APS Healthcare

September 17, 2012

Ms. Dona Jean Watanabe
Department of Human Services
Med-QUEST Division/Finance Office
1001 Kamokila Boulevard, Suite 317
Kapolei, Hawaii 96707

RE: RFP-MQD-2013-007; Behavioral Health Services for Medicaid Eligible Adults who have a Serious Mental Illness

Dear Ms. Watanabe:

On behalf of APS Healthcare Bethesda, Inc. (APS), thank you for the opportunity to submit a response Request for Proposal RFP-MQD-2013-007, to provide behavioral health services for Medicaid-eligible adults who have a Serious Mental Illness. We look forward to the thoughtful consideration of our proposed approach to serving this population within the framework of a full risk for clinical and pharmacy services. In developing our response, APS evaluated and structured all aspects of our approach to meet the requirements of this new scope of work.

As our proposal demonstrates, APS is a national managed behavioral healthcare organization with deep Hawaii experience; a record of delivering exemplary services to Hawaii residents with SMI; strong community ties through our more than 120 employees; a highly specialized and fully compliant provider network; and the infrastructure to meet the managed care expectations of the Med-QUEST Division. Given the inclusion of pharmacy benefits in the scope of work, APS is pleased to subcontract with CVS Caremark, a leading Pharmacy Benefit Manager with a fully compliant pharmacy network in Hawaii and over 2,000 employees in the State. APS joins with our network of over 230 providers and practitioners, our subcontractor CVS Caremark, and our dedicated employees for a Behavioral Health Organization that will create new opportunities for integration of care and recovery for members.

APS provides the following information as required by Section 70.200 of the Request for Proposal:

- APS is a corporation. As the prime contractor, APS anticipates performing 90 percent of the scope of work (as measured by percentage of the total contract price). APS will subcontract pharmacy benefit management to CVS Caremark and estimates this level of effort at 10%.
- APS has current registration to do business in Hawaii. Our State of Hawaii Excise Tax number is W20090954-01.
- APS received the following amendments and addenda to this RFP:
  - Amendment #1
  - Amendment #2
  - Amendment #3

- APS 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.
- Appended to this transmittal letter is a statement from CVS Caremark Corporation signed by an individual authorized to bind the corporation legally to this contract and states the general scope of work it will perform in support of this contract.
- No attempt has been made or will be made by APS to induce any other party to submit or refrain from submitting a proposal.
- Dr. Jerome Vaccaro, the individual signing this transmittal letter, certifies that he is the person in APS' organization authorized to make decisions as to the prices quoted, that the offer is firm and binding, and that he has not participated and will not participate in any action contrary to the above conditions.
- APS has read, understands, and agrees to all provisions of this RFP.
- APS understands that if awarded the contract, APS will deliver the goods and services meeting or exceeding the specifications in the RFP and amendments.
- The following APS exhibits are confidential and/or proprietary as they contain information that, if released, would result in competitive disadvantage to APS and are therefore "trade secrets" in that it other organizations can use it to infer cost and pricing of APS' operations. We consider the resumes of key and other staff member to be confidential. Member Release of Information forms contain Protected Health Information for these members and are therefore confidential.
  - Exhibit 1: Organizational Charts
  - Exhibit 2: APS Financial Statements
  - Exhibit 4: APS Statement of Legal Information
  - Exhibit 5: Quality Improvement Guidelines
  - Exhibit 6: Resumes of Key and Other Staff
  - Exhibit 7: Member Signed Release of Information forms
  - Exhibit 11: Plan of Care

  All confidential and proprietary exhibits are clearly marked as "Proprietary" or "Confidential" on each page. All confidential sections are readily separable from the proposal. If the Department disagrees with our designation and finds that information in these sections is not confidential or proprietary, please notify APS in advance so that we can discuss the differences with Department prior to release of information to the public.
- As the RFP specifies, we have included one (1) original proposal bound and three (3) additional bound copies of the proposal, and one (1) complete electronic version in the required format.

Thank you for your consideration of our proposal. We look forward to continuing our long-standing partnership with DHS/MQD to improve the health and quality of life for adults with Serious Mental Illness or Serious and Persistent Mental Illness who are served through the Community Care Services (CCS) Program. If given the opportunity, our team pledges the highest level of dedication and support to Hawaii's progress toward achieving a more efficient and effective system. Should you need further information, please do not hesitate to contact me at (914) 288-4732 or via email at jvaccaro@apshealthcare.com. Alternatively, you may also contact Cynthia Weinmann at (240) 315-5416 or via email at cweinmann@apshealthcare.com.

Sincerely,

Jerome V. Vaccaro, MD
President and CEO
Phone: (914) 288-4732
E-mail: jvaccaro@apshealthcare.com

Proposal Table of Contents

70.300 Proposal Narrative

The Hawaii Department of Human Services (DHS) seeks to contract with a Behavioral Health Organization (BHO) for Community Care Services (CCS) serving Hawaii residents with Serious Mental Illness (SMI) and Serious and Persistent Mental Illness (SPMI). In a fully capitated model, the BHO will deliver the full range of services through its contracted network of providers, able to staff case management services in addition to contracting with case management agencies as network providers. The current CCS membership will transition to the BHO first, and the DHS plans to expand CCS to serve individuals in QUEST as well as those currently receiving services through the Department of Health Adult Mental Health Division. This approach holds great promise – better aligning services with member needs, building network capacity across the islands, and improving performance and accountability.

APS is the current Community Care Services vendor under contract to the DHS. The APS Hawaii network has over 250 provider locations, which deliver the full range of services to CCS members. APS provides case management through a staffing model as well as through network providers such as the Susannah Wesley Center. In response to the Request for Proposal (RFP) APS proposes to enhance its Hawaii Service Center for full BHO operations and transition our current clinical centers to an enhanced role as Area Resource Centers. These Centers will enable us to strengthen the community-based provider network through telemedicine access, technical assistance, and access to Center physical and information technology infrastructure. In our proposal, we address all aspects of BHO implementation and management through a stable Hawaii Service Center. Highlights of the proposal are:

70.400 Company Background and Experience. APS is a national Behavioral Health Organization (BHO) delivering services to residents of Hawaii with SMI and SPMI for more than a decade. Founded as a BHO, APS roots are in behavioral health and we are a respected BHO in the mainland United States (US), in Hawaii, and in the Commonwealth of Puerto Rico. Our mainland behavioral health programs for Georgia and West Virginia Medicaid began in 1999 and 2000 respectively and our contracts with these states continue to expand. APS added the Maine behavioral health program in 2007, creating a new system of management for behavioral health services, promoting recovery for Maine residents with SMI and SPMI in community settings, expanding the number of people who receive services while reducing costs across the system as a whole. Our outcomes in Maine echo those of our Puerto Rico system, which is a full-risk BHO serving 1.3 million Medicaid residents. These outcomes include reduced length of stay in residential settings, growth in community-based services, and ability of members to experience quality of life through recovery. A long-term relationship with clients also characterizes our commercial managed care experience.

The APS national Managed Behavioral Health (MBH) center in Columbia, Maryland serves commercial clients, including the State of Maryland Employees since 2001. Our account for federal employees who are members of Blue Cross Blue Shield of Montana began in 1999 – and is a reference for APS with this proposal. The national center also supports our newest client – APS parent Universal American Corp. Effective 2012 APS administers behavioral health benefits for over 165,000 Medicare beneficiaries on

the mainland. Continued enhancements to our MBH infrastructure provide value to the CCS BHO through more efficient claims payment and provider credentialing.

APS proposes to subcontract with CVS Caremark Corp (CVSC) for Pharmacy Benefit Management (PBM). With more than 2,800 employees in Hawaii and a pharmacy network of 146 pharmacies, CVSC has the infrastructure in place to serve current and future CCS members. CVSC's background and experience also features significant successes on behalf of their Medicaid and commercial clients, one of which is the Hawaii Medical Services Association (HMSA). One of the leading PBM vendors, CVSC is also the PBM partner for Universal American. We present this experience and offer illustrations that demonstrate the ability of CVSC to manage the pharmacy benefit successfully for clients, providers, and members.

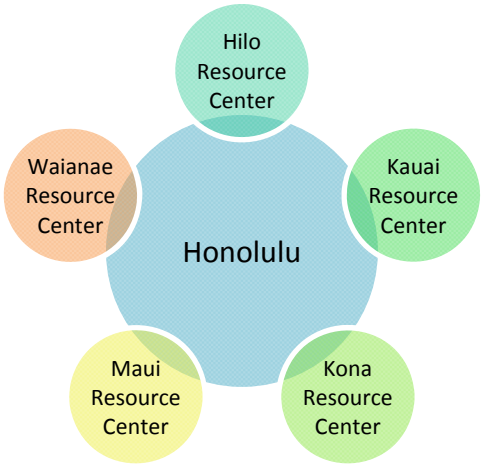
70.500 Organization and Staffing. APS developed the state Service Center model for the Georgia Medicaid contract in 1999 and it is an APS best practice – we now have 36 centers in 13 states and the Commonwealth of Puerto Rico, seven of which are in Hawaii. This model places a significant majority of staff members in state Service Centers, an approach that contributes to local employment and integrates local knowledge and experience of the behavioral health environment through local hiring. APS has significant staffing in place for current CCS clinical operations and proposes to expand our local presence with enhanced Provider Relations and Member Services departments. As the organizational charts in Section 70.500 demonstrate, experienced APS employees fill key positions. The staffing table in this section illustrates our approach to staffing which emphasizes full-time positions for important management functions. We propose Robbyn Takeuchi as the full-time Administrator and Plan Contact. Robbyn is a well-known and respected clinician, and has current responsibility for CCS members as Program Manager. Dr. Toshi Shibata will also continue as the Medical Director and dedicate full-time to this position. New to the Hawaii Service Center is corporate Executive Director Colette Riehl. The Administrator and Plan Contact reports to Ms. Riehl, who joined APS in 2006 and has demonstrated her ability to manage high performing offices in multiple states while with APS.

With our current team of licensed clinicians who meet the Case Manager requirements of the RFP, APS will deliver Case Management services through a staffing solution and through the provider network. Current Provider Relations staff works closely with providers from our Honolulu office and Client Service Representatives support members from our Nimitz Call Center and other Area Resource Centers.

Key to our proposed approach for Organization and Staffing is the transition for our Area Resource Centers. APS currently delivers Case Management services (as well as in community and home settings), Intensive Outpatient, and Psychosocial Rehab services in these centers. Dedicated Area Supervisors, all of whom are licensed Behavioral Health Professionals, are responsible for each Center. The function of these clinical centers will evolve, as they become community-based resources where providers and their members can participate in telemedicine with APS Medical Directors for medication management and other support. As the BHO, APS will only deliver case management services, and will work with providers in each area to transition other services into the network.

We will continue to provide Case Management services in these centers and other locations, and extend access to network providers as needed for their use at no charge. In addition to augmenting delivery sites available for behavioral health services, APS will use the Area Resource Centers for provider training and technical assistance.

70.600 Provider Network. As the incumbent CCS vendor, APS submits this proposal with the majority of providers on our network listing already contracted and serving CCS members. APS' network development in the current contract uses a responsive approach – focusing on assurance of access to services for current CCS members as they enroll. Our network access report demonstrates that this approach is successful: 100% of enrolled CCS members have access to services within driving times stipulated by the RFP. Proposed subcontractor CVSC brings a network of pharmacies that is also 100% compliance with RFP requirements for the next contract period. We understand that the DHS has a vision of the provider network that is responsive *and* proactive – with all provider types contracted to ensure access for future members on all islands. APS is prepared to meet these requirements no later than 60 days prior to the commencement of services.



Area Resource Centers – Building Community Capacity

APS prepared for these requirements in a number of ways. We have contacted Federally Qualified Health Centers (FQHCS) on each island and engaged with the Hawaii Primary Care Association to discuss and plan for capacity building with their membership. These considerations include technology development for access to telemedicine services and APS information tools, co-locating behavioral health professionals, and training on significant issues in behavioral healthcare in primary care settings.

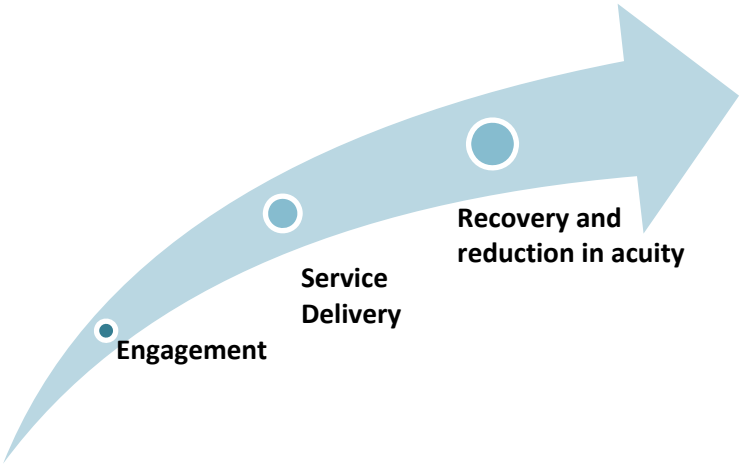
APS also held several Provider Summits to gather information on provider perspectives and concerns. Claims payment is always of interest to APS and providers. Recent data indicates progress on timeliness of claims processing as we show below. This focus will continue in the next contract period, and with dedicated staffing in Hawaii for claims analysis and payment, we expect this positive trend to continue. We propose a dedicated, full-time Claims Analyst position for this contract.

2012 Month	Claims Processed	Processed ≤ 14 days	% Processed ≤ 14 days	Processed ≥ 15 days and ≤ 30 days	% Processed ≥ 15 days and ≤ 30 days	Average Turnaround Time in Days
April	1,589	1,534	96.54%	55	3.46%	8.6
May	1,807	1,415	78.31%	392	21.69%	12.36
June	2,137	1,874	87.69%	263	12.31%	11.2

The basics of claims payment, however, was not the primary consideration for the dozens of providers we met with in the past months. Of more interest to them, especially in the context of the next contract period is the need for capacity development at the community level – including promoting communication between providers, facilitating integrated service planning and delivery, and addressing the medical needs of CCS members as well as their behavioral health needs. APS addresses this interest on the part of the provider community through the Area Resource Centers and with a proposed position for Community Development Specialist. We discuss the Area Resource Centers in the Proposal Narrative for Section 70.500 – and the opportunity to access psychiatric resources through telemedicine will be an important support to community-based providers. The Community Development Specialist will focus on facilitating access to APS tools and resources. Just as importantly, this position will also promote the collaboration between providers they report as a need.

The addition of a Hawaii-based Contracting Specialist to the Provider Relations team will streamline the contracting and credentialing process. With new members transitioning into CCS from QExA and potentially QUEST in the future, as well as with members who have received services through AMHD and the Child and Adolescent Mental Health Division (CAMHD), facilitating the ability of new providers to join our network when their clients enroll in to CCS is essential to maintaining continuity of service for members. Additional staff members in the role of Provider Relations Specialist will join existing staff in this position as the network grows, and ensures that legacy knowledge and capacity transitions to the new contract. A proposed full-time Provider Services Manager dedicated to CCS completes the Provider Services team for a fully configured department to support the comprehensive network for CCS.

70.700 Case Management. Case Management is a core service for CCS members. APS will deliver this service directly and through case management agencies in the provider network. Case Managers help members achieve reduced acuity and recovery. Case Management is one way APS ensures the right care in the right setting for every member, every time. We describe our approach to the CCS system of care, detailing our workflows and strategies to conduct assessments, engage, and support members in the community. Our approach is evidence-based and trauma-informed, and grounded in extensive practice in Hawaii supporting CCS members. We work collaboratively with providers, members and families to develop an individual treatment plan (ITP) that is responsive to member needs, based on medical necessity, and focused on community integration to support member recovery.



Case Management – Supporting the Path to Recovery

An experienced cohort of licensed and trained Case Managers currently working with members and providers across the islands prepares APS for seamless transition to the next contract period. An important transition will occur with the contract – APS will focus activities on BHO operations with case management as one strategy. As the provider network increases engagement across the spectrum of service delivery, APS Case Managers continue to fill essential roles – for technical assistance, support for member transitions into CCS, provider feedback and education, and to address gaps in the network based on location, acuity, or member preference. APS Case Managers are trusted resources for CCS members now – and will be trusted resources for members and providers in the future.

Case Managers work closely with members to ensure a smooth transition into CCS so that members experience continuity of service; retain important relationships with their plan providers and Case Managers; and accessing medically necessary services in the most appropriate setting. After intake, Case Managers conduct an objective assessment that identifies member needs for medical care, behavioral healthcare, and community-based services. Working with members, their families, the plan, and providers, Case Managers then document the ITP and coordinate the initiation of services. We monitor member utilization closely to ensure members keep appointments and adhere to medication regimens through on-going assessment and communication as well as data monitoring in Care Connection.

An innovation APS implemented in Hawaii in 2011 is our next generation information system, APS CareConnection®. APS customized this system for CCS to provide an integrated and member-centered platform for case management. We use this system to maintain comprehensive documentation on all aspects of CCS services to members – assessments, the ITP, follow-up, and coordination of care among providers and between medical care and behavioral health. Another APS innovation, the APS Percolator® uses the CareConnection integrated database. Percolator technology combines public domain measures such as the Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators; nationally recognized measures such as the HEDIS® Follow-up After Hospitalization[1] indicator and other quality indicators; and measures of uncoordinated care, such as readmissions, emergency department utilization, and inpatient admissions. Data analyses and feedback for providers are important support functions that we will deliver using these tools. To further support network providers, APS Case Managers will focus on “transition of care” for “Follow-up after Hospitalization” and “Initiation, engagement, and Treatment” to improve the quality of care. HEDIS measures and outcomes in reduced re-admits and untreated substance abuse cases demonstrate the value of this approach in other APS programs, including the Behavioral Care Connection program APS conducts for HMSA.

70.800 Outreach and Education. Outreach and education are fundamental to the success of CCS. Reaching members whether they are at home or homeless, ensuring they have accurate information about CCS benefits and program features, and aligning service delivery to member needs requires tireless outreach and education for members and providers. APS excels at member outreach. Case Managers are tireless in their willingness to find and engage members, and our member references will

[1] HEDIS is a registered trademark of the National Committee for Quality Assurance

confirm this characteristic. APS provides a detailed discussion about Outreach and Education in this section, including a description of transition procedures for members who join CCS.

Outreach serves many functions – identifying new service needs among members and proactive network development, arrangement for transportation, and cultural/interpretation services, among others. The APS solution for outreach and education is multi-faceted and comprehensive. With existing relationships with translators in Hawaii and telephonic translation services for over 150 languages, APS also supports TTY services for deaf or hard-of-hearing members and has the capacity to create Braille communications for people with vision disabilities. The APS website is straightforward and easy to navigate, supporting screen reader technology for people with vision and hearing disabilities.

A culturally diverse company in Hawaii and nationally, APS promotes cultural competence throughout our business activities. We include formal training for staff members to promote understanding of cultural perspectives among members and network practitioners, also a culturally diverse population. The integration of cultural perspectives and evidence-based behavioral health services into an "ethnobehavioral" environment delivers a culturally competent service system that is meaningful and relevant to all stakeholders.

Our approach to outreach and education provides the sound foundation for procedures that address the transition of members into CCS. We include a comprehensive description of transition procedures in Section 70.800 – how we transition members into CCS; what considerations to address for the plan, members, and existing providers; and how we maintain community linkages among stakeholders in the behavioral health community, among other activities. The BHO is a system approach that must connect all aspects of behavioral health for Community Care Services members and providers in a closely linked system that supports members and organizes service delivery to reduce acuity, avoid crisis, and promote recovery. Open communication among stakeholders to focus on priories for members, feedback and technical assistance that builds capacity among providers, and innovative development of new technologies are characteristics of a successful behavioral health environment. Indicators of this environment are optimal outcomes – reductions in residential admissions and length of stay, decreased emergency room visits, elimination of avoidable readmissions to acute care for behavioral health and medical diagnoses, improved medication adherence and quality of life for members.

Summary. APS has helped members and their providers achieve this system of behavioral health care across the mainland US and in Hawaii for more than a decade. Our proposal presents our background and experience, our staffing approach and model, and our case management philosophy and methods. APS joins with our contracted provider network and subcontractor CVS Caremark to submit this proposal to continue meeting the needs of CCS members in a fully-capitated, accountable, and integrated system of behavioral health to promote recovery for all members.

70.400 Company Background and Experience

70.410 BACKGROUND OF APS HEALTHCARE

General Description and Member Base

APS is a national managed behavioral healthcare organization with deep Hawaii experience and a record of accomplishment characterized by exemplary services to Hawaii residents with Serious Mental Illness (SMI) and Serious and Persistent Mental Illness (SPMI). APS has strong community ties, a robust behavioral health provider network in Hawaii and nationally, and the resources to meet the managed care expectations of the Department of Human Services (DHS). APS and its affiliates currently serve more than 14 million beneficiaries through a variety of full-risk and administrative behavioral health and medical care management solutions.

Founded as a Managed Behavioral Healthcare Organization (MBHO), APS Healthcare (APS) has evolved into a leading healthcare company that offers a unique suite of customized, integrated specialty healthcare products and services across the major product lines of care management and behavioral health. Our innovative solutions promote integration of medical and behavioral healthcare within a holistic and recovery-focused framework. APS Behavioral Health serves over 3.8 million covered lives. A leader in supporting Medicaid programs in the Hawaii, the United States mainland, and Puerto Rico, APS currently serves over 11 million Medicaid members through almost 30 program contracts. Our total client base includes state and local governments, state Medicaid agencies, health plans, employers (public and commercial), and unions/trusts.

APS Area Resource Centers

APS facilitates behavioral health services directly and through our provider network in member homes, facilities, or in other settings when members are homeless. APS also established Area Resource Centers on Kauai, Oahu, Maui, and Hawaii, shown below in Figure 1. These Centers currently provide services such as crisis support, skill-building, and case management. Resource Centers are also service locations for network providers, who deliver outpatient, intensive outpatient, and psychiatric services to current Community Care Services (CCS) members. APS will expand the Resource Centers in the next contract period to enhance technical assistance for providers, delivery of services for members through visiting providers, and case management services delivered by ASP and network providers. They are an important part of the local infrastructure and will be available to providers to augment their own locations as needed. These Centers will promote APS' provider relations and outreach initiatives, generating opportunities for provider-led member counseling and education – both from providers to members and from APS to providers. APS will also arrange transportation for provider and members, as needed, to encourage in-person collaboration and delivery of services to the CCS membership.

An important enhancement to the Resource Centers will be telemedicine capabilities so that primary care and other providers can participate in video- and teleconferences with APS Medical Directors. Medical Directors will be available to assist with medication questions and discuss member care with network providers.

Figure 1. APS Hawaii Locations. The APS Member Call Center is located in the clinical center in Nimitz. APS corporate headquarters for Hawaii operations is in Honolulu. Six Area Resource Centers to support members and providers are located on Kauai, Oahu, Maui, and Hawaii Islands.

APS will streamline implementation for the next contract period and our local presence and experience in Hawaii is a benefit to the DHS in this regard. Systems and processes are already in place and we will focus on innovations to meet BHO requirements and exceed the DHS' expectations for network development, automation, implementation of full-service pharmacy benefit management through subcontractor CVS Caremark, and expansion of services to meet current and future member needs.

Company History and Ownership

The APS family of companies began with APS Healthcare, Inc.'s incorporation in Delaware in September of 1991. Operations began in 1992. The bidding entity, APS Healthcare Bethesda, Inc. (APS) incorporated in October 1993. As of March 2012, APS is a fully owned subsidiary of Universal American Corp (NYSE:UAM), a publicly traded insurer with broad offerings in Medicare Advantage and Special Needs Plans. Joining the UAM family strengthens our corporation and enables us to leverage health plan systems and processes that are consistent with the vision of DHS for the development of the Community Care Services Behavioral Health Organization. As an independent operating unit, APS will continue to manage our contracts with the direction of our corporate officers and management team.

Table 1 lists the corporate officers of APS Healthcare. This management team has an exceptional background of service and organizational performance. Of importance to this bid are the behavioral health backgrounds and experience of APS leadership:

Table 1. APS Officers

Name	Title
Jerome V. Vaccaro, MD	President and Chief Executive Officer
Joanne Brown Lee	Chief Operating Officer
Richard C. Surles, PhD	Chief Development Officer
Richard Chung, MD	Chief Clinical Officer
John McDonough	Chief Financial Officer
Joyce Tichy, J.D.	Chief Legal Officer
Judy Ehrenreich	Chief Human Resources Officer
Dee Warrington	Chief Compliance Officer

- Jerome V. Vaccaro, MD – President and Chief Executive Officer. Dr. Vaccaro is a Board-certified Psychiatrist with more than 25 years of practice in the US and Hawaii. He leads the APS Quality Improvement Committee, and will have an active role in APS Hawaii programs in collaboration with Dr. Chung and corporate Executive Director Colette Riehl.
- Richard Chung, MD – Chief Clinical Officer. Dr. Chung is also a Board-certified Psychiatrist with an extensive background in Hawaii's behavioral healthcare system. Dr. Chung will serve as consultant to APS Hawaii and its delivery of the CCS program throughout the contract term.
- Richard C. Surles, PhD – Chief Development Officer. Dr. Surles has over 30 years of public service related to behavioral health, including as the Director of Mental Health for the States of New York and Vermont and the City of Philadelphia.

Table 2 presents officers of Universal American Corp. We present additional information on Universal American and APS in Section 70.500.

Table 2. Universal American Corp Officers

Name	Title
Richard A. Barasch	Chairman of the Board and Chief Executive Officer
Robert A Waegelein	Executive Vice President and Chief Financial Officer
Theodore M. Carpenter, Jr.	President, Medicare Advantage
Robert Hayes	Senior Vice President, Health Quality
Gary Jacobs	Senior Vice President, Corporate Development
Jason J. Israel, CPA, FLMI	President, Insurance Companies

Exhibit 1a, Organizational Charts, illustrates APS' corporate relationship with UAM and its subsidiaries. Exhibit 1b displays APS' Project Organizational Chart, which shows program roles, responsibilities, and reporting relationships. We also show this Project Organizational Chart in Section 70.510.

Office Locations

Providing health care that serves members in their own communities and neighborhoods is a core tenet of our philosophy of quality medical and behavioral health care. APS staff members live and work in the communities we serve; and as such, we maintain office locations throughout the United States. Our corporate headquarters are located at 44 South Broadway, Suite 1200, White Plains, NY 10601. The toll-free corporate number is (800) 305-3720. Local Service Center Offices are:

- California: Sacramento, Newport Beach and Burbank
- Colorado: Denver
- Florida: Tallahassee
- Georgia: Atlanta
- Hawaii: Honolulu (Administrative Office); Hilo, Kahului, Kona, Lihue, Waianae and Waipahu, Hawaii, Nimitz (Clinical Centers)
- Iowa: Des Moines
- Maine: South Portland
- Maryland: Columbia
- Massachusetts: Boston
- Montana: Billings
- Ohio: Dublin
- Oklahoma: Oklahoma City
- Oregon: Tualatin
- Pennsylvania: North Huntingdon and Mechanicsburg
- Puerto Rico: San Juan (Corporate Office); Aguadilla, Arecibo, Caguas, Carolina, Cidra, Plaza Guayama, Humacao, Manatí, Naranjito, Orocovis, Rio Grande, Vieques and Yauco
- Vermont: Williston
- West Virginia: Charleston
- Wisconsin: Brookfield and Madison

Hawaii Service Location

APS manages the current program from our Honolulu location at Pacific Guardian Center, Makai Tower, 733 Bishop Street, Suite 1500, Honolulu, HI 96813. APS has 121 employees located in Hawaii who are dedicated to improving the lives of Medicaid recipients through various Hawaii-based programs. Our numerous service sites in Hawaii ensure a statewide presence and broad personal outreach to members regardless of where they live. Over 50 other APS employees have the privilege of serving our CCS members through corporate functions such as Human Resources, Finance and Information Technology.

Primary Point of Contact

Robbyn Takeuchi, LCSW will be the Administrator and Plan Contact for the BHO. Ms. Takeuchi is responsible to develop and oversee clinical departments, including interactions with the physician advisors, accounts, providers, patients and all other APS departments. Ms. Takeuchi also works with the Quality Improvement department to implement quality improvements related to key program metric outcomes; clinical services staff performance, identified participant service issues, and/or new initiatives designed to improve outreach to and engagement of identified participants within the service population. Ms. Takeuchi will allocate 100% of her time to the Community Care Services program. We have provided a copy of her resume as Exhibit 6. Ms. Takeuchi's contact information is:

Robbyn Takeuchi, LCSW
Pacific Guardian Center, Makai Tower,
733 Bishop Street, Suite 1500,
Honolulu, HI 96813
800.305.3720 x4202
rtakeuchi@apshealthcare.com

Number of Employees and Organizational Assets

APS has over 1,400 employees located in 50 office locations across the United States and Puerto Rico, including nine sites in Hawaii. For each of our state customers, we employ our local service center model whereby we establish a local office staffed with professionals from the surrounding communities.

APS Healthcare had 2011 revenues of more than $300 million and 2011 EBITDA estimated at approximately $31 million. Our financial resources and stability offer assurance to the State that it will collaborate with a strong, fiscally responsible healthcare vendor. Please refer to Exhibit 2 for our audited financial statements, which provide further information regarding our assets. We also include the most recent Form 10-K filing for Universal American, which provides relevant information about the substantial financial position and resources of APS' corporate parent. We provide Financial Statements for subcontractor CVS Caremark in Exhibit 3.

Areas of Specialization

APS provides integrated care management through programs focusing on behavioral health and co-morbid conditions. We deliver field-based programs for specialized population segments such as individuals with SMI, Medicare Advantage and dual eligible populations, individuals who require long-term care, people with developmental or intellectual disabilities, and children with special health needs. Figure 2 summarizes our comprehensive capabilities and scope of programs.

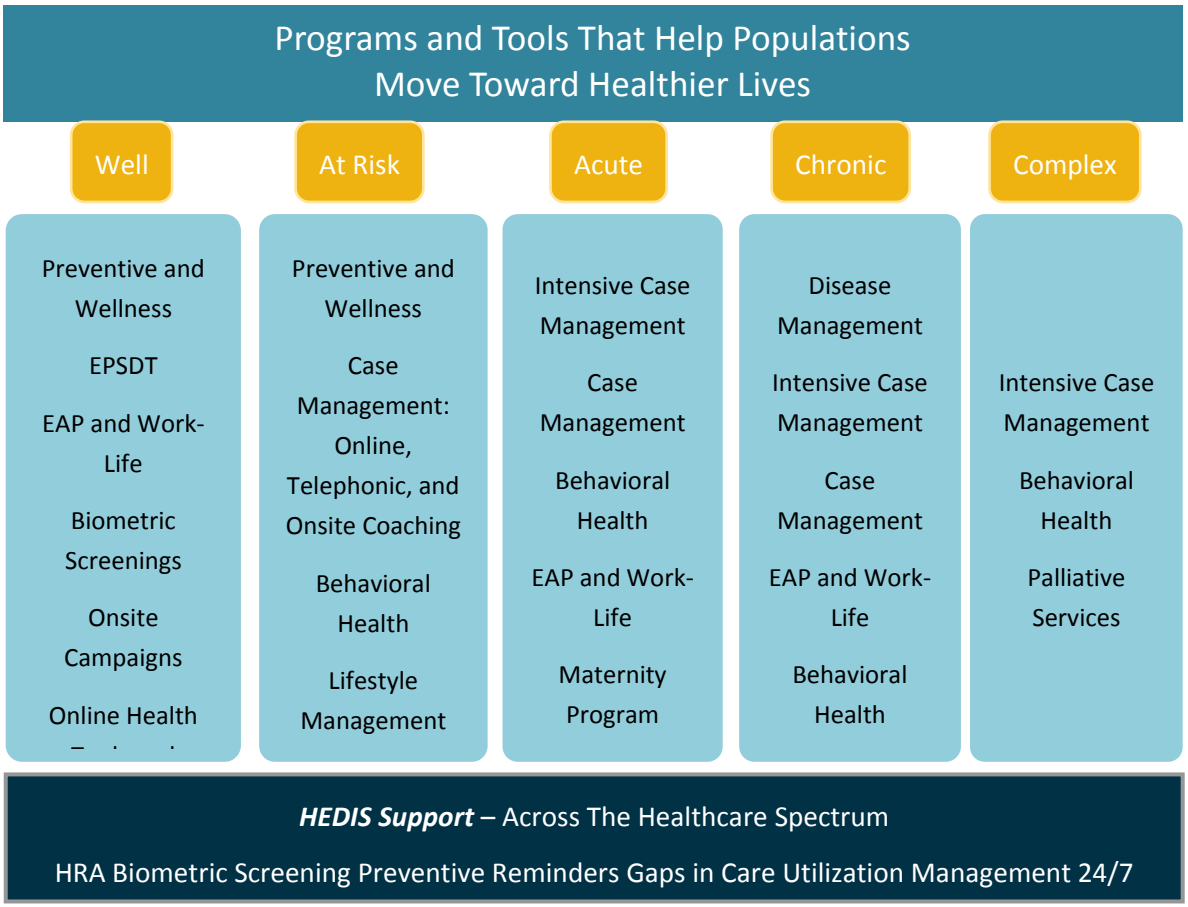


Figure 2. APS Health Management Services

APS specializes in working collaboratively with clients to improve the health of their covered lives and to optimize healthcare expenditures through sustainable behavior change that reinforces seeking and giving care in alignment with best practice clinical guidelines. Our programs address a broad range of geographic and demographic diversity across the United States and Puerto Rico. Each program features a flexible, customer-focused orientation that addresses each client or state's unique needs and program objectives. APS is distinct among vendors due to the depth and breadth of our state, county and local government contracts. We provide a comprehensive and integrated spectrum of uniquely structured programs, including administration of contracts that entail behavioral health/substance abuse; utilization management; claims administration; total population health care management covering wellness, disease management, and case management; high-risk case management; and external quality review to both the public and private sectors.

The industry acknowledges APS for our innovative programs that emphasize community partnerships and holistic clinical care. Accreditations and program awards reflect the quality of APS' programs. The Utilization Review Accreditation Committee (URAC) accredits APS in multiple case, utilization, and disease management programs, including APS Hawaii. APS received awards in 2006, 2007, 2008, and 2009 for public sector, integrated high-risk case management programs. The Care Continuum Alliance

(formerly the Disease Management Association of America) most recently recognized APS for awards Outstanding Provider Engagement Initiative (Georgia) and Best Government Program (Missouri) in 2010.

70.420. Ability to Deliver Services

70.420.1 MEDICAID BEHAVIORAL HEALTH EXPERIENCE

APS began providing comprehensive behavioral health management services, including utilization management, case management services, and claims administration for state Medicaid programs in 1999. Our mission is to be the premier provider of administrative specialty healthcare solutions to government payers and the stakeholders they represent. We currently administer behavioral health programs that serve nearly 3 million Medicaid recipients.

APS has held a number of contracts that demonstrate our commitment to quality and dedication to delivering services in accordance with the latest advances in behavioral health care. Medicaid behavioral health programs form the basis for our public work, with programs in Puerto Rico, West Virginia, and Georgia contracted to APS for more than a decade in each state. APS' experience encompasses programs delivered in urban, island, and rural settings – from external quality review in Los Angeles County to behavioral health in Hawaii and Puerto Rico. APS develops creative and effective approaches to overcoming geographic factors that present barriers to access to care, such as minimal public transportation, low population density, and scarcity of community-based providers. Examples of these approaches include telemedicine, web-based consultations, and, when appropriate, special transportation for members and providers. APS provides case management and other services in the current CCS contract. In the next contract period, we will evolve our approach to focus on delivery of services through the provider network, with case management services that complement and supplement the agencies that deliver case management as network providers.

Each of these approaches has been a consideration of APS' network development in Hawaii. We established the APS Area Resource Centers to address the lack of infrastructure for our own case managers as well as other providers in those locations. APS provides transportation for both members and providers in Hawaii to ensure, for example, that members receive timely psychiatric assessments and medication management. We recently initiated a telemedicine application for member service and technical assistance to primary care providers. APS holds regular "Provider Summits" in our Pacific Guardian Center offices in Honolulu, where we bring the provider community together to discuss opportunities to improve member care through innovations in delivery system design. These approaches to network development and management will continue into the new contract as APS enhances provider functions such as network development and management across the state

We list current Medicaid behavioral health contracts in Table 3, and then discuss specific contracts (other than the CCS program) that are relevant to the current work.

Table 3. Medicaid Contracts for Behavioral Health	Since	Years
Puerto Rico ASES	1999	13
Georgia External Review	1999	13
West Virginia Administrative Services Organization	2000	12
Hawaii Community Care Services	2003	9
California External Quality Review	2004	8
Florida PASRR Level II	2007	5
Maine Behavioral Health ASO	2007	5
Hawaii QUEST Behavioral Health and High-Risk Case Management[2]	2000	10

APS EXPERIENCE

In addition to the CCS Program, APS works with the Hawaii Medical Service Association to support behavioral health services. The established relationship with this QUEST managed care organization allows us to provide synergy for both TANF and ABD Medicaid members with SMI. It also enhances our ability to facilitate provider trainings and network development activities to enhance care in Hawaii.

