STATE OF HAWAII

DEPARTMENT OF HUMAN SERVICES

MED-QUEST DIVISION

KAPOLEI, HAWAII

Legal Ad Date: August 20, 2012

REQUESTS FOR PROPOSAL

No. RFP-MQD-2013-007

COMPETITIVE SEALED PROPOSAL

Community Care Services Program (CCS) That Provides Behavioral Health Services To Medicaid Eligible Adults who have a Serious Mental Illness

Will be received up to 12:00 p.m., Hawaii Standard Time (H.S.T.)

On September 17, 2012

In the Department of Human Services

Med-QUEST Division

1001 Kamokila Boulevard, Suite 317

Kapolei, Hawaii 96707

VALUEOPTIONS®
Innovative Solutions. Better Health.

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: Response to Hawaii DHS/RFP-MQD-007, Community Care Services

Dear Ms. Watanabe:

Thank you for this opportunity to respond to the above-referenced Hawaii Department of Human Services' RFP. ValueOptions offers the proven experience working with state-level Medicaid programs to provide quality, culturally-sensitive and local systems of care that result in reduced costs of care and improved clinical outcomes. Through our 15 years spent serving a wide variety of Medicaid contracts, our clinical programming, implementations, network development and technological innovations have established us as the Medicaid market leader. We look forward to providing Hawaii's Medicaid consumers with the same high quality, innovative and highly effective care that we bring to our 53 other public sector contracts throughout the country.

In compliance with section 70.200 of the RFP, please regard the following statements:

- ValueOptions is a private, for-profit corporation, and wholly owned subsidiary of FHC Health Systems, Inc. For the current contract, we do not intend to use any subcontractors under the definition of a subcontractor relationship, provided with the Q&A document accompanying Addendum 3, as ". . . joint or multiple organizations . . . bidding on the contract (as described in Section 10.400)."

  ValueOptions does have plans to contract with Mental Health Kokua (MHK), Helping Hands Hawaii (HHH) and other case management entities across the state (to be determined) for case management services for consumers referred by ValueOptions, who are part of the Community Care Services (CCS) program.

- ValueOptions is registered to do business in Hawaii and has obtained a State of Hawaii General Excise Tax License. Our Hawaii Excise tax number is W49156040-01.

- ValueOptions confirms our receipt of the following amendments issues to this RFP:
  - Amendment 1: issued on August 24
  - Amendment 2: issued on August 27
  - Amendment 3: issued on August 30

- ValueOptions does not discriminate in 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.

- ValueOptions does not use subcontractors as "joint or multiple organizations bidding on the contract." ValueOptions only employs subcontractors who are providing services (i.e., transportation, interpreter services, PBM). While ValueOptions, Inc. is bidding on this contract, it will utilize a wholly owned subsidiary to perform the contract through a management agreement with ValueOptions, Inc.

- ValueOptions confirms that no attempt has been made or will be made by ValueOptions to induce any other party to submit or refrain from submitting a proposal.

- ValueOptions confirms that the person signing this proposal certifies that she is the person within our organization responsible for and authorized to make decisions as to the prices quoted, that the offer is firm and binding, and that she has not participated and will not participate in any action contrary to the above conditions.

- ValueOptions confirms that we have read, understand and agree to all provisions of this RFP.

- ValueOptions confirms that, if awarded the contract, ValueOptions will deliver the goods and services meeting or exceeding the specifications in the RFP and amendments.

The following content has been marked "Proprietary and Confidential":

- Section 70.300 Proposal Narrative
  - any references to named staff for the purposes of this or any other ValueOptions contract
- Section 70.400 Company Background and Experience
  - any listing of ValueOptions' public sector contract, either within the body of the response or as an addendum, as marked
- Section 70.500 Staffing
  - any reference to specific person named as ValueOptions current or prospective employees, including all resumes, job descriptions and biographical information
  - ValueOptions' organizational charts detailing corporate and regional staffing structures
  - all professional and member references, including the names and contact information of entities listed as prospective partners
- Section 70.600 Provider Networks
  - reference to behavioral health agencies with whom ValueOptions may become affiliated
  - any persons or locations named in our recruitment efforts
  - all provider listing information provided in the Appendix G template
- Section 70.700 Case Management
  - any reference to ValueOptions proprietary information management system
- Attachment C: Forms
  - all personal information including but not limited to Board of Directors compensation, addresses, date of birth and other personal information as marked

- any and all company financial disclosures, including but not limited to any transactional information, audited financial statements, management letters, and interim reports, as marked
- any ValueOptions policy and procedure included as an attachment
- corporate legal information, not limited to ValueOptions list of sanctions and audits

- Any additional information, as indicated and marked in accordance with the RFP guidelines set forth in section 20.900.

Substantial competitive harm would occur if any of this information is released, as it comprises trade secrets and/or personal, financial or otherwise proprietary information that would place ValueOptions at a considerable competitive disadvantage, both for the purposes of this procurement, and throughout the marketplace at large.

We thank you again for this opportunity to respond to the State of Hawaii's Department of Human Services' RFP, and look forward to assisting you as you seek the optimal behavioral health partner to serve your needs.

Sincerely,

Amy Grazer
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70.200: TRANSMITTAL LETTER

70.300: PROJECT NARRATIVE

70.400: COMPANY BACKGROUND AND EXPERIENCE

1. 70.410: Background of the Company
2. 70.420: Company Experience

70.500: ORGANIZATION AND STAFFING

1. 70.510: Organization Charts
2. 70.520: Personnel Resumes

70.600: PROVIDER NETWORK

70.700: CASE MANAGEMENT

70.800: OUTREACH AND EDUCATION PROGRAMS

OTHER DOCUMENTATION: ATTACHMENT C

A. Proposal Application Identification Form
B. State of Hawaii DHS Proposal Letter
C. Certification for Contracts, Grants, Loans and Cooperative Agreements Form
D. Disclosure Statement (CMS) Required
E. Disclosure Statement
F. Disclosure Statement Ownership Form
G. Organization Structure and Financial Planning Forms
H. Financial Planning Form
I. Controlling Interest Form
J. Background Check Information Form
K. Operational Certification Submission Form
L. Grievance System Form
M. Insurance Requirements Certification Form
N. Wage Certification Form
O. Standards of Conduct Declaration Form
P. State and Federal Tax Clearance Certificates Statement

ATTACHMENTS

70.400: Company Background and Experience
1. Medicaid Experience Chart
2. Sanctions and Audits

70.500: Organization and Staffing
1. Resumes
2. Signed Member Releases
3. Case Management Organization LOIs

70.600: Provider Network
1. Provider LOIs
2. Appendix G Formatted List of Providers

70.300: PROPOSAL NARRATIVE

The proposal narrative shall clearly and concisely condense and highlight the contents of the proposal and provide DHS with a broad understanding of the entire proposal. The proposal narrative shall explain how the offeror will implement the CCS program consistent with the requirements of this RFP if a contract is awarded to them.

