Medical Directors of the plans will review and sign all referrals for SMI/SED and any information (such as the assessment of mental state and functional scales) which may have been completed by health plan staff. Thus, the MQD will not make a determination that a member is SMI/SED (if referred by the plan) without the signature of the plan's Medical Director. Referrals for fee-for-service recipients can be made by providers other than the QUEST plans but need to be signed by a psychiatrist or psychologist.
 - 4) The MQD's psychiatric consultant will make a decision based on the information submitted.
 - 5) The Referral Form with the MQD's decision will be returned to the referring provider in most cases within seven (7) business days and not more than 30 days after receipt. The MQD makes one of the following four determinations:
 - a) SMI/SED - yes, full acceptance
 - b) Provisional SMI/SED - yes, provisional acceptance for limited period
 - c) SMI/SED – no
 - d) Additional Information Needed
 - 6) Provisional SMI/SED are those individuals who have a substance abuse condition and are suspected to suffer from a qualifying condition due to their symptoms and functional limitations. These persons have on-going and recent substance abuse which prevents the clinician from making a definitive qualifying diagnosis.
 - 7) If the member is determined to be SMI/SED or provisional SMI/SED, the BHMC plan will receive a copy of all pertinent information submitted by the referring provider. In addition, the MQD's Enrollment Call Center will be notified to add the member's eligibility status to the member's eligibility file.
 - 8) If a member was not determined to be SMI/SED or if additional information is needed, the MQD will indicate the reason for this decision or the additional information needed on the referral form.
 - 9) After a referral has been submitted to the MQD and before the referring provider is notified of a decision, the referring provider shall update the MQD in situations including but not limited to the following:
 - a) The patient was admitted to the hospital.
 - b) The patient has an urgent need for behavioral health managed care services.
 - c) The referring provider has not received a determination seven (7) working days or more after submission of the referral.

Additional clarification which applies to both INPATIENTS and OUTPATIENTS:

- 1) If no records of prior hospitalizations are available, outpatient treatment services will be considered by the MQD's Psychiatric consultant in determining whether a member has an SMI/SED diagnosis. The following criteria will be used for the determination: Treatment for at least 6 months or must have a 6 month minimal expected duration, or must have a combined present and expected duration of 6 months.
- 2) Those members with a qualifying condition will be accepted provisionally into the behavioral health managed care plan for six months to allow for a complete assessment and intensive case management. A case review by the BHMC will begin four months after enrollment for members in this category. Once an SMI/SED diagnosis is established the member will be changed to an SMI/SED category. If the member does not have an SMI/SED diagnosis the member will be disenrolled from the behavioral health managed care plan. It is the responsibility of the referring provider to determine the continued treatment needs of those recipients determined not to have an SMI/SED diagnosis and is in treatment for substance abuse at the time of disenrollment.
- 3) Do not refer the following types of members as they **DO NOT** meet **SMI/SED** requirements:
 - a) Adults with SMI/SED diagnosis or who (in the absence of a diagnosis) have documentation of displaying SMI/SED symptoms for less than a combined and expected duration of at least 6 months.
 - b) Adults whose serious mental illness is not expected to last more than 6 months.
 - c) Adults with substance abuse diagnosis(es) only and NO independent psychiatric diagnosis that would otherwise qualify for SMI/SED consideration. Referrals can be made for those adults with a substance abuse diagnosis and a probable SMI/SED diagnosis which is unclear due to the patients' recent and sustained substance abuse.
 - d) Adults with psychiatric diagnosis(es) and developmental disabilities (DD)/mental retardation (MR) (other than mild DD/MR).
 - e) Patients with SMI/SED diagnosis(es) who are functioning well in the community.
 - f) Patients who do not have Medicaid insurance.
- 4) To expedite processing, the MQD will return only the referral form to the QUEST plan or Medicaid provider. If a provider wishes to have a determination reconsidered, all applicable information should be resubmitted. A decision on the reconsideration will be rendered within seven (7) working days of receipt in most cases and as stated in the RFP, not more than 30 days after receipt.
- 5) If a provider questions a determination, he/she should contact the MQD psychiatric consultant at 692-8115.