Hawaii Medical Service Association

Since 2002, APS has provided an array of healthcare services for the Hawaii Medical Service Association's (HMSA) commercial and Medicaid beneficiaries representing over 690,000 covered lives. HMSA is a beneficiary of the Blue Cross Blue Shield Association and the largest insurer in the state. NCQA accredits HMSA and rates its HMO plan in the top five in the Western region for excellence. Its QUEST Medicaid managed care program is URAC-accredited. APS Hawaii functions as the behavioral health (BH) component of HMSA and is delegated behavioral health case management and utilization management (UM) contractor under NCQA, URAC and other regulatory accreditation standards. Through contracts with HMSA, APS delivers the Behavioral Care Connection (BCC) Program and the He Hãpai Pono (The Good Pregnancy) Program.

As part of the BCC Program, APS delivers behavioral health UM for the entire HMSA membership and telephonic case management for commercial and non-SMI QUEST beneficiaries that meet the clinical eligibility criteria. The BCC Program manages the health status of the entire population, using stratified interventions and predictive modeling tools, with a special case management focus on at-risk populations and high utilizers. APS ensures that delivery of appropriate care to low- and moderate-risk beneficiaries through education to members to improve self-management skills and technical assistance

[2] **APS provided behavioral health under subcontract to Hawaii Medical Services Association beginning in 2002 with case management for the SMI population added in 2010. APS will provide SMI case management and high-risk population care management for HMSA's QUEST contract as to Healthways, Inc. effective July 1, 2012.

to providers on guideline-based interventions. We train staff members in the diagnosis of members with SMI or SPMI for evaluation by DHS/MQD as candidates for CCS and make referrals as appropriate.

APS provides case management services to the HMSA's QUEST and commercial memberships through the BCC program including continuous behavior risk and mental health assessments; customized plans of care developed in collaboration with beneficiaries; and clinical interventions tailored to the unique strengths and needs of the individual. We also provide Intensive Case Management (ICM) for individuals at high risk for psychiatric emergencies and inpatient hospitalization; facilitate access to behavioral health and referrals for beneficiaries to promote timely access to behavioral health services. APS coordinates a Provider Advisory Group, which functions as a forum for community providers to identify service gaps and to develop program design refinements; conducts a smoking cessation program and a Post-Partum Depression program with maternity case managers who work closely with new mothers.

APS Georgia External Review Organization (ERO) Program

In 1999, Department of Behavioral Health and Developmental Disabilities (DBHDD) awarded APS the Georgia External Review Organization (ERO) program to review and promote delivery of high quality and appropriate mental health and substance abuse services covering 143,000 lives. The program includes extensive technical assistance, on-site audits and utilization management to ensure medical necessity of services and appropriateness of the setting of care. The ERO Program also provides individualized technical assistance for providers, detailed quality improvement reporting and staffed community liaison/consumer services.

APS and Georgia collaborated to facilitate the transformation of the public behavioral health system over the past 12 years. Our external review process including prior authorization and concurrent reviews, on-site provider audits and technical assistance/training, care coordination, and QI initiatives, focuses on facilitating recovery, resiliency and self-determination for adults and children who are affected by mental illness, addictive disease and developmental disabilities. The Department expanded APS responsibilities in 2005 to include introduction of utilization management for state-run hospitals and development of an innovative encounter and payment processing system for the State's grant in aid program. The program works to increase the quality of data for services provided to indigent care beneficiaries. APS saved the state over $400 million in the first five-year period of our contract. In fiscal year 2010, the APS ERO program for the State of Georgia provided the following:

- More than 1,800 hours of training and on-site technical assistance to more than 1,500 provider staff including an intensive three-month orientation program and more than 400 on-site audits and review of more than 9,000 consumer medical records and 232,424 billing units to measure provider improvement.
- Utilization review service requests for 140,000 consumers exceeding $1.6 million, approximately 423,000 requests including about 20,000 requests for hospital authorizations.
- Support and information for the more than 14,250 customer service help desk inquiries from the provider community.

- More than 2,238 reports covering provider service provision, claims data, audit trends and more to assist the client make data-driven decisions about service provision.
- Provider data used for recoupment of inappropriately used funds; the value of unjustified services identified exceeded $1,115,339 subject to recoupment.
- An interactive online information tool used to communicate and share resources with all stakeholders; the site averages 45,000 hits per month.

Administración de Seguros de Salud de Puerto Rico (ASES)

APS Puerto Rico (APS-PR) is the Managed Behavioral Health Organization for the Commonwealth of Puerto Rico, providing high quality, effective behavioral healthcare services to the Medicaid population since 1999. With approximately 1,330,000 Medicaid members in our population, APS-PR continues to be a leader in the development of new services that we customize to meet the needs of this island population. Similar to the CCS Program, we offer twenty-four hour a day, seven day a week access to behavioral health professionals. APS-PR also provides a "live response" for callers who contact APS through a comprehensive, 24/7 Call Center. This valuable approach is also a feature of our CCS Call Center operations. APS-PR is a local service model in which decision-making and operations are in the area served. APS-PR's care delivery model optimizes community-based services and during our tenure, beneficiaries have increased access to community-based care without increases in cost to the Commonwealth. This model reallocates cost savings derived from reducing expensive hospitalization utilization to comprehensive community-based ambulatory services.

The islands of Puerto Rico have geographical characteristics – a rural interior and limited transportation to Vieques and Culebra, for example, that impose limits in access to behavioral health services. APS-PR has innovative approaches that address provider shortages. With 15 ambulatory multi-disciplinary Clinical Centers across the Island, APS-PR has increased access to care, improved the overall health and well-being of recipients, and decreased unnecessary admissions to acute services. APS-PR currently sees all consumers who are in need of service within five days of request. The use of twenty-three (23) hour observation beds in area hospitals provides consumers with access to rapid stabilization services and an opportunity for an in-depth assessment to be completed to determine the most appropriate level of care for subsequent treatment. APS-PR offers these alternative levels of care to approximately 40% of individuals who present in crisis. This rate in turn prevents institutionalization and excess cost.

APS-PR also has a significant homebound population. To meet the needs of these consumers and prevent hospitalizations, we established a Home Visit Program, which brings services directly into the homes of consumers who are unable to travel to a provider. Medication therapy was also a concern for the Puerto Rico population. In response, APS-PR established a full-service Pharmacy Call Center that on average handles over 3,000 calls a week and provides an immediate response for telephonic authorization requests. The Pharmacy Department develops clinical guidelines and works with providers to educate them on the appropriate use of medications, the most cost-effective treatment regimen, and the availability of generic equivalents. Puerto Rico providers now prescribe generics 95% of the time when they are available. APS-PR provides actionable pharmacy utilization information to providers both at the practice and member level to improve prescribing practices by network providers. APS has

successfully managed pharmacy expense for the past 13 years with trends and costs well-contained, achieving significant savings for the Commonwealth. Of equal importance, this program simultaneously increases patient safety and promotes better outcomes.

Fully Integrated Physical and Behavioral Health Care

The division of benefits in Puerto Rico is similar to the arrangement in Hawaii where APS provides behavioral health services and contracted health plans are responsible for medical care. In partnership with ASES and its managed care organization (Humana Health Plans of Puerto Rico), APS-PR designed and implemented a program for the integration of mental and physical health, piloted in 2008-2009 and implemented island-wide in 2010. APS-PR uses a three-phase model of integration for delivery of behavioral health and medical services for members of miSalud! Figure 3a displays this model.

The 3-Phase Model of Integration

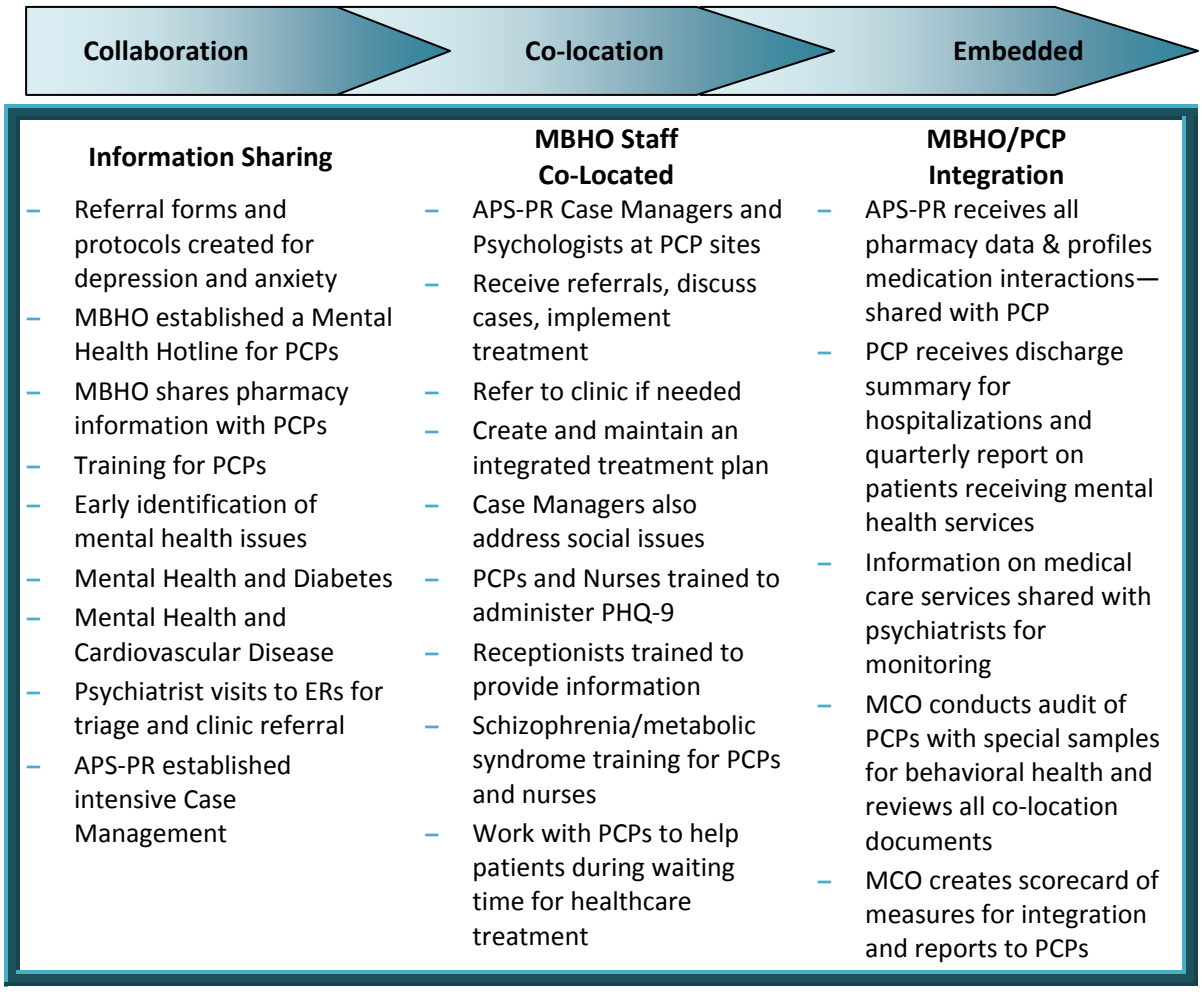


Figure 3a. Three Phase Integration Model

This approach successfully introduced integration concepts to the Managed Care Plans through relationship development and information sharing in the first Phase. The second phase co-locates APS-

PR behavioral health professionals in the Medical Group Practices (MGPs). This approach is ideally suited to deliver services to people with mild and moderate mental illness through our behavioral health professionals and primary care physicians. APS refers members with serious mental illness to an APS-PR clinic for specialized care.

In the MBHO/PCP integration phase, APS-PR facilitates broad exchange of utilization data between the PCPs, treating behavioral health providers, and the managed care organization, including advanced profiles of medications that we share with PCPs and specialized reports on inpatient utilization for PCPs. This phase also includes a PCP "scorecard" of integration measures as feedback to PCPs on referrals, treatment plans, and integration of APS-PR behavioral health professionals in member primary care.

West Virginia Behavioral Utilization Management and Prior Authorization

APS' flagship Medicaid program has provided a comprehensive array of utilization management services to over 400,000 Medicaid recipients in West Virginia since 2000. APS assisted the State in the development and management of a high quality, accountable, public sector system for behavioral health, medical, socially necessary services; nursing home prior authorizations; MR/DD waiver and aged and disabled waiver services.

APS collaborates with multiple state bureaus and consumers, families, and providers throughout West Virginia to improve the quality of Medicaid behavioral health services across the state. As with CCS, the design and delivery of the West Virginia program is patient-centric with community outreach, provider education, and technical assistance as key program components.

Serving as the Administrative Service Organization (ASO), APS administers the utilization management program, incorporating focused quality improvement services, family support and education, community and consumer education, and empowerment activities. APS also provides onsite provider trainings, provider UM analysis, clinical consultations, technical assistance, data analysis, reporting and other activities in support of the Department's goals. APS works in partnership with all stakeholders to build program accountability, enhance efficiencies, and improve overall behavioral health outcomes.

As the partner of choice for West Virginia's Department of Health and Human Resources, APS develops innovative programs to improve quality, ensure medical necessity, and promote program integrity. Examples include social necessity review to ensure accurate Medicaid payments, block grant reporting, and comprehensive management of West Virginia's waiver programs for people who are aged and/or disabled, have traumatic brain injury, or have intellectual or development disabilities. Program accomplishments that are particularly relevant to the CCS Program include:

- A record of performance - 100% of deliverables met since inception.
- Consumer education, outreach and support to family members.
- Quality Improvement planning and CMS reporting;
- Support for the Provider and Consumer Quality Improvement Councils.

- Improved care coordination and provider satisfaction.
- Review of nearly 2 million prior authorization requests since program start in 2000.
- More than 6,000 in person assessments with consumers over the past two years.

Maine Administrative Services Organization

APS' Maine Behavioral Health ASO program covers both mental health and substance abuse services for approximately 300,000 adults and children who are Maine Medicaid (MaineCare) clients. We have managed this contract since 2007. The program's goal is to improve the accessibility and quality of care, improve outcomes of care, and ensure medical necessity of services and appropriateness of setting. Because of successful collaboration and contract performance to date, our client, the Department of Health and Human Services (DHHS), expanded the scope of work multiple times since contract inception. Scope of work enhancements included the following:

- Additional information technology, process and training work to integrate the Bates vs. DHHS consent decree data collection process into the APS review process.
- Prior authorization and utilization review for Grant-Funded Adult Mental Health services for adults with serious mental illness.
- PASRR level 1 and level 2 assessments for mental illness and developmental disabilities for adults being admitted to nursing facilities.
- Long Term Supported Employment and Baxter Fund prior authorizations and utilization review for acute inpatient admissions.
- Utilization review of Targeted Case Management for Children with Chronic Medical Needs.
- Special studies of readmissions and high-cost members, with recommendations for improved coordination of care.

Our program includes prior authorization, utilization management, provider relations and training, client services, quality management, and analysis and reporting for: MaineCare mental health services; State grant funded adult mental health services; nursing facility screenings for mental illness and other conditions; long term supported employment utilization management; and mental health services for Baxter Fund class members. APS also provides a 24/7 customer call center and extensive Web-based and IT resources for both members and providers.

APS Healthcare receives approximately 12,600 requests per month from providers in Maine; providers have submitted over 1.2 million requests since December 2007. In fact, 95% of providers use our HIPAA-compliant internet based web portal, APS CareConnection, to submit authorization requests. Through use of the CareConnection provider portal, APS streamlines data collection and review and reduces the administrative burden on providers.

Additional program accomplishments include:

- Before the contract with APS Healthcare, MaineCare behavioral health costs were increasing. Since APS Healthcare began reviewing behavioral health services in FY 08, costs for these services have declined over 18% based on MaineCare Claims Data.
- Improved access to care – 13% more members are receiving behavioral health services annually.
- Per year payments for managed behavioral healthcare services declined $30 million.
- Extensive collaboration within the community including Client Advisory and Provider Advisory Councils to enhance the ability of the APS ASO to serve Medicaid clients.
- With improved coordination among providers throughout Maine, 71% of children discharged from Child Psychiatric Hospital services are now living in their own or parents' home upon discharge with 20% discharged to other residential settings.
- Training, outreach and support through site visits, conference calls, and telephone on UM process, clinical matters, IT, billing, and data.
- APS provides over 60 reports on a daily, monthly, quarterly and annual basis.

California External Quality Review

Since July 2004, APS has served as the California External Quality Review Organization (CAEQRO) responsible for completing comprehensive annual reviews of the State's 56 County Mental Health Plans (MHPs), as well as an overall statewide annual report, which serves as a guide for system and process improvements that will enhance overall quality of care. California selected APS as its inaugural EQRO in 2004. The contract entails a variety of activities, including performance measure and improvement project validation, as well as other technical assistance activities related to the MHPs that comprise the Prepaid Ambulatory Health Plan in California.

The principle behind the EQR process has remained consistent over the past eight years – using data to develop sound findings concerning access, quality, and cost and providing actionable recommendations for performance improvement. The core components of the CAEQRO pre-site, on-site, and post-site review have remained consistent; as part of the quality improvement process, APS continues to ensure that site reviews evolve to reflect the California Department of Mental Health's (DMH) priorities, as well as stakeholder input. Consistent with DMH's focus on meaningful consumer/family member involvement, the APS site review teams include a consumer or family member advisor that provides valuable perspectives on quality improvement.

We host focus groups that include consumer and family member representatives to explore quality initiatives and cultural competency strategies further. APS site review teams conduct focus groups with community-based organizations, MHP clinical and supervisory staff members, and on occasion with staff members from community clinics (including FQHCs) that make referrals to the MHPs.

Importantly, over the past five years, APS has increased the value of the review process by identifying specific measures of access to, as well as timeliness and quality of, the services that each MHP provides

to its beneficiaries. For example, in the current review process APS introduced a pilot worksheet, "Timeliness Self Assessment." Key data analyses included in in-depth evaluation of disparities of care across all county-based behavioral health plans that Medi-Cal used to develop program level policies and allocate resources to county plans. We share best practices with stakeholder groups including the California Association of Quality Improvement Coordinators.

70.420.2. MANAGED CARE EXPERIENCE

In Section 70.420.1, we profile the experience of APS with programs we conduct for Medicaid agencies in Hawaii and the mainland US. As a national managed behavioral healthcare organization, APS has extensive experience working with health plans and others to deliver behavioral health and other services in a risk environment, some of which are also Medicaid.

We currently work with health plans and other programs to manage behavioral health services for almost 2.5 million covered lives. These programs range in size from fewer than 500 covered members to programs for more than one million covered lives. These contracts demonstrate a record of quality performance through continuity of our client base for over a decade, as well as our continued growth in the market with new contracts added on an almost annual basis.

This experience indicates our flexibility and ability to tailor programs for a highly diverse client base. We present contract experience with managed care in Table 4. Please note that we feature several programs on the tables for both the Medicaid experience and managed care experience as they are both Medicaid and managed care programs.

Table 4. APS Managed Behavioral Health Contracts

Behavioral Health Contracts	Since	Years
Puerto Rico ASES Managed Behavioral Health	1999	13
Maryland State Employee Assistance and BH	2001	11
BC/BS of Montana Federal Employees Program	1999	13
HMSA BCC and HHP for Federal Employees	2002	10
HMSA Quest BCC and HHP	2002	10
Uniformed Services Family Health Plan	2004	8
Community Health Choice Behavioral Health	2004	8
Humana Health Plans of PR BH for Medicare	2007	5
Humana Health Plans of PR Commercial BH	2007	5
Advocate Behavioral Health	2003	9

Table 4. APS Managed Behavioral Health Contracts		
Universal American Behavioral Health	2012	-
Montana Association of Counties Health Care Trust	2005	7
HMC Southern CA Dairy Industry Security Fund	2006	6
HMC Southern CA Soft Drink Industry and Teamsters	2007	5
HMC Teamsters and Food Trust	2007	5
HMC Teamsters Miscellaneous EAP and BH	2007	5
HMC Wisconsin Health Fund EAP and BH	2007	5
UFCW Southern California Employer Benefit Fund	2007	5
HMC Western Teamsters Welfare Trust	2008	4
HMC UFCW North California Employers Trust	2009	3
HMC UFCW Northern CA Drug Benefit Fund	2009	3

Blue Cross/Blue Shield of Montana

Blue Cross Blue Shield of Montana (BCBSMT) contracts with APS since 1999 to provide services to meet requirements of the Federal Employee Program. Current services provided for the BCBSMT Federal Employee Program are URAC accredited and include medical, surgical and behavioral health utilization management and case management services as well as disease management of asthma, COPD, CAD, CHF, depression, and diabetes. The program began with medical and surgical utilization and case management and has expanded over the years adding behavioral health utilization and case management services in 2001. In 2004, BCBSMT added disease management services and effective January 1, 2009 BCBSMT expanded the list of managed disease states to six.

The integration of utilization, case and disease management services affords us the opportunity to manage the *"whole member"* through our person-centered approach, which improves engagement and coordination of care. Our Case Managers provide support, information, and education to members for improved self-management skills and better healthcare utilization. Successful program strategies are:

- Locally based staff with experienced in FEP benefits and workflow processes, and who are knowledgeable of Montana facilities, providers and resources.
- Long-term relationships with BCBSMT staff that promotes open communication on a variety of cases including high-risk/high-cost cases.
- Seamless interfaces between BCBSMT systems and APS CareConnection. System integration ensures that we maintain accurate eligibility files, BCBSMT staff has immediate read-only access to information related to services authorized and cases managed, BCBSMT staff is able to

promptly address any service concerns, and that complete and timely data is readily available for efficient claims verification and payment.

- Experience with FEP allows us to interface with out-of-state FEP plans to make plan-to-plan referrals and efficiently refer members to other FEP resources such as Blue Health Connections.

Program results include:

- FEP measures of admissions per thousand, average length of stay, and days per thousand largely within parameters of a "well-managed delivery system" as defined by Milliman, Inc.
- Achieving 2:1 return on investment on case management activities.
- A trend of increasing engagement in disease management services by FEP members identified by BCBSMT and referred to APS.

APS demonstrates an ongoing commitment to quality. APS collaborated with BCBSMT on three quality improvement projects that focused on measuring:

- Compliance with screening for depression by use of PHQ9.
- The effectiveness of referrals from UM to behavioral health case management to decrease the number of behavioral health cases not meeting established guidelines for scheduling a follow-up outpatient visit discharge from inpatient care.
- The increase in members who have advanced directives after APS interventions.

Community Health Choice, Inc. – State of Texas

Since 2004, APS has served as the behavioral health managed care organization for Community Health Choice, Inc. (CHC), serving members in Texas STAR Medicaid, CHIP (Children's Health Insurance Program) and 3-Share health plans. CHC was recently renewed for an additional three years, and APS will continue to provide comprehensive behavioral healthcare management services for CHC including: member services, case management, claims processing, quality improvement, provider operations and credentialing. APS implemented multiple successful initiatives. These activities included increasing multi-lingual and rural providers in the APS network; a two-phase implementation of the new Substance Use Disorder adult benefit changes and network expansion during 2010-2011; and the STAR Medicaid Expansion, effective 9/1/2011, that includes recruitment, credentialing, contracting and transitional processes for 14 new counties in Southeast Texas.

The STAR Medicaid program provides services primarily for TANF (Temporary Aid to Needy Families) eligible members, including children and parents. In 2011, CHC membership grew to 200,000, following the implementation of the STAR Medicaid Expansion. Currently, CHIP provides services to more than 31,000 children and adolescents that are not eligible for Medicaid, due to a family's income, yet are also unable to afford private health insurance. Texas' 3-Share is a subsidized pilot program solely in the Harris County, Texas area for employees of small businesses that traditionally are unable to afford to provide health insurance.

APS provides access to behavioral health and substance abuse services to these members 24-hours a day, seven days a week via toll-free hotline numbers. Through the APS Behavioral Health Hotline, staffed with Master's-level behavioral health clinicians and psychiatric nurses (triage clinicians), APS also provides CHC's members with access to emergency behavioral healthcare services, including emergency screening services (triage), emergency care and short-term crisis stabilization. This approach is very similar to the CCS Call Center, an approach we will continue in the next contract period.

The CHC program emphasizes the identification and coordination of treatment of members with co-morbid medical and behavioral health conditions as a part of the behavioral healthcare programs. For the STAR and CHIP programs, the CHC Care Management Department coordinates the delivery of behavioral health services with the member's PCP. The Care Coordination teams of APS and CHC exchange information on a frequent basis, consistent with the needs of the individual members and complexity of the condition involved.

APS refers CHC members, including parents, to participating behavioral health care providers with various specialties and/or community services, as appropriate. This includes outpatient substance abuse assessment, as well as to community-based resources for substance abuse education and support and/or substance abuse treatment programs.

APS maintains an extensive network of behavioral health care providers, groups, agencies and facilities, in both the Harris and the Jefferson service areas, while continuing active recruitment of, credentialing, and contracting additional providers. Network expansion includes the addition of psychiatrists, psychologists, and Master's-prepared clinicians, groups, agencies (including Local Mental Health Authorities), and facilities (psychiatric inpatient hospitals, partial hospitalization programs, intensive outpatient programs, crisis services, and residential detoxification/residential treatment facilities).

Advocate Physician Partners, Blue Cross Blue Shield of Illinois

Since 2003, APS has provided a comprehensive array of behavioral health care services for Advocate Physician Partners, a medical group under the HMO program of Blue Cross Blue Shield of Illinois (BSBCIL). In close collaboration with BSBCIL and Advocate Physician Partners, all three entities share accountability for high quality behavioral health services provided to approximately 150,000 covered lives under the care of Advocate Physician Partners.

APS performs utilization management services for all levels of care for behavioral health treatment (inpatient, residential, partial hospitalization, intensive outpatient and standard outpatient) across the Advocate Physician Partners' book of business. APS also provides intensive and standard case management services for Advocate members who need special support and assistance for behavioral health needs. BCBSIL HMO performs semi-annual audits on APS' UM and case management processes to ensure that APS follows BCBSIL HMO procedures.

APS also processes and is at risk for behavioral health claims on the professional side (including responsibility for handling complaints), with BCBSIL HMO handling facility-based charges. Likewise, BCBSIL HMO maintains network contracts with the facilities while APS provides and operates the

network of behavioral health providers. Advocate Physician Partners conducts oversight of APS provider credentialing to ensure the managed care plan that APS service delivery is NCQA compliant.

Reporting on the contract is extensive with provision of monthly reports as defined by BCBSIL HMO and an annual UM plan that outlines APS' compliance with the plan's requirements. Program outcomes have been favorable. In 2012, our tenth year working for and with BSBCIL and Advocate Physician Partners, APS received an incentive of an additional per member per month fee from Advocate due to meeting the BCBSIL HMO Behavioral Health HEDIS goal in 2011. APS achieved a 70% or more compliance with follow-up behavioral health appointments with psychiatric providers within 7 days of discharge from an inpatient behavioral health admission among the membership from 8 of the 9 Advocate medical sites.

State of Maryland Employee Assistance/Behavioral Health

In 2001, the State of Maryland awarded the BH/EAP Benefit Administration Service Program to APS. APS provides behavioral health services, as well as a supervisor-mandated EAP program for approximately 190,000 employees, retirees and dependents employees. The APS Behavioral Health Center based in Columbia administers this contract, which includes claims processing, customer service, network administration, clinical operations and reporting.

According to the State's 2009 Healthcare Data Management, Inc. audit, APS exceeded claims administration standards with 99.99% financial and 99.31% procedural accuracy. Through our extensive provider network, APS provides superior access to care. The access rate of 99% exceeds the State's measure that members be able to schedule 95% of requested routine appointments within five business days. Members and providers reported high levels of satisfaction with an overall member satisfaction level of 87% with our customer services. Our overall satisfaction results have improved in each category in each of the past three years of operations.

Our utilization management program helps contain cost to the State of Maryland by focusing on treatment of members in the least restrictive, least costly levels of care. We conduct preadmission, concurrent and retrospective medical necessity reviews based on approved clinical criteria (APS medical necessity and ASAM). Licensed behavioral health clinicians review care requests. We issue authorizations if care meets medical necessity criteria based on the clinical information provided. If the request does not meet criteria, we refer the request to the Medical Director or a Physician Advisor (board-certified psychiatrist) for review and peer-to-peer consultation as appropriate.

70.420.3. SIMILAR BEHAVIORAL HEALTH PACKAGES

APS has over 10 years of experience administering similar behavioral health packages for commercial and government clients. Table 5 presents an outline of existing behavioral healthcare packages that are similar to the benefit package described for this RFP.

Table 5. Examples of Contracts with Similar Packages

Service	Hawaii QUEST SMI	Puerto Rico ASES	Community Health Choice Behavioral Health	Advocate Behavioral Health	Uniformed Services Family Health Plan	Humana Health Plans of PR BH
Behavioral Health Services	■	■	■	■	■	■
Case Management	■	■	■	■	■	■
Provider Network		■	■	■	■	■
Utilization Management	■	■	■	■	■	■
Claims Payment		■	■	■	■	■
Pharmacy Management		■				■
Member Grievances	■	■	■	■	■	■
Member Education	■	■	■	■	■	■
Cultural Interpretation Services	■	■		■	■	■
Accessible Transportation	■			■	■	■
Outreach	■	■	■	■	■	■
Appointment Follow-Up	■	■	■	■	■	■
Hotline	■	■	■	■	■	■
Adverse Events Reporting	■	■	■	■	■	■
Certification of Physical or Mental Impairment*	M			M	M	M

*Included with assessment of Medical Eligibility for behavioral health services

Utilization Management and Administrative Services

APS serves as the behavioral health administrative service organization for numerous state programs, such as Medicaid programs in California, Maine, and West Virginia and employer programs clients such as the State of Maryland. To manage these programs efficiently, APS developed comprehensive member services programs, proven provider reimbursement systems, sophisticated reporting capabilities, and network recruiting, credentialing, contracting and training procedures. We presented overviews of clients for which we provide utilization management and/or administrative services above (e.g., Maine Behavioral Health ASO, California External Quality Review, and State of Maryland BH/EAP programs). As demonstrated by these programs, APS has proven its ability to deliver clinical and administrative expertise simultaneously to support behavioral health services.

70.420.4. VOLUME OF NON-MEDICAID MEMBERS SERVED

Table 6 shows the volume of non-Medicaid members with a diagnosis of Serious Mental Illness as defined by the following ICD-9-CM codes identified in the current RFP:

- Schizophrenic Disorders (295.1X, 295.2X, 295.3X, 295.6X, 295.9X)
- Schizoaffective Disorders (295.70)
- Delusional Disorders (297.1)
- Mood Disorders-Bipolar Disorders (296.0, 296.4X, 296.5X, 296.6X, 296.7, 296.89)
- Mood Disorders-Depressive Disorders (296.24, 296.33, 296.34)

Table 6. Non-Medicaid Volume

Total Members with SMI By Member Age Group			**Total Members with SMI By Member Gender**		
Age Band	10-17	57	**Gender**	Female	22,359
	18-20	1,349		Male	13,802
	21-24	1,721		Total	36,161
	25-64	28,217			
	65-74	3,239			
	75+	1,578			
	Total	36,161			

70.420.5. VOLUME OF MEDICAID RECIPIENTS SERVED

Table 7 displays the volume of current Medicaid members with a diagnosis of Serious Mental Illness as defined by the following ICD-9-CM codes identified in the current RFP:

- Schizophrenic Disorders (295.1X, 295.2X, 295.3X, 295.6X, 295.9X)
- Schizoaffective Disorders (295.70)
- Delusional Disorders (297.1)
- Mood Disorders-Bipolar Disorders (296.0, 296.4X, 296.5X, 296.6X, 296.7, 296.89)
- Mood Disorders-Depressive Disorders (296.24, 296.33, 296.34)

Table 7. Medicaid Volume

Total Members with SMI By Member Age Group			**Total Members with SMI By Member Gender**		
Age Band	10-17	2,135	**Gender**	Female	57,646
	18-20	3,973		Male	41,235
	21-24	5,365		Total	98,881
	25-64	81,978			
	65-74	3,478			
	75+	1,952			
	Total	98,881			

70.420.6. REPORTED ACTIONS AND FINDINGS

As indicated by Amendment 1 to the RFP, APS provides a comprehensive report of sanctions, corrective action or oversight, or findings of fraud or abuse for APS Bethesda and Innovative Resource Group LLC, its subsidiary. We also describe the report Universal American and its subsidiaries. This information is in Exhibit 4 of the proposal.

70.420.7. CVS CAREMARK (CVSC) – PHARMACY SERVICES

APS will subcontract to CVS Caremark for provision of pharmacy benefit management (PBM) services for the CCS contract. This partnership provides convenient access to pharmacy locations throughout the Islands with nearly 150 pharmacies available. The CVSC pharmacy network is available through APS' subcontract with CVS Caremark (CVSC). CVSC began contracting with Medicaid managed care organizations in 1988. Its current book of business includes 28 clients that represent nearly 4 million

Medicaid lives. In 2002, CVSC formed a specific Medicaid market segment within its account management organization. This approach has allowed CVSC to focus its system and account management resources to ensure the best drug cost management, member access, and operational support. This approach resulted in many service enhancements to Medicaid clients, including:

- Implementation of program enhancements based on Medicaid industry trends, account team experience, and feedback from our Medicaid customers.
- Dedication of account management resources including clinical, account, and client services teams.
- Focused product development and marketing for Medicaid managed care organizations, including additional resources to develop and enhance Medicaid-specific products and services.
- Targeted disease management programs for this population, including an emphasis on such disease states/conditions as HIV and behavioral health.
- Increased policy and legislative tracking activities.

The approach to serving Medicaid members builds on CVSC's high standard of excellence in pharmacy services, supporting aggressive plan designs, higher generic dispensing rates, and formularies to mitigate some of the costs associated with this higher utilizing population.

CVSC History and Current Company Ownership

CVSC is a leading prescription benefit manager ("PBM") that provides specialty/biotech services, disease management and other health services related to pharmacy benefit management. Officially registered as CaremarkPCS Health, LLC, CVSC is a wholly owned direct subsidiary of CaremarkPCS, LLC, a subsidiary of Caremark Rx, LLC, whose ultimate parent company is CVS Caremark Corporation.

Company Background

CVSC is a pharmacy innovation company that has grown to become a national leader in providing programs currently serving more than 2,000 clients and their members across all 50 states, Puerto Rico, and the Virgin Islands. Through mail, retail, and specialty distribution channels, it administers programs for a diverse client base, including corporations, managed care organizations, insurance companies, government entities, unions, third-party administrators, and other organizations that pay for health care products and services.

In 1985, Baxter Healthcare Corporation's Prescription Service Division tapped its expertise in health-care cost management to begin providing PBM services to manage clients' prescription costs better. In 1992, Baxter spun off its PBM business and created Caremark International, Inc. that began operating as an independent company, with no ties to its former parent.

Within a few years, CVS Caremark's strong growth and leadership position attracted the notice of larger health care companies. In 1996, MedPartners, Inc., of Birmingham, Alabama, purchased Caremark International, Inc. Initially a management company for physician practices, MedPartners changed its name to Caremark Rx, Inc. in September 1999 to reflect its focus on core pharmaceutical services.

In April 2002, Caremark Rx, Inc. acquired Choice Source Therapeutics, a specialty distribution business focused primarily on providing pharmacy and clinical services for patients with hemophilia. That business, with 2002 revenues of $43 million, operated out of four pharmacy locations and three satellite offices in the United States and Puerto Rico. Choice Source had built an excellent reputation in all areas, including customer service, reimbursement verification, and compliance. CVS Caremark viewed the business as an excellent fit within existing specialty distribution area and as an opportunity to expand its hemophilia product line. Choice Source Therapeutics is a wholly owned subsidiary of Caremark Rx, Inc.

In March 2004, Caremark Rx, Inc. acquired AdvancePCS and its predecessors' organization that originated the PBM concept in 1969. This acquisition created a $33 billion company and joined two highly complementary organizations in providing the most extensive array of health care offerings available from a single source by providing more product choices at a lower cost for clients, and improved outcomes for the members CVSC serves.

In March 2007, CVS Corporation and Caremark Rx, Inc. completed a transformative merger of equals creating the nation's premier integrated pharmacy services provider. The combined company, renamed CVS Caremark Corporation, unified the nation's largest pharmacy chain with a leading pharmaceutical services company, creating the opportunity to deliver unique products and services that can help manage costs for employers and improve access and choice for consumers. This merger helped create the industry-leading service model CVSC offers today. Using the increased touch points, innovative technology, and consumer trust, CVSC helps improve health and reduce total costs for its clients.

On October 30, 2008, CVSC acquired Longs Drug Stores Corporation ("Longs"), which included Longs' retail drugstores and its RxAmerica subsidiary.

In November 2009, CVSC acquired a majority interest in a genetic benefit management company, Generation Health. This partnership expanded its pharmacogenomics capabilities for both specialty and non-specialty medication therapies. These genetic test-counseling services for physicians and patients help provide clients and their members with smarter drug therapy management, better outcomes, and reduced total costs. In June 2012, CVSC acquired the remaining interest in Generation Health that it did not already own.

In April of 2011, CVSC acquired the Medicare Part D business of Universal American, an investment that helps make CVSC a top provider of service in the Medicare Part D market area, one of the nation's fastest growing health care segments.

In April of 2012, CVSC acquired the stand-alone PDP business of Health Net, a leading PDP sponsor. The acquisition adds approximately 425,000 members to its PDP program, which currently serves more than 3.6 million members.

CVSC Locations

The CVSC Customer Support Center (the corporate headquarters) is located in Woonsocket, Rhode Island. Other major support centers are located in Scottsdale, Arizona; Northbrook, Illinois; and Irvin, Texas. Figure 3b displays CVSC locations. With more than 7,000 CVS/pharmacy and specialty pharmacy

locations in 43 states, Puerto Rico and the District of Columbia, CVSC operates the most drugstores in the nation. As the leader in pharmacy benefit management, CVSC offers a broad range of services, from managing pharmacy benefits to filling prescriptions by mail or offering clinical expertise, through operations and distribution centers across the country.