Our Understanding of the Project

The State of Hawaii has made the care of people experiencing a serious mental illness a high priority for many years. We understand the Med-QUEST Division of the Department of Human Services is seeking to improve access and quality of care for its members, while at the same time improving the effective and efficient use of scarce financial resources.

Even in the best of times, these can be difficult objectives to accomplish simultaneously in proper balance. In the present environment where the demand for behavioral health services often far outpaces the supply of providers, and where government officials face an unprecedented expansion of Medicaid eligibility, the challenge of doing more for the highest need members with less—and doing it better than it has ever been done before—takes on a special urgency.

The State's Community Care Services (CCS) Request for Proposal is straightforward— to select a Behavioral Health Organization that will case manage, authorize, and facilitate the delivery of coordinated behavioral health services to Medicaid eligible individuals in the QUEST Expanded Access Program experiencing a serious mental illness. ValueOptions, with its industry-leading scope of 53 publicly-funded programs under management in 15 states, has a rich foundation of knowledge and experience for designing and providing the requested services for the most complex members—and we have an excellent list of government client references as testament to our capabilities. You have asked that we demonstrate our proven ability in multiple key areas that are central to the role of a Behavioral Health Organization. We do this in detail throughout our proposal.

You will read about our clinical strengths and our experience in case management and care coordination, not only between traditional and non-traditional behavioral health services, but also among medical providers, health plans, and community resources. We believe that you will come to understand that recovery and resiliency are at the heart of our organization, and central to everything we do to create local systems of care and support members. We explain how we build, credential, monitor, and continuously improve our behavioral health networks. We provide extensive detail about our outreach and education programs, and the mechanisms we have established for monitoring and measuring satisfaction at both the member and provider levels. We explain how our operations will be performed by a dedicated team located here in Hawaii. And most importantly, you will be assured that our one-of-a-kind technology platform enables a level of data integration, clinical integration, and real-time reporting that is unequaled in the industry. Our technology story is an important cornerstone of our value to you, because

our advanced technology and information system enables us to commit to implementation timelines, data exchanges, and initiatives like member-centered records that others cannot deliver.

In addition, the Request for Proposal makes it clear that the Department is seeking a behavioral health partner who will pay as much attention to the "how" as to the "what." You have asked us to create capacity at the community level; engage members, their families, and their advocates in care decisions; and account for differences from one island to another. In short, the Request for Proposal tells us that you are seeking value — sustainable financial value and enhanced program value to those we will serve.

We believe that ValueOptions is best able to provide value to the State. We bring a set of strong convictions to our approach in behavioral health management. Not new, they are the "how" that any client of ValueOptions will recognize in us immediately:

1. **We are at our best when serving those most in need:** The most vulnerable in any population are the true test of whether or not we can effectively manage scarce financial resources while improving care coordination and delivery at the same time. Time and again we have demonstrated our ability to serve the most difficult and intransigent Medicaid members—the seriously mentally ill, the homeless, the formerly incarcerated, those who have burned bridges with their providers and those who frequent the Emergency Department. We are deeply committed to providing members with the most effective care in the least restrictive setting. Our proposal describes the proven tools we have at our disposal to accomplish this. ValueOptions' mission is to "…help people live their lives to the fullest potential." We know that one person's best possible health is not the same as another's. That's why the principles of recovery and resiliency are so deeply embedded in everything we do. That's why we focus so extensively on informal peer support, social support, and intensive care coordination. And it's why our clients will always find us willing to try something new or do something more in the service of a better solution.

2. **The member's voice will always be heard:** We often say that our goal is to "wrap" our array of services around members so that they have a full understanding of all the resources available, and have full access to those that will be most helpful. Members are never on the outside looking in; our industry-leading member satisfaction scores at ValueOptions attest to this. You will find that many of our peer and member engagement staff are former Medicaid recipients themselves. In addition, members, their families, and advocates participate actively in our community meetings, on our quality committees, and in virtually every aspect of what we do. We also know that members do not speak with one voice.

3. **Learn globally. Build locally.** With more than 25 years of experience with behavioral health administration, we bring a wealth of leading-edge ideas and solutions to Hawaii's behavioral health system. We've designed "health homes" and "Accountable Care Organizations" in Colorado and pharmacy consultation programs in Texas, and we've co-located our behavioral health clinicians with health plan clinicians in Tennessee. However, we pride ourselves most of all on designing solutions to meet the unique needs of each of our

4. clients. Only in this way can we transfer our national experience in a way that's genuinely useful in a local community.

5. **We deliver financial value by getting people the right care in the right setting:** At ValueOptions, we manage utilization for millions of members in many states. We have never been a denial-based organization. Instead, we specialize in creating systems of care that range from traditional acute services to non-traditional services and peer support. Whether it is the use of telehealth to relieve access problems in a rural area or Braided Funding solutions to stretch financial resources, we deliver savings and return on investment to our government clients by what we say "yes" to far more often than when we say "no."

Over the past few months, we have met with many of the provider organizations and other stakeholders whose cooperation is essential for the success of the CSS Program to learn about their scope of services and their vision for system transformation. These meetings included:

- [redacted]

Our conversations were very instructive and encouraging. We received widespread support from provider organizations and stakeholder organizations alike for our approach. In addition, we received valuable perspective about what is needed for significant improvement.

The Request for Proposal calls for an enduring program model that will defragment Hawaii's behavioral health system to ready the State for collaborative expansion tied to local and national healthcare strategies. It's a high bar—one that demands of the Behavioral Health Organization something more than just incremental change. Rather, it demands that we bring our full skill-set to the challenge, including:

- a rich, diverse experience serving both Medicaid and Non-Medicaid member experiencing a serious mental illness
- a trusting, collaborative relationships with providers
- a proven ability to innovate clinically and to integrate behavioral health and medical care
- a focus on outcomes and a willingness to be evaluated based on our results
- a technology platform that will be a true enabler to case management and care coordination rather than a barrier
- a knowledge of Hawaii, with island specific cultural-sensitivity
- a reputation for building systems of care that enhance the member's experience and overall health

- a readiness to collaborate with the State of Hawaii to help meet its behavioral health program needs in an evolving healthcare environment
- a track record of achieving positive financial results for our government clients

These are the qualities and the attributes that we understand you are seeking in the Behavioral Health Organization. Now, please allow us to tell you why we are not only qualified, but are uniquely qualified, to deliver them. In the following two responses we will provide an overview of our response and the contents of our proposal and how we intent to implement the CCS program.

