STATE OF HAWAII

Department of Human Services

REQUEST FOR PROPOSALS (RFP)

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

RFP–MQD–2018-002

Med-QUEST Division
Health Coverage Services Branch

SECTION 10 ADMINISTRATIVE OVERVIEW

10.100 Purpose of the Request for Proposal (RFP)

This Request for Proposal (RFP) solicits participation by a qualified health care organization to case manage, authorize, and facilitate the delivery of behavioral health services to Medicaid eligible adults who have serious mental illness (SMI) or serious and persistent mental illness (SPMI) who are in QUEST Integration (QI) health plans. The services shall be provided statewide through a single vendor and shall be collectively referred to as Community Care Services (CCS). A health care organization submitting a proposal in response to this RFP will hereinafter be referred to as "Offeror" or "Offerors", as appropriate. The selected Offeror that is ultimately awarded the resulting contract from this RFP, will hereinafter be referred to as the "Behavioral Health Organization" or "BHO".

A separate behavioral health carve out plan is available for children/youth ages 3 through 18 or 20 (depending on their educational status) who are eligible for Department of Health-Child and Adolescent Mental Health Division (DOH-CAMHD) services.

The Adult Mental Health Division (DOH-AMHD) provides services for many individuals in health plans or uninsureds. Only individuals determined eligible by DHS to be QI enrollees may be transitioned into CCS.

For individuals who meet the criteria for the CCS program and will be transferred into it, the BHO shall coordinate with DOH-CAMHD, DOH-AMHD, DOH-DD, the State Hospital, prison, and other agencies involved, to manage and ensure a smooth transition for the individual.

If the individual does not meet the criteria for CCS, the QI health plans are responsible for administering behavioral health services. The QI health plan will conduct a special health care needs assessment to determine behavioral health services needed for each individual member.

Offerors are advised that the entire RFP, any addenda, and the corresponding proposal shall be a part of the contract with the successful Offeror.

The Department of Human Services (DHS) reserves the right to modify, amend, change, add, or delete any requirements in this RFP and the documentation library to serve the best interest of the State. If significant amendments are made to the RFP, the Offerors will be provided additional time to submit their proposals.

10.200 Authority for Issuance of RFP

This RFP is issued under the authority of Title XIX of the Social Security Act, 42 USC § 1396, et. seq. as amended, the implementing regulations issued under the authority thereof, Hawaii Revised Statutes (HRS) chapter 346-14, and the provisions of the HRS Title 9, Chapter 103F. All Offerors are charged with presumptive knowledge of all requirements cited by these authorities, and submission of a valid executed proposal by any Offeror shall constitute admission of such knowledge on the part of such Offeror. Failure to comply with any requirement may result in the rejection of the proposal. DHS reserves the right to reject any or all proposals received or to cancel this RFP, according to the best interest of the State.

10.300 Issuing Officer

This RFP is issued by the State of Hawaii, DHS. The issuing Officer within the DHS is the sole point of contact from the date of release of this RFP until the selection of a successful Offeror. The Issuing Officer is:

Mr. Jon Fujii
Department of Human Services
Med-QUEST Division
1001 Kamokila Boulevard, Suite 317
Kapolei, HI 96707-2005
Telephone: (808) 692-8083
Fax: (808) 692-8087

10.400 Use of Subcontractors

In the event of a proposal submitted jointly or by multiple organizations, one organization shall be designated as the primary Offeror and shall have responsibility for not less that forty percent (40%) of the work to be performed. The project

leader shall be an employee of the prime Offeror and meet all the required experiences. All other participants shall be designated as subcontractors. Subcontractors shall be identified by name and by a description of the services/functions they will be performing. The prime Offeror shall be wholly responsible for the entire performance whether or not subcontractors are used. The prime Offeror shall sign the contract with DHS.

10.500 Campaign Contributions by State and County Contractors

Pursuant to section 11-205.5, HRS, campaign contributions are prohibited from specified State or county government contractors during the term of the contract if the contractors are paid with funds appropriated by a legislative body. For more information, refer to the Campaign Spending Commission webpage (www.hawaii.gov/campaign).

10.600 Organization of the RFP

This RFP is composed of nine sections plus appendices:

- Section 10 – Administrative Overview – Provides general information on the purpose of the RFP, the authorities relating to the issuance of the RFP, and the organization of the RFP
- Section 20 – RFP Schedule and Requirements – Provides information on the rules and schedules for procurement of behavioral services
- Section 30 – Overview and Department of Human Services Responsibilities - Describes the current medical assistance programs, QI, and the role of DHS
- Section 40 – Provision of Services - Provides information on the medical and behavioral health services to be provided under this RFP and contract
- Section 50 – Administrative Requirements – Provides information on the eligibility and disenrollment of members, quality improvement and utilization review requirements, data to be provided by the plan, DHS notification requirements, and the DHS monitoring procedures
- Section 60 – Terms and Conditions - Describes the terms and conditions under which the work will be performed

- Section 70 – Technical Proposal – Describes the required content and format required for submission of a proposal
- Section 80 - Capitation Rates - Defines the methodology that DHS uses for setting capitation rates.
- Section 90 – Evaluation and Selection – Defines the evaluation criteria and explains the evaluation process.

Various appendices are included to support the information presented in Sections 10 through 90.

SECTION 20 RFP SCHEDULE AND REQUIREMENTS

20.100 RFP Timeline

The delivery schedule set forth herein represents the DHS's best estimate of the schedule that will be followed. If a component of this schedule, such as Proposals Due date is delayed, the rest of the schedule will likely be shifted by the same number of days. The proposed schedule is as follows:

Issue RFP	October 19, 2017
Orientation	October 26, 2017
Notice of Intent to Propose	October 31, 2017
Submission of Written Questions	November 9, 2017
Written Responses to Questions	November 22, 2017
Proposal Due Date	December 18, 2017
Contract Award	January 22, 2018
Contract Effective Date	July 1, 2018

20.200 Orientation

An orientation for Offerors in reference to this RFP will be held on the date specified in Section 20.100, at 2:00 pm (H.S.T.) at the Med-QUEST Office, Kakuhihewa Building at 601 Kamokila Boulevard, #577A, Kapolei, Hawaii.

Call-In Number: 866-740-1260
Access Code - 6928088#

Impromptu questions will be permitted at the orientation and spontaneous responses provided at the discretion of the state purchasing agency. However, responses provided at the orientation conference are intended only as general direction and may not represent the official position of the state purchasing agency. To ensure a written response, any oral questions should be submitted in writing following the close of the orientation conference, but no later than the submittal deadline for written questions indicated in Section 20.300, Submission of Written Questions.

20.300 Submission of Written Questions

Offerors may submit questions by email and/or on CD in Word 2013 format, or lower, to the following address:

Mr. Jon Fujii
c/o Dona Jean Watanabe
Med-QUEST Division-Finance Office
1001 Kamokila Boulevard, Room 317
Kapolei, Hawaii 96707-2005
E-mail: HCSBinquiries@dhs.hawaii.gov

The written questions shall reference the RFP section, page, paragraph, and bullet number, if appropriate, in the format provided in Appendix A. Offerors must submit written questions by 2:00 p.m. (H.S.T.) on the date identified in Section 20.100. DHS shall respond to the written questions no later than the date specified in Section 20.100. No verbal responses shall be considered as official.

20.400 Notice of Intent to Propose

Potential Offerors shall submit a Notice of Intent to Propose to the Issuing Officer no later than 2:00 p.m. (H.S.T.) on the date identified in Section 20.100 utilizing the format provided in Appendix B. Submission of a Notice of Intent to Propose is not a prerequisite for the submission of a proposal, but it is necessary that the Issuing Officer receive the letter by this deadline to assure proper distribution of amendments, questions and answers and other communication regarding this RFP.

Notice of Intent can be mailed, e-mailed or faxed to:

Jon Fujii
c/o Dona Jean Watanabe
Med-QUEST Division-Finance Office
1001 Kamokila Boulevard, Room 317
Kapolei, Hawaii 96707-2005
Email: dwatanabe@dhs.hawaii.gov
Fax Number: (808) 692-7989

20.500 Requirements to Conduct Business in the State of Hawaii

Offeror is advised that if awarded a contract under this RFP, Offeror shall, upon award of the contract, furnish proof of compliance with the following requirements of HRS, required to conduct business in the State:

1. HRS Chapter 237, tax clearance
2. HRS Chapter 383, unemployment insurance
3. HRS Chapter 386, workers' compensation
4. HRS Chapter 392, temporary disability insurance
5. HRS Chapter 393, prepaid health care

One of the following:

- Be registered and incorporated or organized under the laws of the State (hereinafter referred to as a "Hawaii business"); or
- Be registered to do business in the State (hereinafter referred to as a "compliant non-Hawaii business").

Offerors are advised that there are costs associated with compliance under this section. Any costs are the responsibility of the Offeror. Proof of compliance is shown by providing the Certificate of Vendor Compliance issued by Hawaii Compliance Express (HCE).

20.600 Hawaii Compliance Express (HCE)

The DHS utilizes the HCE to verify compliance with the requirements to conduct business in the State, upon award of the contract. The HCE is an electronic system that allows vendors/contractors/service providers doing business with the State to quickly and easily demonstrate compliance with applicable laws. It is an online system that replaces the necessity of obtaining paper compliance certificates from the DOTAX and IRS tax clearance Department of Labor and Industrial Relations (DLIR) labor law compliance, and Department of Commerce and Consumer Affairs (DCCA) good standing compliance. There is a nominal annual fee for the service and is the responsibility of the Offeror. The "Certificate of Vendor Compliance" issued online through HCE provides the

registered Offeror's current compliance status as of the issuance date, and is accepted for both contracting and final payment purposes. See website: https://vendors.ehawaii.gov/hce/splash/welcome.html

20.610 Suspension and Debarment

Pursuant to Office of Management and Budget (QMB) 2FR Section 180, no award of contract under this RFP shall be made if the Offeror, its subcontractors, and its principals have been suspended or debarred, disqualified or otherwise excluded from participating in this procurement.

20.700 Documentation

Offerors may review information describing Hawaii's Medicaid programs (QI or fee-for-service (FFS)) by visiting the DHS MQD website: http://www.med-QUEST.us.

All possible efforts shall be made to ensure that the information contained in the website is complete and current. However, DHS does not warrant that the information in the website is indeed complete or correct and reserves the right to amend, delete and modify the information at any time without notice to Offerors.

20.800 Rules of Procurement

To facilitate the procurement process, various rules have been established as described in the following subsections.

20.810 No Contingent Fees

No Offeror shall employ any company or person, other than a bona fide employee working solely for the Offeror or company regularly employed as its marketing agent, to solicit or secure this contract, nor shall it pay or agree to pay any company or person, other than a bona fide employee working solely for the Offeror or a company regularly employed by the Offeror as its marketing agent, any fee commission, percentage, brokerage fee, gift, or other consideration contingent upon or resulting from the award of a contract to perform the specifications of this RFP.

20.820 Restriction on Communication with State Staff

Communication with State staff shall be consistent with requirements identified in Subchapter 4 Allowable Communication Section 3-143, Hawaii Administrative Rules (HAR).

- Prior to Submittal Deadline:

  Discussions may be conducted with potential Offerors to promote understanding of the purchasing agency's requirements.

- After Proposal Submittal Deadline:

  Discussions may be conducted with potential Offerors whose proposals are determined to be reasonably susceptible of being selected for award, but proposals may be accepted without discussions, in accordance with §3-143-403,HAR.

20.830 RFP Amendments

DHS reserves the right to amend the RFP any time prior to the closing date for the final revised proposals. In addition, addenda may also be made after proposal submission consistent with Section 3-143-301(e), HAR.

20.840 Costs of Preparing Proposal

Any costs incurred by the Offerors for the development and submittal of a proposal in response to this RFP are solely the responsibility of the Offeror, whether or not any award results from this solicitation. The State of Hawaii shall provide no reimbursement for such costs.

20.850 Provider Participation in Planning

Provider participation in a state purchasing agency's efforts to plan for or to purchase health and human services prior to the state purchasing agency's release of an RFP, including the sharing of information on community needs, best practices, and providers' resources, shall not disqualify providers from submitting proposals if conducted in accordance with HAR Sections 3-142-202 and 3-142-203, HAR, pursuant to Chapter 103F, HRS.

20.860 Disposition of Proposals

All proposals become the property of the State of Hawaii. The successful proposal shall be incorporated into the contract. A copy of successful and unsuccessful proposal(s) shall be public record as part of the procurement file as described in Section 3-143-616, HAR, pursuant to Chapter 103F, HRS. The State of Hawaii shall have the right to use all ideas, or adaptations to those ideas, contained in any proposal received in response to this RFP. Selection or rejection of the proposal shall not affect this right.

According to Section 3-143-612, HAR, Offerors who submit technical proposals that fail to meet mandatory requirements or fail to meet all threshold requirements during the technical evaluation phase may retrieve their technical proposal within thirty (30) days after its rejection from the purchasing agency. After thirty (30) days, the purchasing agency may discard the rejected technical proposal.

20.870 Rules for Withdrawal or Revision of Proposals

A proposal may be withdrawn or revised at any time prior to, but not after, the Proposal Due Date specified in Section 20.100, provided that a request in writing executed by an Offeror or its duly authorized representative for the withdrawal or revision of such proposal is filed with DHS before the Proposal Due Date specified in Section 20.100. The withdrawal of a proposal shall not prejudice the right of an Offeror to submit a new proposal prior to Proposal Due Date specified in Section 20.100.

After the Proposal Due Date as defined in Section 20.100, all proposals timely received shall be deemed firm Offers that are binding on the Offerors for ninety (90) days. During this period, an Offeror may neither modify nor withdraw its proposals without written authorization or invitation from the DHS.

Notwithstanding the general rules for withdrawal or revision of proposals, the State purchasing agency may request that Offerors submit a final revised proposal in accordance with Section 3-143-607, HAR.

20.880 Independent Price Determination

State law requires that a bid shall not be considered for award if the price in the bid was not arrived at independently without collusion, consultation, communication, or agreement as to any matter relating to such prices with any other Offeror or with any competitor.

An Offeror shall include a certified statement in the proposal certifying that the bid was arrived at without any conflict of interest, as described above. Should a conflict of interest be detected at any time during the contract, the contract shall be null and void and the Offeror shall assume all costs of this project until such time that a new Offeror is selected.

20.900 Confidential Information

The DHS shall maintain the confidentiality of proposals only to the extent allowed or required by law, including but not limited to Section 92F-13, HRS, and Sections 3-143-604 and 3-143-616, HAR. If the Offeror seeks to maintain the confidentiality of sections of the proposal, each page of the section(s) shall be marked as "Proprietary" or "Confidential." An explanation to the DHS of how substantial competitive harm would occur if the information were released is required. If the explanation is sufficient, then to the extent permitted by the exemptions in Section 92F-13, HRS, the affected section may be deemed confidential. Such information shall accompany the proposal, be clearly marked, and shall be readily separable from the proposal to facilitate eventual public inspection of the non-confidential sections of the proposal. The DHS shall maintain the confidentiality of the information to the extent allowed by law. Blanket labeling of the entire document as "proprietary," however, shall result in none of the document being considered proprietary.

21.100 Acceptance of Proposals

DHS reserves the right to reject any or all proposals received or to cancel this RFP according to the best interest of the State.

DHS also reserves the right to waive minor irregularities in proposals providing such action is in the best interest of the State.

Where DHS may waive minor irregularities, such waiver shall in no way modify the RFP requirements or excuse an Offeror from full compliance with the RFP specifications and other contract requirements if the Offeror is awarded the contract.

DHS also reserves the right to consider as acceptable only those proposals submitted in accordance with all technical requirements set forth in this RFP and which demonstrate an understanding of the requirements. Any proposal offering any other set of terms and conditions contradictory to those included in this RFP may be disqualified without further notice.

21.200 Submission of Proposals

Each qualified Offeror shall submit only one (1) proposal. More than one (1) proposal shall not be accepted from any Offeror. The Proposal Application Identification (Form SPO-H-200) shall be completed and submitted with the proposal (Appendix C). The format and content of the proposal is specified in Sections 60 and 70 respectively.

Proposals shall be submitted using Offeror's exact legal name as registered with the DCCA. Failure to do so may delay proper execution of the contract. The authorized signature on the Offer form shall be an original signature in ink. If unsigned or the affixed signature is a facsimile or a photocopy, the Offer shall be automatically rejected unless accompanied by other material containing an original signature, indicating the Offeror's intent to be bound.

Technical proposal shall be submitted in the following manner: original proposal bound and three (3) additional bound copies and (1) complete electronic version in MS Word 2013 or lower or PDF, on a CD. The Issuing Officer shall receive the technical proposals no later than 2:00 p.m. (H.S.T.) on the Proposal Due date specified in Section 20.100 or postmarked by the USPS no later than the date specified in Section 20.100 and received by DHS within ten (10) days of the Proposal Due date. All mail-ins postmarked by USPS after the date specified in Section 20.100, shall be rejected. Hand deliveries shall not be accepted after 2:00 p.m., H.S.T., the date specified in Section 20.100. Deliveries by private mail services such as FEDEX shall be considered hand deliveries and shall not be accepted if received

after 2:00 p.m., H.S.T., the date specified in Section 20.100. Any proposals received after the deadline will be rejected and returned to the Offeror. Proposals shall be mailed or delivered to:

Mr. Jon Fujii
c/o Dona Jean Watanabe
Department of Human Services
Med-QUEST Division / Finance Office
1001 Kamokila Boulevard, Suite 317
Kapolei, HI 96707-2005

The outside cover of the package containing the technical proposal shall be marked:

Hawaii DHS/RFP-MQD-2018-002
Community Care Services (CCS)
Technical Proposal
(Name of Offeror)

Offerors are solely responsible for ensuring receipt of the proposals and amendments by the appropriate DHS office by the required deadlines.

Any amendments to proposals shall be submitted in a manner consistent with this section.

21.300 Disqualification of Offerors

An Offeror shall be disqualified and the proposal automatically rejected for any one or more of the following reasons:

- Proof of collusion among Offerors, in which case all bids involved in the collusive action shall be rejected and any participant to such collusion shall be barred from future bidding until reinstated as a qualified Offeror.
- An Offeror's lack of responsibility and cooperation as shown by past work or services.
- An Offeror's being in arrears on existing contracts with the State or having defaulted on previous contracts.
- An Offeror's lack of proper provider network and/or sufficient experience to perform the work contemplated, if required.

- An Offeror's lack of a proper license to cover the type of work contemplated, if required.
- An Offeror shows any noncompliance with applicable laws.
- An Offeror's delivery of proposal after the proposal due date.
- An Offeror's failure to pay, or satisfactorily settle, all bills overdue for labor and material on former contracts with the State at the time of issuance of this RFP.
- An Offeror's lack of financial stability and viability.
- An Offeror's consistently substandard performance related to meeting the MQD requirements from previous contracts.

21.400 Irregular Proposals

Proposals shall be considered irregular and rejected for the following reasons including, but not limited to the following:

- If either the proposal letter or transmittal letter is unsigned by an Offeror or does not include notarized evidence of authority of the officer submitting the proposal to submit such proposal.
- If the proposal shows any non-compliance with applicable law or contains any unauthorized additions or deletions, conditional bids, incomplete bids, or irregularities of any kind, which may tend to make the proposal incomplete, indefinite, or ambiguous as to its meaning.
- If an Offeror adds any provisions reserving the right to accept or reject an award, or adds provisions contrary to those in the solicitation.

21.500 Rejection of Proposals

The State reserves the right to consider as acceptable only those proposals submitted in accordance with all requirements set forth in this RFP and which demonstrate an understanding of the problems involved and comply with the scope of service. Any proposal offering any other set of terms and conditions contradictory to those included in this RFP may be rejected without further notice.

A proposal may be automatically rejected for any or more of the following reasons:

1. Rejection for failure to cooperate or deal in good faith (HAR §3-141-201);
2. Rejection for inadequate accounting system (HAR §3-141-202);
3. Late Proposals (HAR §3-143-603);
4. Unauthorized Multiple/Alternate Proposals (Section 3-143-605, HAR);
5. Inadequate response to request for proposals (HAR §3-143-609);
6. Proposal not responsive (HAR §143-610(a)(1)); or
7. Offeror not responsible (HAR §3-143-610(a)(2)).

21.600 Multiple or Alternate Proposals

Multiple or alternate proposals shall not be accepted. If an Offeror submits multiple proposals or alternate proposals, then all such proposals shall be rejected unless one of the proposals is clearly designated as the primary proposal, in which case the designated primary proposal will be retained and evaluated, and the other proposals shall be rejected.

21.700 Cancellation of RFP

The RFP may be canceled and any or all proposals may be rejected in whole or in part, when it is determined to be in the best interests of the State. The State shall not be liable for any costs, expenses, loss of profits or damages whatsoever, incurred by the Offeror in the event this RFP is cancelled or a proposal is rejected.

21.800 Proposal Opening and Inspection

Proposals, modifications to proposals, and withdrawals of proposals shall be date-stamped and, when possible, time-stamped upon receipt by the DHS. All documents so received shall be held in a secure place by the State purchasing agency and not opened until the Proposal Due Date as described in Sections 20.100 and 21.200.

Procurement files shall be open to the public inspection after a contract has been awarded and executed by all parties.

21.900 Additional Materials and Documentation

Upon request from the state purchasing agency, each Offeror shall submit any additional materials and documentation reasonably required by the state purchasing agency in its evaluation of the proposal.

22.100 Final Revised Proposal

If requested, final revised proposals shall be submitted in the manner and by the date and time specified by the state purchasing agency. If a final revised proposal is not submitted, the previous submittal shall be construed as the Offerors best and final offer/proposal. The Offeror shall submit only the section (s) of the proposal that are amended, along with the Proposal Application Identification Form (SPO-H-200). After final revised proposals are received, final evaluations will be conducted for an award.

22.200 Notice of Award

The notice of intended contract award, if any, shall be sent to the selected Offeror on or about the date specified in section 20.100.

The contract award is subject to the available funding. The award of a contract and any allowed renewal or extension thereof, is subject to allotments made by the Director of Finance, State of Hawaii, pursuant to HRS Chapter 37, and subject to the availability of State and/or Federal funds.

The successful Offeror receiving award shall enter into a formal written contract.

The State is not liable for work, contract, costs, expenses, loss of profits, or any damages whatsoever incurred by the Contractor prior to the Contract Effective Date.

Any contract arising out of an offer is subject to the approval of the Department of Attorney General as to form and to all further approvals, including the approval of the Governor as required by state, regulation, rule, order, or other directive.

The State of Hawaii is not liable for any costs incurred prior to the Contract Effective Date identified in Section 20.100.

22.300 Cost Principles

To promote uniform purchasing practices among state purchasing agencies procuring health and human services under HRS Chapter 103F, state purchasing agencies will utilize standard cost principles as outlined on the State Procurement Office (SPO) website. See http://spo.hawaii.gov, search Keyword "Cost Principles". Nothing in this section shall be construed to create an exemption from any cost principle arising under federal law.

22.400 Protests

Offerors may file a Notice of Protest against the awarding of the contract. The Notice of Protest form, SPO-H-801, is available on the SPO website http://spo.hawaii.gov/for-vendors/vendor-guide/protests-for-health-and-human-services/. Only the following matters may be protested:

1. A state purchasing agency's failure to follow procedures established by Chapter 103F, HRS;
2. A state purchasing agency's failure to follow any rule established by Chapter 103F, HRS; and
3. A state purchasing agency's failure to follow any procedure, requirement, or evaluation criterion in an RFP issued by the state-purchasing agency.

A Notice of Protest shall be postmarked by USPS or hand delivered to 1) the head of the state purchasing agency conducting the protested procurement, and 2) the procurement officer who is conducting the procurement (as indicated below) within five (5) working days of the postmark of the Notice of Findings and Decision sent to the protestor. Delivery services other than USPS shall be considered hand deliveries and considered submitted on the date of actual receipt by the DHS.

Procurement Officer	**Head of State Purchasing Agency**
Name: Jon Fujii	Name: Pankaj Bhanot
Title: Med-QUEST Division Health Care Services Branch Administrator	Title: Chief Procurement Officer

Mailing Address: 601 Kamokila Blvd., Suite 506A Kapolei, Hawaii 96709-0190	Mailing Address: P.O. Box 339 Honolulu, Hawaii 96809-0339
Business Address: 1001 Kamokila Boulevard, Suite 317 Kapolei, Hawaii 96707	Business Address: 1001 Kamokila Blvd., Suite 317 Kapolei, Hawaii 96707

SECTION 30 Overview and Department of Human Services Responsibilities

30.100 Overview of Department of Human Services (DHS) Responsibilities

MQD is the organizational unit within DHS that is responsible for the operation and administration of the medical assistance programs including QI, CCS, dental and State of Hawaii Organ and Tissue Transplant (SHOTT) programs. For purposes related to this RFP, the basic functions or responsibilities of MQD include:

- Defining the behavioral health benefits to be provided by the BHO;
- Developing the rules, policies, regulations, and procedures to be followed under the medical assistance and behavioral health programs administered by DHS;
- Negotiating and contracting with the BHO;
- Determining initial and continued eligibility of members;
- Enrolling and disenrolling BHO members;
- Monitoring the quality of services provided by the BHO and its providers;
- Reviewing and analyzing utilization of services and reports provided by the BHO;
- Handling unresolved member grievances with the BHO;
- Monitoring the financial status of the BHO;
- Analyzing the effectiveness of the programs it administers in meeting its objectives;
- Managing the various information systems;
- Providing member eligibility information to the BHO;
- Reimbursing the BHO through capitation payments; and
- Imposing civil or administrative monetary penalties and/or financial sanctions for violations of specific contract provisions.

30.200 Overview of Medical Assistance in Hawaii

MQD is the unit within the Department of Human Services (DHS) that administers Hawaii's medical assistance programs. Medicaid, a federal and state partnership program created by Congress in 1965, provides medical assistance benefits to qualified uninsured and underinsured through the QI program.

Together, Medicaid covers approximately 343,101 individuals. In addition to asset and income limits, the basic eligibility requirements for Medicaid include being 1) a U.S. citizen or qualified alien; 2) a Hawaii resident; and 3) not residing in a public institution such as prison or the State psychiatric hospital. Different eligibility categories such as pregnant women and children have different income thresholds and are not subject to an asset limit.

MQD also administers at this time two state-funded programs. The first is a state-funded aged, blind, and disabled (ABD) program for certain lawfully present non-pregnant adults who are ineligible under Medicaid. The second for the Breast and Cervical Cancer program. The MQD retains the ability to add new State funded programs. Eligibility requirements are the same as for Medicaid, but there is no U.S. citizenship requirement. Eligible persons are placed in the QI managed care health plans. Federal dollars are not claimed for these eligibility groups.

30.300 Behavioral Health in MQD

Medical assistance to eligible beneficiaries is provided through the State administered QI, and fee-for-service programs. The MQD, under the DHS, administers these medical assistance programs.

In Hawaii, those with a behavioral health diagnosis of Serious Mental Illness (SMI) or Serious and Persistent Mental Illness (SPMI) may have difficulty in accomplishing their activities of daily living (ADL) and thus require additional services beyond the basic behavioral health services utilized by individuals without SMI or SPMI. Uninsured individuals or those that are legally encumbered with SMI or SPMI receive services through AMHD.

The initial population served under this contract will be those currently receiving additional behavioral health services through CCS.

30.400 BHO Enrolled Population

30.410 Basic Criteria

Potential CCS members must first become a QI beneficiary. Participation in the CCS program is voluntary.

All members in the BHO shall meet the following basic eligibility criteria:

- Be a U.S. citizen or legal resident alien entering the U.S. before August 22, 1996 or allowed to participate in Medicaid under provisions of the Personal Responsibility and Work Reconciliation Act of 1996 and subsequent amendments of those provisions
- Be an adult (age 18 and over)
- Intend to reside in the State of Hawaii
- Provide a verified Social Security Number (SSN)
- Meets eligibility requirements for medical assistance program to include a State-funded medical assistance program
- Not reside in a public institution, including correctional facilities and the Hawaii State Hospital

30.420 Hawaii QUEST Integration (QI)

The QI program is a melding of programs, including but not limited to QUEST and QUEST Expanded Access (QExA), into one Statewide program providing managed care services to all of Hawaii's Medicaid population.

QI is a statewide Medicaid demonstration project (Section 1115 waiver) that provides a package of medical, dental, behavioral health, and Long-Term Services and Support (LTSS) benefits to individuals meeting the Medicaid financial and non-financial eligibility requirements for individuals and families. Description of the individuals eligibility and benefits for QI are found in

Hawaii Administrative Rules, Title 17, Med-QUEST Division (1700 series).

Medicaid Covered Populations

- Children under 18 years of age
- Former foster care children under age 26
- Pregnant women
- Parent or caretaker relatives
- Individuals receiving transitional medical assistance
- Adults 18 to 64 years of age
- Individuals who are aged (age 65 and older), blind, or with a disability
- Non-citizens or refugees
- Repatriates
- Individuals with breast and cervical cancer

30.500 Eligible BHO Members

QI members, who meet criteria for the BHO, shall be eligible to receive the specialized behavioral health services described in this RFP [see Section 40.900]. All BHO members must first be enrolled in a medical assistance program. In such a case, the QI health plan shall be relieved of its responsibility for providing behavioral health services (BHS) including psychotropic medications, but shall remain responsible for providing non-BHS medical services.

If a QI member is provisionally determined to be SMI/SPMI through the MQD evaluation process and currently meet the CCS eligibility criteria, the member will be enrolled into the BHO until an evaluation is completed to determine continued eligibility. Upon enrollment in the BHO, the QI health plan is no longer responsible for the individual's behavioral health services. However, the QI health plan shall remain responsible for all non-BHS medical services available to QI members.

Potentially eligible individuals who have not been enrolled in a QI health plan but call the hotline and require crisis services shall

receive such services, and the BHO shall provide assistance with eligibility and enrollment.

If the program is expanded to include other populations, a process will be established by DHS to determine eligibility that will minimally require meeting clinical criteria in Section 30.520.

For the purpose of this RFP, an adult is defined as an individual who is age 18 years and older.

30.510 Serious Mental Illness (SMI) or Serious and Persistent Mental Illness (SPMI)

Persons who are determined to have a diagnosis of Serious Mental Illness (SMI) or Serious and Persistent Mental Illness (SPMI) are defined as adults who, as the result of a mental disorder, exhibit emotional, cognitive, or behavioral functioning which is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or services of a long-term or indefinite duration. In these persons, their mental disability is serious and persistent resulting in a long-term limitation in their functional capacities for primary activities of daily living such as interpersonal relationships, self-care, homemaking, employment, and recreation. Criteria for designation of a person who has a diagnosis of SMI/SPMI can be found in Section 30.520.

30.520 Evaluation and Referral to the BHO

Upon determination that a QI member would benefit from BHO services, the QI health plan shall refer the member to MQD through use of the referral process (Appendix D, CCS Referral Form and Instructions) for an evaluation to determine eligibility for the BHO.

Adults with a SMI/SPMI diagnosis who are unstable and moderate-high risk are eligible for additional intensive services if the adult:

- Demonstrates the presence of a qualifying diagnosis for at least twelve (12) months or is expected to demonstrate the qualifying diagnosis (as found in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for the next twelve (12) months, and

- Meets at least one of the criteria demonstrating instability and/or functional impairment:
    - Clinical records demonstrate that member is unstable under current treatment or plan or care; or
    - Requires protective services or intervention by housing/law enforcement officials
- Does not meet the eligibility criteria, but is determined by the MQD's medical director or designated person that additional services are medically necessary for the member's health and safety, should be evaluated on a case by case basis for provisional eligibility.

Eligible Diagnoses:

- Substance Induced Psychosis:
    - Alcohol Induced Psychosis (F10.15x, F10.25x, F10.95)
    - Opioid Induced Psychosis (F11.15x, F11.25x, F11.95x)
    - Cannabis Induced Psychosis (F12.15x, F12.25x, F12.95x)
    - Sedative Induced Psychosis (F13.15x, F13.25x, F13.95x)
    - Cocaine Induced Psychosis (F14.15x, F14.25x, F14.95x)
    - Other Stimulant Induced Psychosis (F15.15x, F15.25x, F15.95x)
    - Hallucinogen Induced Psychosis (F16.15x, F16.25x, F16.95x)
    - Inhalant Induced Psychosis (F18.15x, F18.25x, F18.95x)
    - Other Substance Induced Psychosis (F19.15x, F19.25x, F19.95x)
    - PTSD (F43.1x)
    - Schizophrenia (F20.x, includes Schizophreniform disorder F20.81)

- Schizoaffective Disorder (F25.x)
- Delusional Disorder (F22)
- Bipolar Disorder (F30.xx, F31.xx)
- Major Depressive Disorder, Severe: (F32.3, F33.2, F33.3)

DHS reserves the right to modify the clinical criteria for eligibility.