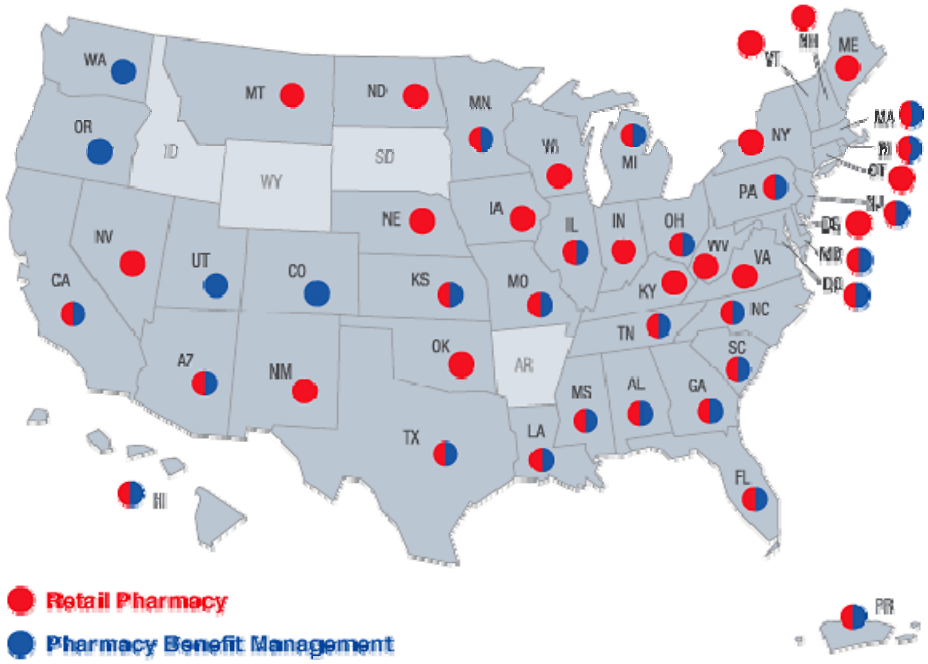


Figure 3b. CVSC locations

CVSC Primary Point of Contact

The CVSC primary point of contact for the State of Hawaii CCS program will be Toni Carnahan, Strategic Account Executive. Her address is 620 Epsilon Drive, Pittsburgh, PA 15238. Her office phone number is 412.967.8324, mobile number is 412.651.7812, and email address is Toni.Carnahan@caremark.com.

CVSC Number of Employees and Organizational Assets

Currently, Caremark's PBM companies have over 200,000 employees nationwide and more than 2,800 employees staffed in the state of Hawaii. In 2011, CVS Caremark had more than $100 billion in annual revenues and ranked 21st on Fortune's 500 List. Please refer to Exhibit 3, which includes CVS Caremark financial statements. Figure 4 presents an outline of the CVSC Organizational Structure.

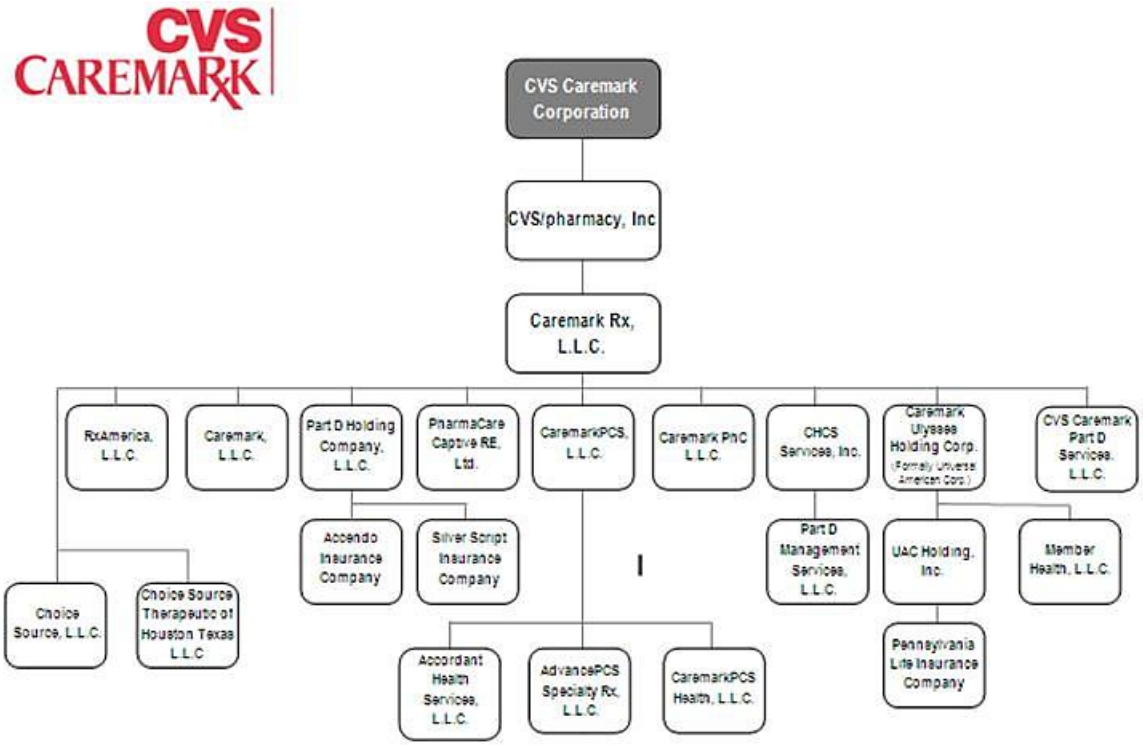


Figure 4, CVS Caremark's Organizational Structure

CVSC Areas of Specialization

CVSC is a full-service pharmacy benefits manager that offers the full range of services from formulary development support to pharmacy network development to member support to timely, accurate claims processing with IT support to identify potential drug interactions and safety issues proactively. Dedicated to supporting the strategies and regulatory requirements associated with managed Medicaid plans, CVSC specializes in assisting Medicaid clients to achieve their goals through a number of pharmacy benefit solutions. Core offerings are as follows:

- **Administrative Support** – CVSC's Medicaid-focused team approach to account management clearly differentiates the organization from competitors. The CCS Program will benefit from having a single point of accountability, better overall communication, and an unprecedented level of experience and understanding of the market segment. The account services team assigned to the CCS Program, along with a Pharmacy Help Desk that provides 24/7 support to all retail pharmacists in the networks, will render excellent service and ongoing administrative support that will exceed expectations.
- **Benefit Plan Administration** – Maximizes cost savings through flexible plan designs. DHS can choose a standard Medicaid plan design template or, collaboratively, CVSC and DHS can create a plan to meet program requirements.

- **Medicaid Formulary Management** – Offers rational access to needed therapies. From closed formularies to therapeutic interchange programs, CVSC has the management expertise to develop the most appropriate level of formulary management. CVSC has developed a Medicaid specific formulary template to provide appropriate clinical and cost effective formulary management for managed Medicaid coverage providers.
- **Utilization Management** – Helps control high utilization, abuse, and access to high-cost drugs. CVSC also provides exception processing and plan participant-level overrides as directed. This includes fully developed, URAC accredited pharmacy prior authorization procedures available 24-hours a day to ensure the most effective approach to medication therapies.
- **Point of Sale (POS) Drug Utilization Review (DUR)** – Proactively prevents complications from prescribed medications. The Point-of-Sale (POS) Drug Utilization Review (DUR) program is an automatic system, performed on all prescriptions at retail locations. CVSC implements the POS DUR program through the single-platform information system that supports CVSC's online national retail pharmacy network (currently consisting of over 65,000 point of sale pharmacy facilities). The system can perform up to 500 edits on every prescription to ensure that prescriptions meet administrative, plan-design, and member safety criteria.
- **Retrospective DUR Program**—CVSC's Safety and Monitoring Solution evaluates pharmacy claims for patterns of potential overuse or misuse. On a quarterly basis, CVSC clinical pharmacists evaluate controlled substance and other select drug claims (along with supporting medical data, if available) to identify potential medication abuse and fraudulent claims for appropriate intervention. This program uses utilization-based clinical rules designed specifically to identify cases of potentially excessive or abusive use. There is also a monthly review of claims for the most egregious cases of overutilization/high cost, in addition to the standard quarterly review. Monthly reviews give us the opportunity to spot egregious claims much sooner, and intervene for better outcomes for both members and clients. CVSC's Enhanced Safety and Monitoring Solution provides for additional investigation and intervention when the system identifies patterns of potential drug overuse or misuse. In addition to the Core Safety and Monitoring Solution, the enhanced solution provides expanded written communications, coordination with pharmacy audit activities, prescriber toolkits, peer prescriber consultations with independent physician experts, and medication therapy counseling for select members.
- **Custom Network Design** – Provides unique pharmacy networks with aggressive discounts to meet the plan's member needs, including a national Medicaid network with Medicaid MAC.
- **Medicaid Reporting** – Offers comprehensive and flexible reports, tailored to Medicaid requirements that support Medicaid-rating categories. CVSC also can provide the State of Hawaii with valuable benchmarking and market segmentation data, including regional comparisons. As an example, CVSC can create benchmark studies within the managed Medicaid market segment that will yield important comparative information for State of Hawaii. With CVSC's considerable market share in all segments, the organization can create segment- and client-specific benchmarking data to support plan design and financial objectives.

- **Pharmacy Rebate Management**—CVSC is adept at identifying and contracting for pharmacy rebates that can help control overall pharmacy costs. In addition to evaluation and contracting for rebates, CVSC is renowned for its sophisticated, accurate and reliable capabilities in both standard and ad hoc rebate reporting. In addition to quarterly rebate summary reports, CVSC has designed a user-friendly online reporting tool that clients can use to access rebate reports to support analysis of distribution by drug category, manufacturer, location, etc.
- **Fraud and Abuse Management** – Uses comprehensive tools, proven in solving fraud and abuse, to control costs effectively in all relevant areas of a Medicaid environment.
- **Specialty Drug Program** – Provides injectable and biotech drugs efficiently and cost-effectively through one full-service source, offers participant support/education, integrates drug utilization and compliance programs, and offers PBM-based electronic claims processing. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredits CVSC's specialty PBM process. JCAHO accreditation is a nationwide symbol of quality; it reflects an organization's commitment to meeting the highest standards for quality and safety in the delivery of health care. CVSC has held this accreditation since the inception of the Home Care accreditation program in 1988. Additionally, in 2010 URAC accredited ten CVSC Specialty Pharmacies under the URAC Specialty Pharmacy Standards. The URAC seal tells CVSC clients and patients that CVSC aligns processes to industry-recognized standards with a strong commitment to quality.
- **Health Management** – Focuses on clinically appropriate management of chronic illness, provides participant and physician outreach, and supports HEDIS® improvement by focusing efforts on process measures.

By contracting with CVSC, APS indicates it understanding of the importance of access to medications in convenient locations for CCS members, with a strong focus on medical necessity, quality, and program integrity. As the PBM for the Hawaii Medical Services Association, CVSC will implement at least four new Minute Clinics in Hawaii. Retail primary care locations, Minute Clinics offer a unique benefit to CCS members. People with SMI often delay or avoid routine and primary care because they are reluctant to experience mainstream medical care. These clinics offer community-based, walk-in services for essential screening and primary care services. Our members will be able to use these services in-network through APS arrangements with CVS and health care plans that we will formalize during implementation.

70.420.6.2 CVSC ABILITY TO DELIVER

Through its CareSolutions™ offering, CVSC provides a comprehensive suite of clinical and drug utilization management programs to help Medicaid clients manage drug costs effectively and promote clinically appropriate therapies among plan participants. CVSC uses a consultative approach – working closely with each client – to better understand cost management objectives, to identify and analyze excesses and opportunities for improving cost management, and to design the most appropriate and effective utilization management program to meet its needs.

As a leader in developing clinically effective programs, CVSC's concurrent, retrospective, and prospective DUR programs effectively optimize drug therapy before, during, and after initiation of drug therapy.

Likewise, programs such as Prior Authorization, Drug Limitations, and Step Therapy will allow State of Hawaii to determine and control drug coverage based on its own criteria; cover determined quantities drugs for certain time periods; and define how and when a particular drug or drug class should be used, based on a plan participant's drug history.

Medicaid Formulary Management

Medicaid populations often require specific formulary components to meet state and federal program guidelines. CVSC has extensive experience in creating and maintaining Medicaid formularies that will meet State of Hawaii's requirements. They have created a suggested Medicaid formulary, which – when used in conjunction with our Prior Authorization and Drug Limitations programs – can bring greater value to State of Hawaii and its plan participants by controlling costs without inhibiting quality of care.

The proposed Medicaid formulary template incorporates a relatively detailed list of commonly covered over-the-counter (OTC) medications. This approach benefits plan participants by encouraging the use of less costly but equally efficacious drugs, which in turn lowers overall costs for State of Hawaii.

Examples of Successful Drug Trend Management

CVSC will work collaboratively with DHS to identify customized strategies for the CCS Program to control overall per-plan participant, per-month drug spend—while continuing to provide high-quality plan participant outcomes. CVSC will provide program performance analysis, evaluate the results of programs and services, and provide recommendations and action plans for the future.

The approach to developing targeted drug management strategies is multifaceted and addresses the CCS Program's goals and objectives, including:

- Controlling drug costs and lowering overall drug spend in a population with higher utilization.
- Overseeing the development and implementation of new pharmacy plan designs and programs to support marketplace demand and appropriate cost management.
- Developing plan designs to meet applicable state and federal requirements, given the complex regulatory environment that faces Medicaid and other managed care plans.

In collaboration with many clients, CVSC consistently helps contain drug costs, and, in some cases has influenced negative trends within client memberships. Here are a few examples:

- By implementing utilization management tools such as step therapy, drug limitations, closed formulary, and specialty benefit management, CVSC was able to help a large east coast Medicaid plan with a significant CHP population contain its PMPM trend to 2.5%.
- When Claritin launched as an OTC product, CVSC implemented step therapy for legend NSAs for a 100,000-member Medicaid plan. Costs decreased from $2.00 PMPM to $0.75 PMPM for NSAs, and a decrease in costs from $3.30 PMPM to $2.00 for the treatment of Allergic Rhinitis.
- For a large Medicaid health plan in the Pacific Northwest, CVSC helped decrease costs for PPIS by $0.30 PMPM by placing legend PPIs on prior authorization, moving members to Prilosec OTC.

- By implementing exclusive OTC coverage for antihistamines, CVSC helped a mid-size east coast health plan save nearly 49%. They also implemented an early mandate for new-to-market generics on Oxycontin, Celexa, and Neurontin.

As CVSC does with all its clients, they will work proactively with DHS to provide ongoing clinical and analytical information, along with recommendations for ways to manage rising drug spend actively. CVSC will assist DHS in achieving these goals by evaluating the results of its current programs and services, and by providing recommendations and action plans for the future.

Sanctions, Corrective Action or Oversight, or Findings of Fraud or Abuse

Legal actions involving CVS Caremark include, without limitation, business disputes, contract disputes, employment disputes, and professional liability claims. The company's 2011 10-K, which details any material investigation(s) of CVS Caremark, has been included as Exhibit 3.

SMI Utilization for Non-Medicaid and Medicaid

CVSC non-Medicaid clients do not track utilization by SMI diagnoses and this information is therefore not available for CVSC. Table 8 presents CVSC data for Medicaid utilizers.

Table 8. CVS Medicaid Utilizations with SMI Diagnoses

SMI By Member Age Group	Utilizers	SMI By Member Gender	Utilizers
Age Band 10 -17	2,475	**Gender**	
18 - 20	737	Female	25,568
21 - 24	2,498	Male	22,311
25 - 64	41,604	**Total**	**47,879**
65 - 74	444		
75+	121		
Total	**47,879**		

70.500 Organization and Staffing

APS' approach to organization and staffing for the BHO contract emphasizes an efficient corporate infrastructure in Honolulu and a community-based infrastructure across the Islands to support members and providers, facilitating delivery of high quality services to members to promote recovery. APS Hawaii has experience serving Medicaid members and the majority of our staff has knowledge and experience specific to the Hawaii SMI membership through APS' role on the current CCS contract. We have worked hand-in-hand with the State of Hawaii to optimize the health and quality of life for individuals with SMI over the past decade and understand the importance of this program to the State, the members, and the providers who deliver direct services.

APS proposes an organizational and staffing model to seamlessly transition from the current contract structure to the risk-based BHO structure. We offer the following salient features of our organizational and staffing design, which enable APS to deliver all contract requirements:

- APS has an established local presence with an administrative center located in Honolulu. Our Hawaii field-based personnel are already in place, and we propose staff for important provider functions such as network development, credentialing, and contracting. APS has six Area Resource Centers to support Hawaii SMI members and providers throughout the State.

- The APS leadership team brings substantial relevant experience and success in leading operations with similar contractual requirements. APS currently serves more than 14 million beneficiaries. We provide behavioral health services through 35 programs that serve over 3.8 million covered individuals. We also support nearly 30 Medicaid programs, serving over 11 million Medicaid members. APS will leverage proven methods and tools to support APS Hawaii service delivery.

- Administrative systems are in place and expanded to implement and deliver contractual obligations. Our IT systems are loaded with Hawaii SMI membership data. The HIPAA-compliance software solution in use, Facets, facilitates claims payment, reporting and customer service functions. Also in use is APS CareConnection that houses Hawaii membership data and individualized member records. APS captures and stores claims information and self-reported information in unique member records used to compile member data and develop Individualized Treatment Plans (ITP). We create interfaces for Facets and CareConnection for comprehensive member, provider, and encounter data collection and reporting. APS network data and CVS Caremark PBM data interfaces with CareConnection to augment data analysis and reporting. With all data captured in CareConnection, the APS Percolator systematically evaluates the CCS membership daily to determine outreach needs, shaping Case Manager outreach priorities and service delivery.

- APS Hawaii knows the CCS membership. We are able to deliver continuity of care during the transition phase, and we have historical data and records for use in health intelligence assessments across the population and provider network. During the past three years, we have worked with over 1,400 CCS members. Based on eligibility, we provide case management services to almost 800

members. APS has processed over 4,500 utilization management activities including prior authorizations. We have also processed close to 120,000 claims since 2009.

- Our organizational model for contract delivery is rooted in APS' heritage as an organization focused on recovery-oriented behavioral healthcare. Since our incorporation as a managed behavioral healthcare company almost 20 years ago, APS has become a national company providing comprehensive healthcare management services to the public and private sectors. Our approach to administrative services exemplifies our belief that every person has the ability to overcome the challenges of living with behavioral health issues and live a safe and healthy life in the community with the right support and encouragement.

Critical to our successful performance of scope of work requirements is our approach to quality. We provide our Quality Improvement Program (QIP) for 2012 in Exhibit 5. Under the guidance of the Medical Director, the APS Quality Improvement Manager developed and customized the program for relevance to the unique characteristics of the contract, our provider network, and the CCS members we serve. As the QIP indicates, we have a sound and capable quality structure in place to ensure delivery of medically necessary, high quality, and person-centered services to all CCS members, on all Islands, 24 hours a day, and 7 days a week. We will enhance the QIP to cover additional components necessary in the transition to BHO. Additions will include network credentialing and re-credentialing, deployment of and technical assistance surrounding the CareConnection provider portal (discussed more in Section 70.600), and provider outreach and education.

70.510 ORGANIZATION CHARTS

The organizational charts presented in Exhibit 1a and 1b depict: 1) the relationship of the bidding entity, APS Healthcare Bethesda, Inc. (APS) to related entities (Exhibit 1a); and 2) the organizational structure, lines of authority, functions and staffing of the APS service structure for this program (Exhibit 1b). Exhibit 1a shows the APS family of companies, originating with our ultimate parent company, Universal American Corp., and shows the relationship of the bidding entity and all affiliated holdings of Universal American Corp. With our flat organizational structure and close supervision by senior leadership, we can make each project a priority. As shown in Exhibit 1b, the Hawaii Administrator leads the program team.

The resources of the APS family of companies support the APS Hawaii team. Corporate operational areas including network management support from the APS National Managed Behavioral Health Organization (MBHO) and from Health Intelligence, Quality, Corporate Communications, Information Technology (IT), Finance, Legal, and Human Resources will support the local Hawaii team during the implementation phase and throughout contract operations.

For example, corporate IT support, working closely with local program management and the State will develop interfaces between CVS Caremark's PBM platform and CareConnection for timely data exchange. We will update individual CCS member records with pharmacy claims information, which the APS Percolator evaluates daily to identify potential changes in member health status that may require outreach by APS case management. The APS corporate Managed Behavioral Health Organization

(MBHO) supports claims processing and payment services. It also consolidates provider credentialing and contracting, managing a national behavioral health network of 27,000 providers.

To support managed care contracts (including the CCS Program), the APS MBHO manages the everyday processes of information in and out of the Facets administrative and claims system, including the eligibility of 1.23 million members, processing of over 450,000 claims annually, and updating over 27,000 provider records.

The APS Health Intelligence Team will provide analyses as needed throughout the contract to permit the local Hawaii team to understand the patterns of utilization among the membership. Support from Health Intelligence permits the program team to focus on event reduction, particularly within the highest risk members, and to target network outreach and education, as needed.

APS has an operational administrative center located in Honolulu, Hawaii. An experienced management team leads our Hawaii operations. Hawaii field-based personnel will deliver in-person case management to CCS members, with use of six Area Resource Centers across the state to facilitate APS-delivered services as well as services delivered by network and other providers. We also deliver face-to-face case management to members in their homes, facilities, or other locations if they are in an inpatient setting or homeless. Figure 5 presents the project organizational chart for the Behavioral Health Organization.

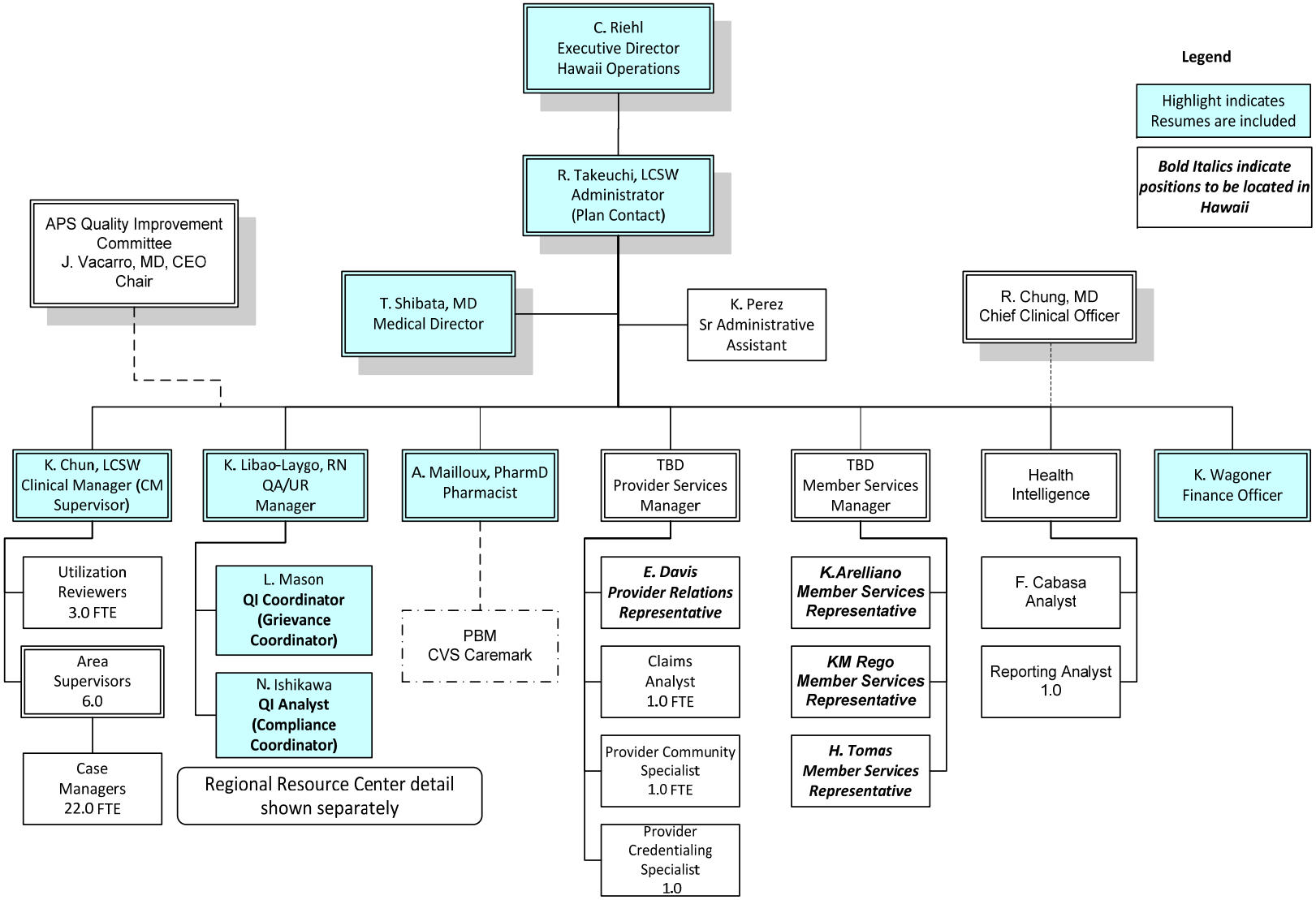


Figure 5. Project Organizational Chart

Organizational Structure and Key Personnel

In Table 9, we present the required positions for this project as described by the Request for Proposal (RFP). In this table, we list the RFP positions and align them to the APS internal title with which they correlate. We then describe the project organizational structure and lines of authority. An indication of APS' readiness to implement the CCS BHO is that current full-time staff members with relevant licensure, qualifications, and experience fill key positions.

Table 9. RFP and APS Roles and Titles

RFP Position	APS Title	Staff Member(s)
Executive Director/Administrator	Program Manager	Robbyn Takeuchi, LCSW
Plan Contact	Program Manager	Robbyn Takeuchi, LCSW
Medical Director	Medical Director	Toshi Shibata, MD
QA/UR Coordinator	Quality Improvement Manager	Kathleen Libao-Laygo, RN
CM Supervisor	Clinical Manager	Kelli Chun, LCSW
Pharmacist	Health Intelligence Consultant	Allan Mailloux, PharmD, BCPS
Finance Officer	Finance Director	Kathleen Wagoner
Grievance Coordinator	QI Coordinator	Liana Mason
Compliance Coordinator	QI Analyst	Nandi Ishikawa
Provider Relations Representative	Senior Provider Relations Specialist	Eleni Davis
Member Services Representative	Client Services Representative	Keesha Arelliano
Member Services Representative	Client Services Representative	K'Marie Rego
Member Services Representative	Client Services Representative	Heather Tomas

Overall responsibility for the Hawaii Service Center resides with Colette Riehl as the corporate Executive Director based in Hawaii. Ms. Riehl has nearly two decades of health management and human service experience. Prior to assuming responsibility for APS services in Hawaii, she was responsible for APS Medicaid behavioral health programs in Florida and a Medicaid high-risk case management program in Ohio, where WellCare of Ohio subcontracts to APS. Ms. Riehl has a bachelor's degree in Psychology and a Master's degree in Human Relations and Community Affairs. She is currently responsible for all program operations in Hawaii to ensure customer-focused approach to quality, personnel development, and close alignment with Hawaii DHS and service providers to advance the Hawaii service system. The proposed Administrator for the CCS program, Robbyn Takeuchi, reports to Ms. Riehl. Please note, since APS uses the title "Executive Director" to refer to *corporate* leadership for service centers, we designate Ms. Takeuchi as the Administrator to indicate that she will provide *program* leadership for CCS.

Robbyn Takeuchi, Administrator. Ms. Takeuchi's 18 years of experience working with people with SPMI in Hawaii includes both service for State agencies and private contractors. This background provides first-hand knowledge of the issues and challenges faced by the CCS program's population. She will be dedicated to this position full time. Her background is a unique blend of clinical and administrative

expertise. During her tenure with APS, she has designed and implemented clinical strategies to improve quality and the achievement of HEDIS measures by providing clinical oversight for telephonic and field-based services for members with behavioral health issues, disease management programs for smoking cessation, depression and substance abuse, and maternity case management.

Her efforts are integral to the ability of APS Hawaii programs to adhere to NCQA standards, including developing program models to enhance productivity. Mr. Takeuchi collaborates with IT to design clinical outcome and productivity reports used to assess the efficacy of the service model and interventions. She also conducts routine site and clinical documentation audits and is responsible for the design, implementation and oversight of Psychosocial Rehabilitation (PSR) programs statewide on the current contract. In addition to her experience with APS, Ms. Takeuchi served as a Case Management and Support Services Director for Hawaii's Adult Mental Health Division. In this role, she developed and coordinated statewide case management and support services for individuals with severe and persistent mental illness, designing the scope of services and implementing the service array in collaboration with AMHD-funded service providers. Ms. Takeuchi received her BS in Gerontology from the University of Southern California. After completing her undergraduate work, she relocated to Hawaii and obtained a Master of Social Work (MSW) and a Graduate Certificate in Aging from the University of Hawaii. Ms. Takeuchi maintains a current license as a Clinical Social Worker with the State of Hawaii.

Medical Director – Toshi Shibata, MD. Dr. Shibata began working with APS in 2008 as the Assistant Medical Director for CCS. Dr. Shibata continues to serve as the Medical Director for the current CCS program while maintaining an active private practice in Honolulu. Dr. Shibata is a licensed psychiatrist with more than 20 years of experience serving in Hawaii, the U.S. mainland and international locations including Japan. He is board certified by the American Board of Psychiatry and Neurology and has subspecialty certifications in both Addiction and Forensic Psychiatry. In his role as Medical Director, Dr. Shibata addresses potential quality of care problems and directs the CCS Quality Improvement Program (QIP). He works closely with the DHS Medical Director when applicable, and participates in committees when requested by DHS, such as those relating to QExA and/or the BHO.

Kelli Chun, LCSW – Clinical Manager. Reporting to Ms. Takeuchi and the Clinical Manager is Kelli Chun, LCSW. Ms. Chun joined APS in 2004 as a case management lead. Promoted to Clinical Supervisor in 2009, Ms. Chun became Clinical Manager in 2011.In her role as Clinical Manager, Ms. Chun directs the day-to-day operations of case and utilization management services to ensure adherence to standard goals/metrics for quality and performance. She oversees the coordination of case management services to include acuity determination and conducts regular reviews of member's charts to ensure appropriateness of quality of care. Ms. Chun assists Ms. Takeuchi with the development and ongoing refinement of case and utilization management tools and procedures used by APS Healthcare. She also participates in the development and review of policies and procedures relating to case management.

Kathleen Libao-Laygo, RN – Quality Improvement Manager. The APS Quality Improvement Manager is Kathleen Libao-Laygo, a Registered Nurse licensed in the State of Hawaii. Kathleen Libao-Laygo joined APS Hawaii in 2009. In her role as Quality Improvement Manager, Ms. Libao-Laygo works supports successful NCQA and URAC accreditation surveys. She has over 10 years of QI and accreditation

experience in both medical and behavioral healthcare. Ms. Libao-Laygo has the knowledge and skills that have contributed to successful NCQA, URAC, Joint Commission, and EQRO survey results with health plans, hospitals, case management, disease management programs, and behavioral health partial hospitalization and addictive disease programs. She has also worked closely with community providers and facilities throughout Hawaii, and with the State Office of Health Care Assurance. Ms. Laygo is fully dedicated to the Hawaii Service Center.

Kathleen J. Wagoner – Finance Officer. Kate Wagoner will serve as the Finance Officer. She will be dedicated to this program full time. She will manage all aspects of billing and financial management. Ms. Wagoner has a Bachelor's degree in Finance from the University of Maryland's RH Smith School of Business. She has served in progressively responsible positions at APS since July of 2008 and is currently Finance Director for Operations. Ms. Wagoner brings more than eight years of experience overseeing all aspects of billing and financial management to support contract operations. She provides financial guidance and support to the Regional Operations groups, overseeing $180M in business revenue through the administration of 10 State Medicaid contracts (including Hawaii). Her focus will shift to the CCS program with the implementation of the new contract to provide oversight of the program's risk-based reimbursement methodology.

Allan Mailloux, PharmD, BPCS - Pharmacist (Interim). Dr. Allan Mailloux is the Manager of Health Intelligence Business Development for APS, responsible for analyzing large datasets to identify opportunities to improve health and reduce costs for prospective and existing disease and total health management programs. Emphasis of analyses includes risk stratification and identifying at-risk subpopulations, identifying uncoordinated care that results in higher costs and poor health outcomes as targets for intervention and to guide cost savings guarantees, and recommending and implementing return-on-investment methodologies as measures of performance for APS programs. Dr. Mailloux has conducted statistical analysis of the Hawaii CCS and QUEST populations to identify opportunities to improve care coordination and quality of care, working with APS clinical leadership to evaluate findings and design clinical interventions with a focus on pharmacy management.

Beginning in 1997 as a pharmacist at APS, he was responsible for administrating the Recipient Lock-in Program for Wisconsin Medicaid and for providing consulting and analytical services on drugs and drug-related issues. He conceptualized and implemented a decision support tool for profiling Medicaid recipient over-utilization of controlled substance medications and has provided key input into the design of Wisconsin's SeniorCare and Medicaid datamart and standard pharmacy reports. Dr. Mailloux will be in Hawaii to assist with program implementation, including recruitment and hiring of the dedicated full time pharmacist for the CCS program.

Liana Mason - Quality Improvement Coordinator (Grievance Coordinator). As the full time Quality Improvement Coordinator for the CCS program, Ms. Liana Mason assists the QA/UR Manager in the coordination and implementation of the quality improvement program that meets or exceeds all quality regulatory and accreditation standards. As the Grievance Coordinator, she assists with all aspects of the complaint and grievance process to ensure that APS acknowledges, resolves and reports grievances in

accordance with contract requirements. Her other responsibilities include: compiling and generating contract performance indicator and contractually required reports; assisting in the preparation and maintenance of URAC/NCQA accreditation; collecting a variety of data, i.e. complaints, clinical document auditing, call statistics, etc., maintaining databases and assisting in identifying opportunities.

Prior to joining APS, Ms. Mason was the Customer Claims Representative for Liberty Mutual Insurance Company in Honolulu, Hawaii. She has over 12 year of experience in analytical and administration environments. Her previous posts have included Claims Assistant/Business Analyst for the Hawaiian Insurance & Guaranty Company, Ltd., in Honolulu; Executive Administrative Assistant for MentorNet in San Jose, California and Administrative Assistant/Receptionist for Integral Development in Mountain View, California. Ms. Mason received a Bachelor of Arts degree from the University of Pennsylvania in Philadelphia, Pennsylvania.

Nandi Ishikawa, MA - Quality Improvement Analyst (Compliance Coordinator). As the full time Quality Improvement Analyst/ Compliance Coordinator/ for the CCS program, Ms. Nandi Ishikawa provides general healthcare data analysis by conducting program and policy research from health care data. She supports the local QA/UR Manager in the development, coordination, implementation and ongoing monitoring of program quality improvement processes and quality measurement systems. Ms Ishikawa performs many functions including general analysis, and understands reporting requirements and documents processes for future and ongoing reference for analysis and reporting of health care data. She supports accreditation and reaccreditation activities to ensure compliance with both contract performance measures and accreditation standards.

Ms. Ishikawa is involved in the policy review, revision and approval process and has an understanding of measuring performance against established standards. Her responsibilities include assisting in formulating options and recommendations for the QI Department and writing reports to support these recommendations; preparing/developing proposals according to client needs and specifications; the preparation and maintenance of URAC/NCQA accreditation; and monitoring and tracking program performance and compliance to standards.

Prior to joining APS, Ms. Ishikawa was the Director of Quality Assurance and Training for Child and Family Service, a non-profit social service organization in Hawaii. Her preceding positions included Director of Training with Child and Family Service; and Program Director, Program Supervisor, Program Coordinator, and Visitation Specialist with Parents and Children Together. Ms. Ishikawa also held the position of School Social Worker with the Department of Education in Honolulu.

Ms. Ishikawa received her Bachelor and Master's degrees in Social Work from the University of Hawaii and Manoa. She is a certified trainer in Non-violent Crisis Intervention (CPI). She is a member of the National Association of Social Workers, and has participated in Hawaii's Domestic Violence Task Force and the Hawaii State Family Visitation Center Network.

APS will expand Provider and Member Services in the next contract period to enhance services to providers and members, improve access to care, prepare for future membership, and streamline

administrative procedures for providers. As the organizational chart in Figure 5 indicates, APS currently has a full complement of staffing in the Member Services Representative and Provider Services Representative roles. APS will augment these important functions with full-time managers. As with the Pharmacist position, APS proposes a long-term and highly qualified staff member to assist with implementation and transition of management responsibilities to full-time staff based in Hawaii. Suzanne Smolkin, Program Director for APS' national Managed Behavioral Health Center in Maryland, will be responsible to assist APS Hawaii with development of member and provider services functions.

Suzanne Smolkin, LCSW-C, Program Director, APS Healthcare

Ms. Suzanne Smolkin is Program Director of the Behavioral Health Group at APS Healthcare. She is responsible for oversight of all operations in this area including network development and credentialing, utilization management and case management, internal reporting, handling of appeals and complaints, eligibility and benefits configuration, and call center operations. The APS Behavioral Health Group provides behavioral health management services to State Medicaid Authorities, Health Plans, Taft Hartley Labor Trusts and State Employee Groups. These services are provided to clients in 10 states.