Clearly and concisely condense and highlight the contents of the proposal and provide DHS with a broad understanding of the entire proposal.

We have built the specific elements of our proposal around four key strategies that we believe give you—and us—the best opportunity for success:

Local application of national best practices: We have combined the best of two worlds. On the one hand, we offer the national experience and award-winning innovation of ValueOptions' 53 Medicaid contracts in 15 other states. On the other hand, we have structured our organization to focus on cultural differences and local access to care, deployment of Geo Teams located throughout the State, and the involvement of key local providers.

A hands-on approach to care coordination and improvement: When it comes to coordinating members' care and getting them the help and support they need, our goal is to provide members with an experience that is very personal. As our proposal describes, we use a medical director and clinical director, intensive care coordinators, peer recovery and wellness liaisons, community based case managers, and other special purpose staff to wrap members in an experience of caring and resources. What's more, principles of recovery and resiliency pervade our entire approach.

Provider partnership: We believe the best way to transform the behavioral health delivery system in the direction of a recovery focus and greater care coordination is to approach the problem in collaboration with key providers, especially those who represent the safety net of the public mental health system at the local community level. ValueOptions has employed this strategy in other states and in managing other complex Medicaid populations, and it works. The strategy helps with provider buy-in. It aligns funding and incentives. It reassures members and advocates. It adds an important dimension of network access for managed care organizations. And it creates unique forums for public and private sector providers to cooperate on clinical initiatives, data integration, quality improvement, and other issues. In Hawaii, we intend to partner with key non-profit care management entities across the State.

Technology integration that delivers on its promises: Technology can look impressive on diagrams. Unfortunately, often when you look closer, you realize that integrating data from multiple providers is not possible after all, and getting the kinds of outcomes reporting you expected would be a "maybe later" deliverable. Simply put, you will avoid these often-seen

scenarios with ValueOptions' integrated system. We have already made the investment in 21st century integrated technology. Data can be organized at the member, provider, population, or just about any other level you desire. It is all one platform, so everything communicates with everything else. And it is ours. We own the source code. So a special request or urgent need will never be out of bounds.

As you review the remainder of our proposal you will find a great deal of detail in each section, addressing the Request for Proposal requirements point by point. However, the following provides a highlight of the key features of our approach that we believe make a difference in the value that we offer you and the State of Hawaii.

- **70.400 Company Organization and Experience:** Incorporated in 1987, ValueOptions employs more than 3,200 individuals nationwide. We are headquartered in Norfolk, Virginia and presently manage behavioral health services for more than eight million Medicaid recipients across the country through some 53 government contracts in 15 states. Overall, ValueOptions serves more than 32 million members through contracts with states and counties, the military, large employers, and managed care organizations. ValueOptions is a $1 billion company with deep experience managing both ASO and risk-based contracts.

  ValueOptions' history and experience in administering state Medicaid programs has no equal in the managed behavioral health care industry. Our willingness to design solutions unique to each of our clients and our attention to the details of operations, provider relations, and member and client service, are reflected in the long persistence of many of our state and county client relationships.

ValueOptions: Facts at a Glance

ValueOptions is a health improvement company that specializes in mental and emotional wellbeing and recovery.

- *Founded in 1983, the largest independent behavioral health company in the U.S.*
- *Behavioral healthcare leader in commercial, federal and public markets*
- *Managing >$5 billion in annual behavioral healthcare spend*
- *32 million members in all 50 states and worldwide*
- *Preferred partner for > 20 health plan clients*
- *Commercial client portfolio includes 52 Fortune 500 employers*
- *One of largest EAP providers globally with > 13 million members*
- *53 Medicaid contracts in 15 states*
- *More than 1 million dual eligibles*

- **70.500 Organization and Staffing:** As indicated, we will establish a new Hawaii-based service center on Oahu and will assign staff to geo-teams on the Big Island, Maui and Kauai. This ensures our intensive care coordination and case management is tied to each local community's services and dynamics. Our Hawaii-based senior leadership will administer the program out of this office. Additionally, member and provider services will be based in Oahu. We have identified key leadership staff with expertise on Hawaii's unique healthcare

delivery system to join our team, and we will make every effort to build a full local staff with demonstrated experience, clinical expertise, and an understanding of the needs of the populations we will serve.

As you will read in more detail in the proposal, we will introduce you to the experienced leadership team that will be led by [redacted] as our Executive Director. [redacted] deep roots in the Hawaii behavioral health system of care, as well as her experience and passion for the CCS program from her professional history in the State of Hawaii, position her to lead the most effective program for ValueOptions' program in Hawaii.

Upon contract award, we will work to immediately secure employment arrangements with each of our identified leadership candidates. Each leadership resource has been thoroughly interviewed by ValueOptions and has expressed a willingness to join our team following contract execution. We have also received a strong initial response of over 50 applicants to our employment postings in *The Honolulu Advertiser* and other Internet job sites. This extensive recruitment effort ensures that we are prepared to begin implementation on day one. We will truly be locals serving locals, and our team will be exclusively dedicated to you and the needs of Medicaid members throughout the State.

- **70.600 Provider Network:** Detailed plans describe our processes for network development, contracting, and credentialing. We pride ourselves on the fact that accuracy audits of our provider directories have consistently given us excellent ratings of more than 95 percent. In addition to our existing contracted network and the services of the mental health agencies that will be contracted to provide our case management, to date we have received a significant number of letters of intent from public and private providers who are interested in joining our network for this program.

- We are aware of the service access issues that exist in Hawaii, particularly as it pertains to limitations in access to psychiatric services on some of the islands. We intend to employ our first in the nation comprehensive telehealth platform, eCareAccess, to address such provider and clinical specialty shortages. Our web-based system is available to all interested members and providers in our ValueOptions network and requires only a computer with an internet connection and basic web camera. We will use our unique platform as a bridge to provide critical psychiatric services from physicians located on Oahu through providers on neighbor islands who will coordinate the consultations with CCS members.

  ValueOptions will not subcontract to another firm's networks for behavioral health service delivery. We will directly contract with our behavioral health network in Hawaii and, as the proposal describes further, we have already begun the process of enhancing our currently existing comprehensive network of Hawaii providers.

- **70.700 Case Management:** Our entire clinical approach focuses on connecting members with the most appropriate and effective level of care, and making a full system of care available to them. We intend to use a blended model for case management services, partnering ValueOptions' Intensive Care Coordinators with Hawaii's community-based case management providers. This model will ensure effective care management oversight is

balanced with the seasoned expertise of local providers. Care will be provided as needed and not ratcheted out in small increments. Coordination of services and care integration will enable health plan resources, providers and members to be a part of, rather than subject to, a care plan. In addition, we use our leading edge technology to reduce the administrative burden on providers via a dedicated, intuitive Web portal available for service authorizations. We will deploy unique Geo Teams in various areas across the Hawaiian Islands to provide tuned-in, local interfaces for members, providers, managed care organizations, and support services, such as housing, transportation, and other such agencies. In short, we leverage every best available local resource to create systems of care that go far beyond traditional behavioral health.