A QI health plan shall submit the designated DHS referral form, completed by a qualified mental health professional (QHMP) [see Appendix D], along with supporting documentation of SMI/SPMI and functional impairment consistent with eligibility criteria (i.e. admission and discharge summaries, day hospital admission and discharge summaries, outpatient admission and discharge summaries, psychiatric assessment, psychological test results, and other pertinent documents). If, after review, it is unclear if the QI member would benefit from BHO services, additional information may be requested by the DHS or the referral will be denied. The cost of completing the forms and obtaining documentation is the responsibility of the health plan. DHS may allow a FFS provider to submit a referral packet under extenuating circumstances.

If all documents are completed and properly submitted on the initial referral, the determination will be made within thirty (30) days from the receipt of the documents. If additional documentation is requested, the determination, if it can be made, will be done within thirty (30) days of receipt of the additional documents.

The evaluation results and the enrollment date into the BHO will be provided to the member's health plan and the BHO. Five (5) working days after notification of the determination, the BHO assumes responsibility for the member. If denied, the referring provider has the right to resubmit the referral with additional information that clearly documents the member's eligibility. The BHO shall verify enrollment with DHS and the member's health plan before providing services.

30.600 Enrollment into the BHO

30.610 Referral process

Potential members of the BHO may be:

- Referrals from the QI health plan
- Referrals from the Hawaii State Hospital who are being discharged
- Referrals from the Department of Health: AMHD, CAMHD or DDD
- Referrals from the Department of Public Safety being discharged from their correctional facilities
- Referrals from the DHS for those young adults (18 years old) being discharged from the Hawaii Youth Correctional Facilities.
- Individuals self-referring to the BHO or making first contact with the BHO through crisis services.

All referrals for potential BHO members will be subject to the SMI/SPMI referral and evaluation process described in Section 30.500 and must meet the criteria for the SMI or SPMI.

There is no enrollment cap for the BHO.

Once a member has been evaluated to meet the criteria for SMI/SPMI determination by DHS, the member will be enrolled in the BHO. Enrollment into CCS is the sole responsibility of the DHS.

The enrollment date, which is five working days after the approval of the referral process described in Section 30.520 or earlier, based upon member behavioral health needs, shall be noted on the determination form. Upon enrollment into the BHO, the QI health plan shall be relieved of its responsibility for providing all behavioral health services to its member. Until the BHO enrollment date, the QI health plan retains responsibility for providing the behavioral health services.

Members who are enrolled in the BHO and who are later determined to no longer meet the criteria for SMI/SPMI shall

be referred to the MQD by the BHO. The BHO will request disenrollment for these members. The process for disenrollment from the BHO is described in Section 30.800. The BHO will review the member's treatment status at least every six (6) months to determine if SMI/SPMI continued eligibility criteria are met.

30.620 Re-Evaluation Process

At the time of eligibility determination, a re-evaluation date is set by MQD. Prior to this re-evaluation date, the BHO shall submit the designated MQD re-evaluation form (Appendix D) with supporting documents for the MQD to review. If it is determined that the member continues to meet eligibility criteria as outlined in Section 30.520, Evaluation and Referral to the BHO, the MQD may set another re-evaluation date as needed. If it is determined that the member no longer meets eligibility criteria, the process for disenrollment will begin as outlined in Section 30.800 Disenrollment from the BHO.

30.630 Involuntary Commitment

The BHO shall be responsible for providing behavioral health services to members who have been involuntarily committed for evaluation and treatment under provisions of Chapter 334, HRS, to the extent that these services are deemed necessary by the BHO's utilization review procedures. In the event that court ordered diagnostic, treatment or rehabilitative services are not determined to be medically necessary, the costs of continuing care under court order shall be borne by the BHO.

30.700 Re-Enrollment into the BHO

Individuals, who are disenrolled from the BHO and request services after an absence from the BHO or regain Medicaid eligibility within six (6) months are not required to be re-evaluated to be re-enrolled unless the MQD or the BHO determines it is necessary, or a six (6) month re-evaluation is due.

Re-enrollment will be effective from the date the member is re-enrolled into the QI health plan and/or requested date by the BHO. Re-enrollment will not be retroactive to the date of the

last disenrollment. The BHO will be expected to assist members with maintaining eligibility.

30.800 Disenrollment from the BHO

Members may be disenrolled from the BHO if they no longer meet the criteria for enrollment. Members or their authorized representative may request disenrollment from the BHO at any time either orally or in writing. Members shall be disenrolled from the BHO at the end of the month and responsibility for behavioral health services will revert to the QI health plan. Only the DHS may disenroll members from the BHO.

The BHO transition plan will be given to the QI health plan in order to ensure continuity of care prior to disenrollment. The QI health plan shall receive written notification from the MQD of the disenrollment from the BHO. Upon disenrollment from the BHO, the QI health plan assumes responsibility for providing all medical and behavioral health services within the established plan behavioral health benefit limits.
The BHO shall not request disenrollment of a member for discriminating reasons including:

- Pre-existing Medical Conditions;
- Missed appointments;
- Changes to the member's health status;
- Utilization of medical services;
- Diminished mental capacity; or
- Uncooperative or disruptive behavior resulting from the member's special needs (except where the member's continued enrollment in the BHO seriously impairs the BHO's ability to furnish services to either the member or other members).

30.810 Criminal Commitment

Adult members who have been criminally committed for evaluation or treatment in an inpatient setting under the provisions of Chapter 706, HRS, shall be disenrolled from the BHO and become the clinical and financial responsibility of the appropriate State agency. The psychiatric evaluation and treatment of recipients who have been criminally committed to a

mental health care setting shall be the clinical and financial responsibility of the appropriate State agency. The BHO shall be relieved of its responsibility for providing behavioral health services.

30.820 State Mental Health Hospital

Upon admission into the State Mental Health Hospital, the individual shall be disenrolled from the BHO.

30.900 BHO Policy Memorandums

The DHS issues policy memorandums to offer clarity on policy or operational issues or legal changes impacting the BHO. The BHO shall comply with the requirements of all the policy memorandums during the course of the contract and execute each memorandum when distributed by MQD during the period of the contract. The BHO shall acknowledge receipt of the memoranda through electronic mail.

SECTION 40 PROVISION OF SERVICES

40.100 BHO's Role in Managed Care

The BHO shall ensure that members enrolled in the CCS program are assessed to determine behavioral health and substance use needs. All members shall have case management services provided to access and facilitate the acquisition and provision of all behavioral health services covered under this agreement. The BHO shall provide each member with a case manager who is responsible for the direction, coordination, monitoring and tracking of the behavioral health services (mental health services) and substance use disorder services needed by the members, as well as setting up a medication regimen, ongoing assessment and management/evaluation of prescribed medications.

Once the service needs and coordination of care are established, the BHO shall ensure that its members have access to behavioral health providers. The BHO shall determine what direct behavioral health services are required by the member, arrange for the provision of these services, and oversee the provision of these services including the issuing of prior authorization. Providers and BHO plan personnel should be knowledgeable about and sensitive toward the behavioral health care needs of their members.

Since the BHO members will retain their primary care provider (PCP) from their health plan, the BHO shall ensure that the PCP is updated on the member's diagnosis, medication, treatment plans, and ongoing care and that close coordination with the member's medical care is maintained.

The BHO shall oversee the delivery of behavioral health and substance use disorder services and ensure their members receive necessary and effective care. The BHO shall undertake all necessary reviews including utilization reviews to ensure efficacy of services.

The BHO shall ensure services are available. The BHO shall be responsible for ensuring access to providers that provide behavioral health and substance use disorder services state-wide to meet the needs of the BHO's members.

While the BHO is precluded from interfering with member-provider communications, the BHO is not required to provide, reimburse for, or provide coverage for counseling or referral services for specific services if the BHO objects to the service on moral or religious grounds. In these cases, the BHO must notify, in writing:

- The DHS within one-hundred twenty (120) days prior to adopting the policy with respect to any service;
- The DHS with the submission of its proposal to provide services under this RFP;
- Members that the DHS will provide information on how and where to obtain such services;
- Members within ninety (90) days of adopting the policy with respect to any service; and
- Members and potential members before and during enrollment.

40.200 Case Management System

In providing case management services, the BHO may employ BHO staff, however, it must ensure it contracts with case management agencies that agree to accept reimbursement at Medicaid fee-for-service rates where members entering into the BHO have an established relationship with a case manager and that case manager is not also employed by the BHO. The BHO shall be able to maintain continuity of care. If in the event the BHO is unable to contract with a member's pre-existing case management provider, the member has the option to not enter the BHO, or the member or their authorized representative may waive the requirement to remain with their pre-existing case manager in writing. The BHO is strongly encouraged to provide continuity of care when possible and is required to have coordinated transfer of care when necessary. Contracts shall, at a minimum, be for six months from the date an individual newly enrolls in the BHO and has an established and active relationship with a case manager. The BHO must ensure an adequate provider network, but is not required to maintain contracts with all providers.

Timely access to behavior health services at the member's location is a key component of effective case management. Timely access shall include 24 hours availability of case

management services. Member's location may include: Emergency Department, doctor's office, or anywhere in the community.

40.210 System Description

Upon enrollment in the BHO, each member shall be assigned to a case manager. The BHO shall have a Case Management (CM) system to:

- Provide the member with clear and adequate information on how to obtain services and make informed decisions about their own behavioral health, employment and supportive housing needs;
- Provide comprehensive case assessment, case planning, ongoing quarterly monitoring of progress toward goals and support towards reaching those goals;
- Face-to-face comprehensive assessment, psychological or psychiatric assessment, and substance use screening on a new BHO member shall occur within fourteen (14) calendar days of enrollment into the program;
- Face-to-face reassessments shall be completed at least annually or sooner if medically necessary;
- Assure development of Individualized Treatment Plan (ITP);
- Initial ITP shall be developed and implemented within fourteen (14) calendar days of completing the face-to-face comprehensive assessment after enrollment into the program;
- ITPs shall be updated every six (6) months or sooner if medically necessary to include a significant change;
- Provide skills development in problem-solving and other skills to remain in/return to the community including housing stabilization and supported employment;
- Ensure crisis resolution;
- Coordinate and integrate the members' medical and behavioral health care and services with their health plan,

behavioral health provider, primary care provider, and other providers/agencies as needed;

- Achieve continuity of members' care and cost effective delivery of services;
- Assist the member to obtain behavioral health interventions, prescribed by the interdisciplinary team as appropriate, and ensure that these services are received and provided in a timely manner;
- Coordinate provision of supportive housing and supported employment activities and services with the goal of promoting community integration, optimal coordination of resources and self-sufficiency for members who meet the eligibility requirements for supportive housing services and/or supportive employment services.
- Ensure that an active, assertive system of outreach is in place to provide the flexibility needed to reach those members requiring services, such as the homeless or others, who might not access services without intervention due to language barriers, acuity of condition, dual diagnosis, physical/visual/hearing impairments, intellectual disability, lack of transportation;
- Facilitate member compliance with recommended medical and behavioral health treatment; and
- Assist members with DHS eligibility requirements (for example, verifications) and compliance.

The BHO must demonstrate that it has a CM system to ensure that all members receive all necessary covered behavioral health services in a person-centered manner. A person-centered manner includes individually identified goals and preferences related to choice of relationships, community participation, employment, access to personal finances, healthcare and wellness, education and others. It shall also promote personal independence.

Specifically, the CM services include member assessment and substance use screening, treatment planning, service linkage and coordination, monitoring and member advocacy (such as completing and filing an application for financial assistance, maintaining Medicaid eligibility and supportive housing pre-

tenancy and tenancy assistance). The level of management will vary in scope and frequency depending on the member's intensity of need.

The BHO shall perform an initial face-to-face comprehensive assessment of each enrolled member to determine and document the behavioral health and case management needs of the individual. The comprehensive assessment shall be conducted within fourteen (14) calendar days of enrollment into the BHO. If an individual loses eligibility or disenrolled for other reasons and is requesting re-enrollment into the BHO within six (6) months, a comprehensive assessment does not need to be conducted upon re-enrollment unless it has been six (6) months since the last assessment.

40.220 CM Policies

The BHO shall have policies and procedures for coordination, cooperation and transition with community programs that provide services to eligible BHO members. In the event an eligible individual will be transferred into the CCS program from another agency or community program, the BHO shall work with such agency or community program (for example, DOH-CAMHD, DOH-AMHD, DOH-DD, the State Hospital, or prison) to manage and ensure a smooth transition for the individual.

In cases where the member has indicated that he/she is receiving services, which are behavioral health benefits, the BHO shall evaluate and determine whether the service is medically necessary. A standard functional assessment form shall be used to determine the types of services the CCS members will receive. BHO may use its standard functional assessment form while the State is developing the official form.

The BHO's policies and procedures regarding CM information shall include:

- How persons (members, family members/guardians, community providers and providers) with proper authorization will access the case management system for member services or inquiries.
- How it will ensure continuity of care with existing case management agencies and ensure the BHO will be able to contract for these services.

- A description and a copy of the plan's assessment tool, which shall include substance use screening, that will be used to gather information on the member as well as the frequency of review and updating of the tool (i.e., period of time between reassessment of tool). The assessment tool shall be subject to approval by DHS.
- How information will be exchanged between the BHO, the health plan, the member's PCP, and other service providers, including non-contracted providers.
- How the BHO will notify the member's PCP of significant changes, sentinel events or crisis situations within 72 hours or sooner.
- How the CM will coordinate with other providers to implement the ITP (see Section 40.230)
- A Description of CM activities reporting plan to include:
    - Encounters including, but not limited to, documentation of physical efforts to locate difficult to contact members
    - Outcomes
    - Notification to health plans
    - Emergency Department visits
    - Hospital admissions
    - Discharge planning
    - Follow up to prevent hospital readmission.
- A description of proposed caseload assignments for each CM classification, as well as policies and procedures for providing CM as they relate to the member's needs as follows:

Case Load (licensed case managers)	**Case Load (unlicensed case managers)**	**Supervision**
○ Maximum of forty (40) CCS members in their case load. ○ Case managers with several members that	○ Maximum of twenty-five (25) CCS members in their case load. ○ Case managers with several members that	Eight (8)** unlicensed case managers caring for no more than 200 CCS members.

are either High Intensive or Intensive shall have a lower case load than forty (40) based upon needs of their members. o Any licensed case manager who has a case load cannot also supervise unlicensed case managers.	are either High Intensive or Intensive shall have a lower case load than twenty-five (25) based upon needs of their members.	
**Should case managers have a lower case load than the maximum allowed, supervision can be for up to ten (10) unlicensed case managers; however, the maximum number of members allowed per supervisor remains unchanged.		

- Case managers: unlicensed case managers shall be supervised by a Qualified Mental Health Professional (QMHP) to include: Licensed Physician, Psychologist, Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Mental Health Counselor (LMHC), or Advanced Practice Registered Nurse (APRN).
- A description of the CM staffing including job descriptions of the case managers, qualifications, and the type of initial and/or ongoing training and education that it will provide to its case managers.
- If CM services are to be subcontracted, submit to DHS for prior approval, the proposed subcontract for the provision of CM services. An oversight and training plan for subcontractors must also be submitted to DHS for prior approval.
- The BHO shall provide CM services upon CCS enrollment until a CM agency is chosen by the member.
- The BHO may choose to subcontract out CM services however; BHO must internally have a CM service team to provide including but not limited to intensive case management to members assessed at Acuity Level V.
- The BHO CM service team shall be comprised of the following: psychiatrist, case managers, nurses, and have access to

Certified Substance Abuse Counselors (CSAC). The psychiatrist shall be separate from the BHO's medical director.

- CM providers shall have a psychiatrist or APRN-RX on staff or contracted to ensure access to direct clinical support and services to their members upon assignment and for ongoing care. They shall also have access to CSAC services to meet member needs.
- CM providers assigned to the member shall be available 24/7 to respond to after hour telephone crisis calls.
- CM providers assigned to the member shall be required to respond, as necessary, within 1.5 hours to crisis situations in the community or EDs to provide in-person support and possible prevention of unnecessary hospitalization.

In addition, the CM system shall function to assist the providers in the plan's network to provide the care needed to bring the member to an optimum level of recovery/functioning with maximum autonomy, and to prevent relapse. Therefore, the system must be readily accessible to the member, not to place unnecessary burdens on the health plan and BHO providers, or compromise good behavioral health care. At a minimum, the plan shall have policies and procedures in place for:

- Providing case management to include coordination of behavioral health and substance use disorder services included in an individual's ITP, as well as coordination of behavioral health and medical services
- Referring members to other programs or agencies
- Changing case managers
- Changing case management providers
- Identifying levels of case management according to member needs using a service level scoring method approved by the DHS and ensuring the required monthly face-to-face case manager contact.
- Definitions of the levels of CM to be employed and a description of the standards for determining the level of CM a member shall receive relative to a continuum with

classifications ranging from routine to intensive/complex case management including frequency and type of case management contact. CM services that are considered appropriate to list as encounters include: face-to-face contact with member/family, other involved service providers, telephone calls involving direct communication with the person being called (does not include attempts to get in touch, leaving messages for call backs), and travel time (actual time spent in taking a member to/from places which must be treatment related). See chart below that provides additional description of CM levels that will be based on the DHS approved service level scoring method. The following are the minimum service requirements that may be exceeded as needed on a case-by-case basis.

Case Management Frequency Service Requirements

Service Level	Minimum Service Contact Requirement
V. Specialized Intensity	Face-to-face three (3) times per week
IV. High Intensity	Face-to-face two (2) times per week
III. Intensive	Face-to-face one (1) time per week
II. Intermediate	Face-to-face every other week
I. Routine	Face-to-face one (1) time per month

- Outreach and follow-up activities, especially for members with special needs (i.e., SUD, homeless, disabled, and homebound members)
- Provide in-person follow-up with members post behavioral health ED visit within 72 hours
- Provide documentation and data reporting of CM services, encounters and outcomes and adverse event reports.
- Providing continuity of care when members transition to other programs (i.e., health plan, fee-for-service program, Medicare, new services in the treatment plan, new housing/living arrangement)

- Ensure continuity of care when members entering into the BHO have an established relationship with a case manager as described in the transition of care section.

40.230 Individualized Treatment Plan (ITP)

An ITP shall be developed for each BHO member, requiring non-emergent treatment, within fourteen (14) calendar days of the comprehensive assessment conducted upon enrollment. When inpatient treatment is required, the assessment and ITP shall be developed within the timeframes below:

- Acute inpatient treatment – generated or updated within 24-hours of admission; and
- Alternative inpatient treatment – within 48 hours of admission.

The BHO shall develop the ITP to contain all necessary services identified by the interdisciplinary team, which includes the health plan, if applicable. These services shall include but not be limited to services provided by psychiatrists, psychologists, social workers, advance practice nurses, Certified Substance Abuse Counselors, and case managers. The case manager is responsible for development and implementation of the ITP in coordination with the referring agency (i.e., DOH-CAMHD, DOH-AMHD, DOH-DD), PCP, and other involved persons as necessary. The treatment plan must be in accord with any applicable State quality assurance and utilization review standards.

The BHO shall have policies and procedures for the ITP process that shall include the forms to be used to document the ITP.

The ITP shall also specify the level of CM services necessary (including minimum frequency of follow-up with the member) and shall minimally include: identification of all necessary services according to the CM and other members of the interdisciplinary team, problems, goals, interventions/services to address each problem, frequency/amount and duration of services, and responsible person(s)/disciplines/agency(s) for each intervention.

The BHO shall ensure the opportunity for meaningful participation by the member or their representative, and as appropriate, family members/significant others, and other

informal caregivers, in the ITP development, modification, treatment, and the treatment plan meetings (provided the member or their representative has provided written consent to allow these individuals to participate in the treatment and ITP activities described in this section).

The ITP shall be reviewed and updated proportional to the intensity and restrictiveness of the level of care, at least every six (6) months or more frequently if clinically necessary.

40.240 Coordination of Case Management

BHO shall schedule monthly meetings on case references with the case managers, service coordinators, health plans, other state agencies and MQD representative. Attendance by MQD representative to this meeting will be decided on a monthly basis.

40.300 Provider Network

40.305 General Provisions

The BHO shall have their own provider network for provision of behavioral health services for their members. In-person services shall be available 24 hours a day, 7 days a week, throughout the State.

The BHO needs to contract with enough providers for their members to have timely access to medically necessary behavioral health services. The BHO's provider network shall meet network adequacy no later than sixty (60) days prior to the Contract Effective Date as specified in Section 20.100.

The BHO may not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If the BHO declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. The BHO shall not discriminate against providers serving high-risk populations or those that specialize in conditions requiring costly treatments. This is not to be construed as: (1) requiring that the BHO contract with providers beyond the number necessary to meet the needs of its members: (2) precluding the BHO from using

different reimbursement amounts for different specialties or for different practitioners in the same specialty; or three (3) precluding the BHO from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members. The BHO is not required to contract with every willing provider. The BHO shall have written policies and procedures for the selection and retention of providers.

The BHO is responsible for assuring that members have access to providers listed below. Members shall have choice of available behavioral health providers within the BHO's provider network in their geographic area. If the BHO's network is unable to provide adequate behavioral health services to a particular member within its network or on the island of residence, the BHO shall adequately, and in a timely manner, provide these services out-of-network or transport the member to another island to access the covered services for as long as the BHO's network is unable to provide the member with behavioral health services on the island of residence as described in Section 40.900.

The BHO shall notify the out-of-network providers providing covered services to its members that payment by the BHO is considered as "payment-in-full" and that those providers cannot "balance bill" the members for the covered services. The BHO is prohibited from charging the member more than it would have if the covered services were furnished within the network.

Payment shall be effected through the BHO. The BHO shall ensure that providers will expeditiously act on prior authorizations for services and provide the required behavioral health services to the BHO members. The BHO bears the responsibility of ensuring services are provided.

The BHO shall ensure the provision of the following services, including, but not limited to:

- Behavioral healthcare specialist services as provided by psychiatrists, psychologists, social workers, certified substance abuse counselors, and advance practice nurses trained in psychology
- Case management

- Inpatient behavioral health hospital services
- Outpatient behavioral health hospital services
- Mental health rehabilitation services
- SUD services
- Day treatment programs
- Psychosocial rehabilitation (PSR)/Clubhouse
- Residential treatment programs
- Pharmacies
- Laboratory Services
- Crisis services: mobile crisis response and crisis residential services
- Interpretation services
- Supportive housing
- Representative payee
- Supported employment
- Peer Specialist (a Peer Specialist is someone who has gone through the same or similar life experience as the member, and will collaborate with the Community Health Worker to address the member's needs in a holistic manner)

DHS reserves the right to include additional behavioral health services as needed.

40.310 Provider Credentialing, Recredentialing and Other Certification

The BHO will follow the most current NCQA credentialing and recredentialing standards including delegation and provider monitoring/oversight, but reserves the right to require approval of standards and thresholds set by the organization (e.g. with regards to performance standards, office site criteria, medical record keeping, complaints triggering on-site visits). The BHO must also meet requirements of the RFP related to appointment availability (Section 40.325) and medical record keeping (Section 40.320).

The BHO shall ensure each behavioral health provider's service delivery site meets all applicable requirements of law and has the necessary and current licenses, certification, accreditation, or designation approval per State requirements. When individuals providing behavioral health treatment services are not required to be licensed or certified, it is the responsibility of the BHO to ensure, based on applicable State licensure rules and/or program standards, that they are appropriately educated, trained, qualified, and competent to perform their job responsibilities.

The BHO shall ensure that all contracted facilities including, but not limited to, hospitals, are licensed as required by the State.

The BHO shall ensure that all contracted providers including, but not limited to, therapists, meet State licensure requirements.

The BHO shall require that all contracted laboratory testing sites providing services under this RFP have either a current Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver shall provide only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests. The BHO shall comply with the provisions of CLIA 1988. The BHO shall ensure that its providers submit full disclosures as identified in 42 CFR Part 455, Subpart B. Disclosures shall include:

1. (i) The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address;

   (ii) Date of birth and Social Security Number of each person with an ownership or control interest in the disclosing entity; and

   (iii) Other tax identification number of each corporation with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has a five (5) percent or more interest.

2. Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person with an ownership or control interest in any subcontractor in which the disclosing entity has a five (5) percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.
3. The name of any other disclosing entity in which an owner of the disclosing entity has an ownership or control interest.
4. The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity.
5. The identity of any individual who has an ownership or control interest in the provider, or is an agent or managing employee of the provider, 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.

The BHO shall obtain disclosures from its providers at the following times:

- When the provider submits a provider application;
- Upon execution of the provider agreement;
- During recredentialing;
- Upon request from the health plan or DHS; and
- Within thirty-five (35) days after any change in ownership of the disclosing entity information to the health plan.

The provider shall submit, within thirty-five (35) days of the date on a request by the health plan, the DHS, or the Secretary full and complete information about:

- The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and
- Any significant business transactions between the provider and any wholly owned supplier, or between the provider and

any subcontractor, during the 5-year period ending on the date of the request.

The health plan may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the Title XX Services Program. In addition, the health plan may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required above.

The BHO shall notify DHS through its Provider Suspension and Termination report identified in Section 50.840.3 of any providers that the health plan refuses to enter into or renew an agreement.

The BHO shall submit its credentialing, recredentialing and other certification policies and procedures to MQD for review and approval by the due date identified in Section 51.400, Readiness Review.

40.315 Provider Contracts

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

1. Specify covered populations and specifically cite the CCS program;
2. Specify covered services;
3. Specify rates of payment;
4. Prohibit the provider from seeking payment from the member for any covered services provided to the member within the terms of the contract and require the provider to look solely to the BHO for compensation for services rendered, with the exception of cost sharing pursuant to the Hawaii Medicaid State Plan;
5. Prohibit the provider from imposing a no-show fee for CCS program members who were scheduled to receive a Medicaid covered service;

6. Require the provider to cooperate with the BHO's quality improvement activities;

7. Require that providers meet all applicable State and Federal regulations, including but not limited to all applicable HAR sections, and Medicaid requirements for licensing, certification and recertification;

8. Require the provider to cooperate with the BHO's utilization review and management activities;

9. Not prohibit a provider from discussing treatment or non-treatment options with members that may not reflect the BHO's position or may not be covered by the BHO;

10. Not prohibit, or otherwise restrict, a provider from acting within the lawful scope of practice, from advising the member and advocating on behalf of a member for the member's health status, medical care, or treatment or non-treatment options, including any alternative treatments that might be self-administered;

11. Not prohibit, or otherwise restrict, a provider from advising the member and advocating on behalf of the member to obtain necessary healthcare services in any grievance system or utilization review process, or individual authorization process;

12. Require providers to meet appointment waiting time standards pursuant to the terms of this contract and as described in Section 40.325;

13. Provide for continuity of treatment in the event a provider's participation terminates during the course of a member's treatment by that provider except in the case of adverse reasons on the part of the provider;

14. Require that providers comply and maintain the confidentiality of member's information and records as required by law, including but not limited to privacy and security regulations adopted under HIPAA and HRS;

15. Keep any records necessary to disclose the extent of services the provider furnishes the members;

16. Specify that CMS, the State Medicaid Fraud Control Unit, and the DHS or their respective designee shall have the right to inspect, evaluate, and audit any pertinent books, financial records, medical records, documents, papers, and

records of any provider involving financial transactions related to this contract and for the monitoring of quality of care being rendered without the specific consent of the member;

17. Require providers that are compensated by capitation payments submit complete and accurate encounter data on a monthly basis and any and all medical records to support encounter data upon request from the BHO without the specific consent of the member, DHS or its designee for the purpose of validating encounters, if applicable;
18. Require provider to certify claim/encounter submissions to the plan as accurate and complete;
19. Require the provider to provide medical records or access to medical records to the BHO and the DHS or its designee, within sixty (60) days of a request. Refusal to provide medical records, access to medical records or inability to produce the medical records to support the claim/encounter shall result in recovery of payment;
20. Specify acceptable billing and coding requirements;
21. Require that providers comply with the BHO's cultural competency plan;
22. Require that the provider maintain the confidentiality of members' information and records as required by the RFP and in federal and state law, including but not limited to:
    a. The Administration Simplification (AS) provisions of HIPAA, Public Law 104-191 and the regulations promulgated thereunder, including but not limited to 45 CFR Parts 160, 162, 164, if the provider is a covered entity under HIPAA;
    b. 42 CFR Part 431 Subpart F;
    c. HAR Chapter 17-1702;
    d. HRS Section 346-10;
    e. 42 CFR Part 2;
    f. HRS Section 334-5; and
    g. HRS Chapter 577A.

23. Require that providers not employ or subcontract with individuals or entities whose owner or managing employees are on the state or federal exclusions list;

24. Prohibit providers from making referrals for designated health services to healthcare entities with which the provider or a member of the provider's family has a financial relationship;

25. Require providers of transitioning members to cooperate in all respects with providers of other agencies, organizations, or health plans to assure maximum health outcomes for members;

26. Require the provider to comply with corrective action plans initiated by the BHO;

27. Specify the provider's responsibilities regarding third party liability;

28. Require the provider to comply with the BHO's compliance plan including all fraud and abuse requirements and activities;

29. Require that providers accept members for treatment, unless the provider applies to the BHO for a waiver of this requirement;

30. Require that the provider provide services without regard to race, color, creed, ancestry, sex, including gender identity or expression, sexual orientation, religion, health status, income status, or physical or mental disability;

31. Require that providers consider enrollee rights when furnishing services; Require that providers offer hours of operation that are no less than the hours of operation offered to commercial members or, if the provider has no commercial members, that the hours of operation are comparable to hours offered to recipients under Medicaid fee-for-service;

32. Require that providers offer access to interpretation services for members that have a Limited English Proficiency (LEP) at no cost to the member, and to document the offer and provision of interpreter services to the same extent as the BHO under the Contract;

33. Require that each provider have a contact number available with live person answering crisis calls 24/7 for members;

34. Require that providers have a permanent site available for members to meet or contact CMs during normal operating hours;

35. Require that providers have case managers to respond in-person 24/7 to crisis situations in the community, ED or for MH-1s, to provide support, and assess for possible prevention of unnecessary hospitalization;

36. Include a statement that the State and the BHO members shall bear no liability for the BHO's failure or refusal to pay valid claims of subcontractors or providers for covered services;

37. Include a statement that the State and the BHO members shall bear no liability for services provided to a member for which the State does not pay the BHO;

38. Include a statement that the State and the BHO members shall bear no liability for services provided to a member for which the plan or State does not pay the individual or healthcare provider that furnishes the services under a contractual, referral, or other arrangement to the extent that the payments are in excess of the amount that the member would owe if the BHO provided the services directly;

39. Require the provider to secure all necessary liability and malpractice coverage as is necessary to protect the BHO's members and the BHO;

40. Require that the provider use the definition for emergency medical condition included in the Medicaid provider manual;

41. Require that the provider provides copies of medical records to requesting members and allows them to be amended as specified in 45 CFR Part 164;

42. Require that the provider provide record access to any authorized DHS personnel or personnel contracted by the DHS without member authorization so long as the access to the records is required to perform the duties of the contract with the State and to administer the CCS program;

43. Require that the provider complies with BHO standards that provide the DHS or its designee(s) prompt access to members' medical records whether electronic or paper;

44. Require that the provider comply with the advance directives requirements specified in 42 CFR Part 49, subpart I, and 42 CFR Section 417.436(d), if applicable;

45. Require all Medicaid related records be retained in accordance with 42 CFR Section 438.3(u), for a minimum of ten (10) years after the last date of entry in the records. For minors, records must be preserved and maintained during the period of minority plus a minimum of ten (10) years after the minor reaches the age of majority;

46. Require that the provider complies with all credentialing and re-credentialing activities; and

47. Require that the provider is licensed in good standing, in the State of Hawaii.

48. Require that provider comply with disclosure requirements identified in accordance with 42 CFR Part 455, Subpart B found in Section 40.310.

The BHO may utilize an addendum to an already executed provider contract if the addendum and the provider agreement together include all requirements to the provider contract. In addition, it must be clearly stated that if language in the addendum and the provider agreement conflict, the language in the addendum shall apply.

The BHO shall submit to the DHS for review and approval a model for each type of provider contract by the due date identified in Section 51.400, Readiness Review, and at the DHS's request at any point during the contract period.

In addition, the BHO shall submit to the DHS, prior to the Contract Effective Date identified in Section 20.100 the signature page of all finalized and executed contracts.

The BHO shall continue to solicit provider participation throughout the contract term should provider network deficiencies develop.

Requirements for contracts with subcontractors (non-providers) are addressed in Section 60.300.

40.320 Review of Medical Records

As part of its Quality Improvement Program, the BHO shall establish medical records standards as well as a record review system to assess and assure conformity with standards. These standards shall be consistent with the minimum standards established by the DHS identified below:

- Require that the medical record is maintained by the provider;
- Assure that DHS personnel or personnel contracted by the DHS shall have access to all records, as long as access to the records are needed to perform the duties of this contract for information released or exchanged pursuant to 42 CFR Section 431.300. The BHO shall be responsible for being in compliance with any and all State and Federal laws regarding confidentiality;
- Provide DHS or its designee(s) with prompt access to members' medical records;
- Provide members with the right to request and receive a copy of his or her medical records, and to request they be amended, as specified in 45 CFR Part 164; and
- Allow for paper or electronic record keeping.