Ms. Smolkin joined APS Healthcare in 2003 as a clinical care manager/EAP counselor and has been steadily promoted to clinical supervisor, clinical manager, clinical director and her current role as program director. Her varied experiences at APS have given her unique insight into all aspects of member and provider services. Ms. Smolkin is a Licensed Clinical Social Worker and has worked for many years in the behavioral health provider community. She continues in private practice as a psychotherapist and prior to joining APS worked as a therapist for Prince George's Hospital Center and other public and private agencies.

Area Resource Center – Organization and Staffing

The staffing and organization that we describe above represents proposed management and administrative staffing for the program. These positions are located in the APS corporate center in Honolulu. As we discuss throughout the proposal, APS also delivers services through its network of facility and individual providers and through a network of Area Resource Centers.

In this section, we describe the Area Resource Center structure and oversight, and discuss how these Centers will provide important support to members and providers in the next contract period. APS Area Supervisors are responsible for the Resource Centers. During the current contract period, APS uses these facilities for case management in addition to providing face-to-face case management in members' homes and other locations convenient to the member. APS also provides psychosocial rehabilitation, medication management, and intensive outpatient services in these locations. In the next contract period, APS will transition service delivery to the provider network, developing the network to provide this capacity. Current APS Case Managers will continue to work with the member base with a maximum ratio of 1:40 Case Managers to members, using a lower ratio for Case Managers with high acuity workloads. In Figure 6 we display the detail for this regional structure.

Hawaii CCS Area Resource Center
Structure and Supervision

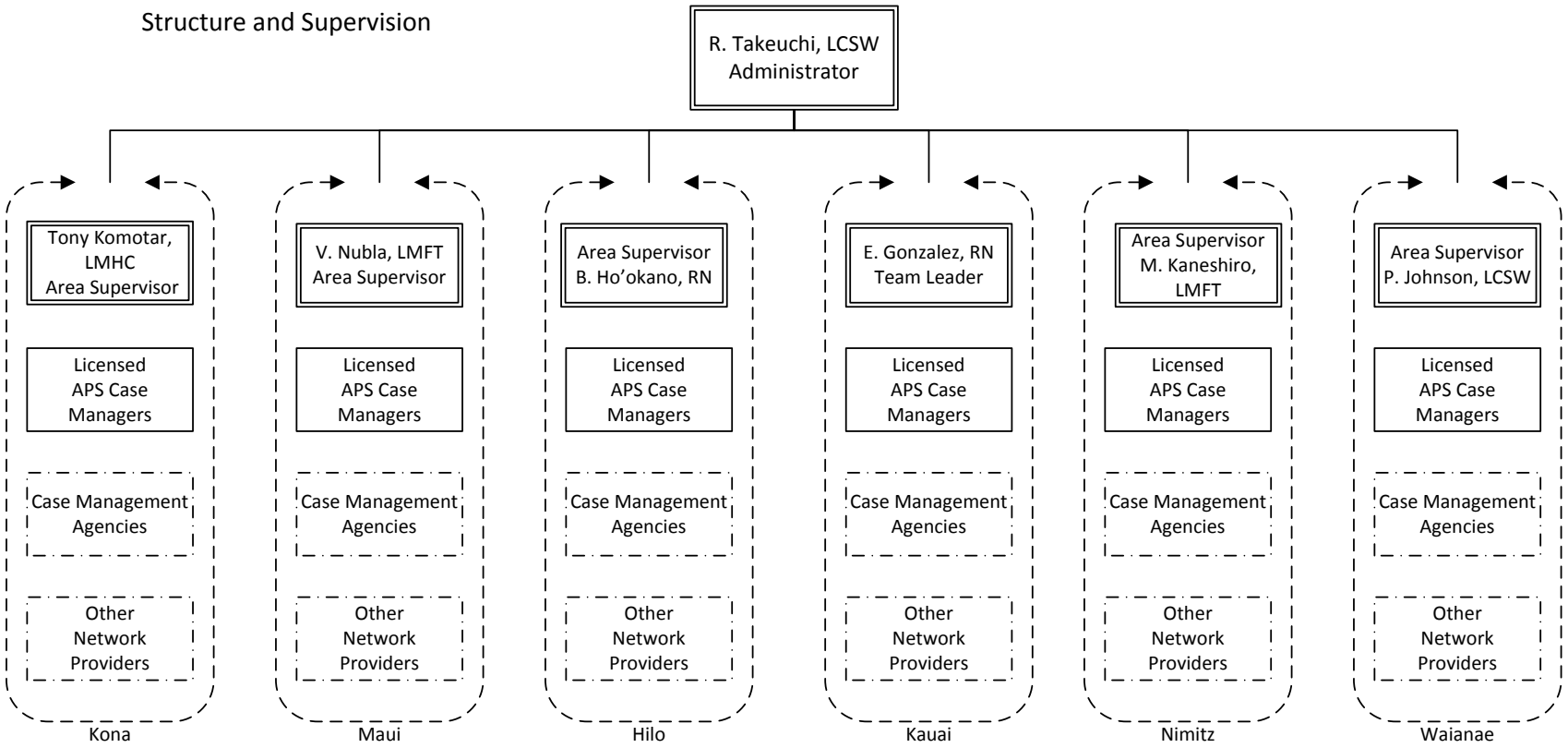


Figure 6. Area Resource Center Detail

Current members will retain their existing Case Managers to ensure continuity of these important relationships. As the CCS program continues to evolve in the next contract period, case management agencies will play a more prominent role with members and the APS focus will shift to development, credentialing, monitoring, and management of a provider network that includes all provider types and services for CCS members. Providers will deliver these services in their own sites, other locations for the convenience of members, and in APS Area Resource Centers, which we will make available to the provider community. In addition to delivering services to *members,* APS will also deliver services to *providers.* These services will include training on CCS program requirements, innovations in behavioral health, technical assistance regarding opportunities to improve the quality of care, and other support services such as access to APS Medical Directors for medication management.

This concept leverages APS' infrastructure, creates opportunities to build capacity in the provider community, and allows individual practitioners to engage with members in a safe environment. With the addition of teleconference capacity for the Resource Centers, APS will expand our ability to support the provider network – and expand services to include technical assistance to medical care providers in an integrated service framework. APS is also in discussion with Federally Qualified Health Centers (FQHCs) across the state. These community-based medical and behavioral healthcare providers will be a valuable part of our network as key partners in integration of care. This model builds on the Accountable Care Organizations that APS' parent Universal American develops for the Medicare population. For example, the Maine Primary Care Association and FQHCs are partners in the Maine ACO.

Expanded Staffing Approach for CCS

We also propose new roles to support the Provider Services functions. These roles will be in Hawaii for optimal flexibility and timely responsiveness to the needs of the Hawaii provider community:

- Claims Analyst. The Claims Analyst will be responsible to research and resolve claims-related questions from providers to facilitate payment of provider claims within 15 days of receipt. The Claims Analysis will also coordinate with the Utilization Management function to ensure that provider billing is consistent with authorizations and includes all information necessary for timely payment as a "clean claim."

- Provider Community Specialist. APS held several Provider Summits during 2012 and invited providers to attend, meet APS staff members, and share their perspectives and experiences. The purpose of these meetings is to gather information we can use to improve our performance in case management, utilization management, and provider services. Through these interactions, we identified the unmet need within the provider community for a role that facilitates communication and coordination between providers at the community level. This role will also identify service needs within communities, and work with providers to enhance, extend, and develop services to ensure each community can comprehensively address member needs. Member needs include, for example, housing, transportation, and medical care in addition to behavioral healthcare.

- Provider Credentialing Specialist. This role will facilitate all aspects of the contracting process for providers, helping to eliminate administrative burden, improve processing time for enrollment of new providers, and facilitating network participation for practitioners and agencies that are existing service providers for new members to help ensure members experience a seamless transition into the CCS program with their service provider.

APS Hawaii – Providing a Foundation for BHO Operations

As we indicate through the discussion in this section, APS has the Hawaii and national infrastructure to implement the BHO program on a timely basis with member-centered and provider friendly operations. APS employees are a critical part of our infrastructure and represent a foundation of experienced and skill on which to base the BHO. Figure 7 displays a summary of APS employees by education level.

The APS Hawaii management team works with an exceptionally educated and experienced clinical and administrative team. Of our 121 employees in Hawaii, 102 or 84.3% have at least an Associates' degree in an administrative or social services field. Almost 50% of our employees in Hawaii are Master's prepared in a related field such as Psychology, Social Work, or Counseling. APS Hawaii Medical Directors are in this category of staff. Case Managers meet the clinical and licensure requirements of the Request for Proposal.

In addition to their educational credentials, APS staff members also bring a substantial record of relevant employment to their positions at APS.

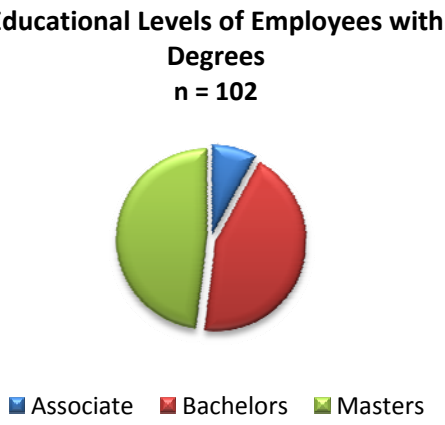


Figure 7. APS Employee Education Level

Figure 8 summarizes the work experience of APS employees. As this figure indicates, over 90% of APS employees have six or more years of employment experience.

This Hawaii experience brings with it cultural competence from deep knowledge of Hawaii, extensive relationships with the Hawaii member and provider communities, and knowledge and understanding of the Hawaii regulatory and Medicaid requirements.

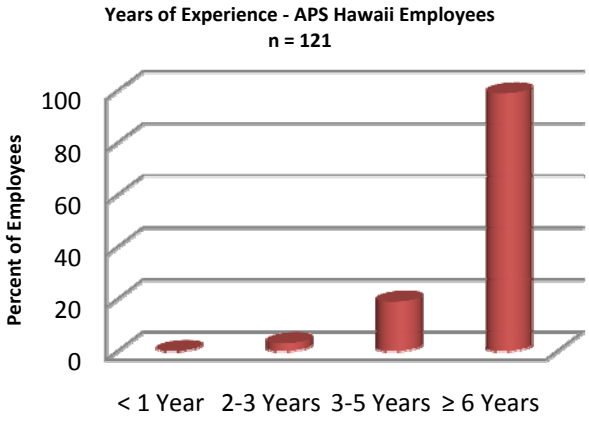


Figure 8. Summary of Experience

70.510.2. KEY STAFFING AND ADMINISTRATIVE POSITIONS

APS has substantive organizational and administrative systems that are capable of implementing and performing contractual obligations. We base our FTE estimates on 20 years of experience as a national managed behavioral healthcare organization. As identified on our organization chart in Figure 5, APS has fully staffed our program to meet CCS contractual requirements on day one. Table 10 depicts our proposed administrative staffing approach for the BHO. Positions for key personnel are in **bold**.

Table 10. BHO Staffing Plan

Position	Name	Location	FTE
Administrator (Plan Contact)	R. Takeuchi, LCSW	Honolulu, HI	1.0
Medical Director	T. Shibata, MD	Honolulu, HI	1.0
Quality Improvement Manager	K. Libao-Laygo, RN	Honolulu, HI	1.0
Clinical Manager	K. Chun, LCSW	Honolulu, HI	1.0
Finance Officer	K. Wagoner, MBA	Columbia, MD	1.0
QI Coordinator (Grievances)	L. Mason	Honolulu, HI	1.0
QI Analyst (Compliance)	N. Ishikawa	Honolulu, HI	1.0
Pharmacist*	A. Mailloux, PharmD	Honolulu, HI	1.0
Senior Provider Relations Specialist	Eleni Davis	Honolulu, HI	1.0
Client Services Coordinators	K. Arelliano KM Rego H. Tomas	Honolulu, HI	3.0
Provider Services Manager** Member Services Manager**	Suzanne Smolkin, LCSW	Honolulu, HI	1.0
Claims Analyst	TBF	Honolulu, HI	1.0
Provider Credentialing Specialist	TBF	Honolulu, HI	1.0
Community Development Specialist	TBF	Honolulu, HI	1.0
Business Analyst	F. Cabasa	Honolulu, HI	0.5
Utilization Reviewers		Honolulu, HI	3.0
Regional Applications Architect	M. Perry	Honolulu, HI	0.5

***APS will hire a Hawaii-based Pharmacist during implementation with approval of the DHS.*

**APS will hire Hawaii-based Member Services and Provider Services Managers during implementation with approval of the DHS.*

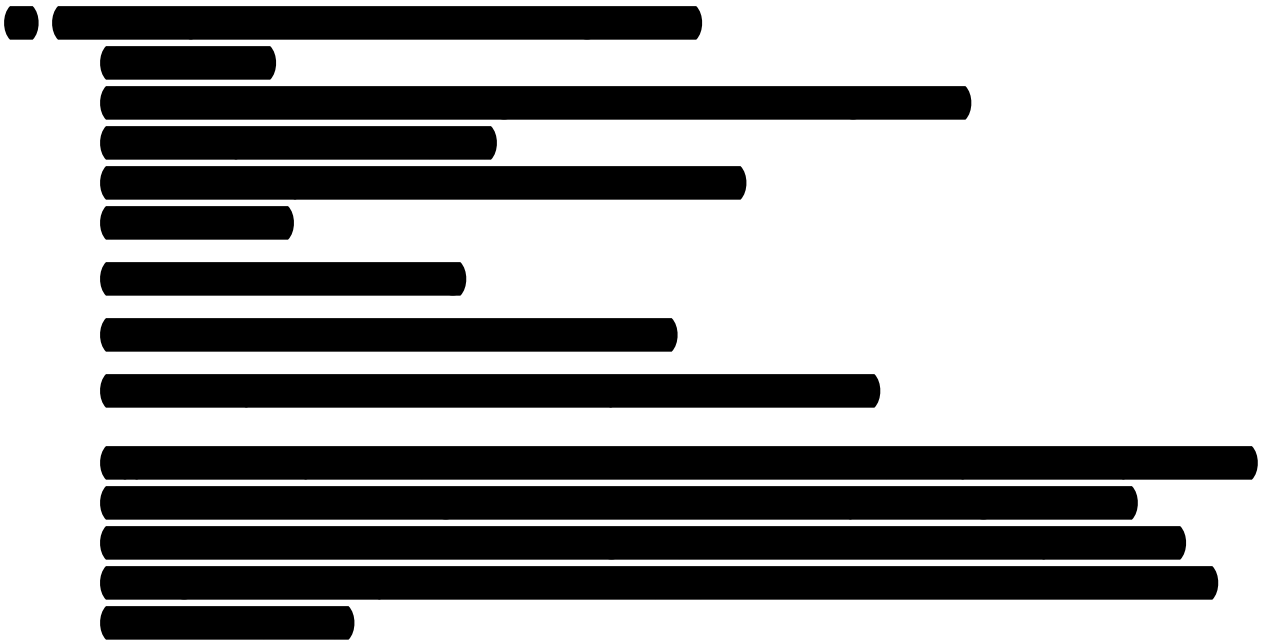
70.520 STAFFING (PERSONNEL RESUMES)

Exhibit 6, Personnel Resumes, contains resumes for the Executive Director, Administrator (key contact person for the BHO), Chief Clinical Officer, Medical Director, Pharmacist, Clinical Manager, QI Manager, Financial Officer, Quality Improvement (QI) Coordinators (Grievance Coordinator), and the QI Analyst (Compliance Coordinator). Resumes include experience with the Medicaid or QUEST or QExA programs in Hawaii, Medicaid programs in other States and experience with managed care systems. We also document he length of time with the BHO or related organization and length of time in the behavioral healthcare industry in the resumes. Each resume includes previous relevant experiences; relevant education and training; and the names, positions titles and telephone numbers of at least two references who can provide information on the individual's experience and competence.

70.530 REFERENCES (PROFESSIONAL AND MEMBER)

APS is pleased to provide the State with five (5) client and five (5) member references. We selected client references based on APS' delivery of similar scopes of work and service delivery to Medicaid and Managed Care plans and populations. We identified members within the CCS population who are willing to interact with the Department regarding this procurement. Releases indicating that the DHS may contact members are included in Exhibit 7.

70.530.1 Client References



APS provides member services, care management, claims processing, quality improvement, provider operations and credentialing. The following projects have been completed to date: 1) Service Area Expansions; 2) Behavioral Health Facility and Provider Expansions; 3) Substance Use Disorder (SUD) Implementation; 4) CHIP Implementation; 5) FQHCs with BH Services

Implementation; 6) 3-Share Product Implementation 7) On-site Behavioral Health Care Manager Implementation; and 8) Multiple Provider Training Modules developed and implemented related to products offered.

[redacted]

2. [redacted]

[redacted]

- Implementation of Criminal Background Checks for potential behavioral health providers;
- Development, maintenance, and expansion of Behavioral Health Network with specific credentialing, contractual and compliance requirements across southeast Texas and western Louisiana;
- Disaster recovery services provided to members following two major hurricanes within the service area in recent years.

- [redacted]

[redacted]

[redacted]

4. [redacted]

[redacted]

access to emergency services when the patient's life or third party lives are in danger. Members receive access to routine evaluations and immediate access to detoxification services.

5. [redacted]

[redacted]

70.530.2 Member References

APS provides the following CCS members as references. Signed release forms are included in Exhibit 7. Please note that in some cases the member does not have a telephone so the phone number of the APS Clinical Center has been provided. In those cases, the members live close to the center and visit the center for frequent in-person sessions with their assigned Case Managers. The assigned APS Case Managers will arrange for the member to use the Clinical Center phone for conversations with DHS.

1. [redacted]
2. [redacted]
3. [redacted]
4. [redacted]
5. [redacted]

70.600 Provider Network

Introduction

APS currently maintains a highly specialized network of over 250 behavioral health providers who deliver services to current CCS members. We configured this network to meet the unique needs of people who are QExA members with Serious Mental Illness. We constantly maintain network participation to ensure that members have access to the full array of behavioral health services covered by the Community Care Services program. APS' approach addresses both short-term and long-term network development. Short-term development activities ensure that the network continually meets the needs of the CCS membership. These activities focus on current and new members, and we recruit providers who deliver services to this membership.

Long-term we focus on the statewide development of a provider system that meets the needs of both the current and a future, expanded membership base that includes AMHD clients and QUEST members. These development activities encompass provider recruitment, retention, management and performance strategies as well as integration of primary medical care and behavioral health in a comprehensive framework of clinical and community-based care. APS has the capability to achieve these long-term goals, with the financial, systems, and clinical resources to build essential capacity in Hawaii's behavioral healthcare environment.

70.610 PROVIDER NETWORK LISTING

Exhibit 8 includes the provider network listing according to the requirements of Section 40.300. The listing follows the format specified in Appendix G. APS lists our contracted network and providers that have signed Letters of Intent (LOIs) in one listing and the subcontracted CVSC pharmacy network in a separate listing. We include electronic files of behavioral health and pharmacy providers in Excel format on the CD with our electronic RFP response. Exhibit 9 includes access reports and maps of each island, indicating driving time to providers. Letters of Intent in the required format are in Exhibit 10.

GeoAccess Reports

The GeoAccess reports we submit in Exhibit 9 indicates that APS is in 100% compliance with network requirements stipulated in the RFP as of submission of this proposal. The GeoAccess software charts covered members in comparison to the provider network and calculates the driving radius between member and provider addresses. For this reason, the map does not show a driving radius where there are no members. The map for the island of Maui is a good example of this feature. It shows the 92 CCS members who live on Maui and presents the drive radius of 60 minutes as the network adequacy measure. Since there are no members in Hana, the software does not show a driving radius.

In discussion with the FQHC in Hana APS identified the opportunity to enhance access in this area in anticipation of future membership. In concert with North Shore Mental Health, which signed a letter of agreement to participate in the provider network, APS will enhance the capacity of the FQHC in Hana with co-located behavioral health providers. APS will reimburse North Shore for services and for

transportation to this location. Exhibit 10 also includes the subcontracted Pharmacy Network GeoAccess report, indicating the pharmacy network will meet RFP requirements as well.

APS will meet two post-proposal stages of network certification. First, according to RFP Section 51.320, APS will submit updated GeoAccess Reports within 30 days of the Contract Effective Date. At this time, we will include all contracted providers in the provider listing. The BHO Provider Network will meet all access standards for the CCS membership as of that date. Additionally, we will also submit updated GeoAccess reports that include all providers who have signed a provider agreement. After that date, we will submit updated reports every two weeks to DHS until 60 days prior to the date of Commencement of Services to Members.

70.610.1 OUT-OF-NETWORK ACCESS AND REIMBURSEMENT

When members require services from providers that are not part of our network, APS negotiates special contracts with the out-of-network provider to ensure members receive medically necessary care in the most appropriate setting. Non-emergent out-of-network services require prior authorization. Since out-of-network providers by definition will not have access to CareConnection to submit prior authorization requests, they will be able to call the APS provider services line for utilization review. If services must be delivered after business hours, providers may submit requests within one business day of initiating services. The member owes only what they would owe for services provided within the network. Our Senior Provider Relations Specialist will arrange with the out-of-network provider to accept payment in full and ensure that providers do not bill members for the balance.

APS staff is available 24 hours a day, seven days a week, by phone to help members locate a provider. In the event that a provider type is not located on a member's island, APS staff arrange for the most appropriate care for our members. We currently arrange transportation for both members and providers to ensure services are available to our members and will continue to use this approach in the next contract period. APS takes into account the recommendations of the member's PCP, member convenience, and other member concerns when arranging out-of-network services. APS Client Services Coordinators will make all arrangements for transportation, meals, interpreter services, and lodging. Member or their primary care providers can contact APS' call center to request this assistance. We provide this assistance at no cost to members.

APS currently contracts with inpatient facilities, community-based agencies, physicians, Advanced Registered Nurse Practitioners, and individual behavioral health practitioners who are part of a clinic or group practice. If a member requests these services and they are available in the geographic area, participating practitioners deliver those services, or we arrange timely out-of-network services.

70.620. MAP OF BEHAVIORAL HEALTH PROVIDERS AND HOSPITALS

Exhibit 9 includes the GeoAccess report for the APS network. As this report documents, APS is 100% compliant with network standards, given the current CCS membership. We will enhance and expand our network on a proactive basis to meet the needs of new membership. Our network development

activities will also focus on managing the network to improve performance, efficiency, and quality of care while increasing provider satisfaction with participation.

ENHANCING THE PROVIDER NETWORK

In Hawaii, the US mainland, and elsewhere, APS programs serve members who are among the most at-risk in the healthcare system. An important consideration in the design of programs to serve members with SMI and SPMI is integration of medical care and behavioral healthcare through network enhancements. This factor is important because of the prevalence of comorbid conditions in high-risk populations. Figure 9 illustrates this issue, showing High Risk/High Cost (HR/HC) members of a population of Aged, Blind, and Disabled Medicaid recipients.

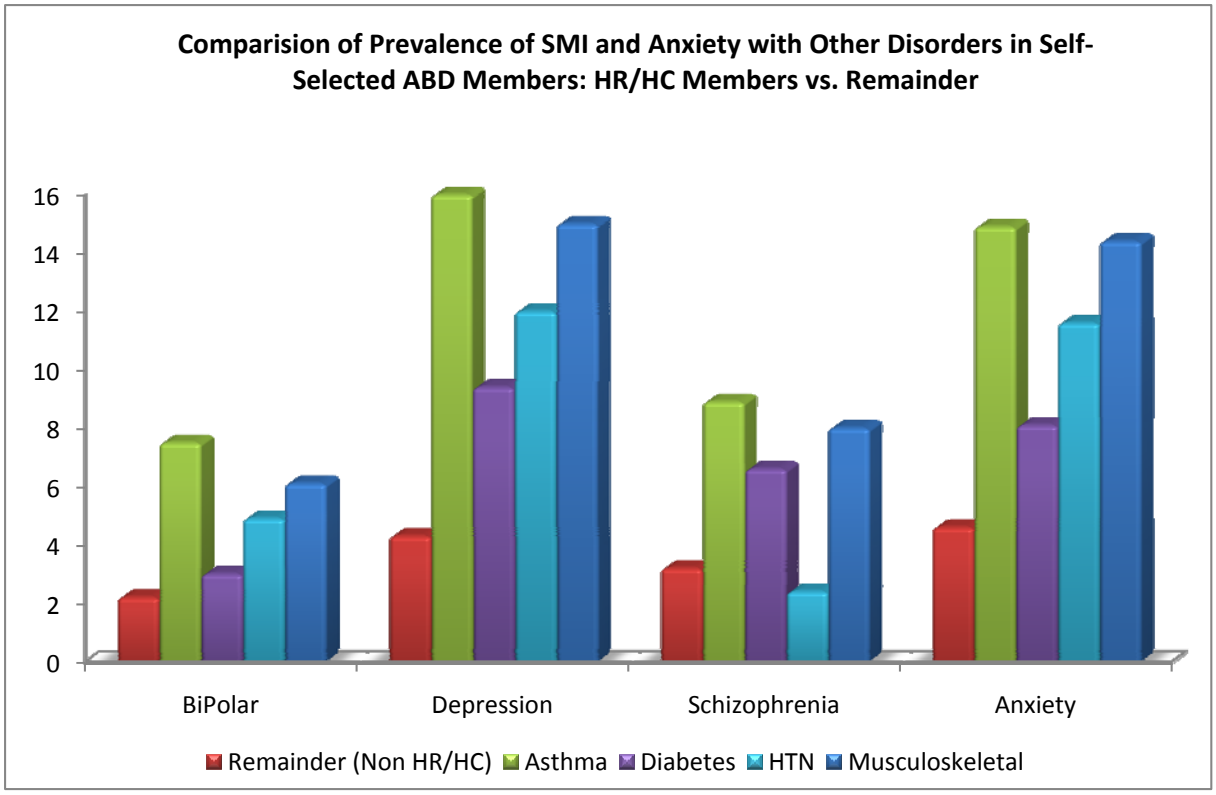


Figure 9. Comparison of Comorbidities in ABD Population

Members with Bipolar Disorder, Depression, Schizophrenia, and Anxiety are more likely to experience medical comorbidities such as asthma or Hypertension (HTN) – and the combination of the two increases both risk and cost dramatically. The burden of illness represented by medical/behavioral health comorbidities has become the central impetus to integration of primary care and behavioral healthcare. Currently, primary care physicians prescribe almost 60% of medications for depression. Supporting these clinicians with medical management advice is necessary to ensure continuation of safe prescribing and management of depression. APS and CVSC are among the most experienced and successful in providing technical assistance, training, and technical tools to integrated provider

networks. Working closely with the DHS and other agencies such as DOH-AMHD, DOH-CAMHD, and DOH-ADAD, APS and CVSC will develop capacity within the primary care system to support integration strategies more efficiently. Additionally, we will work with behavioral health providers to improve co-location of medical care providers to deliver primary care services in their settings.

This approach enhances and integrates the delivery of medical and behavioral care, and supports it with utilization management mechanisms that are effective and do not add to provider administrative burdens. Our methodology focuses on three key areas of support for integration:

- **Data Analytics For Early Identification and Outreach**
  - Outreach to primary care providers
  - Coordination of services and supports
- **Co-location of Behavioral Health and Primary Care Providers**
  - Primary Care Provider (PCP) Offices: screen, refer, coordinate
  - Services for mild-moderate issues delivered in PCP location
  - Referral to specialty Behavioral Health provider for more severe issues
- **Pharmacy Best Practice**
  - Monitor for prescribing patterns; member adherence
  - Data-driven Interventions
  - Improve prescribing of generics
- **CareConnection® - Integrated Care Management System**
  - Physical, Behavioral Health
  - Secure Member Dashboard – Claims, Eligibility, Assessment
  - Plan of Care for Communications with Providers, Care Managers

During implementation and throughout the life the contract, APS will continue to promote enhancement of the provider network through integration strategies that include provider education on screening and referral, as well as provider tools such as feedback reports that identify gaps in care. This proactive and productive approach supports providers and does not increase their administrative burden. In fact, it reduces their administrative burden through improved member self-management skills, more efficient office workflow, and reduced waste.

70.700 Case Management

70.700.1 CASE MANAGEMENT SYSTEM ACCESS

Recovery as a Foundation for Services

The belief that all individuals with severe and persistent mental health conditions have the innate ability to grow and change no matter their circumstances is the cornerstone of the concept of recovery. Recovery for an individual is a person who moves beyond his or her diagnosis, symptoms and perceived limitations to live a meaningful and productive life in the community. Recovery for a system is when services and treatments are member and family-centered. Recovery focuses on individual choice, the member's increased ability to cope successfully with life's challenges, the member's personal recovery journey, the member's improved growth and resilience, and the member's ability to thrive in the community. Case Management is a long established and primary vehicle to support members, families and communities in this endeavor through the effective coordination and utilization of services designed to promote personal independence and improved health and social outcomes.

No "Wrong Door" Entry

Timeliness of services is critical to mitigating crisis, averting decompensation and promoting positive health and social outcomes. APS reinforces a "No Wrong Door" philosophy when interacting with members in need of case management services. Providing timely case management services starts with establishing a responsive and integrated case management system allowing unencumbered and quick access into services. APS as an efficient BHO will ensure that member identification, entry and enrollment into case management services are accessible, informed and seamless.

APS will establish the infrastructure to manage a network of high-quality providers of case management services that are flexible and skilled to exceed the need of members and their communities. There are several key touch-points in case management in which the BHO's critical coordination will embrace members, families, and whole communities in a coordinated recovery system. This approach will ensure providers deliver the right services at the right time in the right manner. APS will remain the clinical stewards in this process to connect members in need of case management with the case management provider best matched to respond to their needs.

Identification / Referral

There are many paths to case management and APS will ensure that access remains unhindered and supported. The Community Care Services (CCS) program has deep community roots and a legacy of providing excellent care to members and families since 2003. Members and families not currently in service seeking case management support may hear of these services and call our offices directly seeking assistance via our local and toll-free numbers. Our compassionate and skilled staff will coordinate with the member, behavioral health provider and QExA plans to discuss options and provide support in determining the services best suited to support the member's needs. Given the outstanding

reputation CCS has with supporting providers, individual behavioral health providers seeking additional case management and treatment support for their challenging members often contact APS directly.

APS as a skilled BHO will assist the provider network in education surrounding the benefits of the CCS program as well as the eligibility criteria and the application process. In this new approach, APS will serve as the single point of contact and entry into Behavioral Health services, including case management. We direct all case management referrals and inquiries through a centralized, coordinated process depicted below in Figure 10:

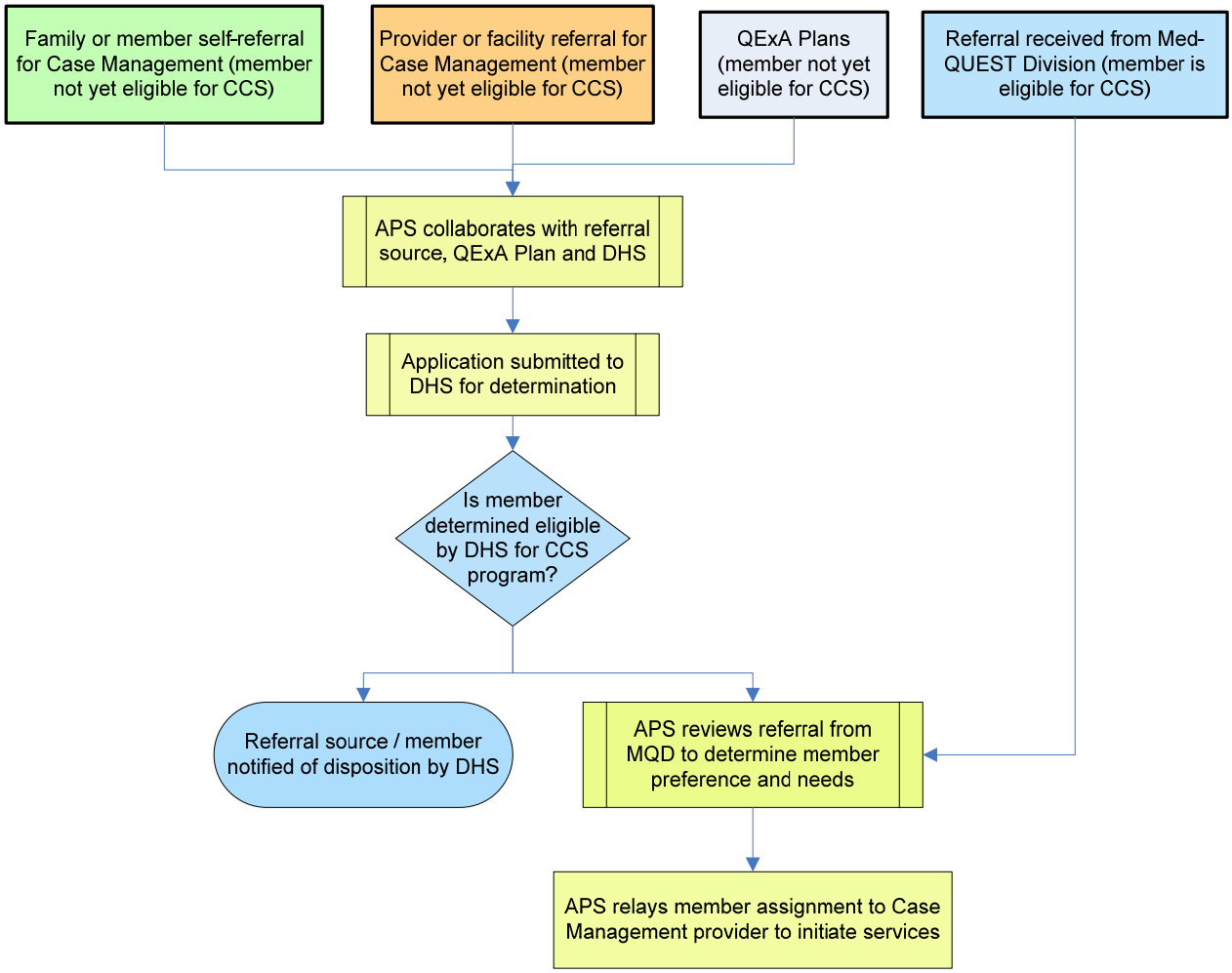


Figure. 10 Pathways into Case Management

If throughout this collaboration process, we discover members already connected with existing case management services, APS staff will help to re-direct members back into their system of care and re-connect them with the services that are available to them. Understanding that authorization into the CCS program ultimately resides with the State, APS will remain an unfailing partner with the QExA plans and DHS in supporting the disposition of the application. In this regard, APS will help to fortify the community safety net to ensure that we link the community's most vulnerable members with the most appropriate services available to them whether it is back to an existing case management provider, their

respective health plan for assistance, or accessing additional services via the CCS program. Finally, we receive formal referrals from DHS for members approved for the CCS program and referred for case management services. We handle these affirmative referrals expeditiously to ensure we assess members within 30 days of identification.

Strategic Partnerships

Once we determine that members are eligible for the CCS program, we link them immediately with a case management provider to initiate the critical task of engagement and service coordination. As a community-grounded BHO, APS will have strategic partnerships with key community-based case management providers with proven success in managing this vulnerable population. We believe that it truly takes a village to change lives, and are proud to collaborate with committed and skilled case management providers who share our vision to support this community.

Our extensive experience as direct providers of case management services gives us unique insight to the enormity of responsibility and profound respect for our case management colleagues. Through this understanding, we are able to build an infrastructure for the case management system that will be intuitive to the needs of members and providers, as well as ever mindful of the critical outcome measures integral to demonstrating clinical success. The assignment of the case management provider will depend on factors including availability, geographic location and, in some cases, specialized team experience or prior established relationship. We take all of these factors into consideration to create the best fit between member and case management provider. APS Intake Specialists will support members upon enrollment into the CCS program and transition them into a soft landing with their case management provider. For new members enrolled into CCS who have an established relationship with a case management agency, APS will make every effort to contract with that provider to ensure a seamless entry for the member into the CCS network while maintaining their case management relationship and continued progress in their recovery. As “one size does not fit all,” the very first contact with new CCS members will be to ensure this “goodness of fit” by the APS Case Managers and administrative support staff, and to begin this custom-designed approach to case management.

Outreach / Engagement

Initializing assertive community outreach is essential to forging a trusting and productive relationship between the case manager and the member. We will expect all case management partners to initiate field-based contact within three (3) business days of notification of the member’s enrollment into the CCS program. The success of case management services with members starts with this initial engagement effort and includes the incorporation of proven best practice strategies including motivation interviewing, person-centered approaches and the stages of change.

70.700.2. ASSESSMENTS AND INDIVIDUAL TREATMENT PLANS

Evolution of Treatment: Assessment and Treatment Plans in Motion

Reducing unnecessary hospitalizations and emergency room visits, establishing meaningful relationships and thriving in the community begin with efforts made early in the case management process. Targeted, rehabilitative interventions are born from specific goals based on a multi-faceted, comprehensive

assessment. As such, arriving at a meaningful, individualized treatment plan occurs in the context of many different processes, values and approaches to treatment. With the goal of the member's recovery in the forefront, we view assessments and treatment plan development as a continuous, dynamic process whereby the treatment plan becomes a living document critical to the member's evolution towards these positive outcomes. The best understanding of an effective treatment planning process is that it is a circular, rather than a linear process, constantly lifting the member to a higher level of functioning, as shown below in Figure 11.