We coordinate services and supports for the member across the full system of care, even beyond Medicaid when appropriate, focusing on a member's physical and social needs rather than being concerned only about their behavioral health. Our proposal describes the member entry process, how we will coordinate with the member's health plan and other involved providers as well as how our partnership with local non-profit mental health agencies ensures integration with the case management they will perform on our behalf. Once again, our advanced technology enables us to create and share a member-centered plan of care that incorporates all information important for care coordination including service authorizations, service histories, pharmacy utilization, and consents.

- **70.800 Outreach and Education Programs:** Our approach to behavioral health improvement is anything but passive. This section of our proposal outlines a wide variety of tools, technologies, and processes to aid in our outreach and engagement. Our outreach and education programs begin with the simple understanding that persons with lived experience are often the best resources for helping others embrace their recovery and resilience. We also know that having a full and meaningful life involves other equally important dimensions, such as occupational – having meaningful work; social – establishing healthy connections with others; spiritual, financial, and others. Our Peer and Wellness Liaisons are key to a strategy of improving our members' wellness, inclusive of their behavioral, physical, and social needs and engaging the entire community of professional and natural supports to meet these needs.

  In addition to our peer programs, you will read about our telehealth capabilities, our recovery and resiliency forums and our targeted programs for high risk members. Appointment assistance is aided by tools like our member portals, our Member Engagement Center, and by our call reminders for appointments. And system coordination with the managed care organizations is managed by our intensive care coordinators and facilitated by monthly meetings with their clinical team, their operations team, and through our Advisory Committees.

Explain how the offeror will implement the CCS program consistent with the requirements of this RFP if a contract is awarded to them.

Successful implementation of the Behavioral Health Organization in Hawaii requires careful planning, active listening to the State's goals and program vision, hard work and the coordinated efforts of all affected parties – you, providers, members, families, and our dedicated implementation team. We will engage our Hawaii-based leadership team as primary participants throughout the implementation process to ensure we are capitalizing on their experience and expertise in installing care management programs for Med-QUEST populations.

ValueOptions brings a proven track record of negotiating and implementing large statewide programs for similar populations such as those covered in the CCS program, on time and to the satisfaction of our state partners in approximately 18 states over the last two decades. We are proud to note that we have never missed a go-live date, nor have we ever paid a penalty for our implementation performance. It is our desire and commitment to illustrate to DHS that a partnership with ValueOptions will prove to be most valuable.

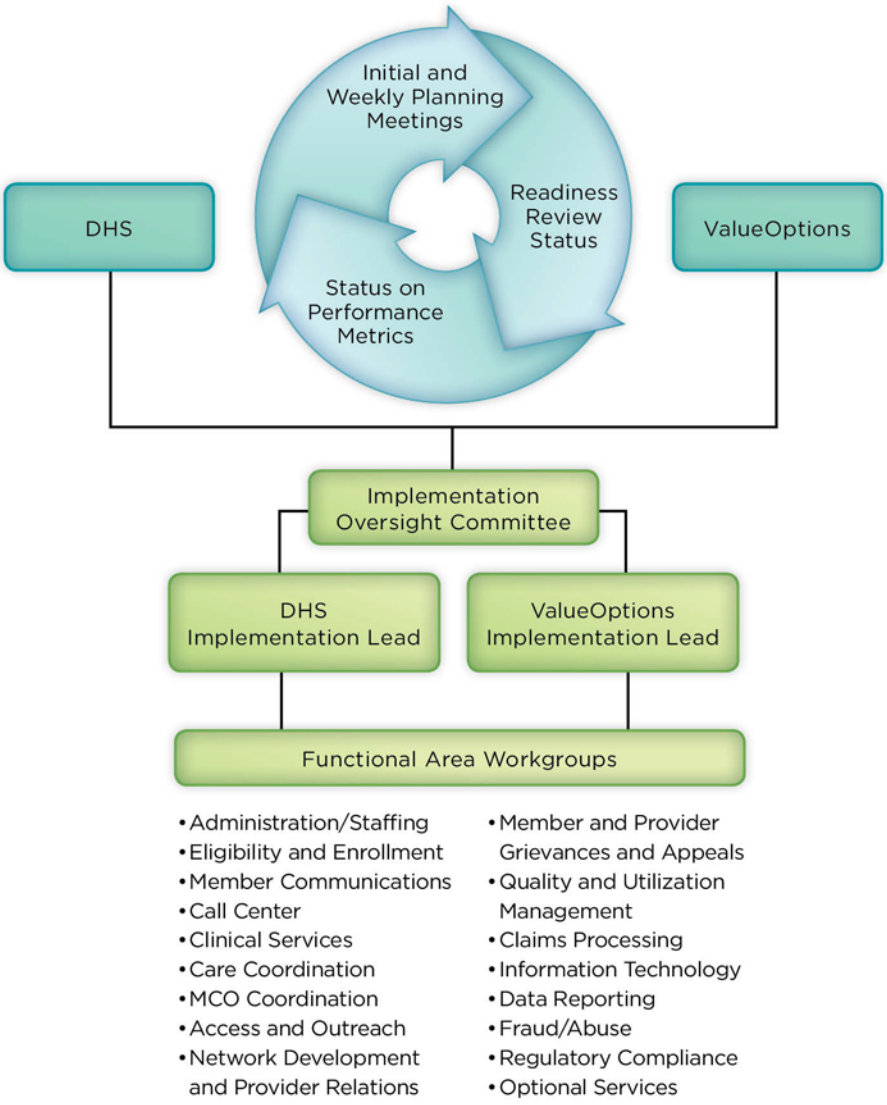
Our highest priority is ensuring that transition processes do not negatively affect the continuity or quality of care that Hawaii members receive. Although some issues are unavoidable, we believe that careful planning and transparency – based on lessons we have learned in similar system transitions –can minimize the impact on members, their families, and providers. Our tested and proven project management structure and detailed work plan form the basis for our implementation and will guide the seamless transition process.

We will employ a suite of industry standardized and tested project management methodologies and best practices to implement the CCS program. Our approach follows a well-defined process and is based on relevant principles adopted from both the Project Management Institute and Six Sigma that include the following seven distinct phases:

1. Pre-Implementation Activities
2. Discovery and Transition Process
3. Implementation Plan Finalization
4. Implementation Activity
5. Readiness Testing and DHS Review and Acceptance
6. Implementation Transition
7. Operations Validation/Lessons Learned

A graphic description of our Implementation Process and Structure is on the following page.