As part of the record standards, the BHO shall require that providers adhere to the following requirements:

- All medical records are maintained in a detailed and comprehensive manner that conforms to good professional medical practice;
- All medical records are maintained in a manner that permits effective professional medical review and medical audit processes;
- All medical records are maintained in a manner that facilitates an adequate system for follow-up treatment;
- All medical records shall be legible, signed and dated;
- Each page of the paper or electronic record includes the patient's name or ID number;

- All medical records contain member demographic information, including age, sex, address, home and work telephone numbers, marital status and employment, if applicable;
- All medical records contain information on any adverse drug reactions and/or food or other allergies, or the absence of known allergies, which are posted in a prominent area on the medical record;
- All forms or notes have a notation regarding follow-up care, calls or visits, when indicated;
- All medical records contain the member's past medical history that is easily identified and includes serious accidents, hospitalizations, operations and illnesses. All medical records include the provisional and confirmed diagnosis(es);
- All medical records contain medication information;
- All medical records contain information on the identification of current problems (i.e., significant illnesses, medical conditions and health maintenance concerns);
- All medical records contain information about consultations, referrals, and specialist reports;
- All medical records contain information about emergency care rendered with a discussion of requirements for physician follow-up;
- All medical records contain discharge summaries for: (1) all hospital admissions that occur while the member is enrolled; and (2) prior admissions as appropriate;
- All medical records include documentation as to whether or not the member has executed an advance directive, including an advance mental health care directive;
- All medical records shall contain written documentation of a rendered, ordered or prescribed service, including documentation of medical necessity; and
- All medical records shall contain documented member visits, which includes, but is not limited to:
    - A history and physical exam;

- Treatment plan, progress and changes in treatment plan;
- Laboratory and other studies ordered, as appropriate;
- Working diagnosis(es) consistent with findings;
- Treatment, therapies, and other prescribed regimens;
- Documentation concerning follow-up care, telephone calls or visits, when indicated;
- Documentation reflecting that any unresolved concerns from previous visits are addressed in subsequent visits;
- Documentation of any referrals and results thereof, including evidence that the ordering physician has reviewed consultation, lab, x-ray, and other diagnostic test results/reports filed in the medical records and evidence that consultations and significantly abnormal lab and imaging study results specifically note physician follow-up plans;
- Hospitalizations and/or Emergency Department visits, if applicable; and
- All other aspects of patient care, including ancillary services.

As part of its medical records standards, the BHO shall ensure that providers facilitate the transfer of the member's medical records (or copies) to the new provider within seven (7) business days from receipt of the request.

As part of its medical records standards, the BHO shall comply with medical record retention requirements in Section 60.400.

The BHO shall submit its medical records standards to the State by the due date identified in Section 51.400, Readiness Review.

40.325 Provider Availability

The BHO shall monitor the number of members cared for by its providers and shall ensure timely access to medically necessary behavioral health services and to maintain quality of care. The BHO shall have a sufficient network to ensure members can obtain needed health services within the acceptable wait times. The acceptable wait times are:

- Emergency medical situations - Immediate care (twenty-four (24) hours a day, seven (7) days a week) and without prior authorization;
- Behavioral health provider visits (urgent) - Appointments within seventy-two (72) hours; and
- Behavioral health provider visits (standard) - Appointments within twenty-one (21) days.

The BHO shall ensure that:

- Network providers accept members for treatment unless the provider has requested a waiver from this provision and the BHO has received a waiver from the DHS;
- Network providers do not segregate members in any way from other persons receiving services, except for health and safety reasons;
- Members are provided services without regard to race, color, creed, ancestry, sex, including gender identity or expression, sexual orientation, religion, health status, income status, or physical or mental disability; and
- Network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to hours offered to members under Medicaid fee-for-service, if the provider has no commercial members.

The BHO shall establish policies and procedures to ensure that network providers comply with these acceptable wait times; monitor providers regularly to determine compliance; and take corrective action if there is a failure to comply. The BHO must post and maintain on the internet an accurate listing of participating providers and who is accepting new patients. The BHO shall submit these availability of providers policies and procedures as required in Section 51.400, Readiness Review.

40.330 Geographic Access of Providers

In addition to maintaining in its network a sufficient number of providers to provide all services to its members, the BHO shall meet the following geographic access standards for all members:

	Urban*	**Rural**
Hospitals	30 minute driving time	60 minute driving time
Emergency Services Facilities	30 minute driving time	60 minute driving time
Mental Health Providers	30 minute driving time	60 minute driving time
Pharmacies	15 minute driving time	60 minute driving time
24-Hour Pharmacy	60 minute driving time	N/A

*Urban is defined as the Honolulu metropolitan statistical area (MSA).

All travel times are maximums for time it takes a member, in normal traffic conditions, using usual travel means in a direct route to travel from his or her home to the provider.

The BHO may submit to the DHS a formal written request for a waiver of these requirements for areas where there are no providers within the required driving time after contract award. In such situations, the DHS may waive the requirement entirely or expand the driving time. The BHO may also submit to the DHS a formal written request for a waiver of these requirements if it is unable to enter into an agreement with a specialty or ancillary service provider within the required driving time. In such situations, the DHS may waive the requirement entirely or expand the driving time.

40.335 Fraud, Waste, and Abuse

The BHO shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud, waste, and abuse activities. In addition, as part of these internal controls and policies and procedures, the BHO shall have ways to verify services were actually provided using random sampling of all members. The BHO shall have resources to investigate unusual incidents and develop and implement corrective action plans to assist the BHO in preventing and detecting potential fraud, waste, and abuse activities. The BHO's fraud, waste, and abuse activities shall comply with the program integrity requirements outlined in 42 CFR Section 438.608.

All suspected fraud, waste, and abuse committed by a member should be reported to the appropriate entity. The BHO shall report eligibility fraud for, medical assistance, financial assistance, or Supplemental Nutrition Assistance Program (SNAP) should be reported to the Investigations Office (INVO) of the Benefit, Employment and Support Services Division (BESSD). The reporting shall be done either through written notification or a telephone call to INVO Hotline. Fraudulently obtaining controlled substances, other medical services, or collusion between provider and member to obtain services would be reported to MQD.

The BHO and all subcontractors shall cooperate fully with federal and state agencies in investigations and subsequent legal actions. Such cooperation shall include providing, upon request, information, access to records, and access to interview BHO employees and consultants, including but not limited to those with expertise in the administration of the program and/or medical or pharmaceutical questions or in any matter related to an investigation.

40.335.1 Reporting and Investigating Suspected Provider Fraud Waste, and Abuse

If the BHO becomes aware of suspected fraud, waste or abuse from any source or identifies any questionable practices, it shall conduct a preliminary investigation. Criminal intent to commit fraud is not determined by either the MQD or the BHO. Based on all the evidence gathered, the MQD or the BHO only determines that an identified activity has the potential to be fraudulent and is not the result of an unintentional error. The BHO is required to report all plausible incidences of suspected fraud, waste, or abuse to the MQD, promptly, within fourteen (14) calendar days of making such a determination. It is possible the BHO may need to report the suspected activity immediately, such as when patient safety is at risk, evidence is being destroyed, or there is ongoing significant monetary loss.

The BHO shall use the report form to be provided by the DHS to report or refer suspected cases of Medicaid fraud, waste, or abuse. At a minimum, this form shall require the following information for each case:

- Subject (Name and ID number);

- Source of complaint;
- Type of provider;
- BHO contact;
- Contact information for BHO staff with practical knowledge of the workings of the relevant programs;
- Date reported to state;
- Description of suspected intention misconduct, with specific details;
    - Category of service.
    - Factual explanation of the allegation. The BHO should provide as much detail as possible concerning the names, positions and contact information of all relevant persons; a complete description of the alleged scheme as it is understood by the BHO, including, when possible, one or more examples of specific claims that are believed to be fraudulent; the manner in which the BHO came to learn of the conduct; and the actions taken by the BHO to investigate the allegations.)
    - Date(s) of conduct. (When exact dates are unknown, the BHO should provide its best estimate.)
- Specific statutes, rules, regulations, or policies violated includes all applicable for Federal/Medicaid as well as BHO policies;
- Amount paid to the provider during the past 3 years or during the period of the alleged misconduct, whichever is greater;
- Sample/exposed dollar amount when available;
- Legal and administrative disposition of the case; and
- Copies of any and all communications between the BHO and the provider concerning the conduct at issue (including, provider enrollment documentation, and any education given to the provider as a result of past problems; as well as advisory bulletins, policy updates, or

any other general communication to the provider community regarding questionable behavior. Letters, emails, faxes, memos, and phone logs are all sources of communication).

In addition to the information required on the form, this report shall include any and all evidence obtained in the preliminary investigation including but not limited to, copies of claims and medical records reviewed, summary of interviews conducted, and copies of audit results or review board determinations.

Once the BHO has determined the activity has the potential to be fraudulent, it shall not contact the provider who is the subject of the investigation about any matters related to the investigation, enter into or attempt to negotiate any settlement or agreement, or accept any monetary or other thing of valuable consideration offered by the provider who is the subject of the investigation in connection with the incident.

If the provider is not billing appropriately, but the BHO has found no evidence of fraud or abuse, the BHO shall provide education and training to the provider in question. In addition, the BHO is required to recover or report all overpayments. "Overpayment" as used in this section is defined in 42 CFR 438.2. All overpayments identified by the BHO shall be reported to DHS as specified in section 50.800. The overpayment shall be reported in the reporting period in which the overpayment is identified. It is understood the BHO may not be able to complete recovery of overpayment until after the reporting period. The BHO must report to DHS the full overpayment identified. The BHO may negotiate and retain a lesser repayment amount with the provider, however, the full overpayment amount will be used when setting capitation rates for the BHO. The BHO shall also maintain documentation of the education and training provided in addition to reporting the recovered amounts. The BHO shall have in place a process for providers to report to the BHO when it has received an overpayment, and a process for the provider to return the overpayment to the BHO within (sixty) 60 calendar days after the date on which the overpayment was identified. The BHO shall require the provider to notify the BHO in writing of the reason for the overpayment. DHS, or its contractor, may recover any overpayments made to the BHO, and the method of recovery shall be determined by DHS. A summary report shall be provided on a report form provided by the DHS.

The BHO shall also report annually to DHS on all recoveries as specified in section 50.800. This report will specify overpayments identified as fraud, waste, and abuse. The BHO will check the reporting of overpayments recoveries for accuracy and will provide such accuracy report to the DHS upon request. The BHO will certify that the report contains all overpayments and those overpayments are reflected in either the claims data submitted in the report, or listed as an itemized recovery.

The BHO is prohibited from recovering overpayments that are being investigated by the State, are the subject of pending Federal or State litigation or investigation, or are being audited by the Hawaii Recovery Audit Contractor (RAC) or other State contracted auditor. Once the BHO receives notice from DHS or other State or Federal agency of such action, the BHO will cease any ongoing recovery efforts and coordinate with the notifying agency. Recoveries retained under False Claims Act cases or through other investigations are not subject to this policy.

If DHS determines there is a credible allegation of fraud against a provider, payments to the provider must be suspended absent a good cause exception. DHS will be responsible for the determination of a credible allegation of fraud and any good cause exception. The DHS will notify the BHO in writing if payments to a provider are to be suspended and the effective date of the payment suspension. The BHO will have in place policies and controls to prevent payments to providers under payment suspension. DHS will notify the BHO in writing if the payment suspension may be terminated. If the BHO fails to suspend payments to a provider after being notified in accordance with this section, any payments made to the provider during the effective suspension may be recovered from the BHO, and sanctions may be imposed in accordance with Section 50.810.

40.335.2 Compliance Plan

The BHO shall have a written fraud, waste, and abuse compliance plan that shall have stated program goals and objectives, stated program scope, and stated methodology. Refer to CMS publications: "Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care", A product of the National Medical Fraud and Abuse Initiative, October 2000 as well as the

CMS publication: "Guidelines for Constructing a Compliance Program for Medicaid and Prepaid Health Plans", a product of the Medicaid Alliance for Program Safeguards, May 2002 for reference regarding Compliance Plans. The BHO shall submit its compliance plan to the DHS for review and approval by the due date identified in Section 51.400, Readiness Review.

At a minimum, the BHO's fraud, waste, and abuse compliance plan shall:

- Require the reporting of suspected and/or confirmed fraud, waste, and abuse be done as required in Sections 40.335 and 40.335.1;
- Submit BHO disclosures timely as described in Section 40.310;
- Ensure that all of its officers, directors, managers and employees know and understand the provisions of the health plan's fraud, waste, and abuse compliance plan;
- Have processes in place to monitor all providers and their officers/directors/agents/managing employees as described in Sections 40.305 and 40.310;
- Require the designation of a compliance officer and a compliance committee that are accountable to senior management;
- Ensure and describe effective training and education for the compliance officer and the organization's employees;
- Ensure that providers and members are educated about fraud, waste, and abuse identification and reporting, and include information in the provider and member material;
- Ensure effective lines of communication between the compliance officer and the organization's employees;
- Ensure the enforcement of standards through well-publicized disciplinary guidelines;
- Ensure provision of internal monitoring and auditing with provisions for prompt response to potential offenses, and for the development of corrective action initiatives relating to the BHO's fraud, waste, and abuse efforts;
- Possess written policies, procedures and standards of conduct that articulate the organization's commitment to

comply with all Federal and State standards related to Medicaid managed care organizations;

- Ensure that no individual who reports BHO violations or suspected fraud, waste, and abuse is retaliated against;
- Include a monitoring program that is designed to prevent and detect potential or suspected fraud, waste, and abuse. This monitoring program shall include but not be limited to:
    - Monitoring the billings of its providers to ensure members receive services for which the BHO is billed;
    - Requiring the investigation of all reports of suspected fraud and over billings (upcoding, unbundling, billing for services furnished by others, and other overbilling practices);
    - Reviewing providers for over-utilization or under-utilization;
    - Verifying with members the delivery of services as claimed; and
    - Reviewing and trending consumer complaints on providers;
- Ensure that all suspected instances of internal and external fraud, waste, and abuse relating to the provision of, and payment for, Medicaid services including, but not limited to, BHO employees/management, providers, subcontractors, vendors, be reported to DHS. Additionally, any final resolution reached by the BHO shall include a written statement that provides notice to the provider that the resolution in no way binds the State of Hawaii nor precludes the State of Hawaii from taking further action for the circumstances that brought rise to the matter; and
- Ensure that the BHO shall cooperate fully in any investigation by federal and state oversight agencies and Federal and State law enforcement agencies and any subsequent legal action that may result from such an investigation.

40.335.3 Employee Education About False Claims Recovery

The BHO shall comply with all provisions of Section 1902(a)(68) of the Social Security Act as it relates to establishing written policies for all employees (including management), and of any subcontractor or designee of the BHO, that includes the information required by Section 1902(a)(68) of the Social Security Act.

40.335.4 Adult Abuse Reporting Requirements

The BHO shall report all cases of suspected dependent adult abuse to the Adult Protective Services Section of the DHS as required by State and Federal statutes.

The BHO shall ensure that its network providers report all cases of suspected dependent adult abuse to the Adult Protective Services Section of the DHS as required by State and Federal statutes.

40.340 Provider and Subcontractor Reimbursement

The BHO may reimburse its providers and subcontractors in any manner, subject to federal rules. However, this does not preclude additional payments such as for a health home or financial incentives for performance. BHOs shall have an incentive to promote electronic claims submission.

The reimbursement by the BHO to its providers and subcontractors, for example, may be a capitated rate or discounted Medicaid fee-for-service amount. Regardless of the payment methodology, the BHO shall require that all providers submit detailed encounter data, if necessary.

The BHO shall not pay out-of-network providers who deliver emergency services more than they would have been paid if the emergency services had been provided to an individual in the Medicaid fee-for-service program.

The BHO shall pay its subcontractors and providers on a timely basis, consistent with the claims payment procedures described in Section 1902(a)(37)(A) of the Social Security Act. The BHOs shall allow providers at least one year to submit claims for reimbursement.

This section requires that ninety percent (90%) of claims for payment (for which no further written information, authorization, or substantiation is required in order to make payment) are paid within thirty (30) days of the date of receipt of such claims and that ninety-nine percent (99%) of claims for payment are paid within ninety (90) days of the date of receipt of such claims. The date of receipt is the date the agency receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment. The BHO and the provider may, however, agree to an alternative payment schedule, provided this alternative payment schedule is reviewed and approved by the DHS.

In no event shall the BHO's subcontractors and providers look directly to the State for payment.

The State and the BHO's members shall bear no liability for the BHO's failure or refusal to pay valid claims of subcontractors or providers. The BHO shall include in all subcontractor and provider contracts a statement that the State and plan members bear no liability for the BHO's failure or refusal to pay valid claims of subcontractors or providers for covered services. Further, the State and BHO members shall bear no liability for services provided to a member for which the State does not pay the BHO; or for which the plan or State does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangement; or for payment for covered services furnished under a contract, referral, or other arrangement, to the extent that these payments are in excess of the amount that the member would owe if the BHO provided the services directly.

The BHO shall indemnify and hold the State and the members harmless from any and all liability arising from such claims and shall bear all costs in defense of any action over such liability, including attorney's fees.

40.340.1 Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) Reimbursement

The BHO shall reimburse non-contracted FQHCs and RHCs at rates no less than the Medicaid fee schedule if those providers are necessary for network adequacy. The BHO shall not be

required to cover services at an FQHC or RHC if that provider is not contracted and not required for network adequacy. The BHO shall reimburse contracted FQHCs or RHCs for PPS eligible services at the PPS rate provided annually by the state. Any other payment methodology to these providers requires prior approval by state.

The state shall calculate and reimburse FQHC/RHC's for any retroactive settlements involving a change in scope of services that result in an increased PPS rate that is not incorporated into the capitation rates. The BHO shall reimburse the FQHC/RHC the annual PPS increase when provided by the state. This annual increase will be incorporated into the capitation rates. The state shall perform reconciliation and make any necessary supplemental payments to FQHCs and RHCs.

40.345 Physician Incentives

The BHO may establish physician incentive plans pursuant to Federal and State regulations, including 42 CFR Sections 422.208, 422.210, and 438.6.

The BHO shall disclose any and all such arrangements to the DHS for review and approval prior to implementing physician incentives, and upon request, to members. Such disclosure shall include:

- Whether services not furnished by the physician or group are covered by the incentive plan;
- The type of incentive arrangement;
- The percent of withhold or bonus; and
- The panel size and if patients are pooled, the method used.

Upon request, the BHO shall report adequate information specified by applicable regulations to the DHS so that the DHS can adequately monitor the BHO.

If the BHO's physician incentive plan includes services not furnished by the physician/group, the BHO shall: (1) ensure adequate stop loss protection to individual physicians, and must provide to the DHS proof of such stop loss coverage, including the amount and type of stop loss; and (2) conduct annual

member surveys, with results disclosed to the DHS, and to members, upon request.

Such physician incentive plans may not provide for payment, directly or indirectly, either to a physician or to physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

40.350 Provider Communication

The BHO shall communicate information to providers on its policies and procedures affecting both providers and members at the time they enter into a contract with a provider. Communication may occur electronically only (via link to the BHO's website or on a CD-Rom or other appropriate storage disc) unless the provider requests a hard copy.

Provider communication shall include at a minimum:

- Requirements for credentialing and recredentialing;
- Medical record requirements described in Section 40.320;
- Provider availability standards described in Section 40.325;
- Process for submitting prior authorizations/pre-certifications;
- Behavioral health services available to members; and
- A description of the BHO's grievance system process and procedures for members which shall include, at a minimum:
    - The member's right to file grievances and appeals with requirements, and time frames for filing;
    - The member's right to a State administrative hearing, how to obtain a hearing and rules on representation at a hearing;
    - The availability of assistance in filing a grievance or an appeal;
    - The member's right to have a provider or authorized representative file a grievance and/or an appeal on his or her behalf, provided he or she has provided consent to do so;
    - The toll-free numbers to file a grievance or an appeal; and

- When an appeal or hearing has been requested by the member, the right of a member to receive benefits while the appeal or hearing is pending and that the member may be held liable for the costs of those benefits if the BHO's adverse action is upheld.

- Any appeal rights that the state chooses to make available to providers to challenge the failure of the BHO to cover a service.

40.400 Authorization of Services

The BHO shall have in place written prior authorization/pre-certification policies and procedures for processing requests for initial and continuing authorization of services and prescription medication in a timely manner. As part of these prior authorization policies and procedures, the BHO shall have in effect mechanisms to: (1) ensure consistent application of review criteria for authorization decisions; and (2) consult with the requesting provider when appropriate. The BHO shall describe their authorization process in their response, how they will facilitate the requirement set forth in this RFP, and be prepared to submit policies and procedures to MQD to review prior to the initiation of services in the event they are selected as the BHO.

The BHO shall submit these policies and procedures to MQD for review and approval by the due date identified in Section 51.400, Readiness Review.

The BHO shall ensure that all prior authorization/ pre-certification decisions, including but not limited to any decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, shall be made by a health care professional who has appropriate expertise in addressing the member's medical, behavioral health, or long-term services and supports needs. Medical necessity approvals may be made by licensed clinical staff or unlicensed staff under the supervision of licensed staff. Medical necessity denials must be made by licensed clinical staff.

The BHO shall not develop a compensation structure that creates incentives for the individuals or entities conducting prior authorization/pre certification activities to deny, limit, or discontinue medically necessary services to any member.

The BHO shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. The BHO may place appropriate limits on a service based on criteria such as medical necessity, or for utilization control provided that: (1) the services furnished can reasonably be expected to achieve their purpose; (2) the services supporting members with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects ongoing need for such services and supports; and (3) family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20.

The BHO shall not require prior authorization of emergency services.

The BHO shall notify the provider of prior authorization/pre-certification determinations in accordance with the following time frames:

- For standard authorization decisions, the BHO shall provide notice as expeditiously as the member's health condition requires but no longer than fourteen (14) days following the receipt of the written request for service from the provider on behalf of the member. An extension may be granted for up to fourteen (14) additional days if the member or the provider requests the extension, or if the BHO justifies a need for additional information and the extension is in the member's interest. If the BHO extends the time frame, it shall give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision. The BHO shall issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.
- In the event a provider indicates, or the BHO determines that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the BHO shall make an expedited authorization determination and provide notice as expeditiously as the member's health condition requires but

no later than seventy two (72) hours after receipt of the request for service. The BHO may extend the seventy two (72) hour timeframe by up to an additional fourteen (14) calendar days if the member requests an extension, or if the BHO justifies to the DHS a need for additional information and the extension is in the member's best interest. If the BHO extends the time frame, it shall give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to appeal if he or she disagrees with that decision. The BHO shall issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

Service authorization decisions not reached within the timeframes specified above and in accordance with the DHS policy guidance shall constitute a denial.

The BHO shall ensure providers are active participants in discharge planning. In cases where members do not meet criteria for inpatient stay or the BHO concurrent review denies additional inpatient days, the BHO shall assure the provider participates actively in the disposition of the member.

40.500 Member Services

40.510 Communication to Members

The BHO shall communicate information to members about covered benefits and services, such as operations of the plan, how to make an appointment, obtain emergency services, change BHO providers or prescribing psychiatrist, member rights and responsibilities, how to file a grievance or appeal, etc. See requirements for written materials in Section 51.320.

40.600 Member Grievance System

40.605 Definitions

Adverse Benefit Determination (may also be referred to as an adverse action)- Any one of the following:

- The denial or restriction of a requested service, including the type or level of service, requirements for medical necessity,

appropriateness, setting, or effectiveness of a covered benefit;

- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or part, of payment for a service;
- The failure to provide services in a timely manner, as defined in Section 40.325 (Provider Availability);
- The failure of the BHO to act within prescribed timeframes and regarding the standard resolution of grievances and appeals;
- For a rural area member or for islands with limited providers, the denial of a member's request to obtain services outside the network:
    - From any other provider (in terms of training, experience, and specialization) not available within the network;
    - 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;
    - 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 60 days;
    - Because the BHO or provider does not provide the service because of moral or religious objections;
    - 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
    - The State determines that other circumstances warrant out-of-network treatment.

Appeal – A review by the BHO of an adverse benefit determination.

Grievance - An expression of dissatisfaction from a member, member's representative, or provider on behalf of a member about any matter other than an adverse benefit determination.

Grievance Review - A State process for the review of a denied or unresolved (dissatisfaction from a member) grievance by the BHO.

Grievance System - The term used to refer to the overall system that includes grievances and appeals handled at the BHO level with access to the State administrative hearing process.

Inquiry - A contact from a member that questions any aspect of the BHO's, subcontractor's, or provider's, operations, activities, or behavior, or requests disenrollment, but does not express dissatisfaction.

40.610 General Requirements

The BHO shall have a formal grievance system that is consistent with the requirements of the State of Hawaii and 42 CFR Part 438, Subpart F. The member grievance system shall include an inquiry process, a grievance process and appeals process. In addition, the BHO's grievance system shall provide information to members on accessing the State's administrative hearing system. The BHO shall require that members exhaust its internal grievance system prior to accessing the State's administrative hearing system.

The BHO shall use templates developed by DHS for communication to members regarding grievance system processes. The DHS shall issue these templates to the BHO.

The BHO shall develop policies and procedures for its grievance system and submit these to DHS for review and approval by the due date identified in Section 51.400 (Readiness Review). The BHO shall submit an updated copy of these policies and procedures within thirty (30) days of any modification for review and approval. Changes must be approved by DHS prior to implementation.

The BHO shall address, log, track and trend all expressions of dissatisfaction, regardless of the degree of seriousness or regardless of whether the member or provider expressly requests filing the concern or requests remedial action. The formal grievance system must be utilized for any expression of dissatisfaction and any unresolved issue.

The BHO shall give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free number that have adequate TTY/TTD and interpreter capability.

The BHO shall acknowledge receipt of each filed grievance and appeal in writing within five (5)[1] business days of receipt of the grievance or appeal. The BHO shall have procedures in place to notify all members in their primary language of grievance and appeal resolutions. These procedures shall include written translation and oral interpretation activities.

The BHO shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made and reviewed by a healthcare professional that has appropriate behavioral health, medical, and clinical, knowledge and expertise in treating the member's condition or disease. All denials of medical, behavioral health, and LTSS shall be reviewed and approved by the BHO medical director. In addition, all administrative denials for children under the age of twenty-one (21) shall be reviewed and approved by the BHO medical director.

The BHO shall ensure that individuals who make decisions on grievances and appeals were not involved in any previous level of review or decision-making, nor is a subordinate of any such individual who has the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease. This requirement applies specifically to reviewers of:

- An appeal of a denial that is based on a lack of medical necessity;
- A grievance regarding denial of expedited resolution of an appeal; or
- A grievance or appeal that involves clinical issues.

[1] The first day shall be the day after the day of receipt of a grievance or appeal. For example, and assuming there are no intervening holidays, if an appeal is received on Monday, the five (5) business day period for acknowledgment of receipt of the appeal is counted from Tuesday. Therefore, the acknowledgment must be sent to the member by the following Monday.

A member, a member's authorized representative, or a provider acting on behalf of the member with the member's authorization, is deemed to have exhausted the BHO's grievance and appeal process if the BHO fails to adhere to the notice and timing requirements set by MQD, and may file for a State administrative hearing.

40.615 Recordkeeping

The BHO shall maintain records of its members' grievances and appeals for a period of no less than ten (10) years in accordance with 42 CFR 438.3(u) and this RFP's requirements for recordkeeping and confidentiality of members' medical records. The record of each grievance or appeal must contain, at a minimum, all of the following information:

- A general description of the reason for the appeal or grievance;
- The date received;
- The date of each review or, if applicable, review meeting;
- Resolution at each level of the appeal or grievance, if applicable;
- Date of resolution at each level, if applicable; and
- Name of the covered person for whom the appeal or grievance was filed.

The record must be accurately maintained in a manner accessible to the State and available upon request to CMS.

40.620 Inquiry Process

The BHO shall have an inquiry process to address all inquiries. As part of this process, the BHO shall ensure that, if at any point during the contact, the member expresses a complaint of any kind, the inquiry becomes a grievance or appeal and the BHO shall give the member, a member's authorized representative, or a provider acting on behalf of the member with the member's consent, their grievance and appeal rights. The inquiry can be in writing or as a verbal request over the telephone.

40.625 Authorized Representative of a Member

Members shall be allowed to authorize another person to represent their interests during any stage of the grievance system process as their authorized representative. The BHO shall submit policies and procedures related to processing of authorization of representation as part of its Grievance System policies and procedures to MQD for review and approval by the due date identified in Section 51.400 (Readiness Review) to include, but not be limited to, its authorized representative form.

Members shall be allowed, in person or by telephone, to verbally identify another person who may communicate with the BHO on the member's behalf, for any matter that does not require a written request or written designation of an authorized representative under this RFP and contract.

40.630 Grievance Process

A grievance may be filed about any matter other than an adverse benefit determination, as defined above. Subjects for grievances include, but are not limited to:

- The quality of care of a provider;
- Rudeness of a provider or a provider's employee; or
- Failure to respect the member's rights regardless of whether remedial action is requested.

Grievance includes a member's right to dispute an extension of time proposed by the BHO to make an authorization decision.

A member or a member's authorized representative may file a grievance orally or in writing with the BHO at any time. The BHO shall accept any grievance filed on the member's behalf from a member's representative even without verbal or written consent of the member. However, the BHO shall send the outcome of any grievance filed by a member's representative without oral or written consent (i.e., AOR form) to the member.

The BHO shall have in place written policies and procedures for processing grievances in a timely manner to include if a grievance is filed by a provider on behalf of the member or member's authorized representative and there is no

documentation of a written form of authorization, such as an AOR form.

As part of the grievance system policies and procedures, the BHO shall have in effect mechanisms to: (1) ensure reasonable attempts were made to obtain a written form of authorization; and (2) consult with the requesting provider when appropriate. The BHO shall submit these policies and procedures as part of its Grievance System policies and procedures to MQD for review and approval by the due date identified in Section 51.400 (Readiness Review).

In addition to meeting all requirements detailed in Section 40.600 (Member Grievance System), in fulfilling the grievance process requirements the BHO shall:

- Send a written acknowledgement of the grievance within five (5) business days of the member's expression of dissatisfaction;
- Convey a disposition, in writing, of the grievance resolution as expeditiously as the member's health condition requires and within thirty (30) days of the initial expression of dissatisfaction; and
- Include clear instructions as to how to access the State's grievance review process on the written disposition of the grievance.

The BHO's resolution of the grievance shall be final unless the member or member's representative wishes to file for a grievance review with the State.

40.635 State Grievance Review

As part of its grievance system, the BHO shall inform members of their rights to seek a grievance review from the State in the event the disposition of the grievance does not meet the satisfaction or expectations of the member. The BHO shall provide its members with the following information about the State grievance review process:

- BHO members may request a State grievance review, within thirty (30) days of the member's receipt of the grievance disposition from the BHO. A State grievance review may be made by contacting the MQD office at or mailing a request to:

- The MQD shall review the grievance and contact the member with a determination within ninety (90) days from the day the request for a grievance review is received; and
- The grievance review determination made by MQD is final.

40.640 Appeals Process

An appeal may be filed when the BHO issues a notice of adverse benefit determination to a member.

A member, a member's authorized representative, or a provider acting on behalf of the member with the member's authorization, may file an appeal within sixty (60) days of the notice of adverse benefit determination. An oral appeal may be submitted in order to establish the appeal submission date; however, this must be followed by a written, signed appeal.

In addition to meeting the general requirements detailed in Section 40.610 (General Requirements), the BHO shall:

- Ensure that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals and confirmed in writing, unless the member, provider or other authorized representative requests expedited resolutions;
- As part of the grievance system policies and procedures, the BHO shall have in effect mechanisms to ensure reasonable attempts were made to obtain a written confirmation of the appeal;
- Send an acknowledgement of the receipt of the appeal within five (5) business days from the date of the receipt of the written or oral appeal;
- Provide the member and his or her authorized representative a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments;

- Provide the member and his or her authorized representative, upon request, the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the BHO. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals; and
- Include as parties to the appeal, the member and his or her authorized representative, or the legal representative in the case of a deceased member's estate.

For standard resolution of an appeal, the BHO shall resolve the appeal and provide a written notice of disposition to the parties as expeditiously as the member's health condition requires, but no more than thirty (30) days from the day the BHO receives the appeal.

The BHO may extend the resolution time frame by up to fourteen (14) additional days if the member requests the extension, or the BHO shows (to the satisfaction of MQD, upon its request for review) that there is need for additional information and how the delay shall be in the member's best interest. For any extension not requested by a member, the BHO shall give the member written notice of the reason for the delay.

The BHO shall include the following in the written notice of the resolution:

- The results of the appeal process and the date it was completed; and
- For appeals not resolved wholly in favor of the member:
    - The right to request a State administrative hearing with the Administrative Appeals Office (AAO), and clear instructions about how to access this process;
    - The right to request and receive benefits while the hearing is pending, and how to make the request; and
    - A statement that the member may be held liable for the cost of those benefits if the hearing decision is not in the member's favor.