- 6) Other individuals such as psychiatrists and psychologists can also make referrals for SMI/SED evaluation.
- 7) If the referring provider needs clarification or has questions on SMI/SED referrals, contact the Medical Standards Branch at 692-8105.

**APPENDIX S
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>
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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 offeror'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.

5) 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 offeror been suspended or excluded from any federal government programs for any reason?

Yes _____

No _____

If yes, please explain:

FINANCIAL PLANNING FORM

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

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

2) Does the offeror prepare an annual financial statement?

Yes _____ No _____ 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 offeror audited by an independent accounting firm/accountant?

Yes _____ No _____

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

b) By whom are they conducted? _____

c) Did this auditor perform the offeror's last audit?

Yes _____ No _____

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

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

Yes _____ No _____

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

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

e) Do you have any uncorrected audit exceptions? Yes _____ No _____

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

5) Does the offeror have an accounting manual? Yes _____ No _____

If no, the offeror 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 offeror agrees to furnish copies of such written accounting policies and procedures for inspection upon request from the DHS.

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

- 9) Are there any suits, judgments, tax deficiencies, or claims pending against the offeror? Yes _____ No _____

Briefly describe each item and indicate probable amount.

\$ _____

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

Yes _____ No _____

When? _____

- 11) Do(es) the offeror'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 offeror 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 offeror intends to provide a bond and/or security to meet established DHS Rules.

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

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

- a) Is your system capable of accurately forecasting all significant claims prior to receipt of all billing? Yes _____ No _____
- b) How often are 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 offeror must provide a copy of their IBNR procedures and a summary of their IBNR practices. If these procedures do not adequately support any response to this item the offeror is cautioned to provide additional data.

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

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

Yes _____ No _____ If yes, Enter Name: _____

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

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

If no, explain why.

16) Was an actuarial firm used to assist in developing capitation rates?

Yes _____ No _____ If yes, what is the name of actuary and actuarial firm.

_____, _____
Actuary Actuarial Firm

17) Did a firm or organization provide the offeror with any assistance in making this offer (to include developing capitation rates or providing any other technical assistance)?

Yes _____ No _____

If yes, what is the name of this firm?

Name

Address

FINANCIAL PERFORMANCE FORM

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

<u>FINANCIAL MEASURES</u>	<u>OFFERORS</u>		<u>TARGET</u> <u>VIABILITY CRITERIA</u>
	<u>(Audited)</u>	<u>(Unaudited)</u>	
Working Capital Ratio	_____	_____	At Least .90
Equity per Enrollee	_____	_____	At Least \$100.
Net Medical Costs as a % of Capitation Revenues	_____	_____	No More Than 88% (plans over 8,000 members) No More Than 86% (small plans of 8,000 members and under)
Administrative Costs (To include Contingencies) as a % of Capitation Revenues	_____	_____	No More Than 8% (plans over 8,000 members) No More Than 8% (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 offeror audited financial statements for the most recently completed fiscal year. Unaudited Current Status means measures developed from the most recent year-to-date offeror 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 offeror's response to this request for proposal.

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

DISCLOSURE STATEMENT (CMS REQUIRED)

DHS may refuse to enter into a contract and may suspend or terminate an existing contract, if the offeror 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 offeror has had business transactions totaling more than \$25,000 during the past 12-month period.
- (6) Any significant business transactions between the offeror and any wholly owned supplier or between the offeror 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 offeror, or is an agent or managing employee of the offeror, and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

- 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 offeror, or one that is controlled or significantly influenced by the offeror. "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 455.101 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 QUEST provider or health plan.
- d) "Other disclosing entity" means any other QUEST disclosing entity and any entity that does not participate in QUEST 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 offeror's 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 DHS 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 offeror or by a person, persons, or other entity with an ownership or controlling interest in an offeror.

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 QUEST.

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 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 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.