Implementation Process



Our implementation process stresses close communication between our organization and DHS throughout all phases of the implementation.

Phase One: Pre-Implementation Activities

This phase identifies the activities that will begin immediately upon contract award to facilitate key foundational activities that enable us to move forward quickly.

Our implementation process is centered on transparency with State resource partners identified for participation in the project. We will work with the State to ensure that the scheduling of tasks and use of resources does not conflict with other DHS activities. More specifically, within the first 10 days of contract award, we will meet with DHS to:

- define the project management team, the communication paths, and reporting protocols
- schedule the implementation kick-off meeting and establish the ongoing oversight and weekly status meetings
- design the initial communication plan structure, identifying key audiences, messages, and vehicles for messaging
- define expectations for content and format of contract deliverables
- define expectations and timeline for readiness review activities

Although we understand the incredible demands on DHS staff time, active participation from your employees will be essential to ensure clear communication of deliverables, issues, and opportunities to make mid-course corrections.

Phase Two: Discovery and Transition Process

This phase includes identifying the most effective methods of gathering specific and detailed information necessary to support the implementation effort. We will work closely with the State prior to any information requests to ensure that they are initiated with the appropriate individuals and do not pose unnecessary burdens on DHS. Such activity fosters both positive relationship development from the onset of implementation, and streamlines the information exchange and knowledge transfer. Information gathered during this phase informs the development of a number of items that are key to the success of the implementation, including:

- finalization of the implementation plan
- validation of the key assumptions that drive the finalization of the operational and developmental deliverables
- confirmation of the transition to managed care strategies to be employed with the network
- agreement on continuity of care plan strategies
- definitions for all benefit configuration, eligibility, and other key data exchanges, including key discussion of the following:
  - confirmation of the agreed upon file layout
  - data dictionary for the file layout
  - any assumptions and applicable processing rules

Phase Three: Implementation Plan Finalization

The initial goal of this phase is to gather a consensus on, and approval of, the detailed implementation plan. Once the discovery process is complete, we will begin with the draft implementation plan (weekly timeline), and combine it with the information we receive from DHS during the discovery phase to develop a fully functional plan. This plan will be provided to DHS within 30 days of contract award. The approved plan will contain the step-by-step detail on how we will seamlessly implement the program no later than March 1, 2013. We will work with you to facilitate understanding and acceptance of the plan to ensure all parties are fully engaged and committed to the identified tasks and timelines.

Our implementation plan includes the following information:

- schedules and timeline for implementation
- relationships between key staff and the specific tasks and assignments proposed
- network development and maintenance plan, including analysis and transition for all existing Medicaid providers
- clinical transition and service continuation strategies
- quality improvement and management plan
- staffing and recruitment tasks
- education/communication plan for providers, members, health plan and all other stakeholders offering care
- utilization management plan
- overall information systems project plan, including reports and interfaces, claims processing and information management integration, hardware equipment acquisition and installation, operating systems and software installation, and systems testing
- business continuity, disaster recovery, and risk management
- contract compliance/fraud and abuse plan
- website development plan
- call center auditing tasks
- operational readiness plan

Phase Four: Implementation Activity

Upon joint approval of the final implementation plan, we will move immediately into the activity phase. This phase includes actively managing the outlined tasks and timelines toward full program implementation.

Examples of some of the specific steps we will take during this phase include:

- developing detailed products by functional area work groups
- designing, developing, testing, and deploying benefit configuration, eligibility, data exchanges, and interfaces
- refining workflows, policies, and procedures

- deploying all approved work plans to include: transition of care, quality monitoring, and improvement/corrective action, provider recruitment and education, covered service authorization, human resources/staffing, and call center training

The key components of our implementation activities cross all of our functional area and are articulated into actionable tasks with responsible parties and timelines in our Implementation Plan. Key implementation activities already underway including staffing and recruitment, network development, and case management are described in detail in our proposal. Other core implementation activities not described elsewhere include:

Transition of Care

ValueOptions recognizes the significance of the effective clinical transition for members with severe mental illness in the CCS program. Thus we are fully committed to meeting all RFP requirements to ensure member care is continuous. To this end, we recommend a number of strategies designed to ease the transition process for members, families, and providers to assure that those who are receiving services prior to March 1, 2013, experience no disruption of care and that providers will experience continued cash flow.

Upon contract award, we will initiate our clinical work group to finalize workflows, service utilization criteria, review and customize clinical policies and procedures to Hawaii's specific programmatic requirements, and establish clinical and medical committees. Other responsibilities of the team will include hiring of the clinical staff and training of clinical, provider relations, customer service, and quality management staff. The team will also finalize the utilization management plan, as well as the work plan. The clinical work group will work with DHS and the incumbent vendor to facilitate a smooth transition for members in treatment and their providers.

To ensure a transition that is both clinically sound and seamless for the member, we will:

- request from DHS:
  - a list of members who are in treatment that will be ongoing at the time of the transition
  - current care, and crisis plans for all members in acute care or identified as members of designated care units
  - eligibility data
  - benefits data, including all authorization rules
  - claim extracts
  - authorization extracts
- subject to DHS approval, meet with the incumbent vendor to obtain authorization detail and case management history information as appropriate
- work with all Managed Care Entities and DHS to obtain the dates and the results of any clinical assessments, so that those results can be utilized for any pending or continuation of service requests begin development of referral protocols and policies outlining coordination of care with the Hawaii MCOs; the protocols will continue to be developed over the contract period
- schedule meetings with all entities involved with case management of high needs members

- communicate with providers and members about the new program through forums and welcome letters and forums
- work with key mental health and substance abuse groups/organizations to assist members and family members, and minimize confusion during the transition
- open our toll-free number 30 days prior to go-live to respond to any member or provider questions about the new program

An important part of the transition process is to ensure that all providers currently serving members are notified of the impending change in behavioral health care management. It also is important that all members who are receiving services and parents or guardians (as clinically appropriate and with the member's approval) who are receiving services are aware of the transition plans. We will coordinate this outreach effort with DHS to ensure communication and ease of transition. Since we know that many services are currently being provided by APS, we will work with DHS to develop a transition plan that may include having the incumbent continue to review, approve, and provide as necessary all service at the current prescribed frequencies upon notification of transition. This approach prevents a large volume of requests coming in at the time of the actual transition. We will work with the incumbent to obtain an authorization extract to be loaded into our IT system so that all existing authorizations will be honored.