The BHO shall notify the member, provider or other authorized representative in writing within thirty (30) days of the resolution.

40.645 Expedited Appeal Process

The BHO shall establish and maintain an expedited review process for appeals. The member, his or her provider or other authorized representative acting on behalf of the member with the member's written authorization may file an expedited appeal either orally or in writing. No additional follow-up shall be required. An expedited appeal is only appropriate when the BHO determines (a request from the member) or the provider indicates (in making the request on the member's behalf) that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

The BHO shall ensure that punitive action is not taken against a provider who requests an expedited resolution or who supports a member's appeal.

For expedited resolution of an appeal, the BHO shall resolve the appeal and provide written notice to the affected parties as expeditiously as the member's health condition requires, but no more than seventy two (72) hours from the time the BHO received the appeal. The BHO shall make reasonable efforts to also provide oral notice to the member with the appeal determination.

The BHO shall include the following in the written notice of the resolution:

- The results of the appeal process and the date it was completed; and
- For appeals not resolved wholly in favor of the member:
    - The right to request a State administrative hearing as described in Section 40.655 (Expedited State Administrative Hearings), and clear instructions about how to access this process;
    - The right to request an expedited State administrative hearing;
    - The right to request to receive benefits while the hearing is pending, and how to make the request; and

- A statement that the member may be held liable for the cost of those benefits if the hearing decision upholds the BHO's adverse benefit determination.

The BHO may extend the expedited appeal resolution time frame by up to fourteen additional fourteen (14) days if the member requests the extension or the BHO needs additional information and demonstrates to MQD how the delay shall be in the member's best interest. For any extension not requested by the member or if the BHO denies a request for expedited resolution of an appeal, it shall:

- Transfer the appeal to the timeframe for standard resolution;
- Make reasonable efforts to give the member prompt oral notice of the delay or denial;
- Within two (2) days give the member written notice of the reason for the decision to extend the timeframe or deny a request for expedited resolution of an appeal;
- Inform the member orally and in writing that they may file a grievance with the BHO for the delay or denial of the expedited process, if he or she disagrees with that decision; and
- Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

The BHO shall notify MQD within twenty-four (24) hours, regarding expedited appeals if an expedited appeal has been granted by the BHO or if an expedited appeal time frame has been requested by the member or the provider. The BHO shall provide the reason it is requesting a fourteen additional (14) day extension to MQD. The BHO shall notify MQD within twenty-four (24) hours (or sooner if possible) from the time the expedited appeal is upheld. The DHS shall provide information on the method of notification to MQD.

The BHO shall provide the member a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. The BHO shall inform the member of limited time available to present this information.

40.650 State Administrative Hearing for Regular Appeals

If the member is not satisfied with the BHO's written notice of disposition of the appeal, he or she may file for a State administrative hearing within thirty (30) days of the receipt of the notice of disposition (denial) as part of the member's internal appeal procedure. At the time of the denied appeal determination, the BHO shall inform the member, the member's provider or other authorized representative, or the legal representative of a deceased member's estate that he or she may access the State administrative hearing process. The member, or his or her authorized representative, may access the State administrative hearing process by submitting a letter to the Administrative Appeals Office (AAO) within thirty (30) days from the receipt of the member's appeal determination.

In addition to the hearing guidance listed in the Hawaii Administrative Rules (HAR) §17-1703.1, the following shall be added in accordance with 42 CFR 431.220 and 42 CFR 431.244.

1. Member's claim for services is denied or is not acted upon with reasonable promptness;
2. Member believes the BHO has taken an action erroneously;
3. Member believes a skilled nursing facility or nursing facility has erroneously determined that he or she must be transferred or discharged; or
4. Member believes the State has made an erroneous determination with regards to the preadmission and annual resident review requirement of section 1919(e)(7) of the Act.

Hearing decisions must be based exclusively on evidence introduced at the hearing. The record must consist only of:

1. The transcript or recording of testimony and exhibits, or an official report containing the substance of what happened at the hearing;
2. All papers and requests filed in the proceeding; and
3. The recommendation or decision of the hearing officer.

The BHO shall provide the following address to the members:

State of Hawaii Department of Human Services
Administrative Appeals Office
PO Box 339
Honolulu, HI 96809-0339

The State shall reach its decision within ninety (90) days of the date the member filed the request for an administrative hearing with the State. The disposition of the appeal at the State administrative hearing level shall prevail.

40.655 Expedited State Administrative Hearings

The member may file for an expedited State administrative hearing only when the member requested or the BHO has provided an expedited appeal and the action of the appeal was determined to be adverse to the member (Action Denied). The member may file for an expedited State administrative hearing process by submitting a letter to the Administrative Appeals Office (AAO) within thirty (30) days from the receipt of the member's appeal determination.

The BHO shall provide the following address to the members:

State of Hawaii Department of Human Services
Administrative Appeals Office
PO Box 339
Honolulu, HI 96809-0339

An expedited State administrative hearing must be heard and determined within three (3) business days after the date the member filed the request for an expedited State administrative hearing with no opportunity for extension on behalf of the State. The BHO shall collaborate with the State to ensure that the best results are provided for the member and to ensure that the procedures comply with State and Federal regulations.

In the event of an expedited State administrative hearing the BHO shall submit information that was used to make the determination, (e.g. medical records, written documents to and from the member, provider notes, etc.). The BHO shall submit this information to MQD within twenty-four (24) hours of the decision denying the expedited appeal.

40.660 Continuation of Benefits During an Appeal or State Administrative Hearing

The BHO shall continue the member's benefits if the following conditions have been met:

- The member timely files for continuation of benefits ;
- The appeal or request for State administrative hearing is filed in a timely manner, meaning on or before the later of the following:
    - Within ten (10) days of the BHO mailing the notice of adverse benefit determination; or
    - The intended effective date of the BHO's proposed adverse benefit determination.
- The appeal or request for State administrative hearing involves the termination, suspension, or reduction of previously authorized services;
- The services were ordered by an authorized provider; and
- The original authorization period has not expired.

If the BHO continues or reinstates the member's benefits while the appeal or State administrative hearing is pending, the BHO shall continue all benefits until one of the following occurs:

- The member withdraws the appeal or request for a State administrative hearing ;
- The member does not request a State administrative hearing and continuation of benefits within ten (10) days from when the BHO mails a notice of an adverse benefit determination ; or
- A State administrative hearing decision unfavorable to the member is made.

If the final resolution of the appeal or State administrative hearing is adverse to the member, that is, upholds the BHO's adverse benefit determination, the BHO may, consistent with the State's usual policy on recoveries and as specified in the BHO's contract, recover the cost of services furnished to the member while the appeal and State administrative hearing were pending,

to the extent that they were furnished solely because of the requirements of this section.

If the BHO or the State reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the BHO shall authorize or provide these disputed services promptly, and as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours from the date it receives notice reversing the determination.

If the BHO or the State reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the BHO shall pay for those services.

40.665 Notice of Adverse Benefit Determination

The BHO shall give the member and the referring provider a written notice of an adverse benefit determination within the timeframes specified below. The notice to the member or provider shall include the following information:

- The adverse benefit determination the BHO has made or intends to make;
- The reason for the adverse benefit determination, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits;
- The member's or provider's right to an appeal with the BHO;
- The member's or provider's right to request an appeal;
- Procedures for filing an appeal with the BHO;
- Member may represent himself or use legal counsel or an authorized representative;
- The circumstances under which an appeal process can be expedited and how to request it; and
- The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with State

policy, under which the member may be required to pay the costs of these services.

The notice of adverse benefit determination to the member shall be written pursuant to the requirements in Section 40.665 of this RFP.

The BHO shall mail the notice within the following time frames:

- For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) days prior to the date the adverse benefit determination is to start except:
    - By the date the adverse benefit determination is to start (date of action), for the following reasons:
        - The BHO has factual information confirming the death of a member;
        - The BHO receives a clear written statement signed by the member that he 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;
        - The member has been admitted to an institution that makes him or her ineligible for further services;
        - The member's address is unknown and the post office returns BHO mail directed to the member indicating no forwarding address;
        - The member has been accepted for Medicaid services by another local jurisdiction;
        - The member's provider prescribes a change in the level of behavioral health care;
        - 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
        - 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.

  - The period of advanced notice is shortened to five (5) days if there is alleged fraud by the member and the facts have been verified, if possible, through secondary sources.

- For denial of payment: at the time of any action affecting the claim.
- For standard service authorization decisions that deny or limit services: as expeditiously as the member's health condition requires, but not more than fourteen (14) days following receipt of request for service, with a possible extension of up to fourteen (14) additional days (total time frame allowed with extension is twenty-eight (28) days from the date of the request for services) if: (1) the member or provider requests an extension; or (2) the BHO justifies a need for additional information and how the extension is in the member's best interest. If the BHO extends the time frame, it must: (1) give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision to extend the time frame; and (2) issue and carry out its determination as expeditiously as the member's health condition requires but no later than the date the extension expires.
- For expedited authorization decisions: as expeditiously as the member's health condition requires but no later than seventy-two (72) hours after receipt of the request for service. The BHO may extend the seventy-two (72) hour timeframe by up to an additional fourteen (14) calendar days if the member requests an extension, or if the health plan justifies to the DHS a need for additional information and how the extension is in the member's best interest.
- For service authorization decisions not reached within the timeframes specified above (which constitute a denial and, thus, an adverse benefit determination), on the date that the timeframes expire.

40.700 BHO Personnel

40.710 Medical Director

The BHO shall have in place a Hawaii based Medical Director licensed to practice medicine with a specialty in psychiatry, in the State of Hawaii, to oversee the quality of behavioral healthcare furnished by the BHO and to ensure care is provided by qualified personnel. The Medical Director shall reside in the State of Hawaii and be employed or contracted in at least a 0.5 full-time equivalent (FTE) position. The Medical Director shall address any potential quality of care problems and direct the Quality Improvement Program (QIP). The Medical Director shall work closely with the MQD Medical Director when applicable, and participate in any committees when requested by DHS, such as those relating to QI and/or the BHO.

The BHO medical director shall not be employed by any community case management provider.

40.720 Supporting Staff and Systems

The BHO shall have in place in Hawaii adequate organizational, management, and administrative systems that are capable of implementing and fulfilling all contractual obligations for this RFP. The staff (may be contracted) shall include but not be limited to the following:

- **Case Management Staff** to ensure timely access to medically necessary services and to assist the member to understand and follow his/her treatment plan.
- **BHO Case Management Staff (not contracted)**:
    - **Psychiatrist** separate from the Medical Director, who resides in the State of Hawaii, employed at least 0.5 FTE.
    - **Case Management Coordinator** responsible to supervise BHO case management staff and ensure services are provided, who is employed at 1.0 FTE, and resides in the State of Hawaii.
    - **Registered Nurse** separate from the QA/UR Coordinator, licensed in the State of Hawaii, and employed at 1.0 FTE, shall be responsible for clinical duties including, but not limited to, the following:

    - Medication administration and education
    - Providing education and clinical care for medical conditions (hypertension, diabetic care, dressing changes, etc.)
    - Assisting psychiatrist (calling in prescriptions, etc.)
- **After-Hours Staff** responsible to respond to crisis calls in-person if crises cannot be resolved via telephone support.
- **Executive Director** that serves as the BHO's key contact, employed at 1.0 FTE for this contract, and resides in the State of Hawaii.
- **Financial Officer** residing in the State of Hawaii.
- **Compliance Officer** residing in the State of Hawaii, responsible for all compliance and detection activities related to fraud, waste, and abuse, and employed at 1.0.
- **Pharmacist** located and residing in the State of Hawaii to address pharmacy needs of members, employed at least 0.5 FTE.
- **QA/UR Coordinator** who is a licensed R.N. in the State of Hawaii employed at least 0.5 FTE, and resides in the State of Hawaii.
- **Member Relations Staff** residing in the State of Hawaii, responsible to answer questions and respond to complaints of members, and address member needs or coordinate services.
- **Provider Relations Staff** residing in the State of Hawaii, responsible to answer questions and respond to complaints of providers, assure that members have access to behavioral health providers, and monitor subcontractor services.
- **Grievance Coordinator** located and residing in the State of Hawaii to investigate member complaints, employed at least 0.5 FTE.
- **Information System Staff** capable of loading member tape information, and ensuring the timely and accurate submission of encounter data and other required information and reports including ad hoc reports as requested by DHS.
- **Support Service Staff** to ensure the timely and accurate processing of other reports and coverage of the toll-free telephone hotline.

- **Clerical Staff** to conduct daily business.
- **Housing Coordinator** to ensure that eligible members are provided the supportive housing services needed to secure and maintain permanent housing, employed at 1.0 FTE, and residing in the State of Hawaii.

40.730 General Requirements

The BHO shall ensure that all staff have the necessary qualifications (i.e., education, skills, and experience) and training to fulfill position requirements and duties. The BHO shall also conduct initial and ongoing training of all staff to ensure they are appropriately informed and trained to perform job duties and fulfill the obligations of this contract.

Some positions indicate the number of FTE that shall be required for this procurement. For example, a 1.0 FTE requirement indicates that an employee serving in the subject position, is specifically designated to perform only the work of the required position as it relates to this RFP. A 0.5 FTE requirement indicates that an employee serving in the subject position, may perform other work unrelated to the required position or to this RFP, at least half-time. The BHO shall ensure that adequate staff is available and assigned to appropriate areas to fulfill the required functions specified in this contract. The BHO shall increase staffing in specific areas if determined by DHS that contractual requirements are not being met.

For each position having an FTE requirement, the BHO must submit to DHS, the FTE that each individual serving in said position, is assigned to perform work only toward that position. This information shall be included in the staffing plan (discussed below), and updated in the staffing change notifications (discussed below) submitted to DHS, as staffing changes occur for said positions.

For purposes of this contract, the BHO shall not employ or contract with any individual that has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under Section 103D-702, HRS; has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or title XXI program in the last 10 years;

and has been excluded through Federal databases to include but not limited to LEIE, SAM, or any such databases.

The BHO is responsible for operating its business in the State of Hawaii. The BHO shall be solely responsible for any additional charges associated with on-site audits or other oversight activities that result when required systems and activities are located outside of the State of Hawaii.

The BHO shall submit to DHS a job description for each position listed in Sections 40.710 and 40.720. The job description shall include position responsibilities related to the CCS program, and the minimum education and experience qualifications required.

For each of the following positions (unless otherwise noted), the BHO shall submit to DHS a resume of the employee currently serving in the position, and whether such employee resides in the State of Hawaii. Additionally, for each of the positions listed below (unless otherwise noted), the BHO shall provide DHS with notification for any staffing change related to the position. Such notification shall be in writing and submitted to DHS within seven (7) days from the date the BHO learned of the intended resignation or other change in the status of the position. The notification shall include the name, position title, and contact information of the interim contact person. In addition, the BHO shall, upon DHS request, provide a written plan for filling a vacant position, including expected timelines. The name of the permanent employee shall be submitted as soon as the new hire has occurred.

1. **Medical Director**
2. BHO CM Staff (not contracted) **Psychiatrist** (not the Medical Director)
3. BHO CM Staff (not contracted) **Case Management Coordinator**
4. BHO CM Staff (not contracted) **Registered Nurse** (not the QA/UR Coordinator)
5. **Executive Director**
6. **Financial Officer**
7. **Compliance Officer**
8. **Pharmacist**

9. **QA/UR Coordinator**
10. **Member Relations Staff** (resume and notification of staffing change, are not required for this position)
11. **Provider Relations Staff** (resume and notification of staffing change, are not required for this position)
12. **Grievance Coordinator**
13. **Housing Coordinator**

The BHO shall submit to DHS, both a staffing plan and a training plan, by the due date identified in Section 51.400 (Readiness Review). The staffing plan shall include the BHO's staffing for the CCS line of business (include the names of all individuals serving in each position or staff category), job descriptions, resumes, and all other staffing information necessary to demonstrate compliance with Section 40.700, BHO Personnel. The training plan shall include a description of the BHO's systems and procedures to ensure employees are appropriately trained and informed to perform job duties, and the processes in place that assure rapid responsiveness to effect changes for contract compliance.

40.800 Daily Rosters/BHO Reimbursement

The DHS shall enroll and disenroll members through daily files. All payments and recoveries shall be detailed on the daily file. The daily membership rosters identify the capitated fee amounts associated with mid-month enrollment and disenrollment transactions. The BHO agrees to accept daily and monthly transaction files from the DHS as the official enrollment record**.**

The DHS shall make capitation payments, with each payment being for a month's services, to the BHO for each enrolled member in the BHO beginning on the Contract Effective Date identified in Section 20.100. Capitation payments shall be in the amounts listed in the BHO's contract with the DHS. Certain services required under this contract but not eligible for federal financial participation or otherwise provided on a limited basis, such as crisis services only, may be paid on a fee-for-service basis.

The DHS shall pay the established capitation rate to the BHO for members enrolled for the entire month. Capitation payments for

members enrolled/disenrolled on dates other than the first or last day of the month shall be prorated on a daily basis based on the number of days in a month.

The DHS shall make additional capitation payments or recover capitation payments from the BHO as a result of retroactive enrollments and retroactive disenrollments.

The DHS shall provide to the BHO a Monthly Payment Summary Report that summarizes capitation payments and recoveries made to the BHO.

The BHO shall not change any of the information provided by the DHS on the daily or monthly transaction files. Any inconsistencies between the BHO and the DHS information shall be reported to the DHS for investigation and resolution. All payments and recoveries shall be detailed on the daily file and summarized on the Monthly Payment Summary Report.

The DHS shall notify the BHO prior to making changes in the capitation amount/rate code.

40.900 Scope of Behavioral Health Services

The services to be provided by the BHO include all medically necessary behavioral health services for eligible individuals who have been determined to be SMI or have a provisional diagnosis of SMI.

The BHO shall utilize the definition found in Section 432E-1.4, HRS defined in the state statute for medical necessity for provision of behavioral health services in this contract.

The BHO shall be responsible for providing all necessary covered services to all eligible members. These necessary covered services shall be furnished in an amount, duration, and scope to achieve the purpose for which the services are furnished.

The BHO shall assure provisions of a full range of psychiatric and SUD inpatient, outreach, treatment, rehabilitation and crisis response services needed by adults with a diagnosis of SMI/SPMI. The BHO shall coordinate its services with the member's health plan to avoid duplication of services and ensure that services are appropriately provided. Services may be

provided or arranged for in a variety of ways such as through natural supports, mental health agencies, general hospitals, family members, consumer help approaches, or through the use of recovering consumers as paid or volunteer staff. The BHO may make arrangements with the member's health plan to assume responsibility for medical case management in order to provide a patient centric approach of a single case manager for both medical and behavioral health needs and services.

BHO services shall assist members to manage their illness, develop the appropriate and necessary living skills and acquire supports and resources they need to maximize their quality of life in the community. The BHO shall ensure that its members have access to medically necessary services to include, without limitation, the following services as medically necessary:

a. Inpatient behavioral health hospital services;

b. Emergency Department services;

c. Ambulatory Behavioral Health Services and crisis management;

d. Medications and Medication Management;

e. Diagnostic services and treatment to include psychiatric or psychological evaluation and treatment;

f. Medically necessary SUD services;

g. Methadone management services;

h. Intensive Case Management;

i. Partial hospitalization or intensive outpatient hospitalization;

j. Psychosocial Rehabilitation/Clubhouse;

k. Therapeutic Living Supports (or Specialized Residential Treatment centers);

l. Supportive housing;

m. Representative payee;

n. Supported employment;

o. Peer Specialist;

p. Behavioral Health outpatient services; and

q. Other services.

BHO shall have direct access to behavioral health outpatient services as described in Section 40.910.

40.910 Covered Behavioral Health Services

The BHO shall facilitate the provision of the appropriate levels and amounts of behavioral healthcare to its members. The BHO may authorize and facilitate a full array of effective interventions and qualified licensed behavioral health practitioners such as psychiatrists, psychologists, social workers, advanced practice nurses, and others. The method and manner in which services are provided shall meet the accepted professional standards of the various disciplines.

The BHO shall submit a detailed plan describing the service delivery system including all current medically necessary behavioral health services covered by the Hawaii Medicaid program and non-traditional services that will be in place to serve members. The plan shall be submitted to the DHS for review and approval by the date specified in Section 51.400, Readiness Review. At a minimum, the BHO shall describe how it shall ensure access to the services listed in this section below:

- Inpatient Psychiatric Hospitalization services (twenty-four hour care). Services include:
  - Room and board
  - Nursing care
  - Medical supplies, equipment and drugs
  - Diagnostic services
  - Psychiatric services
  - Other practitioner services as needed
  - Physical, occupational, speech and language therapy
  - Post-stabilization services
  - Other medically necessary services
- Emergency Department Services
  - Any covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish services

that are needed to evaluate or stabilize an emergency medical condition

- The emergency medical condition shall be a result of SMI or SPMI diagnosis
- The BHO may not deny payment for these services when a representative from the BHO instructed the enrollee to seek ED services

- Ambulatory behavioral health services includes 24-hour, 7 days/week emergency/crisis intervention
  - Mobile crisis response
  - Crisis stabilization
  - Crisis hotline
  - Crisis residential services
- Medication Management
  - Medication evaluation
  - Medication counseling and education
  - Psychotropic medications
- Diagnostic services including:
  - Psychological testing
  - Psychiatric or psychological evaluation and treatment (including neuropsychological evaluation)
  - Psychosocial history
  - Screening for and monitoring treatment of mental illness and substance use shall include tobacco and alcohol use disorders
  - Other medically necessary behavioral health diagnostic services to include labs
- All medically necessary substance use disorder services
- Methadone Management Services which include the provision of methadone or a suitable alternative (i.e. LAAM or buprenorphine) as well as outpatient counseling services
- Intensive Case Management
  - Case assessment

- Case planning (service planning, care planning)
- Outreach
- Ongoing monitoring and service coordination
- Coordination with member's health plan and PCP

- Partial hospitalization or intensive outpatient hospitalization including:
  - Medication management
  - Prescribed drugs
  - Medical supplies
  - Diagnostic tests
  - Therapeutic services including individual, family, and group therapy and aftercare
  - Other medically necessary services
- Psycho-Social Rehabilitation/Clubhouse services including:
  - Work assessment service
  - Intensive day treatment
  - Day treatment
  - Residential treatment services
  - Social/recreational therapy services
- Therapeutic living supports to include specialized residential treatment facilities for SMI/SPMI and/or substance abuse
- Supportive housing services:
  - <u>Pre-tenancy Services</u>
    - Identify eligible individuals
    - Screening/Assessments
    - Develop housing support plan
    - Housing Search
    - Applications prep and submission
    - Identify resources/costs for start-up needs

- Identify equipment, Technology, and other modifications needed
- Ensure housing is safe
- Moving assistance
- Individualized housing crisis plan
- Skill and Acquisition development
- Independent living skills/ Financial literacy

- Tenancy Services
  - Individual Housing and Tenancy Sustaining Services
  - Early identification/ intervention for negative behaviors
  - Education/Training roles and responsibilities of tenant/landlord
  - Coach on development/
  - maintenance of relationships between landlords/property managers
  - Dispute resolution with landlords/neighbors
  - Advocate & link with advocacy groups to help prevent eviction
  - Housing recertification process
  - Update/Maintain housing support and crisis plans
  - Development of daily living skills and maintaining a residence skills to sustain residency
  - Service Care Coordination
  - Housing Crisis Management
  - Training/Education
  - Financial Literacy
  - Relationship building and maintenance
- Other Housing & Tenancy Services
  - Job skills training/Employment activities
  - Peer Supports
  - Non-Medical Transportation

        - Support Groups
        - Caregiver/Family support
        - Outreach and In-reach Services
        - Health Management
        - Counseling and Therapies
        - Service Assessments
        - Service Plan Development
        - Independent living skills/ Financial literacy
        - Equipment, Technology and other modifications
        - Home Management
        - Other Supplemental Services as needed
- Representative Payee
- Supported employment services including:
    - Work assessment service
    - Discovery- Pre-employment service
    - Job Coaching
- Peer Specialist
- Behavioral health outpatient services also include:
    - Treatment/service planning
    - Individual/group therapy and counseling
    - Family/collateral therapeutic support and education
    - Continuous treatment teams
    - Other medically necessary therapeutic services
- Other services
    - Other medically necessary practitioner services provided by licensed and/or certified healthcare providers
    - Other medically necessary therapeutic services including services which would prevent institutionalization
    - Specialized residential treatment options for members who have only SMI/SPMI issues.

- Maintenance of member's medical assistance eligibility

Adult members who have a diagnosis of SMI, provisional SMI, SPMI, and substance use disorder who require diagnosis, treatment and/or rehabilitative services shall receive these services from the BHO. The BHO shall make decisions regarding admission to treatment programs, continued stay, and discharge criteria based on the most recent edition of the American Society of Addiction Medicine (ASAM) Patient Placement Criteria.

40.920 Department of Health Alcohol and Drug Abuse Division (DOH-ADAD)

The BHO shall coordinate with DOH-ADAD, as appropriate.

40.930 Emergency and Post-Stabilization Services

The BHO is responsible for providing or ensuring access to emergency services twenty-four (24) hours a day, seven (7) days a week to treat an emergency medical condition related to SMI or SPMI diagnosis. The BHO shall provide education to its members on the appropriate use of emergency services, and alternatives for members to receive non-emergent care outside of the Emergency Department.

40.940 Behavioral Health Services and Support

BHO must establish and maintain a member advisory committee to members receiving CCS. The committee must include at least a reasonably representative sample of the CCS populations, or other individuals representing those members, covered under the contract with the BHO.

40.950 Supportive Housing Services

BHO shall coordinate supportive housing with the QUEST Integration health plan. BHO is responsible for ensuring eligible members are provided the supportive housing services needed to secure and maintain permanent housing. CCS members who meet the eligibility criteria described below shall be eligible for pre-tenancy and tenancy supportive housing services.

Supportive housing services shall be provided to all CCS members eighteen (18) years of age or older who is:

1. Chronically homeless under the HUD definition;
2. Experiencing homelessness and has one of the qualifying health conditions listed below;
3. Living in an institution and cannot be discharged due to lack of stable housing and has one of the qualifying health conditions listed below; or
4. Living in public housing and at risk of eviction and has one of the qualifying health conditions listed below.

Qualifying Health Conditions

- A mental health disorder which interferes with one or major life activities;
- Has been diagnosed with substance use disorder (SUD);
- Chronic physical or complex health needs; or
- Frequent Emergency Department /in-patient hospital use.

41.100 Out-of-State and Off-Island Coverage

If behavioral health treatments or services required by the member are not available in the State or on the island in which the member resides and the member needs to be referred to an out-of-state or off-island specialist or facility, the BHO shall provide such services including transportation, lodging, and meals for the member and any needed attendant, and make payments to providers. The BHO shall coordinate with the DHS for any out-of-state referrals.

Behavioral health services in a foreign country are not covered for members.

Out-of-state emergency behavioral health services for members are covered under the BHO, if approved by the DHS. Emergency services are defined in §1932(b)(2) to the Social Security Act as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to body functions or serious dysfunction of any bodily organ or part."

The BHO may use this definition to determine whether the services provided on the mainland qualify as emergency services. If the situation is emergent, the BHO shall be responsible for covering all behavioral health emergencies and related services. Prior authorization shall not be required for true behavioral health emergency situations.

If a member is on a different island and requires emergency behavioral health attention, the BHO shall pay for such services. If the BHO has agreements with certain providers, the providers are in close proximity to the member, and the member can be safety transferred, the BHO may require that the member obtain the services from the specified providers.

Members, who plan to be on a different island, shall notify the BHO to arrange for the provision of the needed services. The BHO shall arrange for the provision of the medically necessary services. The BHO may require the member to obtain the needed services from specified providers as long as the provider is in the same geographic location as the member.

41.200 Other Services to be Provided

In addition to the behavioral health services listed in Subsection 40.910, Covered Behavioral Health Services, the plan shall provide certain specialized services. This section lists the required other services:

- Member Education

  The BHO shall effectively communicate with members so that the plan members understand their behavioral health condition, the suggested treatment and the effect of the treatment on their condition including side effects. Educational efforts should emphasize preventive care and that members adhere to their specified treatment programs, maintaining contact with their case manager, etc.

  Member education also includes educating the members on the concepts of managed care, the scope of behavioral health services available through the plan and how to obtain BHO services. At a minimum, the plan shall also provide members with information on the procedures which members need to follow related to the plan's prior authorization process, utilization of case manager services, informing the plan of any

changes in the member status, changing providers, filing a grievance, and notice of off-island travel.

Member education is provided using classes, individual or group sessions, videotapes, written material and also includes outreach efforts through mass mailings and media advertisements. Any materials prepared and distributed to BHO members shall be approved by DHS.

Member education may also include the importance of continuing eligibility and the requirements to remain eligible.

- Provider Education and Outreach

  The BHO shall provide education, training and support to EDs and other community providers to develop provider relationships.

  BHO shall develop protocols for the provider to contact BHO when a CCS member is brought to the ED or community providers. Protocols shall include direct lines of contact with CCS providers. Once contact is made with the provider, it will require an in-person assessment by the assigned CM or representative of that agency unless member displays imminent harm to self or others.

- Cultural/Interpretation Services

  The BHO shall make available to each potential member and member, including individuals with Limited English Proficiency (LEP), oral interpretation services sign language services and TDD services. This must be provided at no cost to the individual. The BHO shall notify its members and potential members of the availability of free interpretation services, sign language and TDD services, and inform them of how to access these services.

  The BHO shall meet the following oral interpretation special requirements:

  - Offer oral interpretation services to individuals with LEP regardless of whether the individual speaks a language that meets the threshold of a prevalent non-English language; and

- Document the offer of an interpreter regardless of whether the individual indicated an ability to provide his or her own, and whether an individual declined or accepted the interpreter service.

The BHO shall meet the requirements on written materials in Section 51.320.

The BHO is prohibited from requiring or suggesting that LEP individuals provide their own interpreters or utilize friends or family members.

The BHO shall identify the health practices and behaviors of the members to design programs, interventions and services which effectively address cultural and language barriers to the delivery of appropriate and necessary health services.

The BHO shall demonstrate the capability to effectively communicate with members so that the members understand their condition(s), the recommended treatment(s), and the effect of the treatment on their condition including side effects.

- Accessible Transportation Services

  For the members who have no means of transportation and who reside in areas not served by public transportation, the BHO shall use the most cost efficient modes of transportation that are available to and from medically necessary behavioral health visits to providers. The BHO shall also provide transportation to members who are referred to a provider that is located on a different island or in a different service area/State. The BHO may use whatever modes of transportation that are available and can be safely utilized by the member. In cases where the member requires assistance, the BHO shall provide for an attendant or assistant to accompany the member to and from medically necessary visits to the providers. The BHO is responsible for the arrangement and payment of the travel costs for the member and the attendant or assistant and the lodging and meals associated with off-island or out-of-state travel due to medical necessity.

- Outreach

  Outreach involves the provision of services wherever necessary to assure all eligible members receive needed behavioral health services, (i.e., outreach to the home,

homebound, homeless, etc.). The BHO shall establish and maintain contact with all eligible members, but especially these special need individuals.

The BHO shall have processes to address the special problems of the poor and persons with physical disabilities will be addressed. For example, some of the eligibles who are most in need of behavioral health services are homeless, or many who do not have ready access to a telephone; some are unable to read or, understand the written word, and many do not speak English as their primary language.

The BHO contracted psychiatrist shall see members out in the field or a place agreed upon by the member who refuse to go to an office or clinic.

The BHO shall develop a CM component within their organization that will provide CM services from date of enrollment into the BHO until the member is assigned to a contracted provider to prevent gap in services. For members that currently are linked to a CBCM and wish to remain with that provider, the CBCM will be notified immediately of the member's enrollment into the BHO.

The BHO shall help their members maintain their medical assistance eligibility.

- Appointment Follow-up

  When the BHO refers the member to another practitioner or service provider for behavioral health services, the BHO shall follow-up to verify that the member received the needed services. If a behavioral health appointment is made but not kept by the member, the BHO shall contact the member to determine the reason and schedule another appointment. When the BHO member requires services provided by a BHO specialist or other practitioner, the BHO's providers or CM shall coordinate the referral with the health plan PCP. The health plan shall follow-up with the specialist or other practitioner to verify that the member received the needed services. Members shall receive a face-to-face case manager visit within two (2) days of discharge from an inpatient psychiatric hospitalization and a visit with their behavioral health provider within seven (7) days following discharge.

Members shall receive a face-to-face case manager visit within seventy-two (72) hours of discharge from an Emergency Department visit.

- Hotline

  The BHO shall provide toll-free hotline telephone services located in Hawaii, available on a 24-hour a day, 7 days a week basis, to its members and providers. The hotline information can be used by providers and members to: 1) identify the individual's case manager or BHO provider; 2) direct members to the nearest most appropriate behavioral health delivery site in cases of crisis, urgent or emergency care; 3) provide required prior approvals; and 4) answer other questions related to treatment of common behavioral health problems and minor emergency care. Non-crisis hotline services may be on-line or provided through other means, such as pagers, with a maximum response time of 30 minutes.