455.105 Information Related to Business Transactions

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

<u>Describe Ownership of Subcontractors</u>	<u>Type of Business Transaction with Provider</u>	<u>Dollar Amount of Transaction</u>
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- f. List any significant business transactions between the offeror and any wholly owned supplier or between the offeror and any subcontractor during the five-year period ending on the date of the request.

<u>Describe Ownership of Subcontractors</u>	<u>Type of Business Transaction with Provider</u>	<u>Dollar Amount of Transaction</u>
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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 offeror, or is an agent or managing employee of the offeror and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs.

Name

Address

Title

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

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

Name/Title

Address

<hr/>	<hr/>
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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/>
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- 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 of Debt</u>	<u>Description of Security</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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 offeror's ability to meet QUEST 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 offeror. 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 offeror 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:

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

Justification

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

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

CONTROLLING INTEREST FORM

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

<u>NAME</u>	<u>ADDRESS</u>	<u>OWNER OR CONTROLLER</u>	HAS CONTROLLING INTEREST	
			<u>YES</u>	<u>NO</u>

BACKGROUND CHECK INFORMATION

The offeror 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.

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

* 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

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

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

Signature

Date

GRIEVANCE SYSTEM FORM

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

I hereby certify that _____
(Offeror Name)

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

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

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

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

Authorized Signature

Date

Printed Name

Title

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 offeror 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 Offeror'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 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 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.

Offeror: _____

Signature: _____

Title: _____

Date: _____

APPENDIX T 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 with the current QUEST, QUEST-Net and ABD programs, 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, 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 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, DHS will share in a significant difference between the capitated revenues and the actual costs experienced by the totality of the plans. Six months following the end of the fiscal year (by December 31), using the financial reports provided by the participating plans, a simple profit and loss statement will be developed for the health services portion of the QUEST and QUEST-Net programs. The health care services portion of the capitation revenues is assumed to be 90%. 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.

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 DHS and the plans and the plans will absorb all of the loss. If the aggregate loss is outside of this risk corridor, 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%, DHS will share equally in the gain between 3.1% and 4.9%. DHS will recover all gains equal to and exceeding 5%.

If there is to be risk sharing, each 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 DHS and the plans up to \$5,000,000. Since DHS and the plans share equally in the loss, the amount to be

remitted back to the plans is 1% of the total capitations paid to the plans for health care. Only 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 DHS and the plans. The second 2% will be returned to the State. Only 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*:

$$\begin{aligned} & \Sigma \text{Total revenue (based on capitations paid to each plan for the health care} \\ & \text{portion)} \\ & \text{Less: } \underline{\text{Net health care expenses}} \text{ (based on the actual experience for health care)} \\ & \underline{\text{Net profit/loss}} \text{ (for the health care services provided to QUEST and QUEST-} \\ & \text{Net populations)} \end{aligned}$$

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 DHS.

* The following definitions apply:

Capitations paid to each plan are computed as follows: (Based on the negotiated rate, the services portion of the capitation rate ÷ total capitation rate) x number of eligible months. Each of the plans' capitations are summed together to determine the total revenues to the plans.

Net services 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 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 DHS by January 15.

All net expenses for all 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 \$	Total Expenses	Net Profit (Loss)	Gain (Loss) Percentage
A	345,000	20,700,000	90%	18,630,000	22,500,000	-3,870,000	-20.77%
B	100,000	6,000,000	90%	5,400,000	7,500,000	-2,100,000	-38.89%
C	92,000	5,520,000	90%	4,968,000	7,500,000	-2,532,000	-50.97%
D	700,000	42,000,000	90%	37,800,000	35,000,000	2,800,000	7.41%
	1,237,000	74,220,000		66,798,000	72,500,000	-5,702,000	-8.54%

Total Capitations Paid to the Plans for Care	66,798,000
Total Expenses Related to Care	<u>72,500,000</u>
Net Loss	5,702,000