In addition and subject to DHS approval, our clinical work group will meet with the incumbent to discuss complex cases, including those members in higher levels of care. The discussion of the complex cases enables us to more fully understand the current treatment plans in place, and eliminates the need for the providers to submit duplicate information. This strategy also enables us to capture members who will be discharged close to the transition date so that follow up can be arranged.

For those services that do not require an authorization, we will review claims data to determine the most accurate number of sessions. If this is not practical due to a claims run-out, we suggest the allowance of current limits so that services are not disrupted.

Upon go-live, our clinical, provider relations, operations, and member engagement team will meet daily to ensure that existing protocols are continuing to provide excellent service to providers and members. We will audit cases more frequently to ensure processing accuracy. In addition, we will address any complaints to ensure that members are satisfied with the transition of care.

Benefit Configuration, Eligibility, and Claims

ValueOptions has more than two decades of experience managing accurate claims processes for similar statewide programs across the country. We are the only ones with a completely proprietary, one-of-a-kind, information systems platform.

During implementation, our claims and systems configuration teams will work closely with you, reviewing and analyzing all of your benefit information and related requirements, ensuring all terminology, and benefit rules are clearly understood. We will then develop a customized system to accommodate your unique eligibility requirements, authorization rules, diagnosis, benefit and place-of-service rules, covered service codes, and age-based benefits. We will

conduct extensive testing to verify that claims are processed according to your specifications, and in accordance with your respective readiness and implementation requirements.

Our dedicated Hawaii-based staff will participate in an extensive claims training program, consisting of six weeks of formal classroom instruction combined with on-the-floor practical experience.

Information Technology

ValueOptions' proprietary information technology platform is a suite of fully-integrated applications that supports complete, complex behavioral health programs from initial member contact through claims adjudication and payment. It also incorporates the full range of management and utilization reporting requirements.

Our experience with other statewide Medicaid behavioral health program implementations is that the technical activities are often large in scope and require significant collaboration with our client and other partners. To this ends, under the oversight of our core implementation team, we will deploy a team comprised of a dedicated IT lead and technical analysts, as well as operational leads representing different functional areas, to ensure a successful, error-free transition. Priority activities will include the implementation of a site-to-site virtual private network to meet DHS' oversight needs, as well as customization of our platform to meet all enrollment, member registration and service requests, claims processing, and electronic data exchange requirements.

Quality Monitoring, Improvement, and Corrective Action

In ValueOptions' experience operating state programs for comparable severely mentally ill populations, quality monitoring is more than a program—it is a way we assure accountability to you, your members and families, providers, advocates, and the general public. It focuses on both our internal operations and the functioning of the behavioral health care delivery system. Quality monitoring is one of our critical strategies for integrating the ideas and perspectives of everyone who is affected by our services. Upon contract award, our quality management team will immediately begin collaborating with you, our contract case management entities, providers, and other invested stakeholders to prioritize the focus of our quality monitoring initiatives. These activities will include:

- establishing the following committees and regional advisory councils/boards for review and approval within 60 calendar days:
  - Quality Monitoring/Quality Improvement Committee
  - Statewide Peer Review Subcommittee
  - Statewide Member/Family Subcommittee
  - Ad Hoc Subcommittees and Time-Limited Workgroups
  - Regional Member/Family Advisory Councils
  - Regional Provider Advisory Boards
- developing unique reports to support monitoring and analysis of the program, including multi-level utilization reports, access to care reports, and key performance indicators
- engagement and training for members in the use of our Web portal
- partnering with you to review all behavioral health management policies and procedures to ensure consistency of DHS quality measures and initiatives

Phase Five: Readiness Testing and DHS Review and Acceptance

The readiness testing phase ensures that we are on track for a seamless transition, and that we have enough time to troubleshoot potential problematic areas prior to go-live. We will fully audit all contract requirements to ensure that each of them is satisfied.

We have extensive experience in a variety of readiness review formats, and this is one of the areas we will want further discussions with you, in our initial meeting post-award, to ensure that the timeline, content, and format expectations are clearly understood so we can plan accordingly.

We will engage in a joint, end-to-end testing process to ensure that all process throughputs designed for the program are operating in the expected manner, and meet the requirements of the program. Prior to moving out of this phase, we will work with you to ensure the acceptance of test results, and receive your approval to move forward.

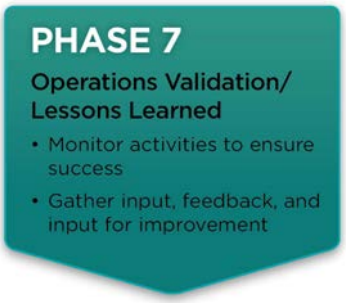
We will complete readiness testing well in advance of the State's formal Readiness Review. Once testing is complete, ValueOptions is prepared to comply with all of the State's requirements for Readiness Review as defined in Section 51.300 of the RFP, to include document review, provider GeoAccess review, and provider network requirements.

Phase Six: Implementation Transition

During the implementation phase, we will facilitate a thoughtful transition to Hawaii service center personnel who will be responsible for the ongoing operations of the program. A hand-off document will be developed for each department/operational area, and will identify specific activities and timeframes that are necessary prior to the transition of services to the operational staff.

Once each department has successfully triggered their internal transitions, we will schedule ad hoc meetings with DHS to review the specific implementation teams' progress. Via these meetings, we will request your signoff on the completion of the implementation phase. Implementation will be considered complete only with your formal approval.

Phase Seven: Operations Validation/Lessons Learned



Post-implementation, we will monitor all aspects of the new operation to ensure success. The following are several examples of our monitoring and audit structures:

- providing a minimum of two weeks of floor support post go-live, staffed by our subject matter experts
- establishing daily reports required from each operational area that measure key management indicators and progress against performance standards
- conducting daily team meetings with representatives from each operational area, reviewing staff effectiveness, response timeliness, and monitoring any post go-live activities
- retaining the implementation team for 30-60 days post go-live, to continue to run/monitor the project in conjunction with the operational leads
- conducting a thorough audit of all knowledge transition activities and hand-offs to the operational teams, and measuring the staff's level of competency in handling required responsibilities

Once implementation is complete, we will request a formal "lessons learned" process to gather feedback, both positive and negative, as part of our commitment to continuous improvement.

Based on our experience, we know that a successful implementation will be predicated on a strong partnership and continuous dialogue with DHS. We will generate and provide weekly reports to DHS, based on implementation metrics and controls. The metrics and controls will include overall and functional area completion percentages, as well as an itemization of delinquent activities, if any, with a remediation corrective action plan.