- Adverse Events Policy/Reporting

  The BHO shall have policies and procedures in place to identify and address adverse events that occur to their members. Adverse events include but are not limited to death, suicide attempts, altercations with law enforcement personnel including incarceration, involvement with Adult Protective Services, homicide or attempted harm to others, medication errors, injuries requiring medical attention, and loss of housing. The BHO shall submit to the DHS, for review and approval, policies and procedures relating to adverse events by the due date identified in Section 51.400, Readiness Review.

- Certification of Physical or Mental Impairment

  All evaluations for continued eligibility for DHS public assistance programs, and certificates of disability (initial and continued) are done through the DHS Panel. The BHO is not responsible for these evaluations. The BHO is responsible however, to assist the members to successfully complete the disability paperwork and connect with the evaluating provider.

41.300 Transition of Care

The BHO shall coordinate the transition of behavioral healthcare services for newly enrolled members with the DOH-CAMHD,

DOH-AMHD, DOH-DD, the State Hospital, prison, QI health plans, and other agencies and organizations involved, since many of the eligible members already have an established behavioral health care provider with the BHO. For some of these individuals, an abrupt change in therapy may be detrimental.

Upon Contract Effective Date identified in Section 20.100, members receiving medically necessary behavioral health services the day before enrollment into the BHO, the BHO shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided by contract or non-contract providers. The BHO shall provide continuation of such services for ninety (90) days for all members or until the member has had an assessment from his or her case manager, had an ITP developed and has been seen by his or her behavioral healthcare specialist. All non-contract providers shall be reimbursed at the Medicaid FFS rates in effect at the time of service delivery.

Individuals who are receiving services from DOH-CAMHD, and will no longer be eligible for services (age 21) with DOH-CAMHD, will also need to be transitioned to the BHO, if determined to have a SMI/SPMI diagnosis, or back to their QI health plan if they are determined to no longer require behavioral health services.

The BHO shall submit to the DHS, for review and approval, policies and procedures relating to transition of care by the due date identified in Section 51.400, Readiness Review.

41.400 On-Site Visits

The department reserves the right to conduct an on-site visit in addition to desk reviews to verify the appropriateness and adequacy of the Offeror's proposal before the award of the contract.

After the award of the contract, prior to implementation an on-site readiness review may be conducted by a team from the Med-QUEST Division and will examine the prospective contractor's information system, staffing for operations, case management, provider contracts, and other areas that will be specified prior to review.

After implementation of the contract, the department shall conduct unannounced on-site visits to the BHO and contracted providers in addition to desk reviews to verify adequate, appropriate, and timely access to services are being provided to the members enrolled in CCS.

41.500 Geographic Areas to be Served

The BHO shall provide the full range of behavioral health services to its members Statewide.

41.600 Advanced Directives

The BHO shall maintain written policies and procedures for advance directives in compliance with 42 CFR Section 438.6(i)(1)-(2) and 42 CFR Section 422.128 and Subpart I of 42 CFR Part 489. For purposes of this section, the term Medicare Advantage ("MA organization") in 42 CFR Section 422.128 shall refer to the BHO. Such advance directives shall be included in each member's medical record. The BHO shall provide these policies to all members eighteen (18) years of age or older and shall advise members of:

- Their rights under the law of the State of Hawaii, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;
- The BHO's written policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience. See 42 CFR Section 422.128(b)(1)(ii); and
- The BHO shall inform individuals that complaints concerning noncompliance with the advance directive requirements may be filed with the State survey and certification agency that is the DOH, Office of Health Care Assurance.

The information must include a description of current State law and must reflect changes in State laws as soon as possible, but no later than ninety (90) days after the effective date of the change. The BHO's information must inform members that complaints concerning noncompliance with the advance directive requirements may be filed with the DOH, Office of Health Care Assurance.

The BHO shall not condition the provision of care or otherwise discriminate against an individual based on whether or not a member has executed an advance directive. The BHO shall ensure compliance with requirements of the State of Hawaii law regarding advance directives.

The BHO shall educate its staff about its advance directive policies and procedures, situations in which advance directives may be of benefit to members, and the BHO's responsibility to educate and assist members who choose to make use of advance directives. The BHO shall educate members about their ability to direct their care using this mechanism and shall specifically designate which staff members or network providers are responsible for providing this education. The BHO shall provide these policies and procedures to its providers and upon request to CMS and DHS.

41.700 Second Opinion

The BHO shall provide for a second opinion in any situation when there is a question concerning a diagnosis, the options for the treatment of a behavioral health condition when requested by the member, any member of the health care team, a parent(s) or legal guardian(s), or a DHS social worker exercising custodial responsibility. A qualified health care professional within the network shall provide the second opinion or the BHO shall arrange for the member to obtain a second opinion outside the provider network. The second opinion shall be provided at no cost to the member.

SECTION 50 ADMINISTRATIVE REQUIREMENTS

50.100 Notification of Enrollment

DHS shall provide the member with written notification of enrollment into the BHO. This notice shall serve as verification of enrollment until the member receives a membership/enrollment card from the BHO.

The BHO shall provide the new member a confirmation of enrollment and other pertinent informational material, (listed in Section 50.110, Responsibilities of the BHO), within fifteen (15) days of enrollment.

DHS and the BHO shall participate in a daily and monthly transfer of enrollment/disenrollment data through an exchange via electronic media. The BHO agrees to accept the daily and monthly enrollment data from DHS as the official enrollment record. At times, in order to correct system errors, the DHS will issue a letter to the plan requesting the BHO change the enrollment information in the plan's system. The plan shall treat these letters also as official enrollment notification.

50.110 Responsibilities of the BHO

DHS shall be the sole authority to enroll members into the selected BHO. DHS shall transmit the necessary enrollment information to the BHO on a daily basis via electronic media and shall be formatted in the manner prescribed by DHS. The enrollment information shall include the member's name, mailing address, social security number, date of enrollment, third-party liability coverage, date of birth, sex, and other data that the DHS deems pertinent and appropriate.

Upon receipt of the information from DHS, the BHO shall enroll the member and perform the necessary procedures to ensure that the member is provided access to care. The following describes the responsibilities of the BHO upon enrollment of a member. The listing is not all-inclusive and DHS may require the plan to perform other tasks as determined necessary. The BHO may also add steps based upon its experiences and the procedures already performed for its members.

- Assign a member number to the member. This may be the member's Medicaid ID number.
- Assign a case manager to each member on the date of enrollment, whether it be from the BHO's CM component or a CBCM provider as described in subsection 40.100. For members that already have a case manager in the community, the BHO shall maintain this relationship. If the member or case manager in the community is not interested in continuing this relationship, then the BHO shall perform transition of care as described in Section 41.300.
- Explain the role of the case manager to the member and the procedures to be followed to obtain needed services. Provide the member with a listing of the providers. Orient and familiarize, then provide each member with a member handbook which explains the operations of the plan including the procedures to follow to make an appointment, obtain emergency services, change BHO providers or prescribing psychiatrist, member rights and responsibilities, file a complaint and grievance procedures, etc.
- Assist the member in the selection of a provider and explain the role and responsibilities of the behavioral health provider and/or the CM, as applicable and the procedures to be followed to obtain needed services. The BHO shall maintain the member with their current provider, if applicable. If the member does not select or does not have their own behavioral health provider from the provider network within ten (10) days of enrollment, the BHO shall identify a provider for the member.
- Explain the confidentiality policies related to the member's case documentation records (includes treatment records).
- Explain to the member the information that needs to be provided by the member to the BHO and DHS upon changes in the status of the member including marriage, divorce, birth of a child, adoption of a child, death of a spouse or child, acceptance of a job, obtaining other health insurance, etc.
- Issue membership card(s) to the enrolled members with adequate information for providers to identify the following:
    - Member number
    - Member name

- Effective date
- Benefit, e.g. behavioral health services only
- Crisis hotline
- Toll-free telephone number
- Third Party Liabilities (TPL's)
- Eligibility renewal date

The membership card need not have all of this information if the BHO can demonstrate that it has other processes or procedures in place to enable providers and members to access this information in a timely manner.

50.120 Eligibility Verification

Providers shall utilize either the DHS Medicaid on-line (DMO) or Automated Voice Response System (AVRS) to verify eligibility in the Community Care Services (CCS) program. The BHO shall assure that all of their providers have access to the DMO or AVRS system.

50.200 Disenrollment Responsibilities

DHS shall be the sole authority allowed to disenroll a member from the BHO. Reasons for disenrollment include, but are not limited to the following:

- Member loses Medicaid eligibility
- No contact with member for total of three (3) months
- Documentation of member refusal of services
- Member no longer meets eligibility criteria as per Section 30.520 Evaluation and Referral to the BHO
- Member moves to another State
- Death of the member
- Incarceration of the member
- Transfer of the member to a long term care nursing facility or an ICF-MR facility
- Member is waitlisted at an acute hospital for a long term care bed

- Member is sent out-of-state for medical treatment by DHS or a health plan and DHS or the health plan will assume responsibility for the behavioral health care needs of the member.
- Member is admitted to the State Hospital
- Member provides false information with the intent of enrolling in a DHS program under false pretenses

In most cases, the eligibility workers become aware of a situation which required action (i.e., member moves to the Mainland) and the person is disenrolled from the BHO. In other instances, the BHO may become aware of circumstances that could affect a person's eligibility. Examples of such situations include the member's death, incarceration, State Hospital admission, or eligibility for Medicare. The BHO is encouraged to bring these situations to the attention of the MQD. DHS shall provide disenrollment data to the BHO via electronic media on a daily and monthly basis.

Additionally, the BHO shall compile a list of members whose ineligibility cannot be explained (i.e., dropped off the daily 834 file). They shall submit the list to MQD Customer Service who will verify and re-enroll eligible members.

50.210 Members Who No Longer Meet the Criteria for SMI

Members who are enrolled in the BHO and who the BHO determines no longer meet the criteria for SMI shall be referred to the MQD. The MQD shall determine whether the member no longer meets the criteria using the same process described in Section 30.520, Evaluation and Referral to the BHO.

If the member no longer meets the criteria for enrollment in the BHO, they shall be disenrolled from the BHO at the end of the month in which the determination is made and responsibility for care is assumed by the QI health plan. The QI health plan shall receive written notification of the disenrollment from the BHO. Upon disenrollment from the BHO, the QI health plan assumes responsibility for providing the medically necessary mental health, drug abuse, and alcohol abuse services needed by the individual.

Members who have not maintained contact for a period of one (1) month the CM provider shall refer the member to the BHO CM component. The BHO then has two (2) months to re-establish contact with the member. If at the end of the two (2) months there is no contact, the member will be placed on a disenrollment list to be submitted to the DHS.

50.300 Claim Processing Capabilities

BHO shall comply with claims processing requirements listed in Section 40.340. The claim processing function and its key personnel shall be located in the State of Hawaii. BHO shall operate a provider toll-free call center located in Hawaii to respond to questions, comments and inquiries regarding claims submission and status. The call center staff must reside in the State of Hawaii. The provider toll-free call center services shall be available and accessible to CCS providers from all islands.

50.400 Assessment and Collection of Fees and Penalties

BHO shall comply with the financial responsibilities listed in Appendix I.

Members of the BHO shall not be assessed finance charges, co-payments for services or no-show fees. Members must be informed that they cannot be terminated from the program for no-show fees, non-covered services or for receipt of services from unauthorized non-plan providers.

In the future, should premiums be required for any individuals, the BHO and providers would be responsible for collecting any cost-sharing.

50.500 Quality Improvement

50.510 Importance of Quality Improvement

A quality improvement program (QIP) is an important and necessary component of a BHO to ensure that the members of a BHO are provided with quality care. QIP's help to ensure that the delivery of cost effective quality care is not compromised.

QIP's provide the BHO with a means of ensuring the best possible outcomes and functional health status of its members through delivery of the most appropriate level of care and treatment. QIP's include such important areas as utilization reviews, grievance procedures, and the maintenance of medical records. Quality care is defined as care that is accessible and efficient, provided in the appropriate setting, provided according to professionally accepted standards, and provided in a coordinated and continuous rather than episodic manner. Quality care includes but is not limited to:

- Provision of services in a timely manner with reasonable waiting times for office visits and the scheduling of appointments
- Provision of services in a manner which is sensitive to the cultural differences of members
- Provision of services in a manner which is accessible for members
- Opportunities for members to participate in decisions regarding their care
- Emphasis on health promotion and prevention as well as early diagnosis, treatment, and health maintenance
- Appropriate use of services in the provision of care by providers
- Appropriate use of technology in the provision of care by providers
- Appropriate documentation, in accordance with defined standards, of the assessment and treatment of patients
- Provision of services in a manner which reflects standards of good practice
- Improved clinical outcomes and enhanced quality of life
- Consumer satisfaction
- User friendly grievance procedures which resolve issues in a timely manner

In addition, the DHS contracts with an External Quality Review Organization (EQRO) to perform, on an annual basis, an external, independent review of the quality outcomes of, timeliness of, and access to the services provided for Medicaid

beneficiaries by the BHO. The EQRO shall monitor the BHO's compliance with all applicable provisions of 42 CFR 438, Subpart D.

50.520 Quality Improvement Programs

QIP requirements are internal programs which consist of systematic activities to monitor and evaluate the care delivered to members according to predetermined, objective standards, and effect improvements as needed.

The BHO shall be required to submit written descriptions of its QIP including definitions of accepted standards of practice and established policies and procedures. The documentation shall be provided to DHS as part of Readiness Review described in Section 51.400 and upon request by DHS.

The standards required in a QIP shall at a minimum include:

- Written QIP Description – The QIP shall be a written document describing the following:
  - Goals and objectives
  - Scope of the QIP
  - Specific activities to be undertaken such as studies
  - Continuous activity and tracking issues
  - Provider review
  - Focus on behavioral health outcomes
  - Systematic process of quality assessment and improvement
  - Evaluation of the continuity and effectiveness of the QIP
- Accountability of the Governing Body – The governing body of the organization, usually the Board of Directors, shall be responsible for the quality of care provided. The responsibilities of the governing body include oversight of the QIP, review of the progress of the QIP, and modifications to the program as needed.
- Active QIP Committee – The Committee shall have regular meetings; document its activities, findings, and recommendations and ensure follow-up; be accountable to

the governing body, and have a cross section of BHO providers.

- QIP Supervision – The QIP Committee should be the responsibility of a senior executive and the Medical Director should have substantial involvement.
- Adequate Resources – The QIP Committee should be provided with sufficient material resources to carry out its activities.
- Delegation of QIP Activities - The BHO shall remain responsible for the QIP even if portions are delegated to other entities. Any delegation of functions requires a written description of the delegated activities and written procedures for monitoring and evaluation.
- Member Rights and Responsibilities – The QIP shall have written policies and procedures that state the plan's commitment to treating members in a manner that respects their rights as well as its expectation of members' responsibilities.
- Standards for Availability and Accessibility – The QIP shall have established standards for access to services, which are to be compared to the plan's actual performance. Access and availability include standards for triage and travel time, telephone access and availability of appointments, which define the level of urgency and appropriate level of care.
- Case Documentation Records Standards – The QIP shall establish standards for the accessibility and availability of case documentation records and the information to be recorded and maintained in the records. A record review system to assess and assure conformance with standards shall be established.
    - At a minimum, the treatment record shall be maintained by the BHO provider and include a record of the member's medical and treatment history, all behavioral healthcare services provided to the member, assessments (including telephone assessments), medication profile (current and historical), treatment plans, and goals for future clinical care. The treatment record shall indicate the current BHO provider, other service provider(s), and history of changes in psychiatrist and other providers, as well as referrals for related specialist care and behavioral health services authorized by the BHO provider and/or CM.

CM records shall be maintained by the CM and include, at a minimum, member vital information, current treatment plan, goals and progress towards those goals, current medication profile, CM encounters, the current BHO provider, PCP/health plan, dentist/dental plan, and all other service providers.

- All case documentation records shall meet NCQA behavioral health guidelines for treatment record review. Records shall be maintained in a detailed, comprehensive, and organized manner which conform to good professional medical practice, permit effective professional medical review and medical audit processes and which facilitate an adequate system for follow-up treatment. All entries shall be legible, signed, and dated.
- Confidentiality of the records shall be maintained. Upon enrollment with the plan, the BHO shall ensure that confidential member records are accessible only to authorized persons, in accordance with written consent granted by a member or a member's representative or with applicable State or Federal laws, rules or regulations. Subcontractors and other network providers are not required to obtain subsequent written consent from the member before providing access to the records, as long as access to the records is needed to perform the duties of this contract and to administer the program. Approval is also not needed for access by authorized DHS personnel or personnel contracted by DHS. (Refer to Section 61.500, Confidentiality of Information, for additional information)

- Utilization Review – The QIP shall include a written description of the BHO's utilization management (UM) program which outlines the program structure and accountability. The scope of UM may include formal preauthorization, triage, concurrent review, discharge planning, retrospective review and case management. The UM plan includes policies and procedures to evaluate care management, sites of service, level of care, triage, benefit coverage and cost of benefits to determine if they are clinically appropriate to the behavioral healthcare needs of the members.
  - The program should include evaluating medical necessity, the criteria used and the process used to review and approve the provision of clinical services. The focus of the

UM program is to detect underutilization, overutilization, and inappropriate utilization.

- The BHO shall have in place a prior authorization (PA) process that ensures timely determination for access to care/services. Individuals shall perform PA determinations with demonstrated competency and knowledge of appropriate treatment/services for conditions/illnesses. The BHO shall have a process with timeframes that address PA decision-making for behavioral health services/procedures that the BHP determines to be medically necessary. The BHO may have different processes for emergencies, urgent, or non-urgent services but in general, all PA's must be completed within 30 days. The PA and the related appeals process shall be documented and made available to all participating providers. Refer to Section 40.400 regarding additional information for Authorization of Services.
- Concurrent review requirements shall be documented and available to appropriate providers

- Continuity of Care System – The BHO shall have a basic system in place that provides for continuity of care and case management.
- QIP Documentation – Documentation on the monitoring of the quality of care of all services and treatment modalities shall be maintained and available for inspection and review.
- Coordination of QI Activity with Other Management Activity – The findings, conclusions, recommendations, actions taken, and results of the actions taken shall be documented and reported to the appropriate individuals.

50.530 Responsibilities of the BHO

The BHO shall be responsible for developing and operating its own internal QIP. The plan shall monitor the quality of care rendered by the providers in the provider network and ensure that the providers meet the plan’s minimum standards and are following acceptable guidelines.

The BHO shall conduct its own utilization reviews. DHS requires that data and information be submitted so that DHS can conduct its own internal audit and monitoring of the QIP of the BHO. Once the plan’s QIP is approved by DHS, the internal review by

DHS will primarily ensure the QIP is being administered and followed. DHS reserves the right to review the detailed records of the BHO as it deems necessary. The BHO shall also provide whatever records and information requested by the contractor selected by DHS to perform an independent external audit of the BHO.

50.540 Performance Improvement Projects (PIPs)

As part of its QAPI Program, the BHO shall conduct two (2) PIPs in accordance with 42 CFR Section 438.330(d) that are designed to achieve, through ongoing measurements and interventions, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction. The PIPs shall include the following:

- A study topic identified by the BHO, CMS, and/or DHS;
- A clearly definable answerable study question;
- The use of objective, measurable, and clearly defined quality indicators to measure performance;
- A correctly identified study population;
- Valid sampling techniques;
- Accurate and complete data collection;
- The implementation of appropriate planned system interventions to achieve improvement in quality;
- An evaluation of the effectiveness of the intervention, including sufficient data and barrier analysis;
- An achievement of real improvement that is sustained; and
- A plan and activities that shall increase or sustain improvement.

The BHO shall report the status and results of each project to the DHS as requested. Each PIP must be completed in the time period determined by DHS so as to allow information on the progress of PIPs in aggregate to produce new information annually on quality of care according to 42 CFR Section 438.233(d)(2).

PIPs may be specified by the DHS and by CMS. The BHO shall submit to the DHS and the EQRO any and all data necessary to enable validation of the BHO's performance under this section, including the status and results of each project.

50.550 Performance Measures

The BHO shall comply with all the DHS quality management requirements to improve performance for DHS established performance measures. Performance measures may be based on CMS core measures or initiatives, State priorities, or areas of concern that arise from previous measurements. Both clinical and utilization measures are included. The following include sets of performance measures that the health plan shall be required to provide:

- HEDIS measures - a set of HEDIS measures (both clinical and utilization measures) is required from the health plan each year. DHS shall provide a list of the HEDIS performance measures at the end of the calendar year for the next years required measures.
- Utilization dashboard - the health plan shall supply information that may include hospital admissions and readmissions, call center statistics, provider network, member demographics, etc. DHS shall provide a list of the measures and a format for submission.

The health plan shall submit to the DHS and the EQRO any and all data necessary to enable validation of the health plan's performance under this section.

50.560 Practice Guidelines

The BHO shall include, as part of its Quality Improvement Program, practice guidelines that meet the following requirements as stated in 42 CFR Section 438.236. Each adopted practice guidelines shall be:

- Relevant to the BHO's membership;
- Based on valid and reliable clinical evidence or a consensus of health care professionals in the behavioral health field;
- Adopted in consultation with in-network providers;
- Reviewed and updated periodically as appropriate; and

- Disseminated to all affected providers, and upon request, to members and potential members.

Additionally, in compliance with 42 CFR Section 438.236, the BHO shall ensure that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

50.600 Performance Incentives

The BHO shall enter into business agreements with the MQD contracted health plans to allow the exchange of information to facilitate case management and the provision of high quality care.

The BHO may be eligible for performance incentives. The amount of incentive and measures shall be determined by the Department. Examples of measures may include but would not be limited to: maintaining Medicaid eligibility, medication adherence, member function/quality of life, reduced Emergency Department visits, and reduced admissions for acute inpatient behavioral health services. The BHO may also be eligible for gain-sharing from the health plans for reduced utilization by its members of non-behavioral health services such as ER or inpatient hospitalization.

50.700 Monitoring and Evaluation

50.710 Internal QIP Monitoring

DHS shall monitor the BHO to assure that its internal QIP's are structured and operating in accordance with the standards for the internal QIP’s.

DHS will evaluate specific aspects of the QIP by a variety of methods. It will review complaint and grievance logs, evaluate complaints from advocacy groups, providers, agencies, and members/representatives, validate that QIP utilization management, concurrent review, and prior authorization procedures are being implemented with an understanding of the behavioral health benefits allowed under the health plans and taking into consideration the medical necessity of the services for the member. Also, DHS will evaluate whether procedures to ensure access to care, continuity of care and coordination of care

and other QIP activities which are part of the plan's written QIP are being implemented.

DHS may elect to monitor the activities of the BHO using its own personnel or may contract with qualified personnel to perform functions specified by DHS. In either case, the BHO shall cooperate and provide the requested information and allow access to the plan and providers' records. Upon completion of its review, DHS will submit a report of its findings to the BHO. The BHO shall submit a plan of action to correct, evaluate, respond to, resolve, and follow-up on any identified problems reported by the DHS.

50.720 External Monitoring

DHS may contract with a qualified entity to conduct an independent medical review or audit of the quality of services provided by the BHO. The cost of the independent review(s) shall be borne by DHS. The plan shall cooperate with the contractor and provide the information requested including medical records, QIP reports and documents and financial information. The BHO shall submit a plan of action to correct, evaluate, respond to, resolve, and follow-up on any identified problems reported by the audit.

DHS shall contract with a qualified entity to conduct an annual, external, independent review of the quality outcomes, timeliness of, and access to, the services covered under each contract.

50.730 Conduct Surveys

DHS may conduct surveys of members and providers, to determine overall satisfaction with the BHO, the quality of care received and the overall behavioral health status of the members. These surveys may be conducted annually, utilizing appropriate sampling techniques, covering member satisfaction and behavioral health status, and provider satisfaction.

The survey instruments shall be developed by DHS with input from the BHO. The DHS shall share the results of the survey with the BHO. Participation in the DHS surveys will not preclude the plan from conducting its own surveys.

DHS may require the BHO to conduct quality of life surveys with their members as part of their quality program.

50.740 Conduct Case Study Interviews

DHS may interview key individuals involved with the CCS program, including representatives of the BHO, associations, and consumer groups to identify what is expected of the program, changes needed to be made, effectiveness of outreach, and enrollment and adequacy of the program in meeting the needs of the populations served.

The BHO shall cooperate in the interview process by allowing selected individuals to meet with and discuss the issues with DHS representatives.

50.750 CMS Contracted Review Organization

The BHO shall cooperate and assist the reviewers of any CMS contracted review organization to access plan personnel, providers, and members to obtain information required in the review, if applicable.

50.800 Reporting Requirements

50.810 Purpose for Data to be Collected

The requirement that the BHO provide the requested data is a result of the terms and conditions established by CMS. The State shall perform periodic reviews in order to ensure compliance. The State is required to have provisions in its contracts with the BHO for the provision of the data and is authorized to impose financial penalties if the data is not provided timely and accurately.

DHS reserves the right to request additional data, information and reports from the BHO, as needed, to comply with CMS requirements and for its own management purposes.

50.820 Timeliness of Data Submitted

All information, data, and reports shall be provided to DHS by the specified deadlines. The BHO shall be assessed a penalty of $200.00 per day until the required reports are received by DHS.

50.830 Reports

The BHO shall submit to the DHS all requested reports identified below and in the time frames identified in this Section. In addition, the BHO shall comply with all additional requests from the DHS, or its designee, for additional data, information and reports. In the event the BHO is under a corrective action plan (CAP), the BHO may be required to submit certain reports more frequently than stated in this Section.

All reporting data shall be submitted to the DHS in electronic format of either Word 2013 or lower (.docx), or Excel 2013 or lower (.xlsx). Reporting data shall not be submitted with read only or protected formatting.

As described in Section 50.820, the State may impose financial penalties for failure to produce accurate reports according to the time frames identified.

Data received from the BHO on quality, performance, patient satisfaction, or other measures shall be used for monitoring, public reporting, and financial incentives. DHS shall also share information about the BHO to promote transparency and sharing of benchmarks/best practices. DHS shall publicly report measures in formats such as a consumer guide, public report, or otherwise, on MQD's website.

The BHO shall submit the following reports electronically to the DHS to the BHOs File Transfer Protocol (FTP) site according to the specified schedule.

Category	Report	RFP Section	Due Dates
Provider Network and Services	Provider Network Adequacy & Capacity Report	50.840.1	April 30 July 31 October 31 January 31
Provider Network and Services	GeoAccess (or similar format) Report	50.840.2	April 30 July 31 October 31 January 31

Category	Report	RFP Section	Due Dates
Provider Network and Services	Provider Suspension & Termination Report	50.840.3	April 30 July 31 October 31 January 31
Provider Network and Services	Provider Grievance & Claims Report	50.840.4	April 30 July 31 October 31 January 31
Member Services	Member Complaints, Grievances & Appeals Report	50.850.1	April 30 July 31 October 31 January 31
Member Services	Behavioral Health Services Report	50.850.2	**Monthly reports:** The last day of the month following the reporting month; **Annual summary report:** January 31 of the following year
Administ-ration & Financial Reports	QIP Report	50.860.1	September 30
Administ-ration & Financial Reports	Prior Authorization Requests Denied/ Deferred Report	50.860.2	April 30 July 31 October 31 January 31
Administ-ration & Financial Reports	Fraud, Waste and Abuse Report	50.860.3	April 30 July 31 October 31 January 31

Category	Report	RFP Section	Due Dates
Administ-ration & Financial Reports	BHO Financial Reports	50.860.4	April 30 July 31 October 31 January 31

50.840 Provider Network and Service Reports

50.840.1 Provider Network Adequacy and Capacity Report

The BHO shall submit a *Provider Network Adequacy and Capacity Report* that demonstrates that the BHO offers an appropriate range of behavioral health services that is adequate for the anticipated number of members for the service and that the network of providers is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.

The BHO shall submit these reports on electronic media in the format specified by the DHS. The information shall, at a minimum, include:

- A listing of all providers and include the specialty or type of practice of the provider;
- The provider's location;
- Mailing address including the zip code;
- Telephone number;
- Professional license number and expiration date;
- Indication as to whether the provider has a limit on the number of the program patients he/she will accept
- Indication as to whether the provider is accepting new patients;
- Non-English language spoken (if applicable);
- Verification of valid license for in-state and out-of-state providers; and
- Verification that provider or affiliated provider is not on the federal or state exclusions list.

The BHO shall provide a narrative that describes the BHO's strategy to maintain and develop their provider network to include but not limited to:

- Take into account the numbers of network providers who are not accepting new patients;
- Consider the geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities;
- Current network gaps and the methodology used to identify them;
- Immediate short-term interventions when a gap occurs including expedited or temporary credentialing; and
- Interventions to fill network gaps and barriers to those interventions.

This report shall be provided in the format to be prescribed by the DHS.

50.840.2 GeoAccess (Or Similar Program) Reports

The BHO shall submit reports using GeoAccess or similar software that allow DHS to analyze, at a minimum, the following:

- The number of providers by specialty and by location with a comparison to the zip codes of members;
- Indication as to whether the provider has a limit on the number of BHO members he/she will accept;
- Indication as to whether the provider is accepting new patients; and
- Non-English language spoken (if applicable).

The BHO shall assure that the providers listed on the GeoAccess reports are the same providers that are described in the Provider Network Adequacy and Capacity Report.

In addition to the due date as identified in Section 50.830, these reports shall be submitted to the DHS at the following times:

- Upon the DHS request;

- Upon enrollment of a new population in the BHO;
- Upon changes in services, benefits, geographic service area or payments; and
- Any time there has been a significant change in the BHO's operations that would affect adequate provider capacity and services. A significant change is defined as any of the following:
    - A loss of providers in a specific specialty where another provider in that specialty is not available on the island; or
    - A loss of a hospital.

50.840.3 Provider Suspensions and Termination Report

The BHO shall notify the MQD within three (3) business days of any provider suspensions and terminations, both voluntary and involuntary because of suspected or confirmed fraud or abuse. The immediate notification shall include provider's name, provider's specialty, reason for the action and the effective date of the suspension or termination. In addition, the BHO shall submit a summary *Provider Suspensions and Terminations Reports* that list by name, all provider suspensions or terminations. This report shall include all providers, each provider's specialty, their primary city and island of services, reason(s) for the action taken as well as the effective date of the suspension or termination. If the BHO has taken no action against providers during the quarter this shall be documented in the *Provider Suspensions and Terminations Report*. The BHO shall utilize the report format provided by the DHS.

50.840.4 Provider Grievance & Claims Report

The BHO shall submit *Provider Grievance & Claims Reports* that include, but is not limited to, the following information (required information may change at the discretion of DHS):

- By grievance type:
    - The total number of grievances received during the reporting quarter;
    - The total number of grievances received and resolved during the reporting quarter;

    - The total number of unresolved grievances of the reporting quarter that are expected to be resolved during the next quarter; and
    - The total number of unresolved grievances of the reporting quarter that are not expected to be resolved during the next quarter.
- For grievances received prior to the reporting quarter that were unresolved as of the start of the reporting quarter:
    - The name of the provider:
    - The date and nature of the grievance;
    - The status of the grievance as of the end of the reporting quarter;
    - An explanation of the delay in resolving the grievance; and
    - The steps taken and/or steps that will be taken to resolve the grievance.
- Claims data, including:
    - The number of new claims received during the month for processing;
    - The number of claims that were previously reported but not processed during the preceding month ("carry-overs");
    - The number of new claims received and processed during the preceding month, that were not previously reported due to receipt and processing after data was captured;
    - The number of new claims received and not processed during the preceding month, that were not previously reported due to receipt after data was captured;
    - The number of claims processed during the month;
    - The number of claims paid during the month;
    - The number of claims denied during the month;
    - The number of claims processed, that were processed at or within 30 days of the claim receipt;
    - The number of claims processed, that were processed at or within 90 days of the claim receipt; and

- The number of claims denied during each month in the reporting quarter, for each of the following reasons, including but not limited to: (1) not meeting prior authorization/referral requirements; (2) late submission; (3) provider not eligible on date of service; (4) member not eligible on date of service; (5) member has another health insurer which shall be billed first; (6) additonal information is needed; (7) duplicated claims; and (8) no member responsibility (ex., General Excise Tax).

Said reports shall be submitted using the format provided by DHS.

50.850 Member Services Reports

50.850.1 Member Complaints, Grievances and Appeals Report

The BHO shall submit *Member Complaints, Grievances and Appeals Reports*. These reports shall be submitted in the format provided by the DHS. At a minimum, the reports shall include:

- The number of complaints, grievances and appeals by type;
- Type of assistance provided;
- Administrative disposition of the case;
- Overturn rates;
- Percentage of grievances and appeals that did not meet timeliness requirements;
- Ratio of grievances and appeals per 100 members; and
- Listing of unresolved appeals originally filed in previous quarters.

Reports shall be submitted using the format provided by the DHS.

50.850.2 Behavioral Health Services Report

The BHO shall submit to the DHS *Behavioral Health Services Reports*. Reports shall include information on services provided by acuity of member as defined in Section 40.220, sentinel incident reporting, and any other quality measures that the DHS deems necessary.