Loss Percentage for the Program 8.54%

Risk corridor is 5% -5.00%

% of loss to be shared equally between plans and DHS 3.54%

% to be returned to plans (50/50 share) 1.77%

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 3.54%). The total amount to be returned to the plans is calculated based on 1.77% of the services portion of the capitations received by the three plans experiencing a loss (1.77% x \$28,998,000). 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 three plans (\$513,265 ÷ 537,000). In this example, the per capita amount would be \$0.96 per recipient month. 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 \$0.96 per recipient month. Plan A would receive \$331,200 (345,000 x .96); Plan B would receive \$96,000 (100,000 x .96); and Plan C would receive \$88,320 (92,000 x .96). Plan D would not receive any payment from the Risk Share Program since 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 \$3.2 million (64% x 5,000,000); Plan B would receive 950,000 (19% x 5,000,000) and Plan C would receive 850,000 (17% x 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 \$	Total Expenses	Net Profit (Loss)	Gain (Loss) Percentage
A	345,000	20,700,000	90%	18,630,000	17,800,000	830,000	4.46%
B	100,000	6,000,000	90%	5,400,000	5,350,000	50,000	0.93%
C	92,000	5,520,000	90%	4,968,000	5,500,000	-532,000	-10.71%
D	700,000	42,000,000	90%	37,800,000	34,500,000	3,300,000	8.73%
	1,237,000	74,220,000		66,798,000	63,150,000	3,648,000	5.46%

Total Capitations Paid to the Plans for Care	66,798,000
Total Expenses Related to Care	<u>63,150,000</u>
Net Gain	3,648,000

Gain Percentage for the Program 5.46%

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: Distribution to the Plans

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 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, since Plan C experienced a loss, it would not return any money to the State. Plan B would also not return any money to the State because its gain was less than 3%. Plan A had a gain of 4.46% and would return half of the gain in excess of 3%, or 0.78% ([4.46 – 3.00] / 2). Plan A would retain \$694,450 and would return \$135,550 to DHS. Plan D had a gain of 8.73% and would be allowed to retain 4%. Plan D would retain \$1,512,000 and would return \$1,788,000 to DHS.

APPENDIX U
TPL MEDICAL/DENTAL EXPENSE REPORT

The report shall include the following data:

1. DHS Recipient I.D. No.
2. Patient Name
3. Birthdate
4. Provider No.
5. Provider Name
6. Referring/Prescribing Physician No.
7. Service dates (from -to)
8. Paydate
9. Claim control no.
10. Reject code
11. N- paydate
12. Payee no.
13. Accident Date
14. Diagnosis code/description 1,2, 3, 4, 5
15. Procedure/MOD/NDC
16. SVC/REV Description
17. SVC - Dt
18. S/Qty
19. Charge
20. Allowance
21. Claim Total
22. Patient's share
23. Other insurance payment
24. Refund code
25. Payment Period
26. Page No.
27. Adjustments

**APPENDIX V
PROVIDER NETWORK MATRIX**

Island: _____

Provider Type: Primary Care Providers*

	Name (last name, first name, M.I.)	Specialty	Location (Address) (list all that apply separately)	City	Zip Code	No. of Current QUEST Plan Members	Accepting New QUEST Members? Y/N	Any Limit on QUEST Members ?Y/N
1.								
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20								
21								

* PCPs include pediatricians, family practitioners, general practitioners, internists, OB/GYNs, clinics. Nurse midwives, pediatric nurse practitioners, family nurse practitioners should be listed separately.
Sort PCPs by different provider types and list alphabetically within the different provider type by last name.
PCPs should be placed on island map.

	Name (last name, first name, M.I.)	Specialty	Location (Address) (list all that apply separately)	City	Zip Code	No. of Current QUEST Plan Members	Accepting New QUEST Members? Y/N	Any Limit on QUEST Members? Y/N
22								
23								
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46								

* PCPs include pediatricians, family practitioners, general practitioners, internists, OB/GYNs, clinics. Nurse midwives, pediatric nurse practitioners, family nurse practitioners should be listed separately.
Sort PCPs by different provider types and list alphabetically within the different provider type by last name.
PCPs should be placed on island map.