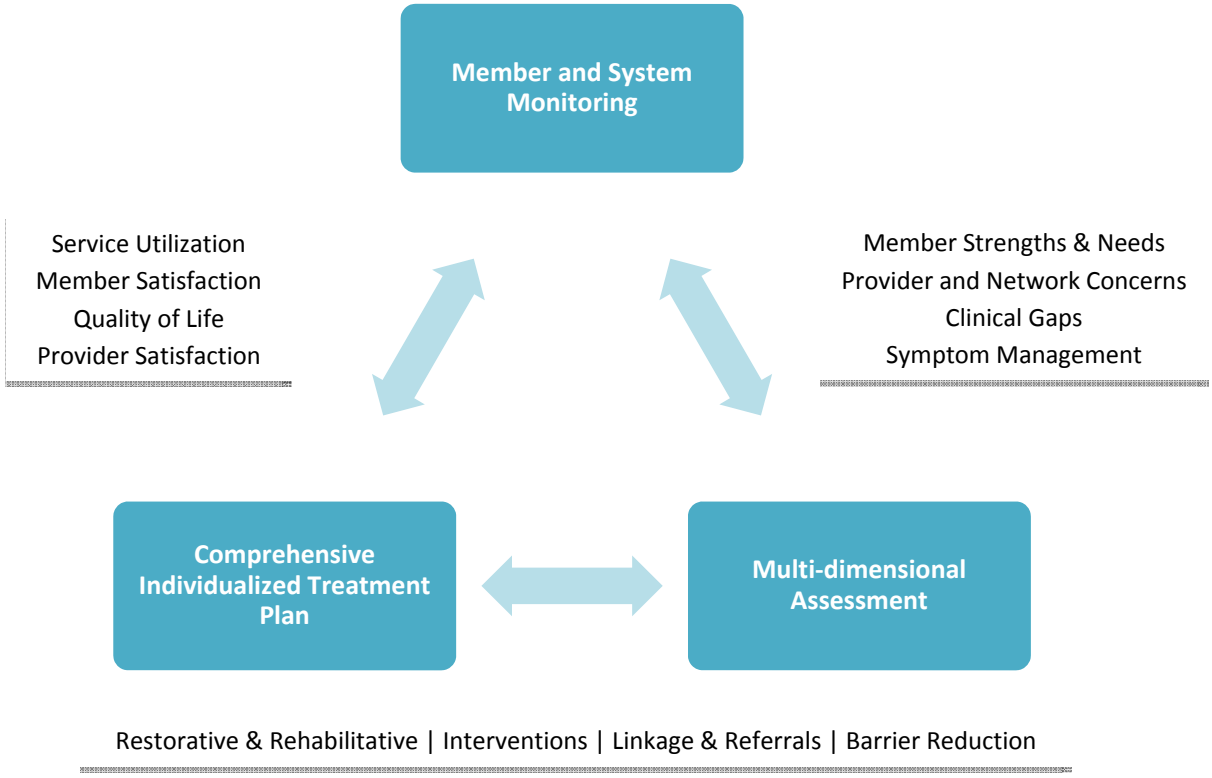


Figure 11. Recovery is Cyclical

Assessment

The first step in developing a meaningful treatment plan is to recognize that the assessment sets the foundation for a meaningful and comprehensive treatment plan. Even before the first question is asked, case managers begin their preliminary assessment of the member based on information received from the referral, health plan assessment and intake packet. This preliminary information is critical to the beginning composite of where the member started by which their future progress will be measured. This early information provides clinical staff with the clues to begin their bio-psycho-social archaeology with members to understand strengths and needs, supports and gaps, and goals and aspirations.

Once DHS notifies APS of a new enrollee, we begin preparations to make an appropriate assignment to a case management provider. If necessary, APS may contact the member to clarify contact or other

information that will assist with a "good fit" assignment. Upon assignment, Member Services relay the member's intake packet, inclusive of the Health Plan assessment, referral form and other pertinent documents to the Case Management provider to initiate outreach. APS conducts outreach to all members enrolled in the CCS program within three (3) business days of notification of their enrollment.

We believe that it will take many hands to lift members towards their recovery, therefore, incorporate Primary Care Providers (PCPs) and Behavioral Health Practitioners (BHPs) in members' CCS experience, as they are key stakeholders in members' care. We send introductory letters to identified PCPs and BHPs identified via the intake process to inform them of the member's enrollment in the CCS program, services available to the member in support of his or her treatment plan, and the name of the case management provider that will enroll the member into his or her care. We expect continued collaboration between the member's treatment team and case management providers throughout their work with CCS members.

During this initial interaction, the first, critical step of establishing rapport and developing a trusting relationship is essential to future success. We understand that sometimes it is necessary to start slow in order to go fast in the end, therefore, initial assessments may be gently started at this first encounter, or completed, based on the pace and readiness of the member. In all cases, we complete a face-to-face comprehensive assessment for all members within 30 days of their enrollment into the program. These assessments gather information about and evaluate significant life domains, which affect a member's ability to function independently within the community and to live meaningful and productive lives. These domains are generally as follows: Medical and Mental Health Issues, Functional Status, Recovery Environment, Treatment & Recovery History, Developmental History, and Education/Vocational. Interwoven with this historical perspective is also an understanding of the member's presenting circumstance, which highlights the nature of the current needs, directs focus to the pertinent issues and begins to shape the direction of this helping relationship.

We understand that not all knowledge comes from one source, therefore, case managers will further seek to develop a full and comprehensive portrait of members to determine how services will best support their individual needs and reinforce their existing resources. We notify PCPs and BHPs of the member's participation in CCS case management via introductory letters at the time of intake, and are primed for the anticipated outreach by the case manager upon assignment of the new enrollee. In addition, the case manager also reaches out to family and other supports identified by the member as critical to their recovery to contribute in this assessment process upon the member's consent. Through these collaborative interactions, we gather additional information from all sources to complete the "whole-person" approach to providing integrated case management.

In addition to the assessment of the individual, a further determination of where the member falls within the CCS program is necessary as determined by their acuity. Appropriate acuity determination is an important and final step of the assessment process. We establish acuity based on the clinical needs of the member as well as the intensity of the clinical interventions needed to maintain the member's current level of functioning in the community and to raise them in their independence. In this regard,

acuity determination is a mid-point between assessment and treatment plan development and serves as a bridge to recovery: mid-point between the biopsychosocial "what" characterization of the assessment and the concrete "how" of the treatment plan.

Treatment Plan Development

The next step in the treatment planning process is perhaps the most critical, as it formally memorializes shared goals and agreements among team members. As treatment plans are living documents, it also brings to life the personal aspirations and fears of members, and holds all participants accountable for the next important steps. For this reason, treatment plans and the treatment planning process is a tremendous responsibility and opportunity to effect real change in an individual's life.

An effective treatment plan is the synthesis of a comprehensive assessment, framed by meaningful and measurable goals and designed with clinically driven and member-relevant interventions. It is a contract between case manager and member, stipulating their shared goals and outlining their road map to recovery. Because the document is critical to progress, the case manager and member complete initial individualized treatment plans within 30 days of the initial assessment. We share completed treatment plans with PCPs and BHPs to help reinforce the support case management offers to the treatment rendered by those important partners.

All case management treatment plans incorporate basic elements intended to provide a clear and concise path to improvement. These elements include: 1) Clear and realistic short and long-term goals; 2) Individualized and clinically driven interventions set with reasonable timeframes for completion; and 3) Defined responsible parties and expected outcomes. Treatment plans are evolving documents, referenced frequently, and updated no less than every six (6) months or sooner if there is a significant change in the member's level of functioning. Treatment plans represent a firm commitment to recovery, but remain malleable and responsive to the changing needs and circumstance of the member and his or her recovery environment.

Reassessment: Case Management as Continuous Quality Improvement

Inherent to the Continuous Quality Improvement (CQI) cycle is ongoing assessment, intervention, and monitoring. Case Management as a service represents the perfect CQI cycle at the member level. As plans for treatment evolve with the member's needs, evolution is dependent on the integration of additional information on the member's status and evaluation of their progress towards his or her goals. Each interaction with a member presents a unique opportunity for case managers to assess the current level of functioning for the member, his/her ability to cope with presenting issues, the supportive resources available, and the remaining gaps in care. Likewise, ongoing collaboration with providers and the member's recovery team also provides important information on member progress and identifies additional opportunities for improvement and potential interventions.

As a quality BHO, APS views each member interaction with case managers as valuable opportunities to gather information and assess member progress. The assessment and treatment planning process is not an esoteric exercise, but the very essence of case management that drives members to recovery. If

viewed as a discrete process to invoke every six months, progress towards goals would be in fits and starts like a car in disrepair. We understand that for the smoothest ride, we must embed our processes within our practice – each outreach and phone call with a member is another step closer to achieving their goals. APS will collaborate regularly with our case management partners to continuously reassess members, re-define their treatment plans, and maintain their steady progress towards recovery.

As a recovery-oriented system, we will use our member's progression through the acuity levels and recovery towards independence as an indicator of success. Recovery is not always a linear process, which underscores the value of a flexible case management and behavioral health system, which can respond to members based on their stage of change. We design the continuous reassessment process specifically with the hills and valleys of recovery in mind and case management is often the singular link between the medical, behavioral health and other recovery supports in the member's journey. We believe in all members' inherent ability to change and rise above their diagnoses, symptoms and circumstances and understand that as a responsible BHO we embrace the challenge of ensuring the system evolves and recovers just as much as the individual.

70.700.3. INCLUSION OF THE HEALTH PLAN'S ASSESSMENT

The Health Plan's assessment offers the critical first step in identifying members for additional services and helping them thrive within the community. The referral process is the key juncture in which members are elevated to a system of care specifically designed to create a recovery environment best suited to improve health outcomes for members and communities. CCS launches the referral process with the completion of the Health Plan assessment that not only identifies demographic and clinical information necessary in determining the appropriateness of services for members, but also marks an important turning point in the member's recovery.

The APS Clinical Department uses information from the health assessment in the assignment of members to a case management program, and identifies collaborating providers with which to direct initial case management efforts. Information received from the health plan provides an initial glimpse into the member's treatment history that depicts member's needs, readiness to change, support network and patterns of utilization. This information provides case managers with an early advantage to understanding the complexities of the member's situation, challenges and preferences.

70.700.4. COORDINATION WITH PCPS AND SERVICE PROVIDERS

Addressing the needs of the whole individual requires attention to all aspects of health: medical, psychological, spiritual and cultural. In this regard, APS as an integrated BHO has proven experience in coordinating care across all of these dimensions through the comprehensive case management services currently provided. We understand that keeping providers informed and engaged in the services we deliver always results in better outcomes for members, improved success for providers and overall efficiencies across the system. Members exist amidst a constellation of supports – medical, behavioral health, family and community – therefore, members should receive case management and treatment services in the context of these supports.

Initial outreach to PCPs and other providers occurs almost immediately upon enrollment of the member into the CCS program. We send an introductory letter of the member's enrollment into CCS, services available via the program, as well as the name and contact information for the assigned case management agency to the member PCPs and BHPs identified on the referral form and Health Plan assessment. We reach out to existing providers by Case Managers through this initial introduction, and it sets the course for close coordination and communication throughout the working partnership.

Subsequent to this formal introduction, individual case managers will outreach to providers as part of the information gathering during the assessment process either to complete the medical picture of the member or to help validate information obtained through other sources. This communication is essential to ensure that we compile all relevant pieces of clinical information to create a comprehensive and integrated plan of care. Part of discussions will also include discerning from providers their individualized treatment plans for members to identify ways in which case management can best support the clinical work of the provider to ensure synergistic improvements for the member. Upon completion of the treatment plan with the member, we share the plan with the PCP and BHP to keep on track with the continued good work of all partners.

While the partnership initiated during the treatment planning process is essential to setting the course for case management and establishing shared goals among the treatment team, the continued follow-up, interventions and monitoring provided through intensive case management is essential to ensuring progress towards goals. Case Managers have long been depicted as the "eyes and ears" of the providers within the communities, establishing close relationships with members and being able to relay concerns related to change in symptoms or conditions based on their observations in the field. More than that, however, effective case management also extends the clinical reach of providers in the community; more than simple observation, skilled case managers are able to anticipate needs and changes and is critical to mitigating crisis rather than just responding to it.

Continuous oversight and responsiveness to members and the overall provider network is precisely the role APS is committed hold as a responsible BHO and the expectation we hold for our case management partners. Integrating medical and behavioral health services at the member and systems level is essential to ensuring positive health outcomes for this vulnerable population often disenfranchised from the very systems designed to support them. APS as an experienced provider of service and administrator of programs is acutely aware of the behavioral, social, and financial challenges involved in caring for complex members. We believe it is our responsibility to create and sustain a behavioral healthcare system that decreases barriers for members and providers and facilitate open and meaningful collaboration between members, providers, and community supports. Through this philosophy, we are able to support NCQA QI 11 standards as well as community best practices.

70.700.5. COORDINATION WITH HEALTH PLANS

A strong partnership between the health plan and BHO is essential to ensure cost-effective and quality-driven services. Approximately two-thirds of people with mental illness have at least one co-morbid chronic medical condition (The Jones DR, Macias C, Barreira PJ, Fisher WH, Hargreaves WA, Harding CM. Prevalence, severity, and co-occurrence of chronic physical health problems of persons with serious mental illness. Psychiatr Serv 2004;55(11):1250-7.) The prevalence of comorbidity means that coordination between medical and behavioral health services is of extreme importance to coordinate services, integrate care and ensure complementary treatment.

As the BHO, APS understands the primary role of coordinating these services at both the member and systems level. A close partnership with health plans to identify members most suitable for the enhanced behavioral health services offered via the CCS program will improve outcomes for members and contain costs for the plan. We can facilitate the timely and appropriate identification of members through this close partnership, along with ongoing communication regarding member status, challenges locating members and difficulties related to coordinating medical and mental health treatment. The high prevalence of co-morbid medical conditions among the SPMI population compromises overall treatment adherence due to the complex psychosocial factors affecting follow-up and understanding of and coping with chronic illness. When members initially admitted or treated for acute psychiatric symptoms have unresolved, underlying medical issues, acute inpatient admissions as well as other treatments are complicated when these conditions emerge. In these instances, coordinated utilization management between medical and psychiatric authorizations is essential to ensure members are receiving appropriate treatment for presenting problems while we also support treating providers.

APS as a cost-effective BHO will collaborate with the health plan to conduct regular claims and data analyses to identify high utilizers of medical and behavioral health services and convene clinical rounds to review these members and identify options to reduce costs and improve care. Case Management is integral to this solution, and APS will guide its case management partners in their critical role. These clinical rounds will include case management and other key treatment, and Health Plan representatives. The clinical rounds will help with compiling all information relevant to the member's presenting circumstance to formulate a composite assessment, and we will review the treatment plan with the group to identify additional clinical interventions and supports to better support the member to achieve shared goals. These joint clinical rounds will increase communication throughout the service network as well as within the member's treatment team.

70.700.8. Implementing Different Levels of Case Management Services

Case Management as a Therapeutic Continuum

Case Management services best designed for the Medicaid SPMI population would be a flexible, consistent partnership between case manager and member through the hills and valleys of the recovery process. Members occasionally receive episodic, acute care followed by long periods of steady improvement and stabilization, only to repeat the cycle again over time. The hope with each turn is that the duration of the cycle is longer and the highs and lows less dramatic and each turn lifting members

higher and higher towards independence and full community integration. In this sense, a responsive and effective behavioral health system will incorporate a case management system with these anticipated changes in mind, and the capacity to support members through each phase of their recovery. We offer services as part of a therapeutic continuum in which the intensity of case management services is titrated based on the infusion of additional formal or informal supports and determined by clinical and social indicators of needs. With this framework of the BHO providing oversight of all services – including case management – the benefits and effectiveness of each service is viewed as a part of the member's whole treatment, just as members as viewed as part of their whole environment. As the member's need for high intensity treatment services and community supports decreases, so too does their need for high intensity case management to coordinate those services.

Acuity as the Foundation of Services

In this regard, acuity determination for case management is a critical process in weighing the member's case management needs against their treatment services and other recovery supports. Accurate determination of member acuity establishes the foundation for case management and other services as it accounts for all of the member's needs, strengths, current and planned treatment and formal and informal support systems. As discussed in the previous section, the essence of appropriate acuity determination relies on careful analysis of the following factors: functional assessment, community stability index, treatment utilization, and treatment adherence.

The combination of these factors in addition to clinical judgment of the case manager based on member observations and interactions creates the multi-faceted profile of the member experience, which drives all subsequent case management interactions. An accurate depiction of a member's clinical needs in case management as determined by an established acuity is the first critical step towards recovery. Once we establish acuity, we can better define the case management process and offer structure in regards to the intensity, course and duration of services.

Acuity as a Driver toward Recovery

A guiding principle of Recovery is that people with psychiatric disabilities can recover, reclaim and transform their lives. A mental health system grounded in recovery requires processes supporting the continued improvement of members. This recognizes that members, with the right supports, will become independent and integrated into the community, eventually outgrowing the very services and system designed as a lifeline. APS embraces recovery in philosophy and practice. We design processes aligned with these principles. Integral to the design of the case management program is the incorporation of an acuity system, which encourages member improvement and continuously assesses members to facilitate their movement through the case management continuum.

APS as a responsible BHO will retain the critical task of determining member acuity across the membership to ensure standardized and clinically driven acuity assignments for all members. Monthly stratification of the membership supports the continuous review of members to ensure they are appropriately moving through the acuity system to prevent members languishing in services unnoticed. This stratification is relayed to case management providers to inform them of the acuity level and also

provide opportunity for clinicians to provide additional clinical information which may impact acuity. Factors used to determine changes in acuity include the following:

- Change in functioning (as determined by a change in the Global Assessment of Functioning (GAF score) from baseline
- Change in stability in the community
- Change in additional behavioral health services utilized IP, crisis, IOP, etc.)
- Change in treatment adherence

Acuity as a Determinant of Case Management Services

Upon assignment of the appropriate acuity level, the important work of case management can commence. The RFP defines the continuum of case management in the CCS into four service categories, which are as follows:

Service Level	Minimum Service Contract Requirement	Contact Description
IV. High Intensity	Two (2) times per week	Face-to-face one (1) time per week, other contact may be telephonic
III. Intensive	One (1) time per week	Face-to-face two (2) times per month, other contact may be telephonic
II. Intermediate	Every other week	Face-to-face one (1) time per month, other contact may be telephonic
I. Routine	One (1) time per month	Face-to-face

For a complete understanding, an optimal; view of the case management system is as a juxtaposition between the clinical characteristics of members within the service level and the parameters of the service. We discuss these factors below.

High Intensity Case Management

Clinical Profile: Members in this level of service are the highest risk and highest utilizers of services. Members falling within this service have multiple or recent acute IP admissions, utilize high acuity services frequently such as crisis and ER services, and have poor follow-up or fragmented care.

Service Parameters: Members in this highest acuity level require the most frequent contact, of at least twice weekly. This may come in the form of face-to-face or telephonic contacts with the member or

other family members to coordinate services, monitor member's stability and safety in the community, and collaborate with the treatment team. At least one of the weekly visits must be face-to face with the member given their level of severity.

Intensive Case Management

Clinical Profile: Members within this service receive poorly coordinated care, although without acute symptoms requiring hospitalization or other higher levels of care. Members are generally participants of some structured behavioral health program and have inconsistent follow-up and the community but are beginning to establish brief periods of stability.

Service Parameters: Members in this level of case management receive services weekly and at least one face-to-face contact with the case manager. Services in this level focus on assisting members with accessing the health care system appropriately and are generally oriented towards reducing readmissions, linking members with providers and overcoming basic barriers to healthcare and survival.

Intermediate Case Management

Clinical Profile: Members are generally familiar with case management services and are generally stable not experiencing too much of the highs and lows of case management. These members are familiar with case management services, have the beginnings of self-advocacy and self-directed recovery, and may potentially move to higher levels of functioning and graduate from CM services altogether. Members are generally following up with providers on a regular basis although may miss some appointments and all of their basic survival needs are generally met.

Service Parameters: Members in this level generally do not require consistent follow-up in case management and for the most part are moving towards independence or in the beginning phases of independence and just require a little additional support for a longer period of time to help with progression out of case management. Members are seen at least every other week, with at least one of the contacts an actual face-to-face contact.

Routine Case Management

Clinical Profile: members in this level of care require the least amount of supervision, demonstrate sustained independence and stability in the community, and have adequate self-motivation and insight to maintain their course in recovery with minimal support.

Service Parameters: Members in routine case management have established relationships and partnerships beyond the case management system. They are connected to their communities and self-directed in their goals. Case managers conduct monthly face-to-face visits with these members to assess their readiness for discharge from CM services continually.

Accounting for Services across the Network

As a consistent BHO, APS will standardize and implement acuity and service protocols throughout the CCS membership and across service providers. This process will be a multi-level practice to ensure we embed these fundamental elements of the case management program at every level. Case Management providers will be required to submit encounter data regarding their case management efforts on a monthly basis. This data will offer critical information regarding the intensity and nature of services provided to members across the system. Encounter data patterns will help to identify effective practices and outcomes within the provider network, as well as opportunities to increase support to members based on their determined clinical needs and the design of the service. CM services appropriate to list as encounters include:

- Face-to-face contact with member/family and 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)
- Travel time (actual time spent in taking a member to/from places which must be treatment related

Case Management providers will also be required to submit quarterly reports, which will reflect program efficacy and outcomes, as well as broader productivity determinants such as services offered by acuity, appropriate combination of field and telephonic interventions, and anticipated movement of members within the acuity system.

70.700.9. Ensuring Compliance with Case Load Ratios

The Clinical Manager makes Case Load assignments to ensure that caseloads are balanced, appropriate, and adhere to the required ratio. Factors considered in the assignment of cases include staff specialization or unique proficiency, overall caseload composition for staff, and the presenting issue of the member, taking into consideration any special requests or allowances needed and appropriate to accommodate. In order to ensure that caseloads are balanced, APS has developed a specialized caseload formula, which accounts for a mixed acuity across staff assigned caseload to help distribute high acuity among routine members within the staff. APS and network providers will comply with a ratio of one Case Manager to 40 CCS members. Our specialized caseload formula allows us to identify and adjust this ratio to a lower one depending on the acuity of the members to avoid reassigning members if possible. We monitor the acuity of the CCS members on a continuous basis using the APS Percolator, and this tool helps us identify when we need to examine and address shifts in caseload ratios for ASP Case Managers as well as for network providers conducting case management services.

Adherence to NCQA QI 7 standards for complex case management requires significant oversight and monitoring. As a BHO, APS will ensure that these standards are reinforced with staff and that the programs remain at a constant level of survey-ready, understanding that the success of programs is measured in each activity and interaction with members. Case management programs will be required to submit monthly reports on the outcome of their monthly chart audits. In addition, APS will conduct

semi-annual audits with each of its network provider to ensure that services provided are consistent and high quality, and adhere to contractual requirements.

The DHS will be able to monitor Case Management ratios in real-time using the CCS program dashboard. We configure the dashboard to report key metrics for program management, such as the number of members scheduled and assessed, follow up metrics such as HEDIS measures, and case manager to member ratios. APS program staff use this tool to monitor program performance, and it will be accessible through the CareConnection interface to the DHS. APS will also train DHS staff members to use CareConnection, and provide User Identifiers so staff members can access the system.

70.700.10 Ensuring Compliance with SMI Criteria

Ensuring members remain eligible for the program is a priority for APS as the BHO. Through the monthly percolator, we will be able to routinely survey the membership to ensure that basic minimum criteria re maintained, including active coverage, eligible diagnoses, appropriate functional status and appropriate community tenure. We flag members who fail to meet these criteria in the monthly stratification and identified for further review by the appropriate case management provider. Prompt response will be required to APS regarding the member's disposition so that we can take appropriate action and report to the State. We share this stratification directly with case management providers who will in turn use these determinations to inform their services. The APS Medical Director reviews all responses to determine final disposition in the event providers request a clinical exception. Members who are determined not to meet the eligibility requirements will return to the health plan for continued services and we will relay a copy of the most recent treatment plan to the plan to assist with the transition.

70.700.11 Individual Treatment Plan Components

The individualized treatment plan (ITP) is member-focused and helps the recovery team maintain focus on progress towards goals, have a framework for identifying and organizing needed resources and measure growth and change. The industry often refers to the ITP synonymously as the care plan, plan of care, or recovery plan in other systems, but the intent is the same regardless of the name assigned to the document. The ITP is a formalized document created in partnership with the member, case manager, and other involved stakeholders, which outlines the goals of service and the steps needed to achieve those stated goals. It is the driving force behind effective case management and is the single document, which integrates the entire treatment team together in support of the member. Effective treatment plans have member and provider in-put reflecting clearly defined problems, meaningful and measureable long- and short-term goals, targeted, rehabilitative interventions, and the individuals responsible for implementing those interventions.

The basic elements of a care plan include the following elements: problem identification, goals, interventions, target dates, case manager assigned, and contact frequency. Each of these elements represents a critical marker in the formulation of services, guides the member's path towards recovery, and delineates the service. We discuss the essential components of the ITP below:

Problem Identification

Through the assessment process and in collaboration with the member and recovery team, the Case Manager identifies and clearly states problems on the ITP to highlight primary issues. Documentation of problems makes the primary barriers to recovery and health clear to the member and recovery team, which require targeted attention. It provides the team with a clear focal point to direct their energy and to ensure that interventions remain on track and consistent with the member's concerns.

Goals

Goals are different from the problems identified as they represent a clear and specific indication of the member's aspirations and they relate to the corresponding problem at hand. The measure of success or progress is better as a positive statement or clearly defined positive outcome, rather than the reduction or movement away from a problem. Without a specific and measureable goal, it is difficult to determine success in a meaningful way to the member and recovery team. Ensuring goals are measurable allow the member and team to track progress towards goals or to establish meaningful benchmarks on the path to success; it drives more positive momentum even if the actual goal is not attained, but progress along the path can be measured and celebrated. Goals may be short- or long-term in nature, with the duration dependent on the amount of time necessary to achieve the goal. Both long and short-term goals are necessary to show consistent progress towards goals, as well as to help the member and team prioritize and pace their efforts. Goals that are established and later achieved provide good positive feedback to the member and recovery team of the progress made and a feeling of overall accomplishment.

Interventions

The most effective interventions target not only the specific needs of the member, but also account for cultural and personal preferences, and available resources. This process tailors the intervention to the specific barriers and strengths of the individual while also remaining mindful of the overall integration of members in their communities and expanding their natural support systems. In this regard, no two interventions are alike as though they may be addressing a similar problem for a different member, the needs and recovery environment of that individual should always shape the intervention to fit the nuances of their unique situation. Well-designed interventions are like tailored suits, which fit the individual by highlighting the best characteristics and compensating for areas in need of improvement. The second component of an effective intervention is also ensuring that the actions identified are rehabilitative and restorative in nature. In this regard, clinically driven interventions, which aim at improving the overall functioning and health of the individual, have the greatest impact on the problem. All interventions should have target dates of completion, and the care plan should capture the start and end dates of all interventions to help to reflect progress towards a goal. Built in to the intervention should also be a determination of frequency of contact required to both implement the specified intervention as well as to achieve the respective goal. The follow-up frequency may range from a single interaction to monthly or weekly follow-up visits by a case manager. Each should reflect the specific intervention and the estimated time required. This designated frequency then helps to shape the overall

frequency of contact anticipated between the member and the case manager and other partners identified in the care plan, thereby building a framework of the general service.

Assigned Case Manager

The assignment of responsibility on the care plan is critical to ensuring accountability for the interventions identified as well as to clarify roles and communication. The completion of this component is straightforward and essential, particularly when Case Managers share care plans with PCPs, BHPs, and other recovery partners as it will help to streamline coordination efforts and underscore the critical link the case manager plays in this role.

70.700.12 Monitoring & Reporting Case Management Services

APS as an outcome-driven BHO will be responsible to provide all case management services in a timely, efficient and effective manner. To facilitate this process, case management providers will be required to submit monthly encounter data for case management services, which will indicate the frequency and nature of case management interactions provided to all CCS members. This degree of oversight is necessary to ensure that Case Managers meet minimum service requirements based on the member's acuity and clinical needs, and ensure consistent and standardized quality services across the system.

Strict encounter data, while useful in determining the frequency of case management services, does little to reflect the quality of services provided. In this regard, we will request that our case management partners conduct monthly clinical documentation audits on their members' clinical records, and we will share in this responsibility by conducting semi-annual audits of each of our case management partners. These frequent collaborations with our partners will not only enable us to remain connected to the services we are coordinating, but also offer additional technical and clinical support to our case management colleagues. Our partnership with case management agencies will remain collaborative and supportive, yet firm in our expectations of high quality, consistent clinical service delivery.

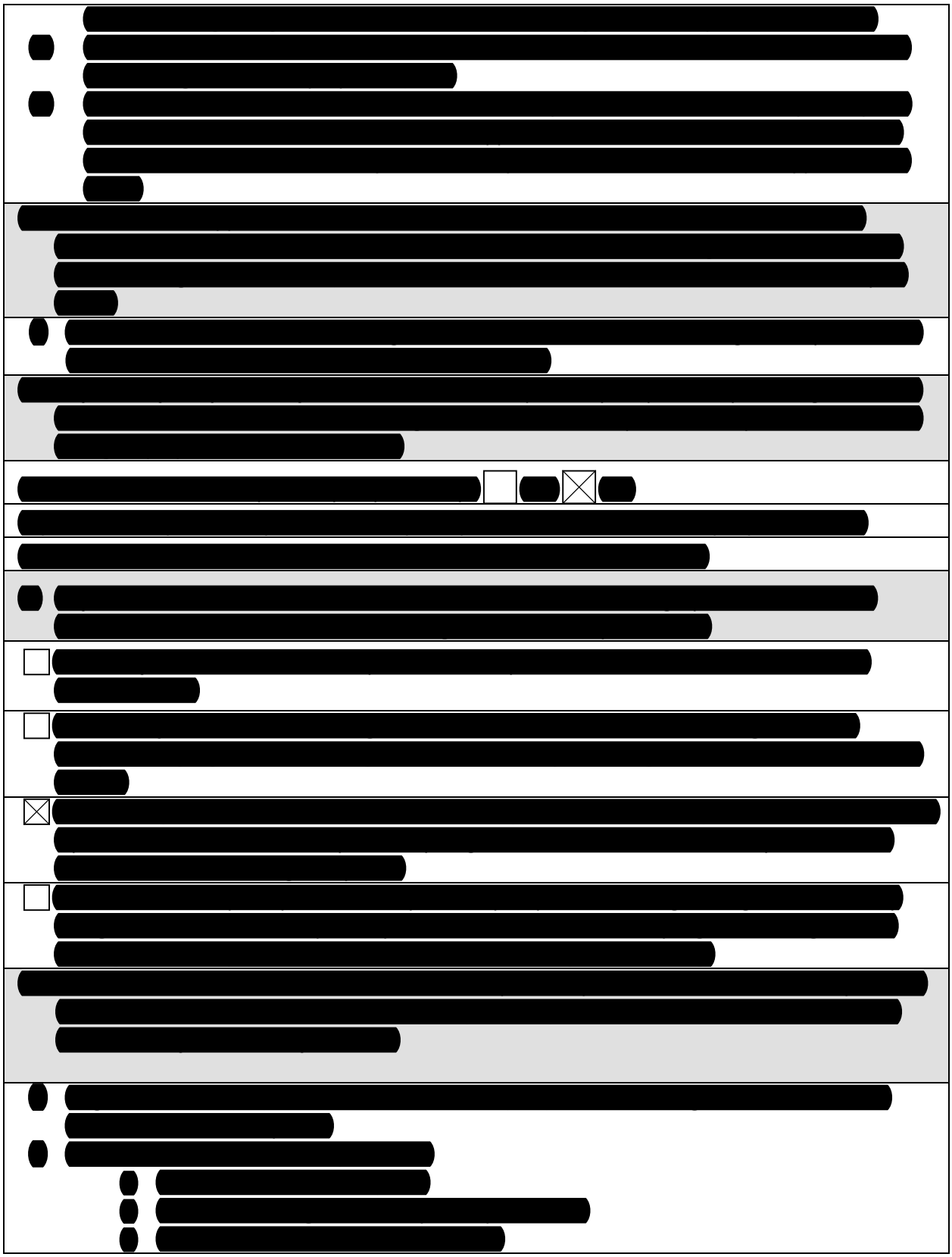
Outcome data, which we will monitor as a quality BHO, will include general utilization targets such as reduced inpatient and ER admission rates and a reduction in readmissions, as well as additional clinical indicators such as measuring the medication possession ratios for members and comparing inpatient versus outpatient utilization costs and outcomes. Additionally, national indicators of quality will be measured as they apply to this population, such as the Behavioral Health HEDIS rates that would apply such as Follow-up After Hospitalization after 7 days (FUH), Initiation and Engagement Into Treatment (IET), and Anti-depressant Medication Management (AMM). With a pulse on national and clinical trends, we will also remain mindful of new and emerging quality outcome measures such as the revised HEDIS measures for the SMI population.

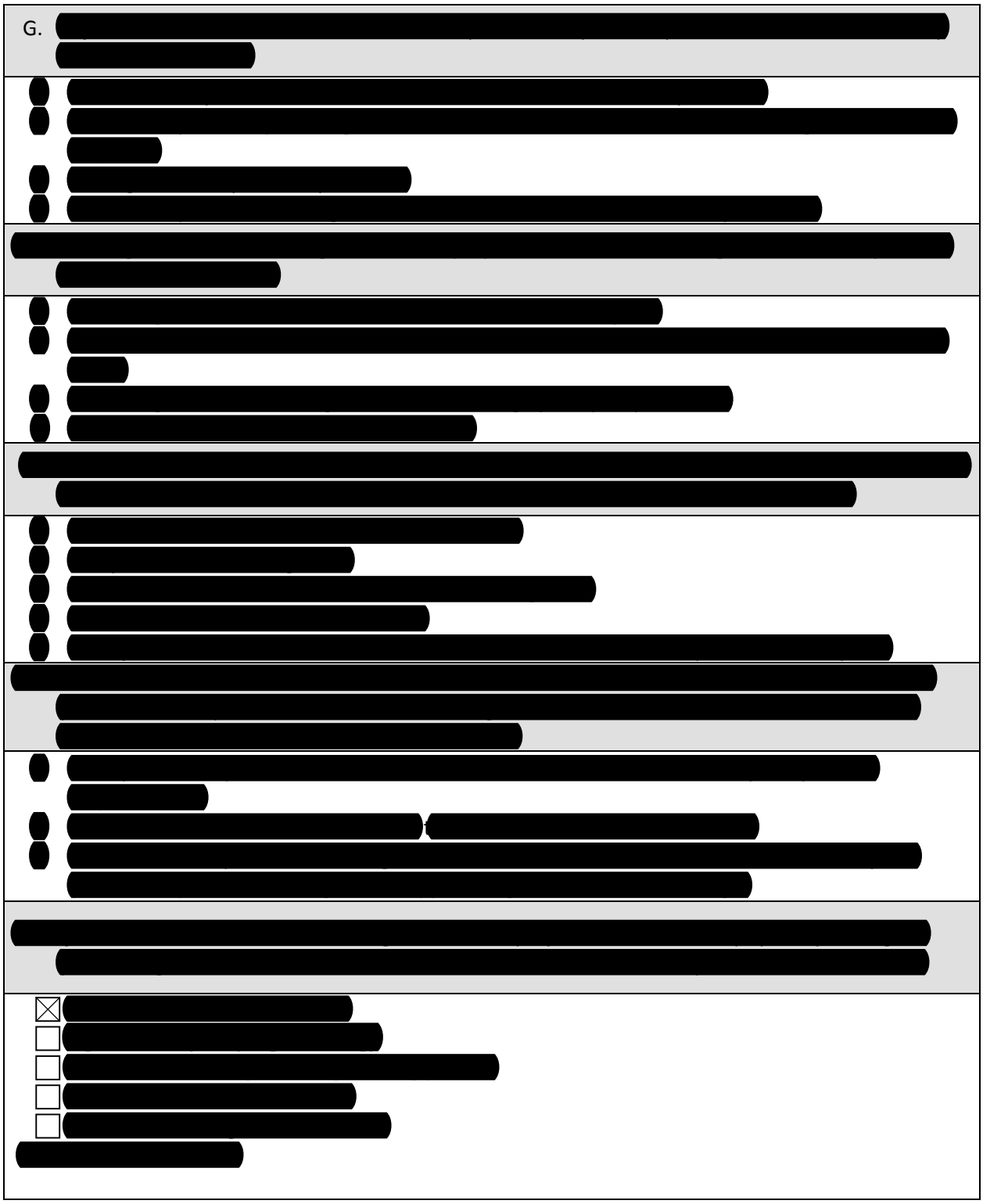
70.700.13 Case Management Staffing and Training

Case Management staff is truly the link between the member and their recovery team, integration of medical and behavioral health services, and the member and their recovery goals. APS will ensure that all case management staff have appropriate credentials and are skilled mental health workers

knowledgeable of their communities and passionate about the work they do. We expect Case Managers with this challenging population to be field-based, willing and ready to meet members where they are and familiar with their communities to know favorite member locations. Below is a job description for a field-based case manager in this program, and reflect the minimum qualifications which we would expect our case management partners to uphold.