Reports shall be submitted using the format provided by the DHS.

50.850.3 Supportive Housing Services Report

The BHO shall submit to the DHS a Supportive Housing Services Report. These reports shall be submitted in the format provided by the DHS. At a minimum, the reports shall include:

- Member Demographics
- Homeless counts
- Types of Pre/Tenancy services
- Length of time to obtain housing
- Type of Housing/Funding
- ED Visits/Expenditures, Hospitalizations/Expenditures, Eviction Prevention Activities by Member
- Notable housing Achievements
- Housing Challenges and Barriers

Reports shall be submitted using the format provided by the DHS.

50.860 Administration and Financial Reports

50.860.1 Quality Improvement Program (QIP) Report

The BHO shall provide an annual *QIP Program Report*. The BHO's medical director shall review these reports prior to submittal to the DHS. The *QIP Program Report* shall include the following:

- Any changes to the QIP Program;
- A detailed set of QIP Program goals and objectives that are developed annually and includes timetables for implementation and accomplishments;
- A copy of the BHO's organizational chart including vacancies of required staff, changes in scope of responsibilities, changes in delegated activities and additions or deletions of positions;

- A current list of the required staff as detailed in Section 40.700 including name, title, location, phone number and fax number;
- An executive summary outlining the changes from the prior QIP;
- A copy of the current approved QIP Program description, the QIP Program work plan and, if issued as a separate document, the BHO's current utilization management program description with signatures and dates;
- A copy of the previous year's QIP Program, if applicable, and utilization management program evaluation reports; and
- Written notification of any delegation of QIP Program activities to contractors.

50.860.2 Prior Authorization Requests Denied/Deferred

The BHO shall submit *Prior Authorization Requests that have been Denied or Deferred Reports*. The specific reporting period, types of services and due dates shall be designated by the DHS. The report shall include the following data:

- Date of the request;
- Name of the requesting provider;
- Member's name and ID number;
- Date of birth;
- Diagnoses and service/medication being requested;
- Justification given by the provider for the member's need for the service/medication;
- Justification of the BHO's denial or the reason(s) for deferral of the request; and
- The date and method of notification of the provider and the member of the BHO's determination.

Reports shall be submitted using the format provided by the DHS.

50.860.3 Fraud, Waste and Abuse Reports

The BHO shall submit *Fraud, Waste and Abuse Report*s that include, at a minimum, the following information on all alleged fraud, waste and abuse cases:

- A summary of all fraud, waste and abuse referrals made to the State during the quarter, including the total number, the administrative disposition of the case, any disciplinary action imposed both before the filing of the referral and after, the approximate dollars involved for each incident and the total approximate dollars involved for the quarter;
- A summary of the fraud, waste and abuse detection and investigative activities undertaken during the quarter, including but not limited to the training provided, provider monitoring and profiling activities, review of providers' provision of services (under-utilization and over-utilization of services), verification with members that services were delivered, and suspected fraud, waste and abuse cases that were ultimately not fraud or abuse and steps taken to remedy the situation; and
- Trending and analysis as it applies to: utilization management, claims management, post-processing review of claims, and provider profiling.

The BHO and its subcontractors shall retain all Fraud, Waste and Abuse data for a period of no less than ten (10) years in accordance with 42 CFR 438.3 (u).

Reports shall be submitted using the format provided by the DHS.

50.860.4 BHO Financial Reporting Guide

The BHO shall submit financial information on a regular basis in accordance with the BHO Financial Reporting Guide provided by the DHS.

The financial information shall be analyzed and compared to industry standards and standards established by the DHS to ensure the financial solvency of the BHO. The DHS may also monitor the financial performance of the BHO with on-site inspections and audits.

The BHO shall, in accordance with generally accepted accounting practices, prepare financial reports that adequately reflect all direct and indirect expenditures and management and fiscal practices related to the BHO's performance of services under this contract.

50.870 BHO Certification

The BHO shall certify the accuracy, completeness, and truthfulness of any data, including but not limited to, encounter data, data upon which payment is based, and other information required by the State, that may be submitted to determine the basis for payment from the State agency. The BHO shall certify that it is in substantial compliance with the contract and provide a letter of certification attesting to the accuracy, completeness, and truthfulness of the data submitted based on best knowledge, information, and belief. The BHO shall submit the letter of certification to the MQD concurrent with the certified data and document submission. In the case of two (2) submissions in one month, the BHO shall submit two (2) letters of certification. The certifications are to be based on best knowledge, information, and belief of the following BHO personnel.

The data shall be certified by:

- The BHO's Chief Executive Officer (CEO);
- The BHO's Chief Financial Officer (CFO); or
- An individual who has delegated authority to sign for, and who reports directly to, the BHO's CEO or CFO.

Source, content, and timing of certification shall comply with the requirements set forth in 42 CFR Section 438.606.

The BHO shall require claim certification from each provider submitting data to the BHO.

50.880 Follow-Up by BHOs/Corrective Action Plans/Policies and Procedures

The DHS shall provide a report of findings to the BHO after completion of each review, monitoring activity, etc.

Unless otherwise stated, the BHO shall have thirty (30) days from the date of receipt of a DHS report to respond to the MQD's

request for follow-up, actions, information, etc. The BHO's response shall be in writing and address how the BHO resolved the issue(s). If the issues(s) has/have not been resolved, the BHO shall submit a corrective action plan including the timetable(s) for the correction of problems or issues to MQD. In certain circumstances (i.e., concerns or issues that remain unresolved or repeated from previous reviews or urgent quality issues), MQD may request a ten (10) day plan of correction as opposed to the thirty (30) day response time.

For all medical record reviews, the BHO shall submit information prior to the scheduled review and arrange for MQD or its designee to access medical records through on-site review and provision of a copy of the requested records. The BHO shall submit this information within sixty (60) days of notification or sooner should circumstances dictate an expedited production of records.

The BHO shall submit the most current copy of any policies and procedures requested. In the event the BHO has previously submitted a copy of a specific policy or procedure and there have been no changes, the BHO shall state so in writing and include information as to when and to whom the policy and procedure was submitted. If there are no formal policies or procedures for a specific area, the BHO may submit other written documentation such as workflow charts or other documents that accurately document the actions the BHO has or shall take.

50.900 Information Technology

50.910 General Requirements

The BHO shall have information management systems that enable it to meet the DHS requirements, state and federal reporting requirements, all other contract requirements and any other applicable state and federal laws, rules and regulations, including the Health Insurance Portability and Accountability Act (HIPAA).

50.920 Expected Functionality

The DHS expects BHO information systems to facilitate and to integrate the following essential BHO case management and coordination of care functions: (1) member health status

assessments; (2) determination of the optimal mix of health care services needed to improve the health status of said members; (3) coordination and oversight of the delivery of said services; and (4) the analysis and reporting of service utilization and outcomes data required to manage these functions effectively.

To achieve this objective, the BHO shall have a suite of properly interfaced, readily accessible yet secured information systems that enable the efficient execution of the aforementioned functions.

50.930 Method of Data Exchange with MQD

The MQD Secure File Transfer (SFT) server is the source of all file transfers between MQD and trading partners, including the BHO. Specific technical specifications and instructions are provided in the Hawaii Prepaid Medical Management Information System (HPMMIS) Health Plan Manual available on the Med-QUEST web site. The SFT server allows the MQD and the BHO to securely transfer member, provider, and encounter data via the internet.

50.940 Chain of Trust Agreement

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the implementation of certain administrative procedures to guard the integrity, confidentiality and availability of data protected under HIPAA. A chain of trust agreement is essentially a non-disclosure agreement that governs the transmission of data through an electronic medium and protects the integrity and confidentiality of the data exchanged.

The BHO shall institute a chain of trust agreement, in compliance with HIPAA, with any parties with whom it will be providing or sharing electronic health information.

A chain of trust agreement is required when data is exchanged between healthcare organizations and any third parties. The purpose is to ensure that a uniform level of security is applied at every "link" in the chain where information passes from one party to another. Verification of uniformity at each link is necessary for optimal protection of transmitted data.

A chain of trust agreement is a proxy for actual physical confirmation. Therefore it is important that the parties to these contracts agree to security mechanisms that:

1. Ensure that all transmissions of data are authorized
2. Protect the integrity and confidentiality of patient information
3. Protect business records and data from improper access

The BHO shall provide a copy of the chain of trust agreement it intends to use to comply with the HIPAA requirements to DHS for review and approval, prior to execution.

50.950 Compliance with the Health Insurance Portability and Accountability Act (HIPAA)

The BHO shall implement the electronic transaction and code set standards and other "Administrative Simplification" provisions, privacy and security provisions of HIPAA, Public Law 104-191, as specified by CMS.

50.960 Possible Audits of BHO Information Technology

The BHO shall institute processes to ensure the validity and completeness of the data submitted to the DHS. The DHS or its contractors may conduct general data validity and completeness audits using industry standard sampling techniques. The DHS reserves the right to have access to the BHO's system at any time when deemed necessary under this contract.

50.970 BHO Information Technology Changes

The BHO shall notify the DHS and obtain prior approval for any proposed changes to its information system that could impact any process or program under this contract.

50.980 Disaster Planning and Recovery Operations

The BHO shall have in place disaster planning and recovery operations appropriate for the BHO industry, and comply with all applicable federal and state laws relating to security and recovery of confidential information and electronic data. The health plan shall provide the DHS with a copy of its documentation describing its disaster planning and recovery

operations by the due date identified in Section 51.400, Readiness Review.

51.100 Encounter Data Requirements

The BHO shall submit encounter data to MQD once per month in accordance with the requirements and specifications defined by the State and included in the Health Plan Manual. Encounters shall be certified and submitted by the BHO as required in 42 CFR Section 438.606 and as specified in Section 50.870.

51.110 Accuracy, Completeness and Timeliness of Encounter Data Submissions

The following encounter data submission requirements apply:

- Accuracy and Completeness – The data and information provided to the DHS shall be accurate and complete. Data and reports shall be mathematically correct and present accurate information. An accurate and complete encounter is one that reports a complete and accurate description of the service provided, and that passes the full edits/audits of the encounter processing cycle.
- Timeliness – sixty percent (60%) of the encounter data shall be received by the DHS no more than one hundred twenty (120) days from the date that services were rendered. BHOs shall have the goal of submitting one hundred percent (100%) and shall submit no less than ninety-nine percent (99%) of encounter data within fifteen (15) months from the date of services. Adjustments and resubmitted encounters shall not be subject to the one hundred twenty (120) day submission requirement. In addition, TPL related encounters shall not be subject to the one hundred twenty (120) day submission deadline.

The BHO shall be notified by the DHS within thirty (30) days from the receipt date of the initial encounter submission of all encounters that have failed the accuracy and completeness edits. The BHO shall be granted a thirty (30) day error resolution period from the date of notification. If, at the end of the thirty (30) day error resolution period, fifteen percent (15%) of the initial encounter submission continues to fail the accuracy and completeness edits, a penalty amounting up to ten percent (10%) of the monthly (initial month's submission) capitation

payment may be assessed against the BHO for failing to submit accurate and timely encounter data. In a case where the BHO contract is not continued, a penalty of up to ten percent (10%) may be assessed against all of the outstanding payments to the BHO for failing to submit accurate and timely encounter data.

51.200 Notification of Changes in Member Status

51.210 Member and BHO Responsibilities

As part of the education conducted by DHS, members shall be notified that they are to provide the BHO and DHS with any information affecting their member status. DHS shall describe the information that is to be provided and explain the procedures to be followed during its educational sessions and in its printed material. The BHO shall also explain the information and the procedures to be followed by the members during the orientation process.

It is expected that not all members will remember to provide DHS with the information on changes to their status. Therefore, it is important for the BHO, which may have more contact with the members, to forward such information to DHS on a timely basis and inform the member of his/her responsibility to report changes directly to DHS. The BHO shall complete the required 1179 form for changes in member status and forward/fax the information to the designated representative on a daily basis.

51.220 Changes in Member Status

The following are examples of changes in the member's status that may affect the eligibility of the member.

- Death of the member or family member (spouse or dependent)
- Marriage
- Divorce
- Adoption
- Change in status (i.e., no longer meets eligibility criteria)
- Change in address (i.e., moved out of state)

- Institutionalization (i.e., imprisonment or long-term care facility, state hospital)
- TPL coverage, especially employer-sponsored or Medicare
- Legal encumbrances - conditional release, jail diversion, released on conditions and mental health court or receiving services from DOH-AMHD
- Change in income

51.300 Educational Materials

51.310 BHO's Responsibilities

A booklet or pamphlet shall explain in more detail the procedures to be followed by the member and the responsibility of the member. It shall be provided to each member within ten days of enrollment and annually thereafter.

The following is the minimum information to be included in the booklet or pamphlet:

- Role and selection of a BHO provider;
- A provider directory that includes the names, location, telephone numbers of, and non-English languages spoken by contracted providers in the member's service area including identification of providers that are not accepting new patients;
- Any restrictions on the member's freedom of choice among network providers
- CM system: role and selection of a CM and how to access CM services;
- Description of the behavioral health services provided as part of the CCS program that includes amount, duration, and scope;
- Member has a right be provided with written notice of any significant change related to member rights and responsibilities procedures at least 30 days before the intended effective date of the change;

- Members have access to the providers contracted with the BHO;
- Member's rights and protections as specified in 42 CFR §438.100;
- Authorization requirements for obtaining behavioral health services;
- Changing behavioral health providers;
- Making an appointment;
- Reporting changes in status and family composition;
- Reporting of a third party liability;
- Right to file a grievances and appeals;
- Access to administrative hearing process;
- Toll-free number to call for questions and assistance and 24 hour crisis line;
- Using the membership card;
- Penalties for fraudulent activities;
- How members may obtain benefits from out-of-network, out-of-state or off-island behavioral health services. Out-of-state or off-island behavioral health services;
- Information on advance directives;
- Cost sharing, if any;
- How and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost sharing, and how transportation is provided. For a counseling or referral service that the BHO does not cover because of moral or religious objections, the BHO need not furnish information on how and where to obtain the service. The DHS must provide information on how and where to obtain the service;
- Confidentiality of member information;
- Information on individuals rights as it pertains to the Health Care Privacy Act;

- Failure to pay for non-covered services will not result in loss of Medicaid benefits;
- Availability of Ombudsman Program services for members
- Information on the extent to which, and how, after-hours and emergency services are provided, including the following:
    - What constitutes an urgent and emergency medical condition, emergency services, post-stabilization services in accordance with 42 CFR 422.113(c);
    - The fact that prior authorization is not required for emergency services;
    - The process and procedures for obtaining emergency services, including the use of the 911 telephone systems or its local equivalent;
    - The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered herein; and
    - The fact that a member has a right to use any hospital or other appropriate health care setting for emergency services;
- Information on the member grievance system policies and procedures, as described in Section 40.600. This description must include the following:
    - The right to file a grievance and appeal with the BHO;
    - The requirements and timeframes for filing a grievance or appeal with the BHO;
    - The availability of assistance in filing a grievance or appeal with the BHO;
    - The toll-free numbers that the member can use to file a grievance or an appeal with the BHO by phone;
    - The right to a state administrative hearing, the method for obtaining a hearing, and the rules that govern representation at the hearing;
    - Notice that if the member files an appeal or a request for a state administrative hearing within the timeframes specified for filing, the member may request continuation of benefits as described in Section 40.660 and be required

to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member; and

- Any appeal rights that the state chooses to make available to providers to challenge the failure of the BHO to cover a service; and

- Additional information that is available upon request, including information on the structure and operation of the BHO and information on physician incentive plans as set forth in 42 CFR Section 438.6(h).

A copy of this booklet shall be submitted to DHS for review and approval in the timeframe described in Section 51.400, Readiness Review.

51.320 Requirements for Written Materials

The BHO shall use easily understood language and formats for all member written materials.

The BHO shall make all written materials available in alternative formats and in a manner that takes into consideration the member's special needs, including those who are visually impaired or have limited reading proficiency. The BHO shall notify all members and potential members that information is available in alternative formats and provide information on how to access those formats.

The BHO shall make all written information for members available in languages comply with Section 1157 of the Patient Protection and Affordable Care Act. When the BHO is aware that the member needs written information in one of these alternate languages, the BHO shall send all written information in this language (not English) to that member within seven (7) days of the request or next business day. The BHO may provide information in other prevalent non-English languages based upon its member population as required in Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d, 45 CFR Part 80.

All written materials distributed to members shall include a language block that informs the member that the document contains important information and directs the member to call the BHO to request the document in an alternative language or

to have it orally translated. The language block shall be printed, at a minimum, in the non-English languages identified in paragraph three (3) of this section.

The BHO shall certify that a qualified individual has reviewed the translation of the information into the different languages for accuracy. The BHO shall submit certification and translation of information into different languages to the DHS for review and approval by the due date identified in Section 51.400, Readiness Review.

All written materials shall be worded such that the materials are understandable to a member who reads at the 6th (6.9 or below) grade reading level. Suggested reference materials to determine whether this requirement is being met are the:

- Fry Readability Index;
- PROSE The Readability Analyst (software developed by Education Activities, Inc.);
- McLaughlin SMOG Index; or
- Flesch-Kincaid Index.

All written material including changes or revisions must be submitted to the DHS for prior approval before being distributed. The BHO shall also receive prior approval for any changes in written materials provided to the members before distribution to members.

51.400 Readiness Review

51.410 Required Review Documents

Prior to the Contract Effective Date described in Section 20.100, the DHS or its agent shall conduct a readiness review of the BHO in order to provide assurances that the health plan is able and prepared to perform all administrative functions required by this contract and to provide high quality service to members.

The DHS' review may include, but is not limited to, a walk-through of the BHO's operations, information system demonstrations and interviews with BHO staff. The review may also include desk and on-site review of:

- Provider network composition and access;
- Quality Improvement program (QIP) standards;
- Utilization Management Program (UMP) strategies;
- Plans for coordination, cooperation and transition with community programs; and
- All required policies and procedures.

Based on the results of the review activities, the DHS shall provide the BHO with a summary of findings including the identification of areas requiring corrective action before the DHS shall enroll members in the BHO.

The BHO shall demonstrate its ability to meet the requirements of the contract, as determined by the DHS, within the time frames specified by the DHS prior to enrolling members. If the BHO, is unable to meet the contract requirements for readiness, the DHS may terminate the contract in accordance with Section 61.300.

The BHO shall comply with all readiness review activities required by the DHS. This includes, but is not limited to, submitting all required review documents identified in the table below by the required due date, participating in any on-site review activities conducted by the DHS, and submitting updates on implementation activities. The DHS reserves the right to request additional documents for review and approval during readiness review.

Document	RFP Reference Section	Due Date
Credentialing, recredentialing and other certification policies and procedures	40.310 Provider Credentialing, Recredentialing and Other Certifications	30 days after contract effective date
Model for each provider contract	40.315 Provider Contracts	10 days after contract effective date
Medical records standards	40.320 Review of Medical Records	60 days after contract effective date

Document	RFP Reference Section	Due Date
Provider availability policy and procedure	40.325 Provider Availability	30 days after contract effective date
Prior authorization/pre-certification policies and procedures	40.400 Authorization of Services	60 days after contract effective date
Translation Certification	51.320 Requirements for Written Materials	Within 30 days of DHS approval of English versions of documents
Grievance system policies and procedures	40.600 Member Grievance System	60 days after contract effective date
Detailed plan for service delivery system	40.910 Covered Behavioral Health Services	30 days after contract effective date
Behavioral Health Adverse Events policy and Procedure	41.200 Adverse Events Policy/Reporting	30 days after contract effective date
Transition of Care policies and procedures	41.300 Transition of Care	30 days after contract effective date
QI Program	50.520 QI Program	60 days after contract effective date
Documentation describing its disaster planning and recovery operations	50.980 Disaster Planning and Recovery Operations	90 days after contract effective date
Member booklet	51.300 Educational Materials	30 days after contract effective date
A GeoAccess (or comparable program) report	51.420 Updated GeoAccess Reports	30 days after contract effective date

Document	RFP Reference Section	Due Date
Subcontractor Agreements	60.300 Subcontracts Agreements	60 days after contract effective date

51.420 Updated GeoAccess Reports

The BHO shall submit, within thirty (30) days of the date of Contract Effective Date identified in Section 20.100, updated GeoAccess reports (or reports generated by a similar program) that include all providers who have signed a provider agreement.

51.430 BHO Provider Network

The BHOs must meet provider network requirements outlined in Section 40.300 no later than sixty (60) days prior to Contract Effective Date described in Section 20.100.

51.500 Member Rights

The BHO shall have written policies and procedures regarding the rights of members and shall comply with any applicable federal and state laws and regulations that pertain to member rights. These rights shall be included in the Member Booklet described in Section 51.310. At a minimum, said policies and procedures shall specify the member's right to:

- Be treated with respect and with due consideration for the member's dignity and privacy;
- Have all records and medical and personal information remain confidential;
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;
- Participate in decisions regarding his or her health care, including the right to refuse treatment;
- Be free from any form of restraint or seclusion as a means of coercion, discipline, convenience or retaliation, as specified in federal regulations on the use of restraints and seclusion;

- Request and receive a copy of his or her medical records pursuant to 45 CFR Parts 160 and 164, subparts A and E, and request to amend or correct the record as specified in 45 CFR Sections 164.524 and 164.526; and
- Freely exercise his or her rights, including those related to filing a grievance or appeal, and that the exercise of these rights shall not adversely affect the way the member is treated.

51.600 Marketing and Advertising

Marketing is any communication from the BHO to a Medicaid beneficiary who is not enrolled in the CCS program that can reasonably be interpreted as intended to influence the beneficiary to enroll in the BHO. Marketing materials are resources that are produced in any medium, by or on behalf of the BHO that can reasonably be interpreted as intended to market to potential enrollees.

51.610 Allowable Activities

The BHO shall be permitted to perform the following marketing activities:

- Distributing general information through mass media (i.e., newspapers, magazines and other periodicals, radio, television, the Internet, public transportation advertising, and other media outlets);
- Distributing brochures and displaying posters at provider offices and clinics that inform patients that the clinic or provider is part of the BHO's provider network; and
- Attending activities that benefit the entire community such as health fairs or other health education and promotion activities.

If the BHO performs an allowable activity, the BHO shall conduct these activities in the entire region in which it is operating.

All materials shall comply with the information requirements in 42 CFR Section 438.10 and as detailed in Section 40.510 of this RFP.

51.620 Prohibited Activities

The BHO is prohibited from engaging in the following activities:

- Seek to influence enrollment in conjunction with the sale or offering of any private insurance;
- Directly or indirectly engaging in door-to-door, telephone, or other cold-call marketing (unsolicited personal contact for the purpose of marketing) activities to potential members;
- Offering any favors, inducements or gifts, promotions, or other insurance products that are designed to induce enrollment in the BHO, and that are not health related and worth more than ten dollars ($10);
- Distributing information that contains any assertion or statement (whether written or oral) that the BHO is endorsed by CMS, the Federal or State government, or DHS;
- Distributing information and materials that contain statements that the DHS determines are inaccurate, false, or misleading. Statements considered false or misleading include, but are not limited to, any assertion or statement (whether written or oral) that the recipient must enroll in a specific BHO to obtain benefits, or to avoid losing benefits, or that any particular BHO is endorsed by the federal or state government, or similar entity; and
- Distributing materials that, according to the DHS, mislead or falsely describe the BHO's provider network, the participation or availability of network providers, the qualifications and skills of network providers (including their bilingual skills); or the hours and location of network services.

The State may impose financial sanctions, as described in Section 61.820, up to the Federal limit, on the BHO for any violations of the marketing and advertising policies.

51.630 State Approval of Materials

All printed materials, advertisements, video presentations, and other information prepared by the BHO that pertain to or reference the programs or the BHO's program business shall be reviewed and approved by the DHS before use and distribution

by the BHO. In addition, the BHO shall submit, to the DHS, any marketing materials it has received from a provider for review and prior approval. The BHO shall not advertise, distribute or provide any materials to its members or to any potential members of the CCS program that have not been approved by the DHS.

The BHO shall not change any approved materials without the consent and approval of the DHS.

51.700 Compliance Plan

The BHO shall have a written fraud and abuse compliance plan that shall have stated program goals and objectives, stated program scope, and stated methodology. Refer to CMS publications: "Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care", A product of the National Medical Fraud and Abuse Initiative, October 2000 as well as the CMS publication: "Guidelines for Constructing a Compliance Program for Medicaid and Prepaid BHOs", a product of the Medicaid Alliance for Program Safeguards, May 2002 for reference regarding Compliance Plans.

At a minimum, the BHO's fraud and abuse compliance plan shall:

- Require the reporting of suspected and/or confirmed fraud and abuse be done as required in Sections 40.335 and 50.860.3;
- Ensure that all of its officers, directors, managers and employees know and understand the provisions of the BHO's fraud and abuse compliance plan;
- Require the designation of a compliance officer and a compliance committee that are accountable to senior management;
- Ensure and describe effective training and education for the compliance officer and the organization's employees;
- Ensure that providers and members are educated about fraud and abuse identification and reporting, and include information in the provider and member material;
- Ensure effective lines of communication between the compliance officer and the organization's employees;

- Ensure the enforcement of standards through well-publicized disciplinary guidelines;
- Ensure provision of internal monitoring and auditing with provisions for prompt response to potential offenses, and for the development of corrective action initiatives relating to the BHO's fraud and abuse efforts;
- Possess written policies, procedures and standards of conduct that articulate the organization's commitment to comply with all Federal and State standards related to Medicaid managed care organizations;
- Ensure that no individual who reports BHO violations or suspected fraud and abuse is retaliated against; and
- Include a monitoring program that is designed to prevent and detect potential or suspected fraud and abuse. This monitoring program shall include but not be limited to:
    - Monitoring the billings of its providers to ensure members receive services for which the BHO is billed;
    - Requiring the investigation of all reports of suspected fraud and over billings (upcoding, unbundling, billing for services furnished by others, and other overbilling practices);
    - Reviewing providers for over-utilization or under-utilization;
    - Verifying with members the delivery of services as claimed; and
    - Reviewing and trending consumer complaints on providers.

51.800 Third Party Liability (TPL)

51.810 Background

TPL refers to any other health insurance plan or carrier (i.e., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance and worker's compensation) or program, that is, or may be, liable to pay all or part of the health care expenses of the member.

Pursuant to Section 1902(a)(25) of the Social Security Act, the DHS authorizes the BHO as its agent to identify legally liable third parties and treat verified TPL as a resource of the member.

Reimbursement from the third party shall be sought unless the BHO determines that recovery would not be cost effective. For example, the BHO may determine that the amount it reasonably expects to recover will be less than the cost of recovery. In such situations, the BHO shall document the situation and provide adequate documentation to the DHS.

51.820 Responsibilities of the DHS

The DHS shall:

- Be responsible for coordination and recovery of accident and workers' compensation subrogation benefits;
- Collect and provide member TPL information to the BHO. TPL information shall be provided to the BHO via the daily TPL roster; and
- Conduct TPL audits every six (6) months to ensure TPL responsibilities are being completed by the BHO.

51.830 Responsibilities of the BHO

The BHO shall coordinate health care benefits with other coverages, both public and private, which are or may be available to pay medical expenses on behalf of any member.

The BHO shall seek reimbursement from all other liable third parties to the limit of legal liability for the health services rendered. The BHO shall retain all health insurance benefits collected, including cost avoidance.

The BHO shall follow the mandatory pay and chase provisions described in 42 CFR Section 433.139(b)(3)(i)(ii).

In addition, the BHO shall:

- Continue cost avoidance of the health insurance plans accident and workers' compensation benefits;
- Report all accident cases incurring medical and medically related dental expenses in excess of five-hundred dollars ($500) to the DHS;

- Provide a list of medical and medically related dental expenses, in the format requested by the DHS, for recovery purposes. "RUSH" requests shall be reported within three (3) business days of receipt and "ROUTINE" requests within seven (7) business days of receipt. Listings shall also include claims received but not processed for payments or rejected;
- Provide copies of claim forms with similar response time as the above;
- Provide listings of medical and medically related dental expenses (including adjustments, e.g., payment corrections, refunds, etc.) according to the payment period or "as of" date. Adjustments shall be recorded on the date of adjustment and not on the date of service;
- Inform the DHS of TPL information uncovered during the course of normal business operations;
- Provide the DHS with monthly reports of the total cost avoidance and amounts collected from TPLs within thirty (30) days of the end of the month;
- Develop procedures for determining when to pursue TPL recovery; and
- Provide health care services for members receiving motor vehicle insurance liability coverage at no cost through the Hawaii Joint Underwriting Plan (HJUP) in accordance with Section 431:10C-401 et. seq., HRS.

51.900 Administrative Meeting

- BHO shall have a quarterly meeting with the QI health plans and state representative to discuss and resolve various issues, such as claims (see Appendix I), coordination of services, continuity of care, and other administrative issues.
- State will make final decisions on administrative issues that cannot be resolved by BHO and QI health plans.

SECTION 60 TERMS AND CONDITIONS

60.100 Contract Documents

The following documents form an integral part of the written contract between the BHO and the DHS (hereafter collectively referred to as "the Contract"):

- Contract for Health and Human Services: Competitive Purchase of Service (AG Form 103F1 (10/08)) (see Appendix E regarding General Conditions for Health & Human Services Contracts), any Special Conditions, attachments, and addenda;
- This RFP, appendices, attachments, and addenda, which shall be incorporated by reference; and
- The BHO's technical proposal submitted in response to this RFP form, which shall be incorporated by reference.

References to "General Conditions" in this Section are to the General Conditions for Health & Human Services Contracts attached as Appendix E.

60.200 Conflict Between Contract Documents, Statutes and Rules

Replace General Condition 7.5, Conflict between General Conditions and Procurement Rules, with the following:

- Contract Documents: In the event of a conflict among the contract documents, the order of precedence shall be as follows: (1) Contract for Health and Human Services: Competitive Purchase of Service (AG Form 103F1), including all general conditions, special conditions, attachments, and addenda; (2) the RFP, including all attachments and addenda, as amended; and (3) Offeror's proposal. In the event of a conflict between the General Conditions and the Special Conditions, the Special Conditions shall control.
- Contract and Statutes: In the event of a conflict between the language of the contract, and applicable statutes, the latter shall prevail.
- Contract and Procurement Rules/Directives: In the event of a conflict between the Contract and the Procurement Rules or a Procurement Directive, the Procurement Rules or any

Procurement Directive in effect on the date this Contract became effective shall control and are hereby incorporated by reference.

- The sections of the rules and regulations cited in this RFP may change as the rules and regulations are amended for MQD. No changes shall be made to this RFP due to changes in the section numbers. The documents in the documentation library shall be changed as needed. The availability and extent of the materials in the documentation library shall have no effect on the requirements stated in this RFP.

60.300 Subcontracts Agreements

Replace General Condition 3.2 (see Appendix E), Subcontracts and Assignments, with the following:

The BHO may negotiate and enter into contracts or agreements with subcontractors to the benefit of the BHO and the State. All such agreements shall be in writing. No subcontract that the BHO enters into with respect to the performance under the contract shall in any way relieve the BHO of any responsibility for any performance required of it by the contract.

The BHO shall submit to the DHS for review and prior approval, all subcontractor agreements related to the provision of covered benefits and services and member services activities to members (e.g., call center) and provider services activities and payments to providers. The BHO shall submit these subcontractor agreements as required in Section 51.400, Readiness Review. In addition, the DHS reserves the right to inspect all subcontractor agreements at any time during the contract period.

The BHO shall notify the DHS at least fifteen (15) days prior to adding or deleting subcontractor agreements or making any change to any subcontractor agreements which may materially affect the BHO's ability to fulfill the terms of the contract.

The BHO shall provide the DHS with immediate notice in writing by registered or certified mail of any action or suit filed against it by any subcontractor, and prompt notice of any claim made against the BHO by any subcontractor that, in the opinion of the BHO, may result in litigation related in any way to the contract with the State of Hawaii.

Additionally, no assignment by the BHO of the BHO's right to compensation under the contract shall be effective unless and until the assignment is approved by the Comptroller of the State of Hawaii, as provided in Section 40-58, HRS, or its successor provision.

All subcontractor agreements must, at a minimum:

- Describe the activities, including reporting responsibilities, to be performed by the subcontractor and require that the subcontractor meet all established criteria prescribed and provide the services in a manner consistent with the minimum standards specified in the BHO's contract with the State.
- Require that the subcontractor fulfill the requirements of 42 CFR Section 438.6 that are appropriate to the service delegated under the subcontract.
- Provide information regarding member rights and processes regarding the Member Grievance System found in Section 40.600, if applicable.
- Include a provision that allows the BHO to:
    - Evaluate the subcontractor's ability to perform the activities to be delegated;
    - Monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule (the frequency shall be stated in the agreement) established by the DHS and consistent with industry standards or State laws and regulations;
    - Identify deficiencies or areas for improvement; and
    - Take corrective action or impose other sanctions including, but not limited to, revoking delegation, if the subcontractor's performance is inadequate.
- Require that the subcontractor submits to the BHO a tax clearance certificate from the Director of the DOTAX, State of Hawaii, showing that all delinquent taxes, if any, levied or accrued under State law against the subcontractor have been paid.
- Include a provision that the BHO shall designate itself as the sole point of recovery for any subcontractor.