The Strengths That Set Us Apart

We believe that we are not only fully qualified to meet the Department's goals and priorities for the behavioral health system of the future, but we are also uniquely qualified in many ways. As you come to understand our approach further, we believe you will appreciate the strengths that set us apart:

- We have created a one-of-a-kind provider partnership with Hawaii's community mental health agencies to inform everything we do. This partnership aligns incentives and ensures a commitment by providers to a redesign of the delivery system.
- We have demonstrated time and again our ability to produce substantial cost savings and improved value, not just on a one-time, basis but repeatedly throughout the life of a project.
- Our unique approach to utilization management and care coordination support provider best practices, "health homes," and system-wide improvement. Concepts such as member-centered planning, recovery and resilience, and wellness are embedded in every aspect of our organizations and our programs.

- We offer the Department, providers, and other stakeholders a fully integrated suite of IT applications on a single platform *that we own.* This means that when we decide together to improve something or launch a new initiative, we will not be in queue waiting for a third-party technology vendor to release their next "system fix."
- On the foundation of our technology platform, we have built a data-driven culture and will make available to you and to providers our online portals, comprehensive reporting and query tools, as well as dashboards and interactive Web-based reporting suites.
- The strength of our implementations is well-documented and will be evident when you talk with our client references.
- We excel operationally, with 99 percent of claims paid within 14 days and industry-leading member satisfaction scores.

Each section in our proposal builds out these highlights in a much more detailed and complete way. However, we hope this overview gives you the assurance that we understand the significance of this project and your vision for transforming the Hawaii CCS program**. We have done this work before, we are confident in our ability to provide a smooth transition and successful ongoing operations, and we are willing to commit to the successful delivery of negotiated performance guarantees.**

You will find us good listeners, quick learners, and great partners in building a behavioral health system of care for the State that will serve members well in their recovery, that will relieve providers of much of the administrative burden they carry today, and that will reflect well on the Department and Hawaii as a whole. DHS has an opportunity to contract with a company that is singularly focused on behavioral health services and one that brings a new energy to member, family and provider collaboration and support for the State's ongoing improvements to the behavioral health system of care. We believe we are the right choice for Hawaii and look forward to partnering with DHS as an integral component of the Hawaii CCS program.

70.400 COMPANY BACKGROUND AND EXPERIENCE

The company background and experience section shall include for the offeror and each subcontractor (if any):

The background of the company, its size and resources (gross revenues, number of employees, type of business, and details of company experience relevant to the operation of managed care plans (type of plan, number of members, etc). The required information is set forth in detail below.

70.410 BACKGROUND OF THE COMPANY

A description of the history of the company and the BHO to include but not limited to:

Provide a general description of the primary business of your organization and its member base.

ValueOptions is a health improvement company that specializes in mental and emotional wellbeing and recovery. We provide behavioral health programs and services to 32 million members from all major market segments: state and federal government agencies, employers, and health plans (including commercial, Medicare Advantage and Medicaid).

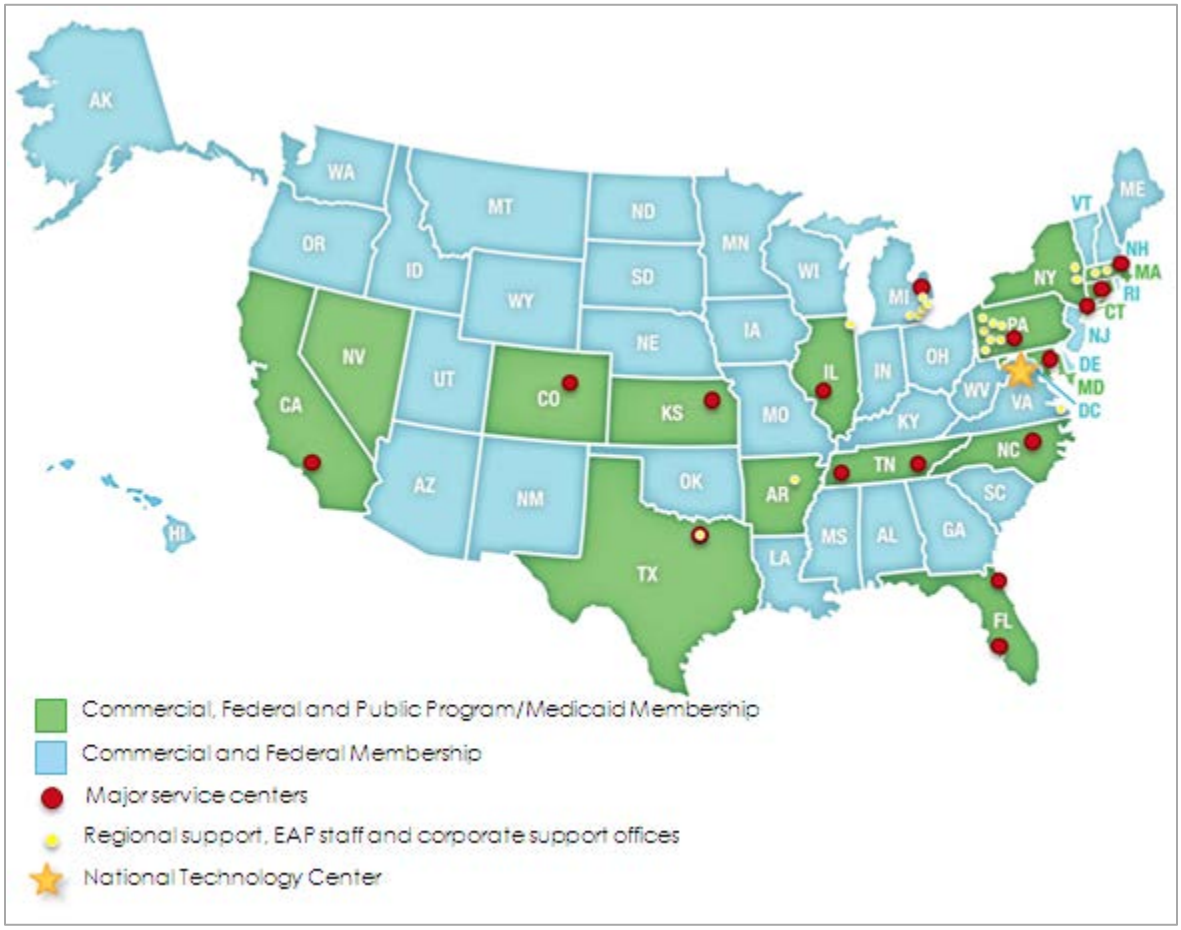
As the nation's largest independent behavioral health care company, we have provided managed mental and behavioral health services for more than 25 years**.** We deliver world class, cost effective behavioral health administration solutions for our partners and their members. ValueOptions specializes in integrating physical and mental health services to improve the health of our members and contain costs. We lead a field that is acknowledged not only for its complexity, but also for its importance as a key driver of overall health care costs. Today, ValueOptions manages more than $5 billion in behavioral health care spend on behalf of our members in all 50 states.