APS Healthcare Position Description





As experienced case management providers, we understand the challenges of recruiting and retaining qualified staff, and have first-hand knowledge of the outcomes of staff turnover and their impact on the program and the member. At the same time, we have also faced the difficult reality of recruiting for qualified candidates in areas with a shortage of licensed clinicians. To mitigate these challenges, APS has adopted a comprehensive training program (Figure 12) for all new case managers, which we will extend to providers to ensure that all case managers providing services to the CCS member are adequately oriented and appropriately trained. We embed the guiding principles of case management from the CMSA into training, as well as program-specific competencies and workflows. Additional mandatory training related to HIPAA, ethics, and corporate compliance is required as terms of employment and regular refresher training. To further off-set the difficulty of recruiting new licensed staff through the effective retention of current qualified staff, we encourage our case management partners to also recruit and retain skilled clinical supervisors who are able to ensure adequate support and guidance is available to case managers to maintain their professional satisfaction and effectiveness with members.

Figure 12 Sample Training Plan

Case Manager Name:				
Key Areas of Orientation	**Trainer Initials**	**Employee Initials**	**Date Completed**	**Trainer**
1. BCC CM Orientation: • CM Policies & Procedures • Professional Role, Responsibilities & Accountabilities • Scope of Practice • Recognized Standards of Case Management Practice • Recognized Knowledge Domains of Case Management • Resources Available to Assist in Management of Cases • Evidence Based Care Plans • Advocacy • Coordination & Transition of Care • Risk Management • Utilization Management				
2. CM System Overview (assessment, care plan, documentation)				
3. CM intake process				
4. Outreach and assessment process				
5. Dis-enrollment process/audits				
6. Member eligibility checks				
7. Interfacing with the Provider Network				
8. General CM Office Procedures				
9. Quality Improvement: Overview • Adverse Incidents • Complaints Management & Grievances • Chart Audits • QIPS • HEDIS				

Case Manager Name:				
Key Areas of Orientation	**Trainer Initials**	**Employee Initials**	**Date Completed**	**Trainer**
10. Quality Improvement: Accreditation Requirements • Regulatory Requirements • NCQA Standards				
11. HIPAA				
12. Code of Conduct				
13. Cultural Competency				
14. Ethics • Advocacy for Member Needs • Professional Role • Conflict of Interest • CMSA Standards of Practice (copy provided to staff)				
15. Motivational Interviewing/Interviewing Techniques				

70.700.14 Monitoring BHO Enrollment and Progress toward Recovery

The most inspiring and gratifying experience in the CCS life cycle is the "graduation" of members from services and full integration into the community. Changes in acuity and improvement in functioning are the primary determinants of the member's ability to transition through the various acuity levels of the CCS program and achieve their goals. As a recovery-based system, APS firmly believes in the member's ability to manage their conditions and create a network of supports in the community to integrate fully and without dependence on formal case management services. In this sense, I ultimate goal for the case management system is to empower members and prepare them with the emotional, psychological and cognitive skills to manage their conditions and lives independently without the supports of the formal mental health system. We achieve this through collaboration and coordination of services, and through member education and advocacy. Members identified and enrolled in the CCS system require additional service beyond those offered by the traditional mental health system to support them in their ability to thrive in the community. These services are additional supports to boost members to their full potential and then integrate into the broader service array. The array of treatment and recovery support services available via the CCS system is critical to the overall treatment of the member. Treatment services such as psychosocial rehabilitation (PSR) , Intensive Outpatient Therapy (IOP) and Group Therapy provide the additional supports to provide therapeutic interventions to address needs identified in case management. Specifically, PSR as an adjunct to case management provides the perfect fit between service coordination and skills training; the very challenges and deficits often identified on the care of plan can be met through the education and training of members to move them to higher levels of functioning and independence. Professionals traditionally considered PSR offered in a classroom setting to help with this skill building. However, we know that adult learners thrive in experiential settings, and the didactic format of traditional PSR groups do not provide the customization to help members integrate these learned skills into their everyday lives. Rather, PSR conducted "in vivo" in groups within

the context of the community offer the highest rates of success, long-term skill development and generalized skill integration.

Through the acquisition and application of new psychosocial skills, members are better equipped to manage their day-to-day lives, as well as adapt to the constant changes in their recovery. Combined with better-coordinated care and improved communication and collaboration with their providers, members inevitably become learn the important skill of self-management critical to independence. Ultimately, the improved functioning, reduction of symptoms and decreased needs of members indicates to the case manager that the member is well equipped to manage independently in the community yet also armed with the knowledge and skills of how to access additional support appropriately in the future if needed. Achievement of care plan goals, reduction of problems and improvement in functioning, signals these changes, which a decrease in acuity reflects. APS as a BHO responsible for the assignment and oversight of overall case management services including acuity assignment will readily recognize the development of members in their progression towards recovery and can assist the case management programs in recommending members for discharge from case management and dis-enrollment from the CCS program. At the member level, the care plan documents a member's change in acuity in the care plan, as well as the specific steps agreed upon in the treatment plan. As members progress towards their goals, Case Managers should update the care plan to reflect members' evolving goals. In this sense, the ITP is truly the single best indicator of outcomes and success as well as the focal point of recovery.

70.700.15 Coordination of Enrollment and Disenrollment

Enrollment and dis-enrollment of members into the BHO is significant in that it definitively identifies the members eligible for this unique service, while differentiating them from the broader QExA membership. This delineation is significant not only on an individual level to ensure that members are receiving the most appropriate care available to them, but is also important from the systems level to ensure that the most vulnerable members are linked with the greatest supports designed to meet their needs. As such, the processes distinguishing between the two groups must be clear and definitive. Conversely, new members also require a delicate transition as they are quickly trying to adapt to new services and providers.

New Member Enrollment

The moment of inquiry initiates the new member enrollment process. As APS staff becomes aware of an inquiry of potential member eligibility, we offer additional support through this process through the disposition of the referral or application. In this sense, we manage all member inquiries as though they may be the initiation of services as all members identified as candidates because the plan or a provider identified concerns that the member was not receiving the full support needed or available to them. APS recognizes the potential in individuals and will do what it takes to support them through the best course of recovery. If a member is ultimately eligible for the CCS program, we match them individually with an appropriate case management provider and a coordinated hand-off is made from intake to services to ease the transition into the CCS service array. Our coordinated initial intake process is best suited to

welcome members into the CCS program and gently guide them to the broad service array available through the CCS program.

Member Disenrollment

Member disenrolled occurs from the CCS program based on either administrative or clinical factors, and members identified for disenrollment are receive equal supports in their transition back to the QExA plan. There are many circumstances, which may prompt disenrollment, and for whatever the reason, APS will support the member, providers, and health plan in the best approach to transition services.

Clinical Dis-enrollment

Members identified for dis-enrollment based on clinical reasons could include members who have recovered to the point of independence and no longer requiring additional behavioral health services and case management. We base a member's readiness for dis-enrollment on the continuous assessment conducted by the case manager and the progress the member is making towards achieving all of their goals on the care plan. Members who are making consistent progress towards their goals will require frequent updates to their care plans to keep pace with their changing needs and goals. As the evolution and update of the ITP is critical to determining the progress made towards goals and overall recovery, below is the policy and procedure on the ITP process, which highlights this importance. We include the APS corporate Policy and Procedure for Case Management Plans as Exhibit 11.

Administrative Dis-enrollment

Another manner in which members the CCS program may disenroll members may be due to administrative reasons. In this sense, members who move out of state, into a long-term care facility or incarcerated no longer meet the eligibility criteria for continued participation in the program. Additionally, members for whom the case management provider has conducted consistent assertive outreach attempts to locate a member who is unengaged or lost to service may also be identified for disenrollment in order to target clinical resources on members who are in an action phase in their readiness to change. This will ensure that those members for whom case management offers the greatest impact receive case management and other rehabilitative treatment resources. This is not to minimize the importance of engaging disenfranchised members into the formal mental health system. For this reason, we will establish a consistent assertive outreach protocol across case management providers to ensure that all members receive exhaustive efforts towards engagement. APS as a responsible BH will oversee and coordinate both the enrollment and dis-enrollment processes and serve as the liaison with the State and QExA plans in ensuring that all members recommended for dis-enrollment receive the same amount of intense and supportive services they receive upon their entry into the program. We believe it is our responsibility to ensure that the right people enter the program and produce the right amount of effort and outcomes with members before they exit the system.

70.800 Outreach and Education Programs

70.800.1 MEMBER SERVICES

Behavioral health services address the clinical needs of our members. CCS members may also need specialized services and supports, including language and transportation services. For optimal effectiveness, cultural competence should underlie all services, promoting a context of understanding and respect for members and their providers. APS currently supports the specialized needs of CCS members and has extensive experience in supporting specialized needs through our administration of waiver programs for people with SMI, Intellectual Disabilities, Autism Spectrum Disorder, Traumatic Brain Injury, and other issues. An important consideration for the BHO is to promote continuous enrollment in Medicaid and CCS for members – an essential component of continuity of service in the program. In this section, we describe our approach to delivering these services, highlighting our current process and describing how we will further enhance services for a broader population.

70.800.1.1 Member Education

APS and our network providers communicate with our members to promote understanding of behavioral health conditions, recommended and planned treatment, and the affect that treatment may have on their conditions, including side effects. We base our communication on members' clinical diagnoses and objective assessment of member needs. Case Managers document these factors in members' plans of care, which include treatment options members select in conjunction with their providers and Case Managers. The plan of care is securely maintained online in CareConnection and can be accessed by Case Managers and service providers on a 24/7 basis. Case Managers and members develop the plan of care together. Case Managers explain members' diagnoses to them, and discuss treatment options that their Case Managers suggest. This discussion also addresses any side effects that members might experience associated with medications. The Case Manager also discusses other needs the member may experience – housing, transportation, dental services, and medical care, for example.

The plan of care is comprehensive and includes clinical and non-clinical services. It is integrated, including behavioral health, medical treatments, and preventive services recommended for the member. APS monitors the plan of care against member utilization of authorized services to identify gaps in care resulting from low member adherence and other reasons. The comprehensive member record that we compile through APS CareConnection data integration serves as the tool for monitoring the plan of care. The APS Percolator escalates members through routine, urgent, and immediate prioritization of needs as documented in the plan of care, and notifies Case Managers concerning utilization events such as hospitalizations, gaps in care, upcoming prescription refills, appointments, re-assessments, and renewal of Medicaid eligibility. All network providers will have access to this tool in the next contract period and will be able to update and print the member plan of care. Case management agencies in the APS network will therefore be able to develop and support the plan of care for their members using the same integrated, efficient tool. APS will also be able to deliver technical assistance through this secure tool, helping providers document and manage member care.

The plan of care serves as the blueprint for member education. The optimal method of educating members is through face-to-face interactions. Since every member participates in a monthly face-to-face meeting at a minimum, continuing education through this method helps to reinforce members' understanding of the plan of care and related issues. Using face-to-face methods to deliver member education also helps Case Managers emphasize prevention and adherence to the recommended treatment. Through these interactions, Case Managers are also aware of areas that members may understand poorly or not at all and can act appropriately to improve member understanding.

We augment education delivered through the Case Manager interface with online and written materials for both members and providers. We will provide these materials in a variety of formats and languages to ensure all members find them accessible. We describe our approach to Cultural/Interpretation services in Section 70.800.1.2. These materials focus on general behavioral health, medical, program, and prevention topics rather than on member-specific information. We also address these topics with provider training sessions, so that providers can deliver and reinforce educational content with members. Providers and members will be able to download materials from the APS BHO website and/or request them through the toll-free contact line.

We use this approach so that providers and members have a shared understanding concerning program benefits and covered services, including how to access out-of-network services, utilization management requirements, services accessible through medical/behavioral integration, and how to access behavioral health and other service providers, including case managers.

70.800.1.2 Cultural/Interpretation Services

Accessing Oral Interpretation Services

APS currently meets RFP requirements for cultural/interpretation services and will continue to do so in the next contract period. We provide translation services, sign language interpreters, and Telecommunications Devices for the deaf (TDD) to assist people with limited English proficiency (LEP). APS arranges for sign language services using the Hawaii Services of Deafness, and currently maintains a TDD phone line to support telephonic communication with the hearing impaired. The ability of members to make good choices about their behavioral and other healthcare services depends on their understanding of their diagnoses and treatment options. For this reason, we ensure members have the resources they need to understand essential information about themselves and their plans of care. We provide these services at no cost to the member.

APS identifies LEP through member education and assessment processes. Our educational materials address assistive services that we offer at no cost such as TDD, sign language, and translator services. We post a statement concerning availability of these services on our website in prevalent languages. Members with differing vision and hearing abilities can also access educational content through Braille versions of member materials and TDD.

We notify members that oral interpretation services are available for their languages even if their languages do not meet the threshold of a prevalent non-English language. APS does not suggest that LEP members provide their own translations services, or that friends or family members should provide

translation services. Staff training on program requirements emphasizes both the availability of services and the prohibitions against suggesting members hire their own interpreters or use family/friends.

We recruit and hire Case Managers and other staff members who are multi-lingual and/or know sign language. Members may also request, and we will provide, translation services when APS Case Managers speak the member's language. We also train the provider community to ensure their awareness of the requirements for translation. For ready access to translators, APS will maintain an island-specific directory of available services that providers and Case Managers can access online. Members who call APS can access immediate translator support through the NetworkOmni translation service. APS uses "over the phone" translation, which offers live translation in over 150 languages including all prevalent non-English languages recognized by the State of Hawaii and other languages that are designated as prevalent. APS now offers video-teleconference for psychiatric services and medical management. Video remote interpretation is also available to support members and/or providers with LEP who access APS telemedicine services. Through these methods, APS provides complete linguistic access for members with LEP.

Documenting Language Preferences of Members

APS documents the language needs and preferences of members in CareConnection. We obtain this information from the member's eligibility record; from member assessments, self-reported language preferences, and requests for translation; and from other means such as provider notifications and requests for translation assistance for the member. The member's Case Manager can change the CareConnection language indicator at any time. Figure 13 displays the member Dashboard in CareConnection, showing the language indicator at the top right hand of the Dashboard display.

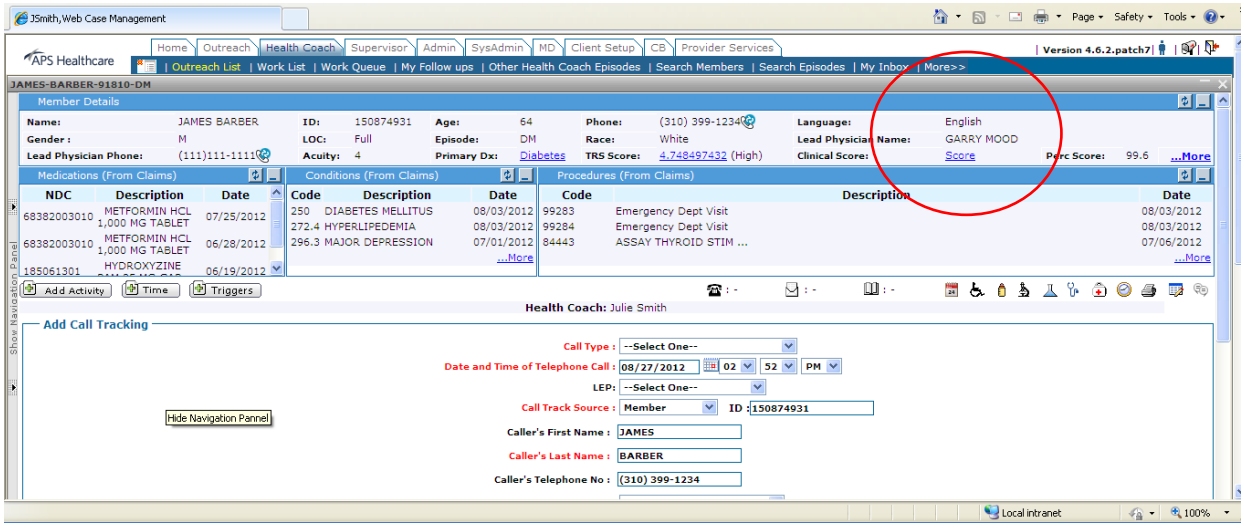


Figure 13. CareConnection Member Dashboard Language Indicator

APS provides access to this record for providers to facilitate easy identification of the member's clinical status, utilization, and other characteristics. CareConnection is an integrated utilization and case management system, and we also use the language indicator to alert us to the need to translate

member utilization review notifications to ensure that members are aware of the authorization status of services and their appeal rights should we issue a modification or denial of service.

Identifying Member Practices and Behaviors

As an organization with a diverse employee population in multiple states and territories, APS is aware of the relationship between health practices and behaviors and individual cultural perspectives and backgrounds. "Health culture" is a complex mix of perspectives in which religious/spiritual, nutrition, gender, and family factors interact with learning and behavior about wellness, illness, and care. What individuals believe about serious mental illness and its treatment in the context of their health cultures can dramatically influence their recovery. APS realizes that "ethnobehavioral care," that is, the development of care approaches that are culturally competent at the individual level, represents an essential foundation for members' plans of care.

Our approach to program, intervention, and service design incorporates this perspective in several ways. First, we conduct a discovery process to identify and understand the health cultures that are present in our member populations. An example of the importance of this exercise is the APS Behavioral Health Program in Maine. Widely viewed as a homogenously rural and Caucasian population, Mainers more recently are among the more diverse populations APS serves based on extensive immigration from the Sudan and other East African nations. Attitudes toward mental illness, personal behavior, and family roles are therefore a critical factor in the ability of individuals to recognize behavioral health issues and understand that treatment can be effective.

Second, our research and design reflects these factors. We incorporate strategies to integrate cultural competence into our intervention and service design, such as assignment of specific Case Managers, content and style of communications materials, and integration of family members and other individuals with significant cultural roles such as community elders into the plan of care.

Third, APS staff training includes a specific module on cultural competence to ensure that Case Managers and other staff members are aware of the influence of culture on health beliefs and behaviors. A significant strength of our local service center model is that by definition it incorporates cultural perspectives into operations through staff members who themselves represent local cultures.

Trained Case Managers identify cultural and language perspectives and barriers during the initial contact with the member and consider these characteristics when matching a member to a Case Manager and treating provider to ensure that interventions and services effectively address cultural preferences and remove language barriers. Our goal is to match a member to a provider that will respect cultural considerations, thereby enhancing the member's potential for recovery. It is essential that members understand their conditions, the recommended treatment and potential side effects, and the importance of adhering to the treatment regimen. The plan of care will include any services that may be available to reduce or overcome any of these barriers to care.

During the member intake and assessment process, Case Managers further identify cultural and/or communication barriers. Case Managers document members' unique cultural and/or linguistic needs in CareConnection. Case Managers review the member plan of care prior to face-to-face and/or telephonic contact with members to streamline case management and service delivery. For example, the APS Hawaii team schedules sign language translators in advance for in-person sessions with members who are hearing impaired and schedules the use of network providers such as Susannah Wesley Community Center for support for members who speak Japanese, Filipino, Samoan, Vietnamese, Chinese, and Chuukese in addition to providing translator services for members with other language needs.

Customized Communications and Support

APS maintains a library of program materials translated for non-English speaking members based on cultural discovery at the local level. In Hawaii, we routinely support communications in English, Japanese, Korean, Tagalog, Illocano, and Hawaiian. We are able to support all local languages with translations of verbal and written communications. APS also provides literacy assistance through an established relationship with the Hawaii Literacy Program. Volunteers actively participate with our members when requested. Several of our current members have successfully completed this tutoring.

Network Diversity and Specialty Providers

APS network development focuses on recruiting and retaining providers to maximize geographic, specialty, and cultural accessibility for our members. APS bases provider referrals on member preferences and characteristics to align members with appropriate providers. For members with disabilities, we identify appropriate providers and facilitate accessible and assistive services, such as wheelchair accessible transportation and specialty web browsers for people who are blind, for example.

70.800.1.3 Accessible Transportation Services

Many consumers have limited or no reliable transportation, particularly in rural areas and on the neighbor islands. Providing transportation is the only way to ensure they keep their appointments and receive the proper care. Our Case Managers assist members to access medically necessary behavioral health services as near as possible to their primary residence. Members can access assistance with transportation services by calling the APS member line and/or Hot Line.

If services are authorized on an island other than the one which the member resides (or out-of-State), we currently arrange and pay for travel, food and lodging for the member and an authorized attendant to access medically necessary behavioral health services in the most appropriate setting. We work closely with our members by:

- Arranging the most appropriate mode of transportation available, such as van transportation, Handivan and Akamai taxi; or
- Authorizing use of private vehicles for transportation and reimbursing gasoline and other costs;
- Purchasing bus passes for consumers.

In addition to making efficient use of private transportation methods, our use of the public transit system when it is safe for the member to do so can help the member become more self-sufficient and empowered. Case Managers educate members on how to access and use the public transportation system. As part of the APS employment process, we train all Case Managers to facilitate appropriate transportation for members.

70.800.1.4 Outreach

APS began services to the covered population since 2003 and we are keenly aware of the special needs our members have, and meet them on a daily basis. We engineered our field-based model for people with chronic conditions and SMI to meet the special needs of people who are poor, do not have stable housing arrangements, consistent telephones or contact numbers, or reliable transportation. We know that many people in our population cannot read or have very limited literacy and may speak English as a second language if at all. In Section 70.800, we have already discussed our approach to language translation, cultural competence, and transportation. In this section, we discuss our basic outreach model, which is field-based and community-activated.

Outreach starts with the Case Manager, who is an APS employee or an employee of a Case Management agency in the APS Network. Case Managers are accessible to the member in locations, selected by, convenient to and comfortable for the member.

This flexibility translates into the plan of care, which we design to identify, authorize, and facilitate delivery of medically necessary services in the most appropriate setting of care – and in this context, that setting may be the member's home, a shelter, the PCP's office, or street location for homeless members. Case Managers facilitate rapport with members by assisting them with immediate needs for daily living, or other appropriate means available to establish a relationship of trust and ensure involvement in the program. Also, as the member's advocate and personal services liaison, Case Managers provide transportation to appointments, assist in completing entitlement forms and respond to crisis situations 24 hours a day, seven days a week. APS Case Managers deliver services "sans frontieres" and we facilitate the delivery of other behavioral health services using the same principle of service where the member benefits most.

We activate community-based organizations to help us reach members and help members reach us. We work closely with agencies providing services to the homeless population on each island. Coordination includes daily communication and attendance at agency treatment team and discharge planning meetings to ensure continuity of care for our members. For members without a known address or phone number, a Case Manager contacts the member's DHS caseworker, provider-of-record and/or someone who knows the member. We make frequent efforts to find and engage members until we are successful. APS also visits homebound members, and arranges appropriate transportation to medical services or access to other assistive services through the QExA Plan. Case Managers also marshal community resources to support homebound members with meals and activities of daily living.

APS Case Managers are field-based and ideally located to coordinate services with PCPs, home health agencies, and other providers. Examples of support for individuals with special needs include providing specialized communications for people with cognitive impairments and transportation services that can accommodate wheelchairs, scooters and other assistance devices for the physically disabled.

Maintaining Eligibility: The Path to Continuity of Service

Field-based Case Managers work face-to-face with members to maintain benefits and eligibility for the CCS Program. APS monitors the date of each member's scheduled re-evaluation through an eligibility file update to our system. We then help the member assemble all required paperwork prior to the re-evaluation, and store it for members who are homeless or do not have suitable storage. Case Managers communicate with members, arrange transportation for, and accompany them to DHS/SSA appointments to meet eligibility and enrollment requirements.

APS also has specialized system tools to prioritize member eligibility determinations and help members prepare on a timely basis. Our proprietary Percolator tool uses CareConnection data to prioritize members for specific workflow activities, such as eligibility redeterminations. APS will configure the Percolator to provide 90-day notice of members' eligibility redetermination dates. The Percolator trigger will resolve when the system updates the members' eligibility with the new redetermination date. In the absence of this update, the Percolator will escalate the member's priority from routine at 90 days to urgent at 60 days to immediate at 30 days. This tool helps to ensure that APS works proactively with members to prevent loss of eligibility. If a member loses their coverage/eligibility, APS also assists with reapplying for benefits and we follow-up with the member and DHS for 60 days after loss of coverage.

APS also assists members to successfully complete disability paperwork and connect with the evaluating provider to facilitate evaluations for continued eligibility for DHS public assistance programs and certificates of disabilities from the DHS panel.

70.800.1.5 Appointment Follow-up

Treatment plan compliance and appointment follow-up are fundamental to the success of clinical treatment. The CCS Program uses a tracking system to ensure members with referrals for treatment are keeping scheduled appointments and following their treatment plan. Case Managers call their members on a regular basis to check in, provide support and monitor compliance with recommended treatment.

We follow up after scheduled appointments to verify that the member received the needed services. If members miss an appointment, we follow up immediately to determine why the member missed the appointment; help resolve the non-compliance issues; and schedule a new appointment. If members have difficulties arranging transportation or are reluctant to follow through with their treatment plans, the Case Manager will arrange transportation and/or accompany the member to the appointment.

When a member requires services provided by a BHO specialist or other practitioner, the member's Case Manager coordinates activities with the health plan PCP to facilitate necessary referrals and follow-up. APS provides follow-up after hospitalizations and tracks the timeliness of appointments. Case Managers

visit members within two days of discharge from an inpatient psychiatric hospitalization and arrange for an ambulatory visit with their behavioral health provider within seven days following discharge.

70.800.1.6 Hotline

Since inception, the Community Care Services (CCS) program has acted as a "safety net" for members by providing 24-hour, seven-day-a-week crisis response coverage through a toll-free hotline. The APS toll-free hotline is located in Hawaii. This crisis hotline has been instrumental in resolving crises as soon as they arise, diverting consumers from hospitalizations, and in providing continuity of care. In the next contract period, APS will provide toll-free hotline telephone services 24 hours a day, seven days a week, to ensure immediate access for both members and providers to critical information and behavioral health resources. Callers can confirm member eligibility, receive the name of the member's care manager or behavioral health provider, and arrange for prior authorization of services and referrals to an appropriate provider for all levels of care. Members and providers can also obtain information related to treatment of common behavioral health problems and minor emergency care. We inform members that in an emergency they are able to seek care from the nearest appropriate provider of care without authorization. APS will provide non-crisis hotline services, such as program information, contact information for regional Clinical Centers, provider network listings, etc. online as well as in hardcopy format. Members will be able to contact the Case Manager for non-crisis reasons using pagers. Response time will be a maximum of 30 minutes.

70.800.1.7 Adverse Events Policy/Reporting

As required by our URAC accreditation, APS has formal policies and procedures in place to identify and address adverse events that occur to our members. Adverse events include but are not limited to death, suicide attempts, altercations with law enforcement personnel (including incarceration), involvement with Adult Protect Services, homicide or attempted harm to others, medication errors, and injuries requiring medical attention. We will submit these policies to the DHS as required by RFP Section 41.100 30 days after the contract effective date for review and approval.

70.800.1.8 Certification of Physical or Mental Impairment

APS understands that the BHO is responsible to assist members to complete disability paperwork successfully and connect with the evaluating provider to facilitate evaluations for continued eligibility for DHS public assistance programs and certificates of disabilities from the DHS panel. APS currently conducts these activities and will continue to in the next contract period.

70.800.2 MEMBER TRANSITION

The safe transition of members into the CCS program is our priority. Members who transition successfully experience continuity of service with trusted medical and behavioral health providers in the context of enhanced benefits that the CCS program offers. APS has the policies and procedures, tools for communication and documentation, and trained staff to work with new members, creating an integrated system of safeguards to ensure successful transition. We understand the needs and

perspectives of members in high-risk populations, especially members who are physically disabled, homeless, or have other special needs. Having delivered programs for adults and children who are involved in the criminal justice and delinquent systems, our approach also recognizes and addresses the special needs of these individuals. In this section, we describe our plan for member transitions.

70.800.2.1 Referral/Coordination with Health Providers and/or CAMHD

With responsibility for case management of many high-risk consumers in our commercial and public programs, APS has formal, well-developed procedures to assure the successful transition for members. We describe these procedures here and highlight special considerations that inform our process.

I. **Receive and establish.** When APS receives referrals from the DHS, the first step is to establish member records in our system. We document the member, demographic information, address, providers, etc. CareConnection creates the electronic record with the receipt of member information in the updated eligibility file.

II. **Document and review.** We review the information on the referral and health plan assessment to identify member special needs if documented and providers who currently deliver services to members. We then validate the provider in our network, and if the provider is not currently in the network, the Provider Relations staff will initiate recruiting activities. The purpose of this process is to transition the member and the provider into CCS to promote continuity of service.

III. **Contact and Coordinate.** We assign a Case Manager to the member. Depending on the member's location and circumstances, the Case Manager will be an APS staff member or staff associated with case management agency in the member's vicinity, or which has specializations relevant to member needs. If the member has a Case Manager from the Health Plan, we coordinate with the Case Manager and the member's current behavioral health provider and PCP. Coordination includes contact to Case Managers and providers to introduce the CCS Case Manager, provide information about the benefits covered through CCS, gather information about the member's prior utilization, and create the coordinating communication with treating providers and health plan Case Managers. We will also work with the health plan to support members in the event they prefer to maintain the health plan Case Manager rather than new staff with CCS. The Case Manager performs the clinical assessment, which documents members' needs. This assessment is basis of information members, providers, and the Case Manager use to create the integrated plan of care.

A special consideration is for members who are transitioning from the Department of Health – Child and Adolescent Mental Health Division (DOH-CAMHD). These members may have relationships with the Child Psychiatrist and/or Psychologist at their Family Guidance Center (FGC) and will have a Care Coordinator at the FGC. Members and their families may have become familiar with the physical location, service provider, and Care Coordinator and it is

important to acknowledge these relationships as they evolve over a transitional period into CCS. We work with the FGC and health plan staff to facilitate the relationship between CCS and these new members. For example, with the approval of DOH-CAMHD we will meet with members at the FGC so that they continue to receive case management in familiar circumstances. Also for example, APS will train Case Managers and providers on the Child and Adolescent Service System Principles (CASSP), which guides DOH-CAMHD approaches, so that CCS providers will be familiar with and adhere to these principles.

The FGC Care Coordinator and CCS Case Manager will also coordinate together to support the transition of the relationship from the Care Coordinator to the CCS Case Manager. An additional factor in this instance is that the member may also be transitioning out of child services and into adult services. This process is significant for members and their families, involving changes to benefits and service levels and potential replacement of pediatric service providers, for example. Preparing to support these members requires a multi-faceted approach. We will coordinate in advance with the health plans and DOH-CAMHD for early identification of members who may be eligible for CCS so that we can prepare for these members pre-transition. Additionally, the CCS Case Manager will meet with face-to-face with members and their families to explain this transition, alerting members to changes in benefits, and assisting with recruitment of their providers into the CCS network. Importantly, Case Managers will also work directly with the health plans and providers to help members continue with pediatric PCPs and other providers in specialties relevant to the members' needs.

IV. **Follow-up and confirm.** As we establish the member's record, build the case file in CareConnection, conduct the assessment, and align provider resources with the member's assessed needs, we follow up frequently with all parties to ensure that the transition occurs successfully. This process includes formal meetings with other clinical staff such as the FCG Care Coordinator and health plan PCP, other providers, and Case Managers, as well as face-to-face engagement with the member, and informal meetings and calls with all parties. Through our work with members who have chronic illnesses and/or SMI/SPMI, we realize that defining handoff responsibilities and current, accurate information is the key to successful transition. We document and share member needs and concerns, preferences, experiences, and expectations; provider and plan background, treatment plans, concerns, and ideas for improvement; and current medications and services, for example, to build a comprehensive representation of each member in the context of the CCS program. With this information stored securely in CareConnection, providers and health plans will have access to this "community health record" in a HIPAA-compliant environment and will therefore have a single, common source of information about the member's plan of care, current providers, past diagnoses and utilization, and Case Manager. APS and/or network Case Managers will update this record on a daily basis or as frequently as member information changes. An important element of data in the record is the member's eligibility date – and

APS will use access to the community health record to alert plans and providers to the importance of maintaining the member's eligibility.

V. **Monitor and assure.** When members are receiving services from CCS service providers it is important to monitor the member's experience and utilization at multiple levels to assure that the transition has occurred and no issues have arisen as a result. As we describe In Section 70.700, Case Management, it is the responsibility of Case Managers to conduct face-to-face visits with members a minimum of once every month depending on acuity. These visits maintain the continuity of the Case Manager and member relationship, enable members to provide ongoing feedback about their experiences, and express concerns as needed. Case Managers also monitor the delivery of services as authorized within the plan of care to assure that members receive services that APS authorizes and reimburses. APS also provides automated tools that alert Case Managers to changes in member status. The integration of utilization management (UM) and case management through CareConnection is an example of these tools – the member's record is updated with UM determinations, care authorizations, and reimbursements. A significant benefit of the capitated environment that the BHO will create has to do with streamlining data integration, and with CVS Caremark as a PBM, CareConnection will incorporate pharmacy data on a real-time basis. CareConnection integrates the CCS network, information technology, and staffing for a system of management to support CCS members with quality behavioral health services.

70.800.2.2 Participation of Health Plan Providers

APS maintains an inclusive CCS network and makes it easy for providers to participate. During implementation, the APS provider relations staff will establish formal points of contact with each health plan, including clinical, member services, and provider relations departments to facilitate the transition of members into CCS with the participation of providers in the APS network to support and coordinate behavioral health services for high-risk members. Formal and informal meetings between APS and health plan contacts will ensure that we align our policies and procedures, information sharing agreements and processes are in place, and provider network requirements are coordinated. Having consistent and shared information and well-coordinated responsibilities for each aspect of member transition will eliminate confusion and ensure a seamless experience of service for members.

When members transition into CCS with providers that are not part of our network, APS will deem their providers based on credentialing information from the health plan. APS will also honor existing fee schedules and other contracting arrangements. This approach reduces the administrative burden on providers and delays associated with the contracting process, helping to ensure that members are able to access these services as in-network benefits. We recognize that not all providers will be interested in becoming part of the CCS network. When this situation occurs, we will work with the member to transition to an acceptable in-network provider within timeframes that are optimal for the member. Members will be able to continue to access services from their traditional provider(s) during this process, and APS will reimburse providers as out-of-network providers. APS recognizes the therapeutic

value of continuity of service. Should members be unable to transition to a new provider, APS will continue to support the member's relationship with legacy providers as an extended benefit.

70.800.2.3 Resolving Treatment Plans/Approaches

Members will transition into CCS having already received behavioral health services coordinated with health plan providers and PCPs. Once members become eligible for CCS because their service needs, diagnoses, and acuity exceed health plan levels, the CCS assessment may indicate new and modified services. To develop the plan of care, Case Managers meet with members, conduct assessments, and document recommended services after discussion with the member. With a well-documented model plan of care in CareConnection, Case Managers will be responsible to review the plan of care with the current PCP prior to finalizing it with the member. Case Managers will explain the CCS plan of care and discuss differences between the current treatment plan/approach and what the CCS Case Manager recommends. This process will resolve differences, respecting the PCP approach and incorporating PCP recommendations into the plan of care along with CCS perspectives. This process will also provide a quality assurance step that the CCS plan of care incorporates needed medical care as well as community and behavioral services. Through this step, APS ensures that the plan of care is integrated and holistic.

70.800.2.4 Maintaining Community Linkages

Community Care Services stakeholders include the health plan, DOH-CAMHD, the DOH Adult Mental Health Division (DOH-AMHD), and the DOH Alcohol and Drug Abuse Division (DOH-ADAD), and other community-based providers. APS will use multi-faceted methods and all levels of staff to engage and maintain this important, extended CCS community.

Staffing Approaches

The Medical Director, Administrator, Provider Relations, and Member Services functions are all community-facing positions. APS will reach out to community stakeholders to introduce these positions to the plans, Divisions, and providers through formal face-to-face meetings and calls and informal discussions with relevant community members. The BHO staff will be accessible members of this community and act as information resources about CCS at the program level and advocates at the individual member level. Case Managers will coordinate directly with the health plan at the member level concerning the plan of care, feedback about gaps in medical care, and coordination with PCPs.

APS proposes to enhance the Provider Services Department with the resources needed to establish and maintain linkages with these stakeholders. APS designates the Community Development Specialist position specifically for this purpose. The Provider Relations Manager will also work closely with the community. APS Program Manager Suzanne Smolkin will assist with the development of the provider services department in the next contract period. We include Ms. Smolkins' biosketch in Section 70.500, Organization and Staffing. Ms. Smolkin is an experience behavioral health professional and practitioner, and currently oversees provider and member services functions for national behavioral health center.

Regional Provider Summits

In addition to requiring CCS staff members to be proactive in maintaining close linkages with community stakeholders, APS will continue to convene Provider Summits. These summits are invitational meetings for all providers, will be held on a regional basis to promote access for a variety of providers, and serve as an informational forum where APS and providers exchange information, resolve system-level issues, and collaborate to improve the quality, timeliness, and integration of behavioral health and other services for CCS members. At the most recent Summit, held on August 14 at APS corporate location on Bishop Street, more than a dozen providers and AMHD staff attended to discuss improvement opportunities with APS staff and Medical Directors.

Provider Advisory Group (PAG)

The PAG is a more formal approach to collecting information from providers. APS currently facilitates the PAG for HMSA in QUEST and commercial plans. The PAG has formal input into the Quality Improvement Program (QIP), receives QIP updates and reports, and meets to discuss the quality of services on a quarterly basis. APS will develop and facilitate a CCS PAG to include plan representatives, community-based stakeholders and DOH-CAMHD, DOH-AMHD, and DOH-ADAD staff with approval of the DHS. The PAG will meet quarterly to review utilization and other reports and identify opportunities to improve integration and coordination of services among plans, providers and agencies. This process will enable APS to continually gather the perspectives of the stakeholder community about CCS processes and outcomes for members with SMI.