- Include a provision that neither the State nor the BHO members shall bear any liability of the BHO's failure or refusal to pay valid claims of subcontractors.
- Require that the subcontractor track and report complaints against them to the BHO.
- Require that the subcontractor fully adhere to the privacy, confidentiality and other related requirements stated in the RFP and in applicable federal and state law.
- Require that the medical records be retained in compliance with Section 60.400. The actual requirements shall be detailed in the agreement.
- Require that the subcontractor follow all audit requirements as outlined in Section 62.400 inclusive. The actual requirements shall be detailed in the agreement.
- Require that the subcontractor comply with all requirements related to confidentiality of information as outlined in Section 61.500. The actual requirements found in this section shall be detailed in the agreement.
- Fulfill the requirements of 42 CFR Section 434.6 that are appropriate to the service delegated under the subcontract.
- Include a description of the BHO's grievance system process and procedures for members which shall include, at a minimum:
    - The member's right to file grievances and appeals with requirements, and time frames for filing;
    - The member's right to a State administrative hearing, how to obtain a hearing and rules on representation at a hearing;
    - The availability of assistance in filing a grievance or an appeal;
    - The member's right to have a provider or authorized representative file a grievance and/or an appeal on his or her behalf, provided he or she has provided consent to do so;
    - The toll-free numbers to file a grievance or an appeal; and
    - When an appeal or hearing has been requested by the member, the right of a member to receive benefits while

the appeal or hearing is pending and that the member may be held liable for the costs of those benefits if the BHO's adverse action is upheld.

  - Any appeal rights that the state chooses to make available to providers to challenge the failure of the BHO to cover a service.

- Provide that enrollees will not be billed for covered services, any amount greater than would be owed if the entity provided the services directly (i.e., no balance billing by subcontractors).
- Require that the subcontractor notify the BHO and the MQD of all breaches of confidential information relating to Medicaid applicants and recipients, as BHO members. The notice to the State shall be within two (2) business days of discovery of the breach and a written report of the investigation and resultant mitigation of the breach shall be provided to the State within thirty (30) business days of the discovery of the breach.

60.400 Retention of Medical Records

The following is added to the end of General Condition 2.3, Records Retention:

The BHO and its providers shall retain all medical records, in accordance with 42 CFR 438.3(u) for a minimum of ten (10) years from the last date of entry in the records. For minors, the BHO shall retain all medical records during the period of minority plus a minimum of ten (10) years after the age of majority.

The BHO shall include in its subcontracts and provider agreements record retention requirements that are at least equivalent to those stated in this section.

During the period that records are retained under this section, the BHO and any subcontractor or provider shall allow the state and federal governments' full access to such records, to the extent allowed by law.

60.500 Responsibility For Taxes

In addition to the requirements of General Condition 3.4.4, PROVIDER's Responsibilities, subject to its corporate structure,

licensure status, or other statutory exemptions, BHOs may be liable for, or exempt from, other federal, state, and/or local taxes including, but not limited to, the insurance premium tax (chapter 431, Article 7, Part II, HRS). Each BHO is responsible for determining whether it is subject to, or exempt from, any such federal, state, or local taxes. The DHS makes no representations whatsoever as to the liability or exemption from liability of the BHO to any tax imposed by any governmental entity.

60.600 Full Disclosure

60.610 Business Relationships

The BHO warrants that it has fully disclosed all business relationships, joint ventures, subsidiaries, holding companies, or any other related entity in its proposal and that any new relationships shall be brought to the attention of the DHS as soon as such a relationship is consummated. The terms and conditions of CMS require full disclosure on the part of all contracting BHOs and providers. The BHO shall notify the DHS of any changes in ownership within five (5) business days of any public announcement.

The BHO shall not knowingly have a director, officer, partner, or person with more than five percent (5%) of the BHO's equity, or have an employment, consulting, or other agreement with such a person for the provision of items and services that are significant and material to the entity's contractual obligation with the State, who has been debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. The BHO shall not, without prior approval of the DHS, lend money or extend credit to any related party. The BHO shall fully disclose such proposed transactions and submit a formal written request for review and approval.

The BHO shall disclose information on individuals or corporations with an ownership or control interest in the BHO to the DHS at the following times:

(1) When the BHO submits a proposal in accordance with the state's procurement process.

(2) When the BHO executes a contract with the state.

(3) When the state renews or extends the BHO contract.

(4) Within thirty-five (35) days after any change in ownership of the BHO.

If the State learns that the BHO has a prohibited relationship with a person or entity who is debarred, suspended, or excluded from participation in federal healthcare programs, the DHS:

(1) Must notify the Secretary of the noncompliance.

(2) May continue an existing agreement with the BHO unless the Secretary directs otherwise.

(3) May not renew or extend the existing agreement with the BHO unless the Secretary provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.

The BHO shall include the provisions of this section in any subcontract or provider agreement.

60.620 Litigation

The BHO shall disclose any pending litigation both in and out of the State of Hawaii for which the company is a party, including the disclosure of any outstanding judgment. If applicable, please explain.

60.700 Fiscal Integrity

60.710 Warranty of Fiscal Integrity

The BHO warrants that it is of sufficient financial solvency to assure the DHS of its ability to perform the requirements of the contract. The BHO shall comply with the solvency standards established by the State Insurance Commissioner for private health maintenance organizations or BHOs licensed in the State of Hawaii, and shall, upon request by the DHS, provide financial data and information to prove its financial solvency.

60.720 Performance Bond

The BHO shall obtain a performance bond issued by a reputable surety company authorized to do business in the State of Hawaii in the amount of one-million dollars ($1,000,000) or more, conditioned upon the prompt, proper, and efficient performance of the contract, and shall submit the same to the DHS prior to or at the time of the execution of the contract. The performance bond shall be liable to forfeit by the BHO in the event the BHO is unable to properly, promptly and efficiently perform the contract terms and conditions or the contract is terminated by default or bankruptcy of the BHO.

The amount of the performance bond shall be adjusted at the time members begin enrolling in the plan. At that time, the amount of the performance bond shall approximate eighty percent (80%) of one month's capitation payments. The BHO shall update their performance bond annually. The BHOs shall submit to DHS a revised performance bond no later than sixty (60) days after the start of the benefit period. The revised capitation payment shall be based upon the last capitation payment for the previous benefit period.

The BHO may, in place of the performance bond, provide the following in the same amount as the performance bond:

- Certificate of deposit, share certificate, or cashier's, treasurer's, teller's or official check, or a certified check made payable to the Department of Human Services, State of Hawaii, issued by a bank, a savings institution, or credit union that is insured by the Federal Deposit Insurance Corporation (FDIC) or the National Credit Union Administration, and payable at sight or unconditionally assigned to the procurement officer advertising for offers. These instruments may be utilized only to a maximum of one hundred thousand dollars ($100,000) each and must be issued by different financial institutions.
- Letter of credit with a bank insured by the FDIC with the Department of Human Services, State of Hawaii, designated as the sole payee.

Upon termination of the contract, for any reason, including expiration of the contract term, the BHO shall ensure that the performance bond is in place until such time that all of the terms

of the contract have been satisfied. The performance bond shall be liable for, and the DHS shall have the authority to, retain funds for additional costs including, but not limited to:

- Any costs for a special plan change period necessitated by the termination of the contract;
- Any costs for services provided prior to the date of termination that are paid by MQD;
- Any additional costs incurred by the State due to the termination; and
- Any sanctions or penalties owed to the DHS.

60.800 Term of the Contract

This is a multi-term contract solicitation that has been deemed to be in the best interest of the State by the Director of the DHS in accordance with Section 3-149-302(c), HAR. The contract is for the initial term from the Contract Effective Date described in Section 20.100 to June 30, 2020. Unless terminated, the contract shall be extended without the necessity of re-bidding, for not more than one (1) additional twelve (12) month period or parts thereof, only upon mutual agreement of the parties in writing. The BHO shall not contract with the State of Hawaii unless safeguards at least equal to Federal safeguards (41 U.S.C. 423, section 27) are in place.

The State of Hawaii operates on a fiscal year basis, which runs from July 1 to June 30 of each year. Funds are available for only the first fiscal period of the contract ending June 30 in the first year of the initial term. The contractual obligation of both parties in each fiscal period succeeding the first fiscal period is subject to the appropriation and availability of funds to DHS.

The contract will be terminated only if funds are not appropriated or otherwise made available to support continuation of performance in any fiscal period succeeding the initial fiscal period of the contract; however this does not affect either the State's rights or the BHO's rights under any termination clause of the contract. The State shall notify the BHO, in writing, at least sixty (60) days prior to the expiration of the contract whether funds are available or not available for the continuation of the contract for each succeeding contract extension period. In the event of termination, as provided in this paragraph, the BHO

shall be reimbursed for the unamortized, reasonably incurred, nonrecurring costs. The award of a contract and any allowed renewal or extension thereof, is subject to allotments made by the Director of Finance, State of Hawaii, pursuant to HRD Chapter 37, and subject to the availability of State and/or Federal funds.

The BHO acknowledges that other unanticipated uncertainties may arise that may require an increase or decrease in the original scope of services to be performed, in which event the BHO agrees to enter into a supplemental agreement upon request by the State. The supplemental agreement may also include an extension of the period of performance and a respective modification of the compensation.

60.900 Insurance

60.910 Liability Insurance Requirements

The BHO shall maintain insurance acceptable to the DHS in full force and effect throughout the term of this contract, until the DHS certifies that the BHO's work has been completed satisfactorily.

Prior to or upon execution of the contract, the BHO shall provide to the DHS certificate(s) of insurance dated within thirty (30) days of the effective date of the contract necessary to satisfy the DHS that the insurance provisions of this contract have been complied with. Upon request by the DHS, BHO shall furnish a copy of the policy(ies) or endorsement(s) necessary for DHS to verify the coverages required by this section.

The policy or policies of insurance maintained by the BHO shall be written by insurance companies licensed to do business in the State of Hawaii or meet the requirements of Section 431:8-301, et seq., HRS, if utilizing an insurance company not licensed by the State of Hawaii.

The policy(ies) shall, at a minimum, provide the following limit(s) and coverage:

Coverage		**Limits**
Commercial General Liability		Per occurrence, not claims made • $1 million per occurrence • $2 million in the aggregate
Automobile		May be combined single limit: • Bodily Injury: $1 million per person, $1 million per accident • Property Damage: $1 million per accident
Workers Compensation / Employers Liability (E.L.)		• Workers Comp: Statutory Limits • E.L. each accident: $1,000,000 • E.L. disease: $1,000,000 per employee, $1,000,000 policy limit • E.L. $1 million aggregate
Professional Liability, if applicable		May be claims made: • $1 million per claim • $2 million annual aggregate

Each insurance policy required by this contract shall contain the following clauses, which shall also be reflected on the certificate of insurance:

1. "The State of Hawaii is an additional insured with respect to operations performed for the State of Hawaii."
2. "Any insurance maintained by the State of Hawaii shall apply in excess of, and not contribute with, insurance provided by this policy."

Automobile liability insurance shall include excess coverage for the BHO's employees who use their own vehicles in the course of their employment.

The BHO shall immediately provide written notice to the DHS should any of the insurance policies required under the Contract be cancelled, limited in scope, or not be renewed upon expiration.

Failure of the BHO to provide and keep in force the insurance required under this section shall be regarded as a material

default under this contract, entitling the DHS to exercise any or all of the remedies provided in this contract for a default of the BHO.

The procuring of such required policy or policies of insurance shall not be construed to limit BHO's liability hereunder nor to fulfill the indemnification provisions and requirements of this contract. Notwithstanding said policy or policies of insurance, BHO shall be liable for the full and total amount of any damage, injury, or loss caused by BHO in connection with this contract.

If the BHO is authorized by the DHS to subcontract, subcontractors are not excused from the indemnification and/or insurance provisions of this contract. In order to indemnify the State of Hawaii, the BHO agrees to require its subcontractors to obtain insurance in accordance with this section.

60.920 Reinsurance

The BHO may obtain reinsurance for its costs for program members.

60.930 Waiver of Subrogation

Offeror shall agree by entering into a contract with DHS to provide a Waiver of Subrogation for the Commercial General Liability, Automobile Liability, and Workers Compensation policies. When required by the insurer, or should a policy condition not permit Offeror to enter into a pre-loss agreement to waive subrogation without an endorsement, the Offeror shall agree to notify the insurer and request the policy be endorsed with a Waiver of Subrogation in favor of DHS. This Waiver of Subrogation requirement shall not apply to any policy, which includes a condition specifically prohibiting such an endorsement, or voids coverage should Offeror enter into such an agreement on a pre-loss basis.

61.100 Modification of Contract

The following is added as General Condition 4.1.4:

All modifications of the contract shall be negotiated and accompanying capitated rates established. If the parties reach an agreement, the contract terms shall be modified accordingly by a written amendment signed by the Director of the DHS and

an authorized representative of the BHO. If the parties are unable to reach an agreement within thirty (30) days of the BHO's receipt of a contract change, the MQD Administrator shall make a determination as to the contract modifications and capitation rate, and the BHO shall proceed with the work according to a schedule approved by the DHS, subject to the BHO's right to appeal the MQD Administrator's determination of the contract modification and price under Section 61.700, Disputes.

61.200 Conformance with Federal Regulations

Any provision of the contract which is in conflict with federal Medicaid statutes, regulations, or CMS policy guidance is hereby amended to conform to the provisions of those laws, regulations, and federal policy. Such amendment of the contract shall be effective on the effective date of the statutes or regulations necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

61.300 Termination of the Contract

The contract may terminate or may be terminated by DHS for any or all of the following reasons in addition to the General Conditions in Appendix E:

- Termination for Default;
- Termination for Expiration of the Programs by CMS; or
- Termination for Bankruptcy or Insolvency

61.310 Termination for Default

The failure of the BHO to comply with any term, condition, or provision of the contract or applicable requirements in Sections 1932, 1903(m) and 1905(t) of the Social Security Act shall constitute default by the BHO. In the event of default, the DHS shall notify the BHO by certified or registered mail, with return receipt requested, of the specific act or omission of the BHO, which constitutes default. The BHO shall have fifteen (15) days from the date of receipt of such notification to cure such default. In the event of default, and during the above-specified grace period, performance under the contract shall continue as though the default had never occurred. In the event the default is not

cured within fifteen (15) days, the DHS may, at its sole option, terminate the contract for default. Such termination shall be accomplished by written notice of termination forwarded to the BHO by certified or registered mail and shall be effective as of the date specified in the notice. If it is determined, after notice of termination for default, that the BHO's failure was due to causes beyond the control of and without error or negligence of the BHO, the termination shall be deemed a termination for convenience under General Condition 4.3 in Appendix E.

The DHS' decision not to declare default shall not be deemed a waiver of such default for the purpose of any other remedy the BHO may have.

61.320 Termination for Expiration or Modification of the Programs by CMS

The DHS may terminate performance of work under the contract in whole or in part whenever, for any reason, CMS terminates or modifies the programs. In the event that CMS elects to terminate its agreement with the DHS, the DHS shall so notify the BHO by certified or registered mail, return receipt requested. The termination shall be effective as of the date specified in the notice.

61.330 Termination for Bankruptcy or Insolvency

In the event that the BHO shall cease conducting business in the normal course, become insolvent, make a general assignment for the benefit of creditors, suffer or permit the appointment of a receiver for its business or its assets or shall avail itself of, or become subject to, any proceeding under the Federal Bankruptcy Act or any other statute of any State relating to insolvency or the protection of the rights or creditors, the DHS may, at its option, terminate the contract. In the event the DHS elects to terminate the contract under this provision it shall do so by sending notice of termination to the BHO by registered or certified mail, return receipt requested. The termination shall be effective as of the date specified in the notice.

In the event of insolvency of the BHO, the BHO shall cover continuation of services to members for the duration of period for which payment has been made, as well as for inpatient admissions up until discharge. Members shall not be liable for

the debts of the BHO. In addition, in the event of insolvency of the BHO, members may not be held liable for the covered services provided to the member, for which the State does not pay the BHO.

61.340 Procedure for Termination

In the event the State decides to terminate the contract, it shall provide the BHO with a pre-termination hearing. The State shall:

- Give the BHO written notice of its intent to terminate, the reason(s) for termination, and the time and place of the pre-termination hearing; and
- Give the BHO's members written notice of the intent to terminate the contract, notify members of the hearing, and allow them to disenroll immediately without cause.

Following the termination hearing, the State shall provide written notice to the BHO of the termination decision affirming or reversing the proposed termination. If the State decides to terminate the contract, the notice shall include the effective date of termination. In addition, if the contract is to be terminated, the State shall notify the BHO's members in writing of their options for receiving Medicaid services following the effective date of termination.

In the event of any termination, the BHO shall:

- Stop work under the contract on the date and to the extent specified in the notice of termination;
- Complete the performance of such part of the work as shall not have been terminated by the notice of the termination;
- Notify the members of the termination and arrange for the orderly transition to the new BHO(s), including timely provision of any and all records to the DHS that are necessary to transition the BHO's members to another BHO;
- Promptly supply all information necessary for the reimbursement of any outstanding Medicaid claims;
- Place no further orders or enter into subcontracts for materials, services, or facilities, except as may be necessary

for completion of the work under the portion of the contract that is not terminated;

- Terminate all orders and subcontracts to the extent that they relate to the performance of work terminated by the notice of termination;
- Assign to the DHS in the manner and to the extent directed by the MQD Administrator of the right, title, and interest of the BHO under the orders or subcontracts so terminated, in which case the DHS shall have the right, in its discretion, to settle or pay any or all claims arising out of the termination of such orders and subcontracts;
- With the approval of the MQD Administrator, settle all outstanding liabilities and all claims arising out of such termination of orders and subcontracts, the cost of which would be reimbursable, in whole or in part, in accordance with the provisions of the contract.
- Take such action as may be necessary, or as the MQD administrator may direct, for the protection and preservation of any and all property or information related to the contract which is in the possession of the BHO and in which the DHS has or may acquire an interest; and
- Within thirty (30) business days from the effective date of the termination, deliver to the DHS copies of all current data files, program documentation, and other documentation and procedures used in the performance of the contract at no cost to the DHS. The BHO agrees that the DHS or its designee shall have a non-exclusive, royalty-free right to the use of any such documentation.

The BHO shall create written procedures for the orderly termination of services to any members receiving the required services under the contract, and for the transition to services supplied by another BHO upon termination of the contract, regardless of the circumstances of such termination. These procedures shall include, at the minimum, timely notice to the BHO's members of the termination of the contract, and appropriate counseling. The BHO shall submit these procedures to the DHS for approval upon their completion, but no later than one hundred eighty (180) days after the effective date of the contract.

61.350 Termination Claims

After receipt of a notice of termination, the BHO shall submit to the MQD Administrator any termination claim in the form and with the certification prescribed by the MQD Administrator. Such claim shall be submitted promptly but no later than six (6) months from the effective date of termination. Upon failure of the BHO to submit its termination claims within the time allowed, the MQD Administrator may, subject to any review required by the State procedures in effect as of the date of execution of the contract, determine, on the basis of information available to him/her, the amount, if any, due to the BHO by reason of the termination and shall thereupon cause to be paid to the BHO the amount to be determined.

Upon receipt of notice of termination, the BHO shall have no entitlement to receive any amount for lost revenues or anticipated profits or for expenditures associated with this or any other contract. The BHO shall be paid only the following upon termination:

- At the contract price(s) for the number of members enrolled in the BHO at the time of termination; and
- At a price mutually agreed to by the BHO and the DHS.

In the event the BHO and the DHS fail to agree, in whole or in part, on the amount of costs to be paid to the BHO in connection with the total or partial termination of work pursuant to this section, the MQD Administrator shall determine, on the basis of information available to the DHS, the amount, if any, due to the BHO by reason of the termination and shall pay to the BHO the amount so determined.

The BHO shall have the right to appeal any such determination made by the MQD Administrator as stated in Section 61.700, Disputes.

61.400 Expiration of the Contract

At the expiration of this contract, or if at any time the State or BHO should terminate this contract, the BHO will cooperate with any subsequent BHO who might assume operation of the CCS. BHO shall continue to work with the QI health plans to provide continuity of care. The MQD will withhold final payment to the

BHO until transition to the new BHO is complete. The State will give the BHO sixty (60) days notice that a transfer will occur.

In the event that a subsequent BHO is unable to assume operations on the planned date for transfer, the BHO will continue to perform CCS operations on a month to month basis for up to six months beyond the planned transfer date.

61.500 Confidentiality of Information

In addition to the requirements of General Condition 8, the BHO understands that the use and disclosure of information concerning applicants, recipients or members is restricted to purposes directly connected with the administration of the Hawaii Medicaid program, and agrees to guard the confidentiality of an applicant's, recipient's or member's information as required by law. The BHO shall not disclose confidential information to any individual or entity except in compliance with the following:

- 42 CFR Part 431, Subpart F;
- The Administrative Simplification provisions of HIPAA and the regulations promulgated thereunder, including but not limited to the Security and Privacy requirements set forth in 45 CFR Parts 160, 162 and 164, (if applicable);
- Section 346-10, HRS; and
- All other applicable federal and State statutes and administrative rules, including but not limited to:
    - Section 325-101, HRS, relating to persons with HIV/AIDS;
    - Section 334-5, HRS, relating to persons receiving mental health services;
    - Chapter 577A, HRS relating to emergency and family planning services for minor females;
    - 42 CFR Part 2 relating to persons receiving substance abuse services;
    - Chapter 487J, HRS, relating to social security numbers
    - Chapter 487N, HRS, relating to personal information.

Access to member identifying information shall be limited by the BHO to persons or agencies that require the information in order

to perform their duties in accordance with this contract, including the U.S. Department of Health and Human Services (DHHS), the DHS and other individuals or entities as may be required by the DHS. (See 42 CFR Section 431.300, et seq. and 45 CFR Parts 160 and 164.)

Any other party shall be granted access to confidential information only after complying with the requirements of state and federal laws, including but not limited to HIPAA, and regulations pertaining to such access. The BHO is responsible for knowing and understanding the confidentiality laws listed above as well as any other applicable laws. The BHO, if it reports services to its members, shall comply with all applicable confidentiality laws. Nothing herein shall prohibit the disclosure of information in summary, statistical or other form that does not identify particular individuals, provided that de-identification of protected health information is performed in compliance with the HIPAA Privacy Rule.

Federal and State Medicaid rules, and some other Federal and State statutes and rules, including but not limited to those listed above, are often more stringent than the HIPAA regulations. Moreover, for purposes of this contract, the BHO agrees that the confidentiality provisions contained in Chapter 17-1702, HAR, shall apply to the BHO to the same extent as they apply to MQD.

As part of the contracting process, the Offeror shall sign a Business Associate Agreement (BAA) found in Appendix J to assure compliance with HIPAA regulations.

The BHO shall implement a secure electronic mail (email) encryption solution to ensure confidentiality, integrity, and authenticity of email communications that contain information relating to members.

All breaches of confidential information relating to Medicaid enrollees, as BHO members, shall be reported to the MQD. The BHO shall notify the MQD within two (2) business days following actual knowledge of a breach of confidentiality, including any use or disclosure of confidential information, any breach of Unsecured PHI, and any Security Incident (as defined in HIPAA regulations) of which the BHO becomes aware with respect to PHI in the custody of the BHO. In addition, the BHO shall provide the MQD with a written report of the investigation and

mitigation efforts within thirty (30) business days of the discovery of the breach. The BHO shall work with MQD to ensure that the breach has been mitigated and reporting requirements, if any, or complied with. The actual requirements found in this section shall be detailed in all provider and subcontractor agreements.

61.600 BHO's Progress

61.610 BHO Reporting

On-site reviews may be conducted by DHS to verify the accuracy and appropriateness of information provided by Offerors in their proposals. If awarded a contract, the BHO shall submit a plan for implementation of behavioral health services and shall provide progress/performance reports every two weeks beginning two weeks after the notification of contract award. The format to be used shall be approved by DHS. The purpose of the reports is to ensure that the BHO will be ready to enroll members as of Contract Effective date described in Section 20.100, and that all required elements such as the QIP are in place.

61.620 Inspection of Work Performed

In addition to the ongoing monitoring described in Section 50.700, the DHS, the State Auditor of Hawaii, the U.S. Department of Health and Human Services (DHHS), the General Accounting Office (GAO), the Comptroller General of the United States, the Office of the Inspector General (OIG), Medicaid Fraud Control Unit of the Department of the Attorney General, State of Hawaii, or their authorized representatives shall, during normal business hours, have the right to enter into the premises of the BHO, all subcontractors and providers, or such other places where duties under the contract are being performed, to inspect, monitor, or otherwise evaluate the work being performed. All inspections and evaluations shall be performed in such a manner to not unduly delay work. All records and files pertaining to the BHO shall be located in the State of Hawaii at the BHO's principal place of business or at a storage facility on Oahu that is accessible to the foregoing identified parties.

61.700 Disputes

Any dispute concerning a question of fact arising under the contract which is not disposed of by agreement shall be decided by the Director of the DHS or his/her duly authorized representative who shall reduce his/her decision to writing and mail or otherwise furnish a copy to the BHO within ninety (90) days after written request for a final decision by certified mail, return receipt requested. The decision shall be final and conclusive unless determined by a court of competent jurisdiction to have been fraudulent, or capricious or arbitrary, or so grossly erroneous as necessarily to imply bad faith. In connection with any dispute proceeding under this clause, the BHO shall be afforded an opportunity to be heard and to offer evidence in support of his/her dispute. The BHO shall proceed diligently with the performance of the contract in accordance with the disputed decision pending final resolution by a circuit court of this State.

Any legal proceedings against the State of Hawaii regarding this RFP or any resultant contract shall be brought in a court of competent jurisdiction in the City and County of Honolulu, State of Hawaii.

61.800 Liquidated Damages, Sanctions and Financial Penalties

61.810 Liquidated Damages

In the event of any breach of the terms of the contract by the BHO, liquidated damages shall be assessed against the BHO in an amount equal to the costs of obtaining alternative medical benefits for its members. The damages shall include, without limitation, the difference in the capitated rates paid to the BHO and the rates paid to a replacement BHO.

Notwithstanding the above, the BHO shall not be relieved of liability to the State for any damages sustained by the State due to the BHO's breach of the contract.

The DHS may withhold amounts for liquidated damages from payments to the BHO until such damages are paid in full.

61.820 Sanctions

The DHS may impose sanctions for non-performance or violations of contract requirements. Sanctions shall be determined by the State and may include:

- Imposing civil monetary penalties (as described below);
- Suspending enrollment of new members with the BHO;
- Suspending payment; or
- Terminating the contract (as described in Section 61.300).

The State shall give the BHO timely written notice that explains the basis and nature of the sanction as outlined in 42 CFR Part 438, Subpart I. The BHO may follow DHS appeal procedures to contest the penalties or sanctions. The DHS shall provide these appeal procedures to the BHO prior to the Date of Contract Effective Date identified in Section 20.100.

The civil or administrative monetary penalties imposed by the DHS shall not exceed the maximum amount established by federal statutes and regulations on the BHO.

The civil monetary penalties that may be imposed on the BHO by the State are as follows:

Number	Activity	Penalty
1	Misrepresentation of actions or falsification of information furnished to the CMS or the State	A maximum of one hundred thousand dollars ($100,000) for each determination
2	Acts to discriminate among members on the basis of their health status or need for healthcare services	A maximum of one hundred thousand dollars ($100,000) for each determination
3	Failure to implement requirements stated in the BHO's proposal, the RFP or the contract, or other material failures in the BHO's duties, including but not limited	A maximum of fifty thousand dollars ($50,000) for each determination

Number	Activity	Penalty
	to failing to meet performance standards	
4	Substantial failure to provide medically necessary services that are required under law or under contract, to an enrolled member	A maximum of twenty-five thousand dollars ($25,000) for each determination
5	Imposition upon members premiums and charges that are in excess of the premiums or charges permitted under the program	A maximum of twenty-five thousand dollars ($25,000) or double the amount of the excess charges (whichever is greater). The State shall deduct from the penalty the amount of overcharge and return it to the affected member(s)
6	Misrepresentation or false statements to members, potential members or providers	A maximum of twenty-five thousand dollars ($25,000) for each determination
7	Violation of any of the other applicable requirements of Sections 1903(m), 1905(t)(3) or 1932 of the Social Security Act and any implementing regulations	A maximum of twenty-five thousand dollars ($25,000) for each determination
8	Failure to comply with the requirements for physician incentive plans, as set forth in 42 CFR Sections 422.208 and 422.210	A maximum of twenty-five thousand dollars ($25,000) for each determination
9	Failure to resolve member appeals and	A maximum of ten thousand dollars

Number	Activity	Penalty
	grievances within the time frames specified in Section 40.600	($10,000) for each determination of failure
10	Failure to provide accurate information, data, reports and medical records, including behavioral health and substance abuse records to the DHS by the specified deadlines provided in Section 50.800.	Two hundred dollars ($200) per day until all required information, data, reports and medical records are received
11	Failure to report confidentiality breaches relating to Medicaid applicants and recipients to the DHS by the specific deadlines provided in Section 61.500	One hundred dollars ($100) per day per applicant/recipient. A maximum of twenty-five thousand dollars ($25,000) until the reports are received
12	Distributing marketing materials that have not been approved by the State or that contain false or misleading information, either directly or indirectly through any agent or independent contractor	A penalty of up to $25,000 for each distribution.

Payments provided for under the contract shall be denied for new members when, and for so long as, payment for those members is denied by CMS in accordance with the requirements in 42 CFR section 438.730.

61.900 Acceptance

The BHO shall comply with all of the requirements of this RFP and DHS shall have no obligation to enroll any members in the BHO until such time as all of said requirements have been met. Any legal proceedings against the State of Hawaii regarding this RFP or any resultant contract shall be brought in a court of

competent jurisdiction in the City and County of Honolulu, State of Hawaii.

62.100 Compliance with Laws

In addition to the requirements of General Condition 1.3, Compliance with Laws, the BHO shall comply with the following:

62.110 Wages, Hours and Working Conditions of Employees Providing Services

Pursuant to Section 103-55, HRS, services to be performed by the BHO and its subcontractors or providers shall be performed by employees paid at wages or salaries not less than the wages paid to public officers and employees for similar work. Additionally, the BHO shall comply with all applicable federal and state laws relative to workers compensation, unemployment compensation, payment of wages, prepaid healthcare, and safety standards. Failure to comply with these requirements during the contract period shall result in cancellation of the contract unless such noncompliance is corrected within a reasonable period as determined by the DHS. Final payment under the contract shall not be made unless the DHS has determined that the noncompliance has been corrected. The BHO shall complete and submit the Wage Certification provided in Appendix C.

62.120 Compliance with other Federal and State Laws

The BHO shall agree to conform with the following federal and state laws as affect the delivery of services under the Contract including, but not limited to:

- Titles VI, VII, XIX, and XXI of the Social Security Act;
- Title VI of the Civil Rights Act of 1964;
- The Age Discrimination Act of 1975;
- The Rehabilitation Act of 1973;
- The Americans with Disability Act;
- Chapter 489, HRS (Discrimination in Public Accommodations);
- Education Amendments of 1972 (regarding education programs and activities);

- Copeland Anti-Kickback Act;
- Davis-Bacon Act;
- Debarment and Suspension;
- All applicable standards, orders or regulations 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) and the Federal Water Pollution Control Act, as amended (33 U.S.C. Section 1251, et seq.);
- The Byrd Anti-Lobbying Amendment (31 U.S.C. Section 1352);
- E.O. 11246, "Equal Employment Opportunity," as amended by E.O. 11375 "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 C.F.R. part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor";
- All applicable federal and state laws regarding privacy and confidentiality; and
- Compliance and reporting is required under 42 CFR 438.6(f)(2) as applicable to the services contractually provided.

The BHO shall recognize mandatory standards and policies relating to energy efficiency that are contained in any State energy conservation plan developed by the State in accordance with the Energy Policy and Conservation Act (Pub. L. 94-163, Title III, Part A).

The BHO shall include notice of grantor agency requirements and regulations pertaining to reporting and patient rights under any contracts involving research, developmental, experimental or demonstration work with respect to any discovery or invention which arises or is developed in the course of or under such contract, and of grantor agency requirements and regulations pertaining to copyrights and rights in data.

62.200 Miscellaneous Special Conditions

62.210 Use of Funds

The BHO shall not use any public funds for purposes of entertainment or perquisites and shall comply with any and all conditions applicable to the public funds to be paid under the contract, including those provisions of appropriate acts of the Hawaii State Legislature or by administrative rules adopted pursuant to law.

62.220 Prohibition of Gratuities

Neither the BHO nor any person, firm or corporation employed by the BHO in the performance of the contract shall offer or give, directly or indirectly, to any employee or designee of the State of Hawaii, any gift, money or anything of value, or any promise, obligation, or contract for future reward or compensation at any time during the term of the contract.

62.230 Publicity

General Condition 6.1 is amended to read as follows: Acknowledgment of State Support. The BHO shall not use the State's or the DHS's name, logo or other identifying marks on any materials produced or issued without the prior written consent of the DHS. The BHO also agrees not to represent that it was supported by or affiliated with the State of Hawaii without the prior written consent of the DHS.

62.240 Force Majeure

If the BHO is prevented from performing any of its obligations hereunder in whole or in part as a result of major epidemic, act of God, war, civil disturbance, court order or any other cause beyond its control, the BHO shall make a good faith effort to perform such obligations through its then-existing facilities and personnel; and such non-performance shall not be grounds for termination for default.

Neither party to the contract shall be responsible for delays or failures in performance resulting from acts beyond the control of such party.

Nothing in this section shall be construed to prevent the DHS from terminating the contract for reasons other than default during the period of events set forth above, or for default if such default occurred prior to such event.

62.250 Attorney's Fees

In addition to costs of litigation provided for under General Condition 5.2, in the event that the DHS shall prevail in any legal action arising out of the performance or non-performance of the contract, the BHO shall pay, in addition to any damages, all expenses of such action including reasonable attorney's fees and costs. The term 'legal action' shall be deemed to include administrative proceedings of all kinds, as well as all actions at law or in equity.

62.260 Time is of the Essence

Time is of the essence in the contract. As such, any reference to "days" shall be deemed calendar days unless otherwise specifically stated.

62.270 Authority

Each party has full power and authority to enter into and perform this contract, and the person signing this contract on behalf of each party certifies that such person has been properly authorized and empowered to enter into this contract. Each party further acknowledges that it has read this contract, understands it, and agrees to be bound by it.

62.280 Health plan request for waiver of contract requirements

The BHO may request a waiver of operational contract requirements from DHS that are described in the RFP. The BHO plans may submit this request in a format provided by the DHS. DHS shall only approve the BHO's request for waiver of a contract requirement that does not adversely affect the outcome of services that its members receive. DHS reserves the right to revoke these waivers at any time upon written notice to the BHO. Whenever possible, DHS shall provide reasonable advance notice of any such revocation to allow the BHO to make any necessary operational changes.

62.300 Conflict of Interest

The following is added to the end of General Condition 1.7, Conflicts of Interest:

No official or employee of the State of Hawaii or the federal government who exercises any function or responsibilities in the review or approval of the undertaking or carrying out of the programs shall, prior to the completion of the project, voluntarily acquire any personal interest, direct or indirect, in the contract. All officials or employees of the State of Hawaii shall be bound by Chapter 84, HRS, Standards of Conduct.

The BHO shall not contract with the State of Hawaii unless the conflict of interest safeguards described in 42 CFR §438.58 and in section 27 of the Office of Federal Procurement Policy Act (41 U.S.C 423) are in place and complies with the requirement described in section 1902 (a)(4)(c) of the Social Security Act applicable to contracting officers, employees, or independent contractors.

62.400 Audit Requirements

The state and federal standards for audits of the DHS designees, contractors and programs conducted under contract are applicable to this subsection and are incorporated by reference into the contract. The DHS, the HHS, or the Secretary may, at any time, inspect and audit any records, inspect the premises, physical facilities, and equipment of the BHO and its subcontractors, subcontractor's contractors, or providers. There shall be no restrictions on the right of the State or Federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services and reasonableness of their costs. The right to audit shall exist for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later.

62.410 Accounting Records Requirements

The BHO shall, in accordance with generally accepted accounting practices, maintain fiscal records and supporting documents and related files, papers and reports that adequately reflect all direct

and indirect expenditures and management and fiscal practices related to the BHO's performance of services under the contract.

The BHO's accounting procedures and practices shall conform to generally accepted accounting principles and the costs properly applicable to the contract shall be readily ascertainable from the records.

62.420 Inclusion of Audit Requirements in Subcontracts

The provisions of Section 60.300 and its associated subsections shall be incorporated in every subcontract/provider agreement.

SECTION 70 TECHNICAL PROPOSAL

70.100 Introduction

The following sections describe the required content and format for the technical proposal. These sections are designed to ensure submission of information essential to understanding and evaluating the proposal. There is no intent to limit the content of the proposal, which may include any additional information that the Offeror deems pertinent. It is essential that the Offeror provide the information in the following order separated by tabs:

- Proposal Letter
- Transmittal letter
- Financial Status
- Executive Summary
- Company background and experience
  - Background of the company
  - Company experience
- Organization and staffing
  - Organization charts
  - Personnel resumes
- Provider Network
- Case Management
- Outreach and education programs
- Other Documentation (Appendix C)

  A. The Proposal Application Identification form (Form SPO-H-200);

  B. The State of Hawaii DHS Proposal Letter*;*

  C. The Certification for Contracts, Grants, Loans and Cooperative Agreements form;

  D. The Disclosure Statement (CMS required) form;

  E. Disclosure Statement;

  F. The Disclosure Statement (Ownership) form;

G. The Organization Structure and Financial Planning form;

H. The Financial Planning form;

I. The Controlling Interest form;

J. The Background Check Information form;

K. The Operational Certification Submission form;

L. The Grievance System form;

M. Insurance requirements certification form;

N. The Wage Certification form;

O. The Standards of Conduct Declaration form; and

P. The State and Federal Tax Clearance certificates from the prime Offeror and, upon request from subcontractors, as assurance that all federal and state tax liabilities have been paid and that there are no significant outstanding balances owed (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.).

70.200 Proposal Letter

The proposal letter (refer to Appendix C) shall be signed by an individual authorized to legally bind an Offeror and be affixed with a corporate seal, if applicable. Please provide a Corporate Resolution or a certificate of authority to sign on behalf of the company.

70.300 Transmittal Letter

The transmittal letter shall be on official business letterhead and shall be signed by an individual authorized to legally bind the Offeror. It shall include:

A. A statement indicating that the Offeror is a corporation or other legal entity. All subcontractors shall be identified and a statement included indicating the percentage of work to be performed by the prime Offeror and each subcontractor, as measured by percentage of total contract price. If subcontractors will not be used for this contract, a statement to this effect shall be included.

B. A statement that the Offeror is registered to do business in Hawaii and has obtained a State of Hawaii General Excise Tax License. Provide the Hawaii Excise tax number (if applicable).

C. A statement that the Offeror's Hawaii Compliance Express is current and provide a copy of the "Certificate of Vendor Compliance" conducted no later than seven (7) days prior to proposal submission.

D. A statement identifying all amendments and addenda to this RFP issued by the issuing office and received by the Offeror. If no amendments or addenda have been received, a statement to that effect should be included.

E. A statement of affirmative action that the Offeror does not discriminate in its employment practices with regard to race, color, creed, ancestry, age, marital status, arrest and court records, sex, including gender identity or expression, sexual orientation, religion, national origin or mental or physical handicap, except as provided by law.

F. A statement that neither cost nor pricing is included in this letter or the technical proposal.

G. If the use of subcontractor(s) is proposed, a statement from each subcontractor must be appended to the transmittal letter signed by an individual authorized to legally bind the subcontractor and stating the general scope of work to be performed by the subcontractor(s).

H. A statement that no attempt has been made or will be made by the Offeror to induce any other party to submit or refrain from submitting a proposal.

I. A statement that the person signing this proposal certifies that he/she is the person in the Offeror's organization responsible for, or authorized to make, decisions as to the prices quoted, that the offer is firm and binding, and that he/she has not participated and will not participate in any action contrary to the above conditions.

J. A statement that the Offeror has read, understands, and agrees to all provisions of this RFP.

K. A statement that it is understood that if awarded the contract, the Offeror's organization will deliver the goods and services meeting or exceeding the specifications in the RFP and amendments.

L. If any page is marked "Confidential" or "Proprietary" in the Offeror's proposal, an explanation to DHS of how substantial competitive harm would occur if the information is released.

70.400 Financial Status

The financial status of an Offeror and related entities shall be reviewed in order to determine the financial solvency of the organization. If an Offeror does not have adequate resources and fails to meet the financial requirements, the proposal shall not be scored and be returned to the Offeror.

70.410 Audited Financial Statements

Audited Financial statements for the applicable legal entity and any subcontractor that is providing at a minimum of twenty (20%) of the work shall be provided for each of the last two years, including at a minimum:

- Balance Sheets
- Statements of Income
- Federal Income Tax returns
- Cash on hand

If an Offeror seeks confidentiality on a part of a submission, each page of the section of that submission which is sought to be protected must be marked as "Proprietary" and an explanation of how substantial competitive harm would occur if that information was released upon request. If the explanation is sufficient, then, to the extent permitted by the exemptions in Section 92F-13, HRS, 45 CFR Part 5, Office of Information Practices, or a Court, the affected section may be deemed confidential. Blanket labeling of the entire document as "Proprietary," however, is inappropriate.

70.500 Executive Summary

The executive summary shall clearly and concisely condense and highlight the contents of the proposal and provide DHS with a broad understanding of the entire proposal. The executive summary shall explain how the Offeror will implement the CCS program consistent with the requirements of this RFP if a contract is awarded to them.

70.600 Company Background and Experience

The company background and experience section shall include for the Offeror and each subcontractor (if any): the background of the company, its size and resources (gross revenues, number of employees, type of businesses), and details of company experience relevant to the operation of managed care plans (type of plan, number of members, etc.). The required information is set forth in detail below.

For each subcontractor (if any), the Offeror shall include within this section of the proposal, a break-down of responsibilities and functions, that describe and clearly illustrate the percentage of work (scope of services required under this RFP) to be performed by the subcontractor, in comparison to the percentage of work to be performed by the Offeror. The total percentage of work performed by subcontractors shall not exceed 60%.

70.610 Background of the Company

A description of the history of the company and the BHO to include but not limited to:

A. The legal name any names under which the Offeror has done business;

B. Address, telephone number and email address of the Offeror's headquarter office;

C. Date company was established;

D. Date company began operations;

E. Provide a general description of the primary business of your organization and its member base;

F. Provide a brief history and current company ownership including the ultimate parent organization and major shareholders/principals. Include date incorporated or formed and corporate domicile, and the date the company began operations. An out-of-state Offeror must become duly qualified to do business in the State of Hawaii before a contract can be executed;

G. Ownership of the company (names and percent ownership), including the officers of the corporation;

H. The home office location and all other offices (by city and state);

I. The location of office from which any contract would be administered;

J. The name, address and telephone number of the Offeror's point of contact for a contract resulting from this RFP;

K. The number of employees both in Hawaii and nationally;

L. The size of organization in assets, revenue and people;

M. The areas of specialization;

N. Description of any allegations against the company and each subcontractor is a party, both in and out of the State of Hawaii in the past ten (10) years, if applicable, please explain; and

O. Disclosure of any past and pending, (within ten (10) years), litigation both in and out of the State of Hawaii for which the company and each subcontractor is a party, including the disclosure of any outstanding judgment, if applicable, please explain.

If the company operates a variety of businesses, the offer shall identify for each operations, the type of business, the date the business was established and began operations, the related gross revenues and total number of employees.

70.620 Company Experience

The details of company experience including subcontractor experience, relevant to the proposal shall include but not limited to the following:

- Length and quality of previous experience in providing the required behavioral health services to a Medicaid population or low-income group.
- Length and quality of previous experience with managed care, including experience in working with behavioral health agencies and behavioral health agencies as subcontractors.
- Outline of existing behavioral healthcare packages offered that are similar to the package described for this RFP.

- Existing volume of current non-Medicaid members receiving SMI services broken down by age and sex.
- Existing volume of Medicaid recipients receiving SMI services broken down by age and sex.
- Any instances of sanctions, corrective oversight, findings of fraud or abuse, or dissatisfaction with performance on the part of the Offeror, or their subcontractors or agents. (Describe the event, findings, agency bringing the action, outcome, and any other relevant facts that relate to the matter listed.)

70.700 Organization and Staffing

The organization and staffing section of the proposal shall include organization charts of company structure and personnel, job descriptions, resumes of individuals serving in the positions specified below, FTE projections (for specific positions, and for general areas of work, listed below), and Offeror references.

The information should provide DHS with a clear understanding of the Offeror's organizational structure, the functions of key personnel, and demonstrate compliance with the requirements of Section 40.700, BHO Personnel.

70.710 Organization Charts

The organization charts shall show the following:

- Relationships of the Offeror to related entities.
- Organizational structure, lines of authority, functions and staffing of the Offeror or proposed entity.
- Current (include names of individuals) or proposed personnel, with indication of the major areas of responsibility and relative placement within the organization.
- Geographic location of key personnel.

70.720 Job Descriptions and FTE Projections (for specific positions)

The Offeror shall include job descriptions in its proposal, for at least the positions listed below. Job descriptions shall include position responsibilities related to the CCS program, and the minimum education and experience qualifications required. For the positions listed below that are followed with an asterisk (*),

the Offeror shall also provide its FTE projection(s). [Note: The list below does not contain all the required positions included in Section 40.700, BHO Personnel. Should Offeror become the BHO, all information required in Section 40.700, BHO Personnel, shall be submitted to DHS.]

1. **Medical Director***
2. BHO CM Staff (not contracted) **Psychiatrist*** (not the Medical Director)
3. BHO CM Staff (not contracted) **Case Management Coordinator***
4. BHO CM Staff (not contracted) **Registered Nurse*** (not the QA/UR Coordinator)
5. **Executive Director***
6. **Compliance Officer***
7. **Pharmacist***
8. **QA/UR Coordinator***
9. **Grievance Coordinator***

70.730 FTE Projections (for general areas of work)

The Offeror shall include in its proposal, FTE projections for the following general areas of work. The projections should provide DHS with a clear indication of the total amount, division, and focus of labor resources that the Offeror proposes to provide toward these general areas of work in executing the CCS program. The Offeror shall also include a brief explanation for the FTE projections provided.

- Member Services
- Provider Services, including monitoring of subcontractor services
- Case Management Services - contracted and BHO CM (not contracted)
- Information Systems
- Fraud, Waste, and Abuse Investigation
- Administrative Support

70.740 Resumes

The Offeror shall include in its proposal, the resumes of individuals to serve in, at least, the positions listed below. Each resume shall include whether the subject individual resides in the State of Hawaii. [Note: The list below does not contain all the positions for which resumes are required from the BHO, in Section 40.700, BHO Personnel. Should Offeror become the BHO, all information required in Section 40.700, BHO Personnel, shall be submitted to DHS.]

1. **Medical Director**
2. BHO CM Staff (not contracted) **Psychiatrist** (not the Medical Director)
3. BHO CM Staff (not contracted) **Case Management Coordinator**
4. BHO CM Staff (not contracted) **Registered Nurse** (not the QA/UR Coordinator)
5. **Executive Director**
6. **Financial Officer**
7. **Pharmacist**
8. **QA/UR Coordinator**

The resumes shall also include, where applicable:

- Experience with the Medicaid or QUEST Integration programs in Hawaii or Medicaid programs in other states;
- Experience in managed care systems;
- Length of time with the Offeror or related organization;
- Length of time in the behavioral healthcare industry;
- Previous relevant experiences;
- Relevant education and training; and
- Names, titles, phone numbers, and email addresses of at least two references who can provide information on the individual's experience and competence.

70.750 Offeror References (professional and member)

The Offeror shall provide a list of no more than five (5) organizations for which the Offeror is currently providing services, or has previously provided services, and shall notify each organization listed that DHS might contact it. The following information shall be provided for each organization.

- Name of the organization.
- Name, title, phone number, and e-mail address of a key contact at the organization who is familiar with the services provided by the Offeror.
- Name, title, address, phone number, and e-mail address of the contract manager.
- Number of members served under the contract with the Offeror, the duration of the contract, and the type of services provided (e.g., behavioral health, TANF, ABD, etc.).

The Offeror shall provide a list of no more than five (5) members it is serving, or has served, in any of its current or previous programs, and shall notify the members listed that DHS might contact them. The following information shall be provided for each member.

- Name, address, phone number, and email address of the member.
- A release, signed by the member, allowing DHS to contact the member.

70.800 Provider Network

70.810 Provider Listing

The Offeror shall have a provider network that complies with the requirements of Section 40.300. The Offeror shall identify its providers on each island by specialty. The Offeror must provide the full range of behavioral health services to members included in their proposal statewide. All providers required in Section 40.305 shall be included in the proposal.

The provider network shall be based on either existing contracted providers or the Offeror may provide its network based on providers' intent to contract with the BHO. The

provider letter of intent (LOI) format provided in Appendix F shall be used to identify providers that are willing to contract with the BHO. A copy of each LOI shall be submitted in the proposal. Within one month of notice of award, the Offeror must submit its preliminary network to the DHS. Failure to meet the requirements of the contract will result in a delay in implementation of the plan.

The Offeror shall provide its provider listing (to include providers who have signed a LOI) for each island using the format in Appendix G. For each provider type, the Offeror shall list the following information:

- Provider type
- Specialty (i.e., psychiatrist, psychologist, psychiatric nurse practitioner, social workers, substance abuse counselors, etc.)
- Island/County (for Oahu, include the city)
- List the provider name (last name, first name, M.I.)
- Provider address (location where service is provided)
- City
- Zip code
- Indication as to whether the provider is accepting new BHO patients from the plan (Y/N)
- Indication as to whether the provider has a limit on the number of BHO QUEST patients he/she will accept from the plan (Y/N)

Separate the providers by provider type noted below:

- Behavioral healthcare specialist services such as psychiatrists, psychologists, social workers, certified substance abuse counselors, and advance practice nurses trained in psychology
- Case management
- Inpatient behavioral health hospital services
- Outpatient behavioral health hospital services
- Mental health rehabilitation services
- Day treatment programs

- Psychosocial rehabilitation (PSR)/Clubhouse
- Residential treatment programs
- Pharmacies
- Laboratory Services
- Crisis services: mobile crisis response and crisis residential services
- Interpretation services
- Supportive housing
- Representative payee
- Supported employment
- Peer Specialist

Each provider should be listed only once.

For clinics serving in the capacity of a behavioral health provider, list the clinic and under the clinic name, identify each specific provider (e.g., psychiatrist, psychologist, psychiatric practitioner, etc.). The address of the clinic should be placed in the address field. The number of BHTPA members assigned to the clinic should be noted. Physicians serving as specialists should be listed on the specialty care matrix with the clinic's name. If the clinic also provides translation, it should be listed on the translation services matrix.

In addition to a hard copy of the provider listings, the Offeror shall include with its proposal an electronic file of providers in Excel format.

Finally, the Offeror shall describe in narrative format how it will reimburse for services for which there are either no contracted providers or the number of providers fail to meet the minimum requirement. Additionally, if the plan does not meet the required providers in its network, it should identify how it will enable its members to access these services. Please describe in this narrative portion how it will arrange to reimburse for meals and lodging for out-of-town medically necessary stays.

70.820 Map of Behavioral Health Providers and Hospitals

The Offeror shall include in its proposal a map of each island indicating the locations of all of its behavioral health providers to include acute psychiatric hospitals. The Offeror shall include all providers that have signed a LOI in their maps as well as contracted providers.

70.900 Case Management

The Offeror shall explain how its case management system complies with section 40.200, including but not limited to:

- How persons (members, family members, community providers and providers) may access the case management system;
- How the BHO intends to perform assessments and develop individual treatment plans (ITP) for their members;
- A description and inclusion of the health plan's assessment that was used to gather information on the member, when referred by a health plan, provider, DOH-CAMHD, DOH-AMHD, DOH-DD, or others;
- How the BHO will interface with the member's PCP in the BHO and other service providers;
- How the BHO will coordinate with the health plans;
- How the BHO will perform concurrent review during acute psychiatric hospitalization and perform safe and appropriate discharge planning;
- How the BHO will prioritize cases for case management (i.e., how it will address the various levels of complexity and intensity of members' behavioral health care needs);
- How the BHO intends to implement the different levels of CM services described in Section 40.220;
- How the BHO intends to assure that case load ratios described in Section 40.220 are met;
- A description of how the BHO will review cases suspected of not meeting SMI criteria;
- A description of the components of a ITP;

- A description of how the BHO will monitor CM services to report encounters, discharge planning and outcomes;
- A description of the case management staffing including a job description of the case manager and the type of initial and/or on-going training and education that it will provide to its case managers;
- A description of how the BHO will monitor member's progress and continued need for enrollment in the BHO; and
- A description of how the BHO will coordinate enrollment and disenrollment with DHS description of the Offeror's policies and procedures for the ITP process that includes the forms to be used to document the ITP.

71.100 Outreach and Education Programs

The Offeror shall describe how they intend to perform all of the requirements described in Section 41.200, "Other Services to be provided" (i.e., the Offeror's efforts to contact persons who are homeless, homebound, and physically disabled, and the Offeror's ability to provide cultural and linguistic services to meet the needs of the members). This section should include information on how the Offeror intends to support members in maintaining their medical assistance eligibility.

In addition, the Offeror shall describe how members will be transitioned and what safeguards will be put into place to ensure that there is no disruption of services and to avoid an abrupt change in treatment plan or service providers, especially for the members in high risk populations; i.e., the physically disabled, homeless, delinquent populations and other persons who have a SMI/SPMI diagnosis with special needs. The proposal shall include the transition procedures for:

- Referral and coordination for members who have received behavioral health services from their health plan provider and/or DOH-CAMHD, DOH-AMHD, DOH-DD.
- Inclusion of certain health plan providers into the behavioral health network to support and coordinate behavioral health services to high-risk members.
- The BHO will resolve differences in treatment plans/approaches with the current PCP.

- How the BHO intends to establish and maintain community linkages with other service providers, i.e., health plan, DOH-CAMHD, DOH-AMHD, DOH-DD, DOH-ADAD, and other community-based providers.

SECTION 80 CAPITATION RATES

80.100 Introduction

This section describes the rate structure and the guidelines for future rate setting.

80.200 Overview of the Rate Structure

For any given behavioral health member, the DHS will pay a capitation rate as one of four base rates. Rates shall be pro-rated for partial month enrollments. Rates shall be based on age as described below.

- Medicaid Only: < 40
- Medicaid Only: 40 and older
- Medicare Eligible: < 40
- Medicare Eligible: 40 and older

All behavioral health services listed in Section 40.900 shall be provided as part of the capitation rate except for those listed below:

- Supportive housing;
- Representative payee;
- Supported employment; and
- Peer Specialist.

These services shall be reimbursed by the BHO and submitted to the DHS for reimbursement monthly via an invoice. DHS shall reimburse the BHO for direct services provided. No additional charges may be submitted for reimbursement.

80.300 Risk Share Program

The DHS shall implement and manage a risk share arrangement and shall share in any significant savings or losses. Additional information about the risk share program is available in Appendix H. The risk share program and parameters will be reviewed and maybe adjusted each contract year.

80.400 Rate Development

The DHS shall provide all Offerors with capitation rates with supporting documentation. The Offeror shall submit any questions regarding capitation rates by the date identified in Section 20.100.

The DHS may modify the capitation rates based upon updated claims experience, fee schedule changes, change in benefits or any other material change.

80.500 Future Rate Setting

Subject to limitations imposed by CMS, legislative direction or other outside influence for which the DHS must comply, it is the intent of the DHS to publish revised rates each state fiscal year.

The DHS may consider adverse selection or risk adjustment in the future years. In the event that any adjustments are made, the DHS will utilize audited data tied to financial records to make such adjustments.

SECTION 90 EVALUATION AND SELECTION

90.100 Introduction

The evaluation of proposals received in response to the RFP will be conducted comprehensively, fairly and impartially. Structural, quantitative scoring techniques will be utilized to maximize the objectivity of the evaluation.

90.200 Evaluation Committee

The DHS shall establish an evaluation committee that shall evaluate designated sections of the proposal. The committee shall consist of members who are familiar with the programs and the minimum standards or criteria for the particular area. Additionally, the DHS may, at its discretion, designate additional representatives to assist in the evaluation process. The committee shall evaluate the proposal and document their comments, concerns and questions.

90.300 Mandatory Requirements

Each proposal shall be evaluated to determine whether the requirements as specified in this RFP have been met. The proposal shall first be evaluated against the following criteria:

- Proposal was submitted within the closing date and time for proposals as required in Section 21.200;
- The proper number of separately bound copies are in sealed envelopes as required in Section 21.200;
- All information required in Section 70 has been submitted;
- Ability for Offeror and their subcontractors, if applicable, to remain solvent for the length of the contract in accordance with information submitted for Section 70; and
- Proposal contains the necessary information in the proper order.

A proposal must meet all mandatory requirements prior to the technical evaluation. Any proposal that does not meet all mandatory requirements shall be rejected.

90.400 Proposal Evaluation

90.410 Step I- Technical Proposal

The proposals that have met the minimum mandatory requirements shall be evaluated in order to identify those Offerors that meet the minimum technical requirements detailed in this section.

Evaluation Categories	**Available Points**
Proposal Letter	Pass/Fail
Transmittal Letter	Pass/Fail
Financial Status	Pass/Fail
Proposal Application	
Executive Summary	10 points
Company Background and Experience	15 points
Organization and Staffing	15 points
Provider Network	25 points
Case Management	25 points
Outreach and Education Programs	10 points
TOTAL POSSIBLE POINTS	**100 points**

90.500 Evaluation Criteria

Each evaluated category shall be given a rating score using the following rating system:

Rating Score	Description
Each 5	The response has no deficiencies and provides a detailed and comprehensive description that demonstrates the ability to more than minimally meet the contractual requirements.
4	The response has no deficiencies and describes how the requirements will be minimally met.
Value 3	The response has no major deficiencies and only minor deficiencies that are easily correctible.
Iuated 2	The response has one major deficiency and/or multiple minor deficiencies that do not appear to be easily correctable.
t 1	The response has multiple major deficiencies that do not appear to be correctable.
ed 0	No response provided.

The Evaluation Committee scores each criterion with a 0, 1, 2, 3, 4, or 5. No fractional scores will be allowed. Scores will be based on the content as communicated in the proposal. Unclear and disorganized presentation of information may impact the evaluators' ability to clearly understand the responsiveness to proposal requirements.

A comment section is provided on the Technical Evaluation Scoring Form. The Evaluation Committee must record a comment for any score of 1, 2, 3 or 5. Comments for criteria receiving a score of 4 are not required.

The Offeror must receive a rating score of 3 for each Evaluation Category or the proposal will not be considered technically acceptable and shall be rejected. Those proposals that do not meet the minimum points to pass each of the required criteria shall be returned to the Offeror with a letter of explanation.

The rating score (0-5) shall represent the corresponding conversion factor used to calculate the points awarded for each Evaluation Category listed in section 90.400, as follows:

Rating Score	Conversion Factor
0	0
1	25%
2	50%
3	75%
4	88%
5	100%

The total maximum number of points available for each Evaluation Category will be multiplied by the applicable conversion factor, based on the rating score given, to determine the number of points awarded for the Evaluation Category. The points awarded for each Evaluation Category shall be totaled to yield a final score. The Offeror with the highest final score shall be awarded the contract.

Scoring will be based on the entire content of the proposal and the information as communicated to the evaluators. The information contained in any part of the proposal may be evaluated by the DHS with respect to any other scored section of the proposal. Lack of clarity and inconsistency in the proposal will impede effective communication of the content and may result in a lower score.

The broad criteria for each Evaluation Category are listed below and includes consideration of the specific elements identified in Section 70. MQD reserves the right to add, delete or modify any criteria in accordance with applicable procurement rules.

90.510 Proposal Letter (Pass/Fail)

- Signed by an individual authorized to legally bind the Offeror and affixed with a corporate seal, if applicable;
- Includes a Corporate Resolution or a certificate of authority to sign on behalf of the company; and
- Includes all statements as specified in Section 70.200.

If the proposal letter is incomplete, the proposal will be rejected and not be scored and will be returned to the Offeror since this is part of the mandatory requirements established in Section 90.300.

90.520 Transmittal Letter (Pass/Fail)

- Presented on an official letterhead and signed by an individual authorized to legally bind the Offeror; and
- Includes all statements as specified in Section 70.300.

If the transmittal letter is incomplete, the proposal will be rejected and not be scored and will be returned to the Offeror since this is part of the mandatory requirements established in Section 90.300.

90.530 Financial Status (Pass/Fail)

- Describes the financial status of an Offeror and related entities shall be reviewed in order to determine the financial solvency of the organization. Quality services cannot be provided without adequate resources; and
- Addresses other factors identified in section 70.400.

If the Financial Status is incomplete or is determined that the Offeror does not have adequate resources, the proposal will be rejected and not be scored and will be returned to the Offeror since this is part of the mandatory requirements established in Section 90.300.

90.540 Executive Summary (10 points possible)

- Provides a broad understanding of the proposal;
- Clearly and concisely condenses the proposal;
- Highlights the contents of the proposal;
- Identifies how the Offeror will implement the CCS program consistent with the RFP requirements if a contract is awarded to them;
- Includes all the required information described in Section 70.500.

90.550 Company Background and Experience (15 points possible)

- Includes all information required in Section 70.600 for both themselves and each subcontractor, if applicable;
- Describes the company background and experience including experience implementing a program of the nature/size required by this contract;
- Provides each subcontractor's background and experience;
- Explains the extent to which the scope of services under this RFP can and will be completed by the Offeror;
- Describes the quality with which scope of services under this RFP can be completed by the Offeror;
- Sets forth the Offeror's ability to meet the contract requirements; and
- Addresses other factors identified in section 70.600 for both the Offeror and each Subcontractor.

90.560 Organization and Staffing (15 points possible)

- Explains the basis of relevant experience and member references. Note: for Offerors currently providing services to Medicaid members, MQD reserves the right to contact previous and current members beyond those provided in Section 70.750;
- Includes past and current management experience for similar services of like projects in scope;
- Describes the Offeror's and Subcontractor's ability to provide high-quality behavioral health services;
- Includes description of relevant program experience and success in performing projects of similar scope to that described herein;
- Includes provider network and QIP;
- Describes the competence of proposed key professionals and other employees;
- Includes the qualifications of personnel including education, experience with behavioral health populations, length of time with the organization, and Hawaii Medicaid experience. (Resumes of personnel specified in Section 70.740 must be provided.);

- Capability of organizational and administrative systems in Hawaii to implement contractual obligations for this RFP;
- Description of sufficient staff and resources identified and allocated to fulfill the requirements of the contract; and
- Addresses other factors identified in Section 70.700.

90.570 Provider Network (25 points possible)

- Includes the data required in Section 70.800;
- Describes the capability of Offeror's provider network of providing the services set forth in the RFP in all areas statewide;
- Describes the sufficiency of provider network to meet the behavioral health needs of its members;
- Presents the comprehensiveness of the provider network to provide access to all required services as set forth in the RFP;
- Includes the Provider availability and geographic access, especially on the islands other than Oahu; and
- Addresses other factors identified in Section 70.800.

90.580 Case Management (25 points possible)

- Describes the process for providing case management;
- Describes staff functions, interactions, and internal coordination;
- Includes information of staff level and case load ratios;
- Includes a plan for monitoring and coordinating needed clinical and other services to support the member in the community;
- Describes the relationship of BHO with case management agencies in the community;
- Answers all of the questions from Section 70.900; and
- Addresses other factors identified in Section 70.900.

90.590 Outreach and Education Programs (10 points possible)

- Includes a plan for serving persons who are homebound and/or physically disabled;

- Includes a plan to serve difficult to find members (to include those that do not have a home);
- Describes the Offeror's and subcontractor's ability to provide services to members whose primary language is not English;
- Includes a plan to support members in maintaining their Medicaid eligibility;
- Includes a plan for transition of care for new members into the BHO to include but not be limited to, cooperation with health plans, DOH-CAMHD, DOH-AMHD, DOH-DD, the State Hospital, prison, and other involved agencies and organizations; and
- Addresses other factors identified in Section 71.100.

APPENDIX A – WRITTEN QUESTIONS FORMAT

APPENDIX B – NOTICE OF INTENT TO PROPOSE

APPENDIX C – PROPOSAL DOCUMENTS

A. **Proposal Application Identification form (Form SPO-H-200)**
B. **State of Hawaii DHS Proposal Letter**
C. **Certification for Contracts, Grants, Loans and Cooperative Agreements form**
D. **Disclosure Statement (CMS required) form**
E. **Disclosure Statement**
F. **Disclosure Statement (Ownership) form**
G. **Organization Structure and Financial Planning form**
H. **Financial Planning form**
I. **Controlling Interest form**
J. **Background Check Information form**
K. **Operational Certification Submission form**
L. **Grievance System form**
M. **Insurance requirements certification form;**
N. **Wage Certification form**
O. **Standards of Conduct Declaration form**

APPENDIX D – CCS REFERRAL FORM AND INSTRUCTIONS

APPENDIX E - GENERAL CONDITIONS

APPENDIX F – PROVIDER LETTER OF INTENT

APPENDIX G – PROVIDER LISTING

APPENDIX H – RISK SHARE PROGRAM

APPENDIX I –FINANCIAL PAYER RESPONSIBILITY GUIDELINES

APPENDIX J – BUSINESS ASSOCIATE AGREEMENT