APS Healthcare

Specialty / County	Hawaii	Honolulu	Kauai	Maui	TOTAL
Inpatient Facilities	2	2	1	1	**6**
Behavioral Health Specialists					
Masters Level Therapist	12	30	2	5	**49**
Nurse Practitioner	0	2	2	1	**5**
Psychiatry	5	45	2	3	**55**
Psychologist	8	60	2	5	**75**
Other Behavioral Health Providers					
Clinic	11	18	1	3	**33**
Case Management	3	1	0	2	**6**
Crisis Services	0	0	0	2	**2**
Day Treatment Programs	3	5	1	1	**10**
Residential Treatment Programs	1	5	0	3	**9**
Substance Abuse Treatment	0	0	0	1	**1**
Transitional Housing	0	1	0	0	**1**
TOTAL PROVIDERS	**45**	**169**	**11**	**27**	**252**
TOTAL MEMBERS	**145**	**517**	**19**	**92**	**773**
Provider-Member Ratio	**1 : 3.2**	**1 : 3.1**	**1 : 1.7**	**1 : 3.4**	**1 : 3.1**

APS Healthcare

Provider Type	Island/ County (for Oahu also include city)	Last Name	First Name	Address	Suite	City	ST	Zip	Accepting new CCS Members (Y/N)	Any Limit on CCS Members (Y/N)
Behavioral Healthcare Specialist Services	Honolulu	Adair-Leland	Jean	4211 Waialae Ave	Ste 206 B	Honolulu	HI	96816	Y	N
Behavioral Healthcare Specialist Services	Hawaii	Adamson	Dave	32 Kino'ole St	Ste 103	Hilo	HI	96720	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Ahokovi	Melanie	86-260 Farrington Hwy		Waianae	HI	96792	Y	N
Behavioral Healthcare Specialist Services	Maui	Aiyana	Kelley	2511 S Kihei Rd	Ste 1	Kihei	HI	96753	Y	N
Behavioral Healthcare Specialist Services	Hawaii	Albatrosov	Albert	1045 Kilauea Ave		Hilo	HI	96720	Y	N
Behavioral Healthcare Specialist Services	Hawaii	Albatrosov	Albert	234 Waianuenue	Ste 105	Hilo	HI	96720	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Albatrosov	Albert	606 Coral Street		Honolulu	HI	96813	Y	N
Residential Treatment Programs	Maui	Aloha House		200 Ike Drive		Makawao	HI	96768	Y	N
Crisis Services	Maui	Aloha House	Lanai	730 Lanai Ave., #102		Lanai City	HI	96763	Y	N
Crisis Services	Maui	Aloha House	Wailuku	1787 Wili Pa Loop		Wailuku	HI	96793	Y	N
Community Based Case Management	Maui	Aloha House	Wailuku	270 Ho'okahi Street #207		Wailuku	HI	96793	Y	N
Outpatient	Maui	Aloha House	Wailuku	220 Imi Kala Street		Wailuku	HI	96793	Y	N
Substance Abuse Treatment	Maui	Aloha House	Wailuku	250 Waiehu Beach Road		Wailuku	HI	96793	Y	N
Behavioral Healthcare Specialist Services	Maui	Andrus	Jason	221 Mahalani Street		Wailuku	HI	96793	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Armstrong	Amanda	1600 Kapiolani Blvd	Ste 1650	Honolulu	HI	96814	Y	N
Behavioral Healthcare Specialist Services	Hawaii	Austin	Beatrice	101 Aupuni Street	Ste 250	Hilo	HI	96720	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Baile	Betsy	319 A North Cane Street	Ste A	Wahiawa	HI	96786	Y	N
Behavioral Healthcare Specialist Services	Hawaii	Baldwin	Howard	213 Ululani St		Hilo	HI	96720	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Banik	Donald	86-260 Farrington Hwy		Waianae	HI	96792	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Barham	Martha	615 Piikoi Street	Suite 2002	Honolulu	HI	96814	Y	N
Behavioral Healthcare Specialist Services	Maui	Bass	C.P.	1129 E Main Street	Ste 305	Wailuku	HI	96793	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Baumel	Lee	1188 Bishop Street	Suite 1106	Honolulu	HI	96813	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Beardsley	Gale	600 Kapiolani Blvd	Ste 402	Honolulu	HI	96813	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Beardsley	Rebecca	1833 Kalakaua Ave	#503	Honolulu	HI	96815	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Beardsley	Rebecca	845 22nd Ave		Honolulu	HI	96815	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Bell	Stephanie	86-260 Farrington Hwy		Waianae	HI	96792	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Belmonte	Glorifin	2239 N School Street		Honolulu	HI	96819	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Berkey	Trenda	98-211 Pali Momi Street	Suite 707	Aiea	HI	96701	Y	N
Day Treatment Programs	Hawaii	Big Island Substance Ab		135 Puuhonu Way	Ste 201	Hilo	HI	96720	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Blaisdell-Brennan	Helen	86-260 Farrington Hwy		Waianae	HI	96792	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Brandmand	JD	606 Coral Street		Honolulu	HI	96813	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Brennan	Jerry	651 Kaumakani St		Honolulu	HI	96825	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Bressem	Michael	98-1247 Kaahumanu Street	Ste 223	Aiea	HI	96701	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Bridge	Michael	1188 Bishop Street	Ste 2605	Honolulu	HI	96813	Y	N
Behavioral Healthcare Specialist Services	Kauai	Brown	Robert	4566 Ohia St		Kapaa	HI	96746	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Browne	Gregory	1221 Kapiolani Blvd	Ste 345	Honolulu	HI	96814	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Buffenstein	Alan	1100 Ward Ave	Ste 1070	Honolulu	HI	96814	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Buffenstein	Alan	1221 Kapiolani Blvd	Ste 345	Honolulu	HI	96814	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Bullen	Doris	1150 S King St	Ste 302	Honolulu	HI	96814	Y	N
Behavioral Healthcare Specialist Services	Hawaii	Care Hawaii Inc	Hilo Office	21 Kalanianaole Avenue	Building C	Hilo	HI	96720	Y	N
Behavioral Healthcare Specialist Services	Honolulu, Oa	Care Hawaii Inc	Honolulu Office	606 Coral Street	3rd Floor	Honolulu	HI	96813	Y	N
Behavioral Healthcare Specialist Services	Hawaii	Care Hawaii Inc	Kona Office	74-5620 Palani Road	Suite 212	Kailua Kona	HI	96740	Y	N
Behavioral Healthcare Specialist Services	Maui	Care Hawaii Inc	Maui Office	1598 Mill Street		Wailuku	HI	96793	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Carr	Linda	3705 Waialae Ave	#201	Honolulu	HI	96816	Y	N
Inpatient Behavioral Health Hospital Services	Honolulu	Castle Medical Center		640 Ulukahiki Street		Kailua	HI	96734	Y	N

Provider Type	Island/ County (for Oahu also include city)	Last Name	First Name	Address	Suite	City	ST	Zip	Accepting new CCS Members (Y/N)	Any Limit on CCS Members (Y/N)
Behavioral Healthcare Specialist Services	Honolulu	Central Oahu CMHC	Pearl City Clinic	860 Fourth Street		Pearl City	HI	96782	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Central Oahu CMHC	Wahiawa Clinic	910 California Avenue		Wahiawa	HI	96786	Y	N
Day Treatment Programs	Honolulu	Central Oahu CMHC	Waipahu Aloha clubhou	94-091 Waipio Pt. Access Road		Waipahu	HI	96797	Y	N
Behavioral Healthcare Specialist Services	Hawaii	Chabora	Nidhi	1045 Kilauea Ave		Hilo	HI	96720	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Chang	Kyle	86-260 Farrington Hwy		Waianae	HI	96792	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Charlton	Kimberly	1130 N Nimitz Hwy	C301	Honolulu	HI	96817	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Cho-Sutler	Laura	86-226 Farrington Hwy		Waianae	HI	96792	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Choy	Stephen	1314 S King St	Ste 720	Honolulu	HI	96814	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Clute	Rose	1374 Nuuanu Avenue		Honolulu	HI	96817	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Collis	Robert	1188 Bishop Street	Ste 607	Honolulu	HI	96813	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Collis	Robert	1441 Kapiolani Blvd	Suite 905	Honolulu	HI	96814	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Crabbe	Kamana'opono	86-260 Farrington Hwy		Waianae	HI	96792	Y	N
Behavioral Healthcare Specialist Services	Maui	Dawson	Terri	1325 Lwr Main Street	Ste 205D	Wailuku	HI	96793	Y	N
Behavioral Healthcare Specialist Services	Maui	de Guia	Christina	221 Mahalani Street		Wailuku	HI	96793	Y	N
Day Treatment Programs	Honolulu	Diamond Head CMHC	Diamond Head Clubhou	3627 Kilauea Avenue	Room 408	Honolulu	HI	96816	Y	N
Behavioral Healthcare Specialist Services	Hawaii	Donovan	Kelly	75-5591 Palani Road	Ste 3006	Kailua Kona	HI	96740	Y	N
Behavioral Healthcare Specialist Services	Hawaii	Donovan	Kelly	75-5751 Kuakini Hwy	Hwy 101	Kailua Kona	HI	96740	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Duke	Lisa	86-260 Farrington Hwy		Waianae	HI	96792	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Eagan	Amy	328 Uluniu St	#203	Kailua	HI	96734	Y	N
Behavioral Healthcare Specialist Services	Honolulu	East	Courtny	86-260 Farrington Hwy		Waianae	HI	96792	Y	N
Day Treatment Programs	Hawaii	East Hawaii CMHC	Hale O'luea Clubhouse	1045 B Kilauea Avenue		Hilo	HI	96720	Y	N
Behavioral Healthcare Specialist Services	Hawaii	East Hawaii CMHC	Hilo Clinic	37 Kekaulike Street		Hilo	HI	96720	Y	N
Behavioral Healthcare Specialist Services	Hawaii	East Hawaii CMHC	Honoka'a Clinic	45-3380 Mamane Street		Honoka'a	HI	96727	Y	N
Behavioral Healthcare Specialist Services	Hawaii	East Hawaii CMHC	Kamuela Clinic	67-5189 Kamamalu St.		Kamuela	HI	96743	Y	N
Behavioral Healthcare Specialist Services	Hawaii	East Hawaii CMHC	Pahoa Clinic	15-2866 Pahoa Village Road		Pahoa	HI	96778	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Ebesutani	Jenny	86-260 Farrington Hwy		Waianae	HI	96792	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Fairfax	Jon	1350 S King St	#325	Honolulu	HI	96814	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Ferrer	Maria	98-1238 Kaahumanu Street	Suite 302	Pearl City	HI	96782	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Feuer	Carrie	305 Lala Pl		Kailua	HI	96734	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Fisher	Jane	1188 Bishop Street	Suite 2302	Honolulu	HI	96813	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Fisher	Jane	6925 Niumalu Loop		Honolulu	HI	96813	Y	N
Behavioral Healthcare Specialist Services	Kauai	Foley	Michael	4374 Kukui Grove Street	#102	Lihue	HI	96766	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Fox	Evarts	1301 Punchbowl Street		Honolulu	HI	96813	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Fox	Evarts	1374 Nuuanu Avenue		Honolulu	HI	96817	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Frauens	Anne	680 Ala Moana Blvd.	Suite 306	Honolulu	HI	96813	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Fujimoto	Kevin Lee	45-955 Kamehameha Hwy	Ste 206	Kaneohe	HI	96744	Y	N
Behavioral Healthcare Specialist Services	Hawaii	Fujioka	Terry	79-7460 Mamalahoa Hwy	Ste 110	Kealakekua	HI	96750	Y	N
Behavioral Healthcare Specialist Services	Hawaii	Galiano	Cynthia	75-5751 Kuakini Hwy	Ste 201 A	Kailua Kona	HI	96740	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Giannasio	Joseph	606 Coral Street		Honolulu	HI	96813	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Gitter	Olaf	1350 S King St	#325	Honolulu	HI	96814	Y	N
Behavioral Healthcare Specialist Services	Maui	Goldberg	Margaret	1787 Wili Pa Loop		Wailuku	HI	96793	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Gomes	Joseph	86-226 Farrington Hwy		Waianae	HI	96792	Y	N
Behavioral Healthcare Specialist Services	Kauai	Graham	Jere	4566 C Ohia St		Kapaa	HI	96746	Y	N
Behavioral Healthcare Specialist Services	Kauai	Graham	Jere	3412 Hinahina St		Lihue	HI	96766	Y	N
Behavioral Healthcare Specialist Services	Hawaii	Ham	Shelley	169 Puueo Street		Hilo	HI	96720	Y	N
Behavioral Healthcare Specialist Services	Hawaii	Hansen	Bruce	101 Aupuni Street	#118	Hilo	HI	96720	Y	N
Behavioral Healthcare Specialist Services	Hawaii	Hashimoto	Don	56 Waianuenue Ave	Ste 202	Hilo	HI	96720	Y	N
Behavioral Healthcare Specialist Services	Hawaii	Heaster	John	122 Haili Street		Hilo	HI	96720	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Henry	Thomas	91-2301 Fort Weaver Rd		Ewa Beach	HI	96706	Y	N

Provider Type	Island/ County (for Oahu also include city)	Last Name	First Name	Address	Suite	City	ST	Zip	Accepting new CCS Members (Y/N)	Any Limit on CCS Members (Y/N)
Behavioral Healthcare Specialist Services	Honolulu	Herman	Lyle	1188 Bishop Street	Ste 3102	Honolulu	HI	96813	Y	N
Inpatient Behavioral Health Hospital Services	Hawaii	Hilo Medical Center		1190 Waianuenue Ave		Hilo	HI	96720	Y	N
Residential Treatment Programs	Honolulu	Hina Mauka		45-845 Po'okela Street		Kaneohe	HI	96744	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Hla	Mya	606 Coral Street		Honolulu	HI	96813	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Hla	Mya	2239 N School Street		Honolulu	HI	96819	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Horn	Mary	45-955 Kam Hwy	Ste 306	Kaneohe	HI	96744	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Horton	Jamie	86-260 Farrington Hwy		Waianae	HI	96792	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Huynh	Ann	86-260 Farrington Hwy		Waianae	HI	96792	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Huynh	Thuy	438 Hobron Lane	Ste 315	Honolulu	HI	96815	Y	N
Transitional Housing	Honolulu	Institute for Human Serv		546 Ka'aahi St		Honolulu	HI	96817	Y	N
Behavioral Healthcare Specialist Services	Maui	Jacobs	Karl	1135 Makawao Ave	Ste 226	Makawao	HI	96768	Y	N
Residential Treatment Programs	Honolulu	Kahi Mohala Hospital		91-2301 Old Fort Weaver Road		Ewa Beach	HI	96706	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Kai	Mutsuoki	1441 Kapiolani Blvd	Suite 2000	Honolulu	HI	96814	Y	N
Day Treatment Programs	Honolulu	Kalihi-Palama CMHC	Hale O Honolulu	1700 Lanakila Avenue		Honolulu	HI	96817	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Kaneshiro	Lisa	1266 Kamehameha Ave		Hilo	HI	96720	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Kang	Mark	PO Box 30160		Honolulu	HI	96820	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Kang	Michelle	86-260 Farrington Hwy		Waianae	HI	96792	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Kaplan	Aaron	438 Hobron Lane	Ste 315	Honolulu	HI	96815	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Kariel	Sasha	66-303 Haleiwa Rd	Suite 302	Haleiwa	HI	96712	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Kariel	Sasha	319 A North Cane Street	Ste A	Wahiawa	HI	96786	Y	N
Day Treatment Programs	Kauai	Kauai CMHC	Friendship House	4-1751 Kuhio Highway		Kapaa	HI	96746	Y	N
Behavioral Healthcare Specialist Services	Kauai	Kauai CMHC	Kauai Clinic	3-3212 Kuhio Highway		Lihue	HI	96766	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Keifer	Jason	4211 Waialae Ave	Suite 207	Honolulu	HI	96816	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Kemble	Stephen	1301 Punchbowl Street		Honolulu	HI	96813	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Kemble	Stephen	600 Kapiolani Blvd	Ste 402	Honolulu	HI	96817	Y	N
Behavioral Healthcare Specialist Services	Maui	Kennedy	James	2200 Main St	Ste 512	Wailuku	HI	96793	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Kiehl	Julia	56-119 Pualalea Street		Kahuku	HI	96731	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Kiehl	Julia	319 A North Cane Street	Ste A	Wahiawa	HI	96786	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Kim	Seungtai	1188 Bishop Street	Ste 3005	Honolulu	HI	96825	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Kim	Tammie	4747 Kilauea Ave	Ste 108	Honolulu	HI	96816	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Kiyota	Heide	319 A North Cane Street	Ste A	Wahiawa	HI	96786	Y	N
Residential Treatment Programs	Honolulu	Kline-Welsh Behavioral I		PO Box 3045		Honolulu	HI	96802	Y	N
Inpatient Behavioral Health Hospital Services	Hawaii	Kona Community Hospit		79-1019 Haukapila Street		Kealakekua	HI	96750	Y	N
Behavioral Healthcare Specialist Services	Hawaii	Kondo	Glenn	688 Kinoole Street	Suite 119B	Hilo	HI	96720	Y	N
Behavioral Healthcare Specialist Services	Hawaii	Koneck	Carolyn	74-5620 Palani Road	Ste 212	Kailua Kona	HI	96740	Y	N
Behavioral Healthcare Specialist Services	Maui	Kosel	Sandra	1325 S Kihei Rd	230A	Kihei	HI	96753	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Kou	Michael	98-1247 Kaahumanu Street	Ste 223	Aiea	HI	96701	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Koyanagi	Chad	1356 Lusitana St	Floor 4	Honolulu	HI	96820	Y	N
Outpatient Behavioral Health Hospital Services	Honolulu	Ku Aloha Ola Mau		1130 N Nimitz Hwy	C302	Honolulu	HI	96817	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Latimer	Renee	1374 Nuuanu Avenue		Honolulu	HI	96817	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Lawson	Marva	86-260 Farrington Hwy		Waianae	HI	96792	Y	N
Behavioral Healthcare Specialist Services	Hawaii	Lee	Devon	56 Waianuenue Ave	Ste 202	Hilo	HI	96720	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Lippert	Christina	1374 Nuuanu Avenue		Honolulu	HI	96817	Y	N
Residential Treatment Programs	Hawaii	Lokahi Treatment Cente		68-1845 Waikoloa Road	Suite 224B	Waikoloa	HI	96738	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Luke	Kenneth	600 Kapiolani Blvd	Ste 402	Honolulu	HI	96813	Y	N
Day Treatment Programs	Honolulu	Makaha CMHC	Hale Lahelahe Clubhous	84-1150 Farrington Hwy		Waianae	HI	96792	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Maki	Peggy	91-1001 Kaimalie St	Ste 201 A	Ewa Beach	HI	96706	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Makini	George	600 Kapiolani Blvd	Ste 402	Honolulu	HI	96813	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Makini	George	4057 Koko Dr		Honolulu	HI	96816	Y	N

Provider Type	Island/ County (for Oahu also include city)	Last Name	First Name	Address	Suite	City	ST	Zip	Accepting new CCS Members (Y/N)	Any Limit on CCS Members (Y/N)
Residential Treatment Programs	Maui	Malama Family Recover		1931 Baldwin Ave		Makawao	HI	96768	Y	N
Residential- Lanai	Maui	Malama Family Recover	Lanai	730 Lanai Ave., #103		Lanai City	HI	96763	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Malloy	Sharon	758 Kapahulu Ave	Ste A319	Honolulu	HI	96816	Y	N
Behavioral Healthcare Specialist Services	Maui	Mancini	Judith	210 Imikala Street	Suite 104	Wailuku	HI	96793	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Mancini	Judith	1221 Kapiolani Blvd	Ste 345	Honolulu	HI	96814	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Marvit	Roben	1314 S King St	713	Honolulu	HI	96816	Y	N
Behavioral Healthcare Specialist Services	Hawaii	Matsunami	Margaret	308 Kam Ave	Ste 209	Hilo	HI	96720	Y	N
Day Treatment Programs	Maui	Maui CMHC	Hale O Lanakila	1977 Main Street		Wailuku	HI	96793	Y	N
Behavioral Healthcare Specialist Services	Maui	Maui CMHC	Wailuku Clinic	121 Mahalani Street		Wailuku	HI	96793	Y	N
Maui Counseling Group	Maui	Maui Counseling Group	Wailuku	1787 Wili Pa Loop		Wailuku	HI	96793	Y	N
Inpatient Behavioral Health Hospital Services	Maui	Maui Memorial Medical (		221 Mahalani Street		Wailuku	HI	96793	Y	N
Behavioral Healthcare Specialist Services	Kauai	McKenna	Gerald	4374 Kukui Grove Street	Ste 104	Lihue	HI	96766	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Mee-lee	Denis	928 Nuuanu Ave	Ste 2	Honolulu	HI	96817	Y	N
Residential Treatment Programs	Honolulu	Mental Health Kokua		1221 Kapiolani Blvd	Suite 345	Honolulu	HI	96814	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Miller	Marian	1454 Akeke Place		Kailua	HI	96734	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Miyasato	Sherry	1374 Nuuanu Avenue		Honolulu	HI	96817	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Mizumoto	Mavis	1350 S King St	#325	Honolulu	HI	96814	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Mizumoto	Mavis	1802 A Keeaumoku	Suite 5	Honolulu	HI	96822	Y	N
Behavioral Healthcare Specialist Services	Hawaii	Moore	Jerri Ann	190 Keawe St	Ste 22	Hilo	HI	96720	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Moreno	Conrad	758 Kapahulu Ave	Ste A319	Honolulu	HI	96816	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Myers	Mary	1188 Bishop Street	Ste 3206	Honolulu	HI	96813	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Myhre	John	86-260 Farrington Hwy		Waianae	HI	96792	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Nakama	Helenna	1374 Nuuanu Avenue		Honolulu	HI	96817	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Neal	Randolph	1601 Punahou Street		Honolulu	HI	96822	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Needels	Terri	615 Piikoi Street		Honolulu	HI	96814	Y	N
Behavioral Healthcare Specialist	Honolulu	North Shore Mental Hea		99-128 # 704 Aiea Heights Drive		Aiea	HI	96701	Y	N
Behavioral Healthcare Specialist	Honolulu	North Shore Mental Hea		91-2141 Fort Weaver Rd.		Ewa	HI	96706	Y	N
Behavioral Healthcare Specialist	Oahu	North Shore Mental Hea		66-125 Kamehameha Hwy		Haleiwa	HI	96712	Y	N
Behavioral Healthcare Specialist	Hawaii	North Shore Mental Hea		297 Waianuenue Ave.		Hilo	HI	96720	Y	N
Behavioral Healthcare Specialist	Honolulu	North Shore Mental Hea		98-211 Pali Momi Street		Honolulu	HI	96701	Y	N
Behavioral Healthcare Specialist	Honolulu	North Shore Mental Hea		745 Fort St.	# 330	Honolulu	HI	96813	Y	N
Behavioral Healthcare Specialist	Honolulu	North Shore Mental Hea		95-1249 Meheula Parkway		Honolulu	HI	96813	Y	N
Behavioral Healthcare Specialist	Honolulu	North Shore Mental Hea		1286 Queen Emma Street		Honolulu	HI	96815	Y	N
Behavioral Healthcare Specialist	Honolulu	North Shore Mental Hea		200 N. Vineyard Boulevard		Honolulu	HI	96817	Y	N
Behavioral Healthcare Specialist	Honolulu	North Shore Mental Hea		928 Nuuanu Ave.	#2	Honolulu	HI	96817	Y	N
Behavioral Healthcare Specialist	Honolulu	North Shore Mental Hea		56-117 Pualalea Street		Kahuku	HI	96731	Y	N
Behavioral Healthcare Specialist	Hawaii	North Shore Mental Hea		94-1040 Mamalahoa Hwy.		Kamuela	HI	96743	Y	N
Behavioral Healthcare Specialist	Honolulu	North Shore Mental Hea		46001 Kamehameha Hwy.		Kaneohe	HI	96744	Y	N
Behavioral Healthcare Specialist	Hawaii	North Shore Mental Hea		B.I.S.A.C. Building		Kona	HI	96740	Y	N
Behavioral Healthcare Specialist	Honolulu	North Shore Mental Hea		981247 Kaahumanu St.	#310	Pearl City	HI	96701	Y	N
Behavioral Healthcare Specialist	Wahiawa, O	North Shore Mental Hea		302 California Ave	Suite 212	Wahiawa	HI	96786	Y	N
Behavioral Healthcare Specialist	Honolulu	North Shore Mental Hea		84-1170 Farrington Hwy.	#4	Waianae	HI	96792	Y	N
Behavioral Healthcare Specialist	Honolulu	North Shore Mental Hea		1110 University Ave.		Waikiki	HI	96826	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Oakes	Shirley	680 Ala Moana Blvd.	Suite 306	Honolulu	HI	96813	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Oune	Ronnie	520 Lunalilo Home Rd.	#250	Honolulu	HI	96825	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Palazzo	Michael	606 Coral Street		Honolulu	HI	96813	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Parker-Dias	Joan	1374 Nuuanu Avenue		Honolulu	HI	96817	Y	N
Residential Treatment Programs	Honolulu	Poailani, Inc.		553 Kawainui Street		Kailua	HI	96734	Y	N
Behavioral Healthcare Specialist Services	Hawaii	Pressel	Glenn	200 Kanoelehua Ave	Suite 262	Hilo	HI	96720	Y	N

Provider Type	Island/ County (for Oahu also include city)	Last Name	First Name	Address	Suite	City	ST	Zip	Accepting new CCS Members (Y/N)	Any Limit on CCS Members (Y/N)
Behavioral Healthcare Specialist Services	Hawaii	Preston	Elizabeth			Kailua Kona	HI	96740	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Quinn	Cynthia	98-1247 Kaahumanu St 223		Aiea	HI	96701	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Ralston	Kirsten	3599 Waialae Ave	3rd Floor	Honolulu	HI	96816	Y	N
Behavioral Healthcare Specialist Services	Hawaii	Ridley	David	56 Waianuenue Ave	Ste 202	Hilo	HI	96720	Y	N
Behavioral Healthcare Specialist Services	Maui	Roberts	Riggs	1883 Mill St		Wailuku	HI	96793	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Rohr	Anne-Marie	3454 Waialae Ave	#6	Honolulu	HI	96816	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Roscoe	David	45-1144 Kamehameha Hwy	Ste 402	Kaneohe	HI	96744	Y	N
Behavioral Healthcare Specialist Services	Hawaii	Rosen	Eliot	13-3564 Moku Street		Pahoa	HI	96778	Y	N
Behavioral Healthcare Specialist Services	Hawaii	Ross	D	73-4434 Mamalahoa Hwy		Kailua Kona	HI	96740	Y	N
Behavioral Healthcare Specialist Services	Maui	Rubenstein	R Susan	221 Mahalani Street		Wailuku	HI	96793	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Sakai-Costigan	Kristy	86-260 Farrington Hwy		Waianae	HI	96792	Y	N
Behavioral Healthcare Specialist Services	Hawaii	Sallee	Nancy	79-7460 Mamalahoa Hwy	Ste 214	Kealakekua	HI	96750	Y	N
Inpatient Behavioral Health Hospital Services	Kauai	Samuel Mahelona Memo		4800 Kawaihau Rd		Kapaa	HI	96746	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Seto	Dawn	1301 Punchbowl Street		Honolulu	HI	96813	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Seto	Dawn	1374 Nuuanu Avenue		Honolulu	HI	96817	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Shibata	Toshiyuki	600 Kapiolani Blvd	Ste 402	Honolulu	HI	96813	Y	N
Behavioral Healthcare Specialist Services	Kauai	Skow	Stephanie	4334 Rice St	Ste 203 A	Lihue	HI	96766	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Sliwowski	Donna	1286 Queen Emma St		Honolulu	HI	96817	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Spina	Laila	1188 Bishop Street	Suite 3509	Honolulu	HI	96813	Y	N
Behavioral Healthcare Specialist Services	Maui	Squires	Terri	1787 Wili Pa Loop		Wailuku	HI	96793	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Stein	David	1350 S King St	#325	Honolulu	HI	96814	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Stojanovich	Kosta	555 University	Ste 2303	Honolulu	HI	96826	Y	N
Behavioral Healthcare Specialist Services	Kauai	Stoll	Karin	3412 Hinahina St		Lihue	HI	96766	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Strauss	Marilyn	735 Bishop St	Ste 302	Honolulu	HI	96813	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Streltzer	Jon	1356 Lusitana St	Floor 4	Honolulu	HI	96820	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Sturgis	Laura	85-671 Farrington Hwy		Waianae	HI	96792	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Sturgis	Laura	2851 E Manoa Rd	Ste 1-203	Honolulu	HI	96822	Y	N
Case Management	Honolulu	Susannah Wesley Comr		1117 Kaili Street		Honolulu	HI	96819	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Taylor	Chad	86-260 Farrington Hwy		Waianae	HI	96792	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Teruya	Dustin	758 Kapahulu Ave	Ste A319	Honolulu	HI	96816	Y	N
Inpatient Behavioral Health Hospital Services	Honolulu	The Queen's Medical Ce		1301 Punchbowl Street		Honolulu	HI	96813	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Tomita-Ariyoshi	Dawn	86-260 Farrington Hwy		Waianae	HI	96792	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Tsukamoto	Donna	615 Piikoi Street	Ste 1409	Honolulu	HI	96814	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Twentyman	Craig	100 N. Beretania Street	Suite 208	Honolulu	HI	96817	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Unkrur	Paul	401 Kamakee St	Ste 401	Honolulu	HI	96814	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Vinson	Amber	438 Hobron Lane	Ste 315	Honolulu	HI	96815	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Wai	Angela	99-115 Alea Heights Drive	Suite 207	Aiea	HI	96701	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Watanabe	Karen	1481 S King St	Ste 523	Honolulu	HI	96814	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Watson	Mei Wah	86-260 Farrington Hwy		Waianae	HI	96792	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Watts	William	1374 Nuuanu Avenue	3rd Floor	Honolulu	HI	96817	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Welch	Robin	615 Pilko Street	Suite 1603	Honolulu	HI	90814	Y	N
Behavioral Healthcare Specialist Services	Hawaii	West Hawaii CMHC	Ka'u Clinic	219B Kaalaiki Road		Naalehu	HI	96772	Y	N
Behavioral Healthcare Specialist Services	Hawaii	West Hawaii CMHC	Kona Clinic	79-1020 Haukapila Street		Kealakekua	HI	96750	Y	N
Day Treatment Programs	Hawaii	West Hawaii CMHC	The Kona Paradise Clul	77-6435 Kuakini Highway		Kailua Kona	HI	96740	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Wiggins	John	PO Box 29640		Honolulu	HI	96820	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Williams	Steven	1356 Lusitana St	Floor 4	Honolulu	HI	96820	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Windward Oahu CMHC	Kaneohe Clinic	45-691 Keaahala Road		Kaneohe	HI	96744	Y	N
Day Treatment Programs	Honolulu	Windward Oahu CMHC	Ko'olau Clubhouse	46-016 Alaloa Street		Kaneohe	HI	96744	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Windward Oahu CMHC	Ko'olauloa Clinic	54-010 Kukuna Road		Hauula	HI	96717	Y	N

Provider Type	Island/ County (for Oahu also include city)	Last Name	First Name	Address	Suite	City	ST	Zip	Accepting new CCS Members (Y/N)	Any Limit on CCS Members (Y/N)
Behavioral Healthcare Specialist Services	Kauai	Winnes	John	4374 Kukui Grove Street	Ste 102	Lihue	HI	96766	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Wolf	Robert	1188 Bishop Street	Suite 1106	Honolulu	HI	96813	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Wood	Carol	615 Piikoi Street	Suite 1409	Honolulu	HI	96814	Y	N
Behavioral Healthcare Specialist Services	Maui	Wright	Lynda	2200 Main St	Ste 505	Wailuku	HI	96793	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Wright	Nicole	86-260 Farrington Hwy		Waianae	HI	96792	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Wu	Edward	46-001 Kamehameha Hwy	Suite 304	Kaneohe	HI	96744	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Yamada	Lynn	1374 Nuuanu Avenue		Honolulu	HI	96817	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Yamamoto	Charlene	1221 Kapiolani Blvd	Ste 345	Honolulu	HI	96814	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Young	Robert	86-260 Farrington Hwy		Waianae	HI	96792	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Yuen	Gregory	1188 Bishop Street	Ste 806	Honolulu	HI	96813	Y	N
Behavioral Healthcare Specialist Services	Honolulu	Zafrani	Michael	98-1247 Kaahumanu Street	Ste 312 A	Aiea	HI	96701	Y	N

Provider/Member Geographic Analysis
Hawaii Community Care Services Program

September 14, 2012

This analysis uses current information on members enrolled in Hawaii's Community Care Services (CCS) Program and APS' Behavioral Health provider network to show compliance with the provider access parameters set by the program. The program requires that all members located in urban areas (Honolulu) are within a 30 minute drive radius of a Behavioral Health provider, and that members located in other rural areas are within a 60 minute drive radius of a Behavioral Health provider.

Summary Findings:

All 773 current Community Care Services enrolled members (100%) are within the required drive radius from a Behavioral Health provider.

Methods:

The most current member information was obtained from our database containing CCS eligible members. The provider data was obtained from our current provider network information. Both the member and provider data included what is believed to be the most current address information. Microsoft® MapPoint 2010 was used to determine the geographic location of each member and provider. This software also has the capability of calculating drive radius from any location it is able to plot. Of the 775 members run through the MapPoint software, 621 were found by the address information provided, 151 were located based on the member zip code and 3 were located by hand. Of the 234 providers run through the MapPoint software, 220 were found by the address and 14 were located based on provider zip code.

Summary Statistics:

Providers (252):	6 Inpatient Facilities
	184 Behavioral Health Specialists
	62 Other BH Providers (RTC, Subst Tx, Case Mngmt, Day Tx, Clinic)
Members (773):	517 Oahu
	145 Hawaii
	92 Maui
	19 Kauai

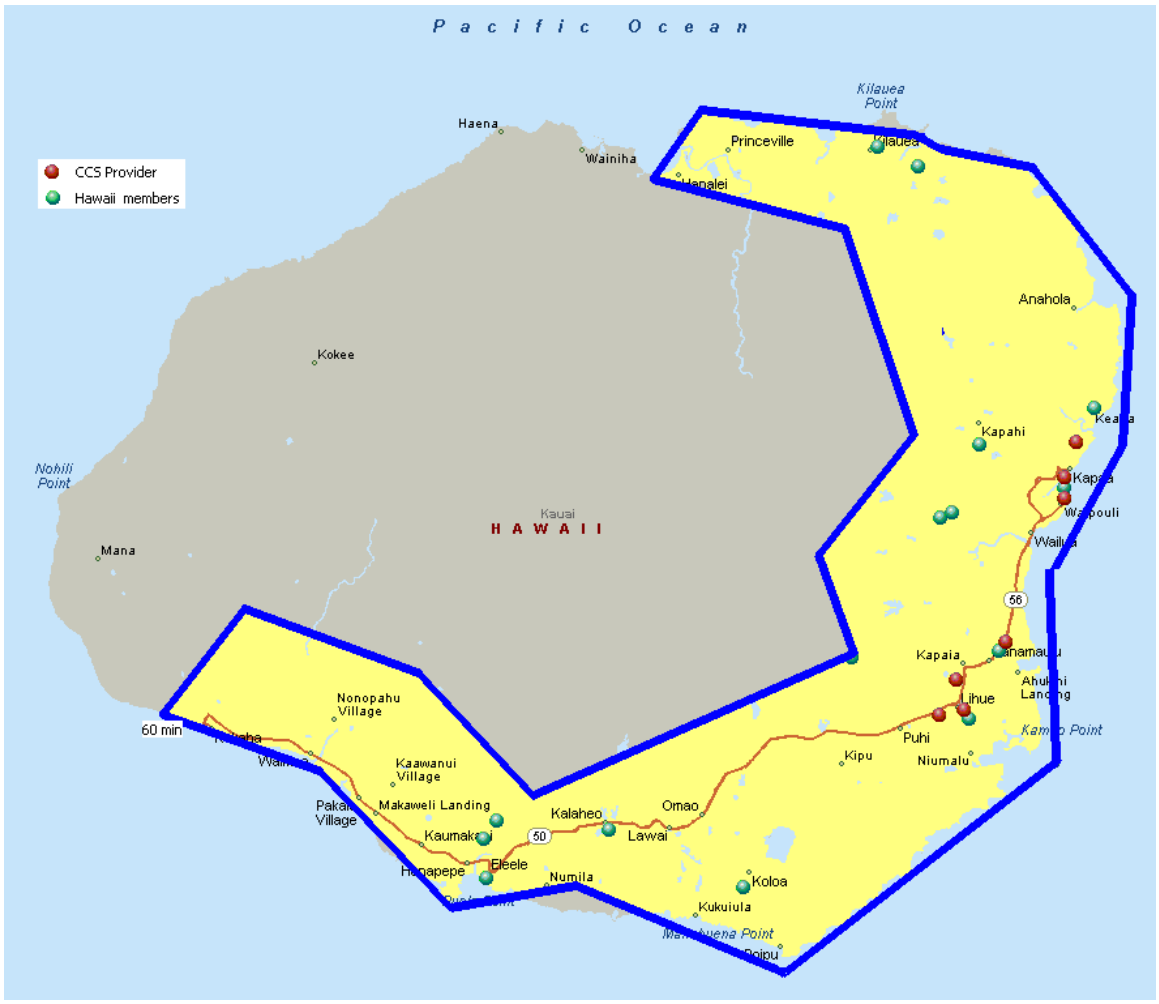
Specialty / County	Hawaii	Honolulu	Kauai	Maui	TOTAL
Inpatient Facilities	2	2	1	1	**6**
Behavioral Health Specialists					
Masters Level Therapist	12	30	2	5	**49**
Nurse Practitioner	0	2	2	1	**5**
Psychiatry	5	45	2	3	**55**
Psychologist	8	60	2	5	**75**
Other Behavioral Health Providers					
Clinic	11	18	1	3	**33**
Case Management	3	1	0	2	**6**
Crisis Services	0	0	0	2	**2**
Day Treatment Programs	3	5	1	1	**10**
Residential Treatment Programs	1	5	0	3	**9**
Substance Abuse Treatment	0	0	0	1	**1**
Transitional Housing	0	1	0	0	**1**
TOTAL PROVIDERS	**45**	**169**	**11**	**27**	**252**
TOTAL MEMBERS	**145**	**517**	**19**	**92**	**773**
Provider-Member Ratio	**1 : 3.2**	**1 : 3.1**	**1 : 1.7**	**1 : 3.4**	**1 : 3.1**

Maps:

There are 4 maps, one for each of the primary islands where all members and providers are located. The maps show a green dot for the geographic location of each current CCS eligible member. A red dot is used to show the geographic location of each behavioral health provider. The maps also include a line for the drive radius around each provider. The blue line represents a 60 minute rural drive radius and is found on all 4 islands. The red line represents a 30 minute urban drive radius. It is only found on the island of Oahu and includes the providers located in the Honolulu MSA.

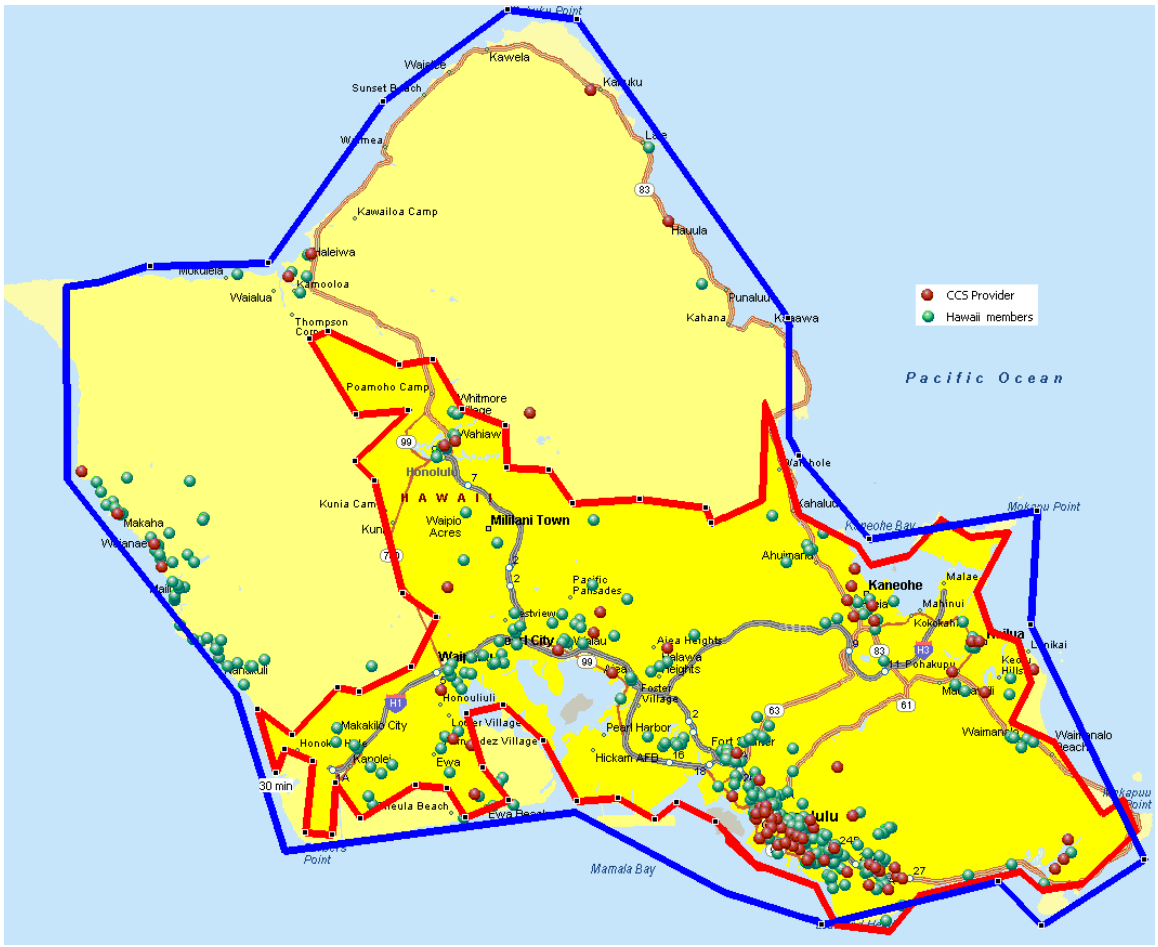
Provider Accessibility Summary: Kauai

Population	**19 Members**
Providers	**1 Inpatient Facility** **8 Individual BH Specialists** **2 Other**
Provider Ratios	**Inpatient: 19 : 1** **BH Specialists: 2.4 : 1** **Other: 9.5 : 1**
Access Standard	**60 Minute Drive Radius**
Access Compliance	**100% Compliance**



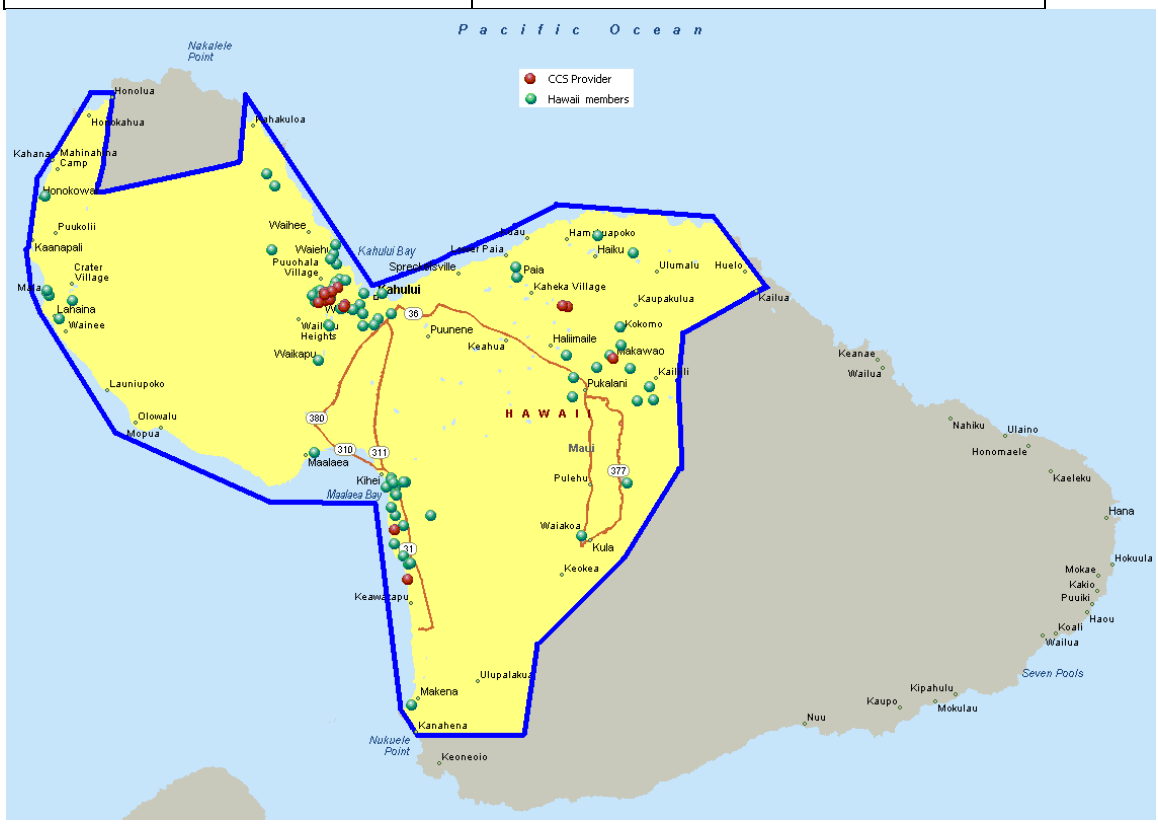
Provider Accessibility Summary: Oahu

Population	**517 Members**
Providers	**2 Inpatient Facilities** **137 Individual BH Specialists** **30 Other**
Provider Ratios	**Inpatient: 285.5 : 1** **BH Specialists: 3.8 : 1** **Other: 17.2 : 1**
Access Standard	**30 Minute Drive Radius (Urban)** **60 Minute Drive Radius (Rural)**
Access Compliance	**100% Compliance**



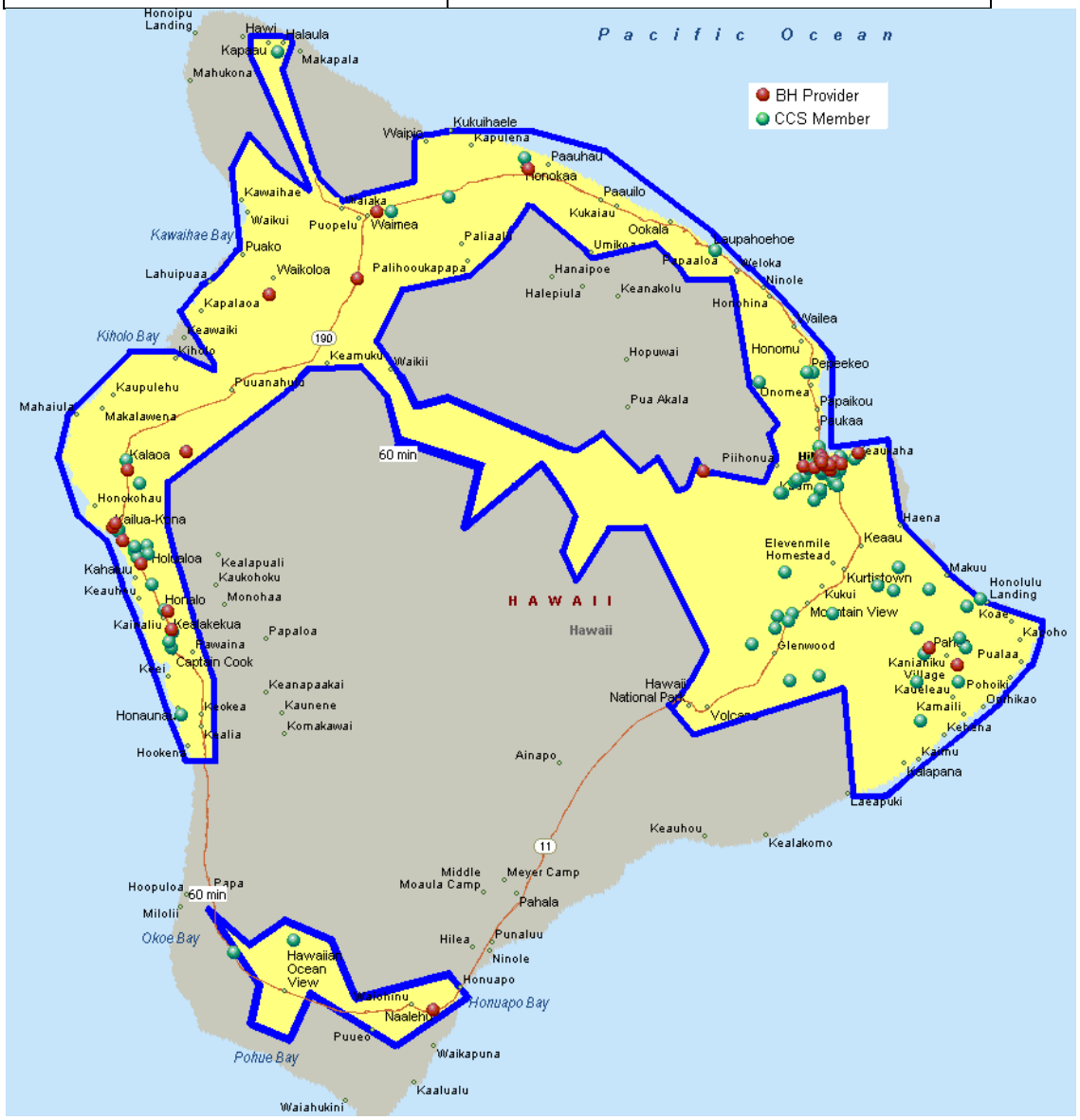
Provider Accessibility Summary: Maui

Population	**92 Members**
Providers	**1 Inpatient Facility** **14 Individual BH Specialists** **12 Other**
Provider Ratios	**Inpatient: 92 : 1** **BH Specialists: 6.6 : 1** **Other: 7.7 : 1**
Access Standard	**60 Minute Drive Radius**
Access Compliance	**100% Compliance**



Provider Accessibility Summary: Hawaii

Population	**145 Members**
Providers	**2 Inpatient Facility** **25 Individual BH Specialists** **18 Other**
Provider Ratios	**Inpatient: 73.5 : 1** **BH Specialists: 5.8 : 1** **Other: 8.1 : 1**
Access Standard	**60 Minute Drive Radius**
Access Compliance	**100% Compliance**



APS Healthcare

LETTER OF INTENT (LOI) TO ENTER INTO CONTRACT NEGOTIATIONS WITH APS HEALTHCARE FOR PROVISION OF BEHAVIORAL HEALTH SERVICES TO CCS MEMBERS

This letter is subject to verification by the Hawaii Department of Human Services (DHS). A provider should not sign this LOI unless he or she intends to enter into contract negotiations with APS Healthcare for the provision of behavioral health services to Community Care Services (CCS) members. Signing this LOI does not obligate the provider to sign a contract with APS Healthcare for the provision of behavioral health services to CCS members.

APS Healthcare is proposing to participate in the CCS program. The provider signing below is willing to enter into contract negotiations with APS Healthcare, for the provision of behavioral health services to CCS members enrolled with APS Healthcare as indicated below.

This provider intends to sign a contract with APS Healthcare if APS Healthcare is awarded the CCS contract **and** an acceptable agreement can be reached between the provider and APS Healthcare.

NOTICE* TO *PROVIDERS:
This LOI will be used by the DHS in its bid evaluation and contract award process for the CCS RFP. You should only sign this LOI if you intend to enter into contract negotiations with APS Healthcare should they receive a contract award. If you are signing on behalf of a physician, please provide evidence of your authority to do so.

Do not return completed L0I to the DHS. Completed L0I needs to be returned to APS Healthcare via Fax, or Email.

→ FAX (Oahu number): APS Healthcare, Attention: Leni Davis, Provider Relations: (808) 952-4451

→ Email: edavis@apshealthcare.com

1. **PROVIDER'S SIGNATURE** _____
2. **DATE:** 8/28/12
3. **PRINTED NAME OF SIGNER:** Terri Sowers FNP-C, PMHNP-C
4. **TITLE OF SIGNER:** APRN-RX, FNP-C, PMHNP-C
5. **PRINTED NAME OF PROVIDER (IF DIFFERENT FROM SIGNER):** _____
6. **APS HEALTHCARE REPRESENTATIVE'S SIGNATURE** _____
7. **DATE:** August 28, 2012
8. **PRINTED NAME OF SIGNER:** Kenneth N. Luke, M.D.
9. **TITLE OF SIGNER:** Medical Director

APS Healthcare

September 12, 2012

Dan Kehoe, PhD
CEO
North Shore Mental Health
56-117 Pualalea Street
Kahuku, HI 96731

Re: Letter of Intent for Network Participation

Dear Dr. Kehoe:

The purpose of this letter is to confirm and document the mutual intent of APS Healthcare Bethesda, Inc. ("APS") and North Shore Mental Health ("Provider") for Provider's participation in APS' network of independent providers under its anticipated program with the State of Hawaii, Department of Human Services (the "Department") regarding the provision of Behavioral Health Services to Medicaid members (the "Program").

APS is in the process of submitting a proposal to the Department for the provision of services under the Program beginning March 1, 2013. If awarded the contract, APS desires to include Provider in its network under the Program and Provider wishes to participate in such network. Pursuant to this mutual intent, APS and Provider shall negotiate in good faith a definitive service agreement (the "Provider Service Agreement"). The negotiation shall commence as soon as practicable, but no later than 60 days from the date of Program award. The negotiations can be initiated by either the Provider or APS.

The Provider Service Agreement shall contain the following provisions, and other provisions mutually agreed upon by the parties:

Services
Provider shall provide a listing of all services the Provider is capable of performing as allowed in the State of Hawaii.

In recognition of underserved areas in the State of Hawaii, such as the islands of Molokai and Lanai or portions of the State such as Hana, Maui. The Provider shall provide a proposal for a scope of services that would allow for access to, and/or availability of, services to those eligible members as designated in the Department's Request for Proposal for Behavioral Health Services.

The scope of services to be discussed shall meet the requirements as listed in section 40.800 of the Department's Request for Proposal for Community Care Services (CCS) That

Provides Behavioral Health Services to Medicaid Eligible Adults who have a Serious Mental Illness (RFP-MQD-2013-007).

Compensation
Provider shall be paid the applicable Medicaid rate for services provided, or as allowable under the Program and mutually agreed upon by the parties.

Term and Termination
The Provider Services Agreement shall be effective on March 1, 2013, and continue with an initial term of one year and subsequent automatic annual renewal terms.

In recognition of Provider's existing patient relationships and the importance of continuity of care, APS shall not terminate the Provider Services Agreement on a "without cause" basis during the initial one year term.

In addition, except as required or directed by the Department, or in the event of material breach of the terms of the Provider Services Agreement, there shall be a minimum of a 60 day notice of termination by either party.

The Provider Services Agreement shall contain "without cause" and "for cause" termination provisions mutually agreed upon by the parties, as well as termination provisions required by applicable law, regulation or Department requirements.

Contractual Requirements
The Provider Services Agreement shall contain all provisions required by applicable law, regulation or Department requirements. In addition, Provider shall comply with all APS rules and requirements relating to network providers, and APS shall administer such rules and requirements in a nondiscriminatory manner.

Completion of Provider Services Agreement
The parties shall exercise best efforts to complete negotiation of the Provider Services Agreement on or before the contract effective date. The parties shall negotiate in good faith, and meet as appropriate for the prompt completion of the Provider Services Agreement.

Please sign and date this letter in the space provided below to document and confirm the agreement of the terms of this Letter of Intent by North Shore Mental Health.

Thank you for your cooperation on this matter. APS looks forward to continued discussions with you and completion of the Provider Services Agreement.

Sincerely,

Richard S. Chung, M.D.
Chief Clinical Officer

Agreed and Accepted:

North Shore Mental Health, Inc.

By: _____

Title: DIRECTOR - NORTH SHORE MENTAL HEALTH, INC.

Date: 9-13-12

APPENDIX C

STATE OF HAWAII
STATE PROCUREMENT OFFICE
PROPOSAL APPLICATION IDENTIFICATION FORM

STATE AGENCY ISSUING RFP: Department of Human Services, Med-Quest Division

RFP NUMBER: RFP-MQD-2013-007

RFP TITLE: Community Care Services (CCS) That Provides Behavioral Health Services to Medicaid Eligible Adults who have Serious Mental Illness

Check one:
☒ Initial Proposal Application
☐ Final Revised Proposal (Completed Items _____ - _____ only)

1. APPLICANT INFORMATION

Legal Name: APS Healthcare Bethesda, Inc.

Doing Business As:

Street Address: 44 South Broadway, Suite 1200
White Plains, NY 10601

Mailing Address: Same as above.

Contact person for matters involving this application:
Name: Cynthia Weinmann
Title: Vice President of Sales
Phone Number: 240-315-5416
Fax Number: 914-288-4605
e-mail: cweinmann@apshealthcare.com

2. BUSINESS INFORMATION

Type of Business Entity *(check one)*:

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

If applicable, state of incorporation and date incorporated:
State: Iowa Date: 1992

3. PROPOSAL INFORMATION

Geographic area(s): N/A

Target group(s): N/A

4. FUNDING REQUEST

FY N/A		FY	
FY		FY	
FY		FY	
		Grand Total	

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

J. Vaccaro — Sept. 10, 2012
Authorized Representative Signature — *Date Signed*

Jerome V. Vaccaro, President & CEO
Name and Title

SPO-H 200 (Rev.9/06)

STATE OF HAWAII

Department of Human Services

PROPOSAL LETTER

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

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

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

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

J. Vaccaro — Sept. 10 2012

Authorized Offeror's Signature/Corporate Seal — Date

APS Healthcare Bethesda, Inc.

Incorporated IOWA 1992

CERTIFICATION FOR CONTRACTS, GRANTS, LOANS AND COOPERATIVE AGREEMENTS

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

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

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

Offeror: Jerome V. Vaccaro
Signature: J. V. Vaccaro
Title: President & CEO
Date: September 10, 2012

DISCLOSURE STATEMENT

Instructions

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

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

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

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

Description of Transaction(s)	Name of Related Party and Relationship	Dollar Amount for Reporting Period
None		

Justification

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

Description of Transaction(s)	Name of Related Party and Relationship	Dollar Amount for Reporting Period
None		

Justification

DISCLOSURE STATEMENT

BHO NAME/NO. APS Healthcare Bethesda, Inc.

DISCLOSURE STATEMENT FOR THE YEAR ENDED 2011

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

September 10, 2012
Date Signed

Jerome V. Vaccaro, President & CEO
Chief Executive Officer (Name and Title Typewritten)

Notarized

Signature

CHRISTINA SHEAN
Notary Public - State of New York
No. 01SH6200596
Qualified in Westchester County
My Commission Expires: 02/02/20

DISCLOSURE STATEMENT
OWNERSHIP

BHO Name, BHO No.: APS Healthcare Bethesda, Inc.
Address (City, State, Zip): 44 South Broadway, Suite 1200 White Plains, NY 10601
Telephone: 800-305-3720

For the period beginning: January 2013 and ending _____ Type of BHO:

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

Type of Entity:

- [X] Sole Proprietorship
- [ ] Partnership
- [ ] Corporation
- [ ] Governmental

- [X] For-Profit
- [ ] Not-For-Profit
- [ ] Other (specify)
- [ ] _____

455.104 Information on Ownership arid Control

a. List the names and addresses of any individuals or organizations with an ownership or controlling interest in the disclosing entity. "Ownership or control interest" means, with respect to the entity, an individual or organization who (A)(1) has a direct or indirect ownership interest of 5 per centum or more in the entity, or in the case of nonprofit corporation, is a member; or (ii) is the owner of a whole or part interest in *any* mortgage, deed or trust, note, or other obligation secured (in whole or in part) *by* the entity or any of the property or assets thereof, which whole or part interest is equal to or exceeds 5 per centum of the total property and assets of the entity; or (B) has the ability to appoint or is otherwise represented by an officer or director of the entity, if the entity is organized as a corporation; or (C) is a partner in the entity, if the entity is organized as a partnership.

Name	Address	Percent of Ownership Control
Universal American	6 International Drive, Suite 190 Rye Brook, NY 10573	100%

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

Name	Address	Percent of Ownership Control
Universal American	6 International Drive, Suite 190 Rye Brook, NY 10573	100%

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

Name	Address	Percent of Ownership Control
N/A		

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

Name	Address	Percent of Ownership Control
N/A		

455.105 Information Related to Business Transactions

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

Describe Ownership of Subcontractors	Type of Business Transaction with Provider	Dollar Amount of Transaction
N/A		

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

Describe Ownership of Subcontractors	Type of Business Transaction with Provider	Dollar Amount of Transaction
N/A		

455.106 Information on Persons Convicted of Crime

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

Name	Address	Title
N/A		

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

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

Name/Title	Address
Jerome V. Vaccaro, President & CEO	10 Fox Den Road Mount Kisco, NY 10549
John McDonough, CFO	88 LaCosta Drive Annadale, NJ 08801
Richard Surles, CDO	1614 Tillman Drive Montvale, VA 21422

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

Name/Title			Address				
Name	Address	Title	2012 Salary	Bonus	Cash Compensation		Stock Shares#
Vaccaro, Jerome	10 Fox Den Rd. Mount Kisco, NY 10549		President & CEO APS Healthcare	$475,000	$165,000	$640,000	123,000
McDonough, John	88 La Costa Drive Annandale, NJ 08801		CFO	$350,000	$90,000	$440,000	52,125
Brown Lee, Joanne	3633 Lone Wolf Trail St. Augustine, FL 32086		Chief Operating Officer	$250,000	$170,000	$420,000	16,975
Glazer, David	146 Hills Station Road Southampton, NY 11968		SVP Operations	$257,500	$115,000	$372,500	8,775
Chung, Richard	7724 Kalohelani Place Honolulu, HI 96825		Chief Clinical Officer	$300,000	$50,000	$350,000	11,925
Surles, Richard	1614 Tillman Drive Montvale, VA 24122		Chief Development Officer	$278,500	$60,000	$338,500	10,200
Cardona, Alex	P O Box 366984 San Juan, PR 00936		President - Puerto Rico	$240,000	$70,000	$310,000	17,801
Ehrenreich, Judy	1004 Commercial Avenue Anacortes, WA 98221		Chief HR Officer	$253,500	$50,000	$303,500	6,000
Tichy, Joyce	13 Blossom Terrace Larchmont, NY 10538		Chief Legal Officer	$253,500	$45,000	$298,500	8,376
Schwartz, Talya	526 E 20th St. New York, NY 10009		VP Clinical Prod. Devlp.	$254,800	$25,000	$279,800	2,450

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

Name	Address	Amount of Debt	Description of Security
N/A			

Financial Reporting Guide Forms
Organization Structure and Financial Planning Form

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

      APS Healthcare Bethesda, Inc. was established in 1992.

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

Jerome V. Vaccaro , President 10 Fox Den Road Mount Kisco, NY 10549	John McDonough, CFO 88 LaCosta Drive Annadale, NJ 08801	Richard Surles, CDO 1614 Tillman Drive Montvale, VA 24122

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

Service Component	License/Requirement	Renewal Date

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

      Yes X No _____ If yes, please explain:

In 2011, APS Healthcare Bethesda, Inc. applied for a Third Party Administrator license in the State of Indiana which was denied. Had the State of Indiana accepted our consolidated financial statement for Partner Healthcare Solutions, Inc. our application would have been approved. However, our stand alone subsidiary company financial statement did not meet their statutory requirements.

3) Civil Rights Compliance Data

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

   Yes _____ No X If yes, please explain:

4) Handicapped Assurance

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

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

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

5) Prior Convictions

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

None

6) Federal Government Suspension/Exclusion

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

Yes _____ No X If yes, please explain:

Financial Planning Form

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

2) Does the offeror prepare an annual financial statement?

   Yes X No _____ If yes, please explain:

3) Are interim financial statements prepared? Yes X No _____

   a. If yes, how often are they prepared? MONTHLY

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

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

   d. If yes, provide a copy of the latest statements including all necessary data to support your answers in (a) through (c) above. SEE APPENDIX 1 (ATTACHED)

4) Is the offeror audited by an independent accounting firm/accountant?
   Yes X No _____

   a. If yes, how often are audits conducted? SEE APPENDIX 1 (ATTACHED)

   b. By whom are they conducted? SEE APPENDIX 1 (ATTACHED)

   c. Did this auditor perform that offeror's last audit? SEE APPENDIX 1 (ATTACHED)
      Yes X No _____
      If no, provide the name, address, and telephone number of the firm that performed the offeror's last audit.

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

Yes _____ No X

SEE APPENDIX 1 (ATTACHED)

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

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

e. Do you have any uncorrected audit exceptions?

Yes _____ No X

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

5) Does the offeror have an accounting manual?

Yes _____ No X

SEE APPENDIX 1 (ATTACHED)

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

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

Yes X No _____

Explain principal allocation techniques used or to be used. Note the allocation base used for each type of cost allocated. SEE APPENDIX 1 (ATTACHED)

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

a. With what company(s)? ATTACHED

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

8) Provide a complete analysis of revenues and expenses by business segment (lines of business) and by geographic area (by county) for the offeror or its owner(s). SEE APPENDIX 1 (ATTACHED)

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

Briefly describe each item and indicate probable amount.
SEE APPENDIX 1 (ATTACHED)

10) Has the offeror or its owner(s) ever gone through bankruptcy?
Yes _____ No X

If yes, when? _____

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

If yes, describe the dollar amount(s) and source(s) of all funding. SEE APPENDIX 1 (ATTACHED)

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

12) Does the offeror have a performance bonding mechanism in accordance with DHS rules?
Yes _____ No X

If yes, provide the following information:

Amount of Bond $ _____
Term of Bond _____
Bonding Company _____
Restrictions on Bond _____

If no, describe how the offeror intends to provide a bond and/or security to meet established DHS rules. SEE APPENDIX 1 (ATTACHED)

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

Yes X No _____

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

a. Is your system capable of accurately forecasting all significant claims prior to receipt of all billing? Yes X No _____

b. How often are IBNRs projected? MONTHLY

c. Identify all major data sources most often used.

d. Are data from open referrals and prior notifications used?

Yes _____ No X If so, how?

e. Are detailed written procedures maintained? Yes _____

No X

f. Are IBNR amounts compared with actuals and adjusted when necessary?

Yes X No _____

g. Is the basis of periodic IBNR estimates well documented?

Yes X No _____

h. The offeror must provide a copy of their IBNR procedures and a summary of their IBNR practices. If these procedures do not adequately support any response to this item the offeror is cautioned to provide additional data. SEE APPENDIX 1 (ATTACHED)

Please identify the developer and name of any computerized IBNR system utilized. Indicate if it is administered by internal or external staff. If administered by external staff, state by whom, define how the offeror will control this function. Specify what other IBNR estimation methods will be used to test the accuracy of IBNR estimates, along with the primary system previously identified. (For the purposes of this item "administered" refers to either performing computer related operations or to providing direct supervision of staff operating a system). SEE APPENDIX 1 (ATTACHED)

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

Yes X No _____ If yes, enter name: Craig Barattin, Controller; John McDonough, CFO

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

a. Medicare reimbursement Yes _____ No X

b. Other third-party recoveries Yes _____ No X

If no, explain why. SEE APPENDIX 1 (ATTACHED)

Appendix I

General Note

Effective March 2, 2012, the Company was acquired by Universal American, Inc. ("UAM"), a publicly traded company, and now operates as a wholly-owned subsidiary of UAM. We report our financial results on a monthly basis and our results are then consolidated into our parent company.

3d. As a wholly owned subsidiary of a publicly traded company, we cannot release financial information. Please refer to the most recently filed March 31, 2012 10-Q by our parent company, UAM for all available consolidated financial information.

4 a., b. and c. Prior to being acquired by UAM on March 2, 2012, we were audited by an independent audit firm, Deloitte and Touche, LLP on an annual basis. Our last standalone audit was for fiscal year 2010; no audit was required for 2011 due to the pending acquisition. As of March 2, 2012, we are now a wholly owned subsidiary of UAM and our financial results are included in UAM's consolidated results. As a publicly traded company, UAM is subject to quarterly reviews and filing of respective form 10-Qs, along with annual audits of its financial statements and the filing of form 10K, and accordingly as a wholly owned subsidiary of UAM, we are now included in the scope of the respective procedures performed during the reviews and audits. UAM's review and audit procedures are performed by the independent accounting firm Ernst & Young.

4 d. and 5. We did not receive a management letter from our auditors in connection with our 2010 audit (last standalone audit). Since the Company was acquired by a publicly traded entity, we are now required to become Sarbanes Oxley ("SOX") compliant with respect to our internal controls. We are in the process of compiling all the required documentation and such internal control processes will be audited by Ernst & Young over the remainder of 2012 with a target completion date of December 31, 2012 for SOX compliance. As such our internal control environment would be included in UAM's overall control environment report issued by Ernst and Young going forward.

6. The Company currently allocates certain IT expenses (i.e. telephony/software) based on specific projects and/or headcount.

8. As a wholly owned subsidiary of a publicly traded company, we cannot release financial information. Please refer to the most recently filed 10-Q by our parent company, UAM, for all available consolidated financial information.

9. The Company does not comment on specific litigation. There are no pending litigation matters that would adversely affect the ability to provide services under this agreement or adversely affect the company's financial condition.

11. Our parent company, UAM has sufficient capital to provide funding for all necessary payments of related liabilities on a timely basis in connection with this business, if necessary.

12. We do not currently have any performance bonds in Hawaii; however, if we are awarded this contract, we will obtain all necessary performance bonds to service the business in accordance with the DHS rules.

13. On a monthly basis we record cost of care and the corresponding liability based on authorized days and the budgeted rate for our acute care. We book Outpatient expense/liability based on the history of claims lag due to the volatility of that type of care. The liability is then reduced for paid claims during the month for each risk contract. Using third-party software, (internally managed), we calculate the estimated unpaid claims liability. Based on history, seasonality, trend, and other known factors, management analyzes and discusses the variance between the calculated liability and the actual IBNR balance. Based on those discussions the IBNR balance may or may not be adjusted.

15. The Company does not currently engage in any Medicare transactions; however our parent Company, UAM, does provide Medicare services as part of its business.

Controlling Interest Form

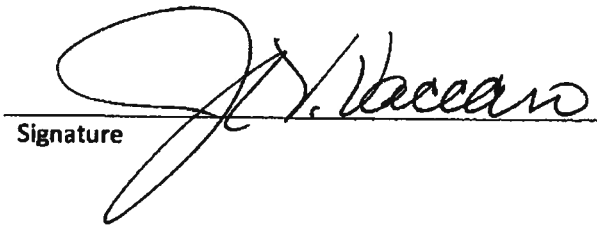
The offeror must provide the name and address of any individual which owns or controls more than ten percent (10%) of stock or that has a controlling interest (i.e., ability to formulate, determine or veto business policy decisions, etc.). Failure to make full disclosure may result in rejection of the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

Name	Address	Owner or Controller	Has Controlling Interest? Yes	No
N/A				

Operational Certification Submission Form

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

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



Signature

Sept. 10, 2012

Date

Operational Certification Submission Form

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

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

Signature

Sept. 10, 2012

Date

Grievance System Form

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

I hereby certify that APS Healthcare Bethesda, Inc.
Offeror Name

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

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

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

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

Authorized Signature — Sept. 10, 2012 (Date)

Jerome V. Vaccaro (Printed Name) — President & CEO (Title)

INSURANCE REQUIREMENTS CERTIFICATION

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

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

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

(Check and complete one)

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

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

_____

_____

_____

_____

_____

_____

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

APS Healthcare Bethesda, Inc.

Name of Offeror

J. Vaccaro

Authorized Representative Signature

September 10, 2012

Date

Jerome V. Vaccaro, President & CEO

Print Name and Title

Wage Certification

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

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

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

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

Offeror: Jerome V. Vaccaro
Signature: J. V. Vaccaro
Title: President & CEO
Date: September 10, 2012

CONTRACT NO. _____

PROVIDER'S
STANDARDS OF CONDUCT DECLARATION

For the purposes of this declaration:

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

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

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

On behalf of:

APS Healthcare Bethesda, Inc.

(Name of PROVIDER)

PROVIDER, the undersigned does declare as follows:

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

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

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

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

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

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

CONTRACT NO. _____

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

PROVIDER

By _____ (Signature)

Print Name Jerome V. Vaccaro

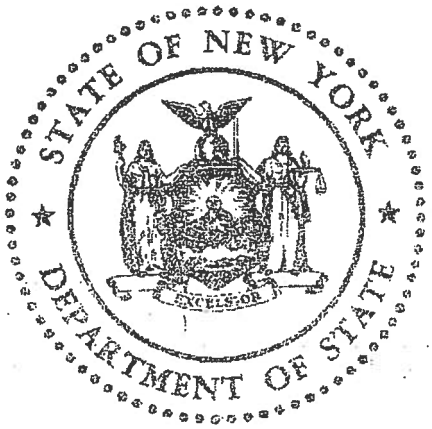
Print Title President & CEO

Date September 10, 2012

State of New York
Department of State } ss:

I hereby certify, that AMERICAN PSYCH SYSTEMS, INC., a IOWA corporation, filed an Application for Authority to do business in the State of New York on 01/04/2000. I further certify that so far as shown by the records of this Department, such corporation is still authorized to do business in the State of New York.

A certificate changing name to APS HEALTHCARE BETHESDA, INC. was filed on 02/01/2001.



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WITNESS my hand and the official seal of the Department of State at the City of Albany, this 26th day of March two thousand and twelve.

First Deputy Secretary of State

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APS HEALTHCARE BETHESDA INC.
ATTN: UBA OGBEUEHI
44 SOUTH BROADWAY STE 1200
WHITE PLAINS NY 10601

Enclosed is the information you requested. Your payment of $50.00 is hereby acknowledged.

If the name on the enclosed document(s) does not match exactly with the name of the entity you requested, this office does not have a record of the exact name you requested. The document(s) provided appear(s) to be of sufficient similarity to be the entity requested.

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