ValueOptions is the Medicaid market leader. We have 53 Medicaid contracts in 15 states, serving more than eight million Medicaid lives. Key characteristics of our Medicaid program history include:

- unparalleled experience in managed behavioral health care
- lengthy tenure with state clients reflecting their satisfaction
- reducing costs while improving outcomes
- facilitating long-term systems change through realignment of financial incentives
- expanding treatment for high-cost/high-risk consumers through chronic care and disease management programs

Our approach enables coordination among members, providers and other stakeholders to maximize the efficiency, effectiveness and overall benefits of care. We ensure adequate screening and links to vital services and resources, quality monitoring and integrated tracking and reporting at each stage. Our proven innovations in case management result in improved outcomes for the most vulnerable Medicaid and severely mentally ill (SMI) populations.

ValueOptions Nationally



Hawaii will benefit directly from our nationwide Medicaid leadership and experience.

Provide a brief history and current company ownership including the ultimate parent organization and major shareholders/principals. Include date incorporated or formed and corporate domicile, and the date the company began operations. An out-of-state contractor must become duly qualified to do business in the State of Hawaii before a contract can be executed.

Headquartered in Norfolk, Virginia, ValueOptions is a wholly owned subsidiary of FHC Health Systems, Inc. ValueOptions is duly qualified to do business in the State of Hawaii.

Incorporated on April 6, 1987, ValueOptions employs more than 3,200 individuals nationwide.

In 1989, ValueOptions (then known as "FHC Options") was awarded the first managed behavioral health care contract in the country. That pilot led to multiple innovations such as intensive outpatient care, telephonic assessments, and 24-hour crisis stabilization – each designed and implemented by ValueOptions. We demonstrated a change in provider behavior through education and direct involvement in quality improvement and quality management initiatives. ValueOptions' involvement in this program has expanded over the years, and these and other innovations have become standard practice today.

Our willingness to design solutions customized for our clients and our attention to operations, provider relations, and member and client service excellence distinguish our service.

ValueOptions: Facts at a Glance

ValueOptions is a health improvement company that specializes in mental and emotional wellbeing and recovery.

- *Founded in 1983, the largest independent behavioral health company in the U.S.*
- *Behavioral healthcare leader in commercial, federal and public markets*
- *Managing >$5billion in annual behavioral health care spend*
- *32 million members in all 50 states and worldwide*
- *53 Medicaid contracts in 15 states*

Ownership of the company (names and percent ownership), including the officers of the corporation

ValueOptions is a privately held, wholly owned subsidiary of FHC health Systems, Inc. (FHC), with Ronald I. Dozoretz, M.D. as Chairman and Founder. As a privately held company, ValueOptions, Inc. does not have individual shareholders. All of our company's shares are held by FHC.

The home office location and all other offices (by city and state)

Our headquarters are in Norfolk, Virginia. ValueOptions business divisions consist of three distinct segments: Medicaid (Public), which includes state and county governments, Commercial, which includes Health Plan and Employer customers, and Federal, which includes federal government programs serving the military and their families.

In addition to our corporate headquarters, ValueOptions has service centers, staff model offices, and corporate offices that support our business. Following is a list of our service centers, staff model offices and corporate offices.

MEDICAID

Service centers focusing on alcohol, drug, and mental health treatment services for publicly funded operations:

- Colorado Health Networks (Colorado Springs, CO)
- Dallas NorthSTAR (Dallas, TX)
- Massachusetts Behavioral Health Partnership (Boston, MA)
- North Carolina (Morrisville, NC)
- Pennsylvania Service Center (Trafford, PA)
- Tampa Regional Service Center (Tampa, FL)
- Kansas (Topeka, KS)
- Connecticut (Rocky Hill, CT)
- Illinois (Chicago and Springfield, IL)
- Maryland Service Center (Linthicum, MD)
- TennCare (Chattanooga and Memphis, TN)

EMPLOYERS AND HEALTH PLANS

Service centers focusing on commercial employer business, including EAP, Mental Health and Substance Abuse, and Work/Life services:

- Texas (Coppell, TX)
- North Carolina (Morrisville, NC)
- California (Cypress, CA)
- Great Lakes (Southfield, MI)
- New York City (New York, NY)

In addition, we have staff model offices in the following locations:

- Louisville, KY
- Boston, MA
- Ann Arbor, MI
- Dearborn, MI
- Livonia, MI
- Monroe, MI
- Taylor, MI
- Warren, MI
- Morrisville, NC
- Lexington, NC

MILITARY AND THEIR FAMILIES

We serve the military and their families from our Tricare South Service Center in Jacksonville, Florida and from our Military One Source offices in Arlington and Chesapeake, Virginia.

CORPORATE SUPPORT OFFICES

National support across the country:

- Headquarters (Norfolk, VA)
- Corporate Support Office (Reston, VA)
- Northeast Service Center (Troy, NY)
- Corporate Support Office (Latham, NY)

The location of office from which any contract would be administered

For Hawaii, we will staff a service center on Oahu. This complete service center will provide a central location for all clinical, quality, compliance, provider relations, member services and other administrative functions for the CCS program. Our Oahu office will be supported by our corporate support office in Latham, New York for call overflows, night service, and claims.

The name, address and telephone number of the contractor's point of contact for a contract resulting from this RFP

Amy Grazer, Vice President of Public Sector Development, will be your primary point of contact. Following is her contact information:

Amy Grazer
Vice President, Public Sector Development
ValueOptions, Inc.
240 Corporate Boulevard
Norfolk, VA 23502
(757) 323-9378
amy.grazer@valueoptions.com

The number of employees both in Hawaii and nationally

Nationally, ValueOptions employs more than 3,200 employees. For the staffing efforts currently underway in Hawaii, please see Section 70.500.

The size of organization in assets, revenue and people

ValueOptions' 2011 total assets were valued at $386 million. Our annual revenue for fiscal year 2011 was $915 million, and we currently employ a more than 3,200 people.

The areas of specialization

We offer unparalleled experience in innovative, cost-saving and clinically effective programs to statewide delivery systems for Medicaid's most vulnerable members.

As a partner with multiple Medicaid state programs, we expertly coordinate with local and regional supports, including local provider networks, community-based organizations, criminal justice systems and juvenile courts, pharmacy benefits managers, and residential treatment centers, among others. We leverage our experience to craft innovative programs and services around the needs and challenges unique to each market. Our customized, contract-specific approach to all aspects of case management, from staffing models to clinical reviews and outreach, begins by addressing the features that make your population unique. Key examples of our experience include:

- Our collaborative role in the Connecticut Behavioral Health Partnership, serving nearly 600,000 people, where we have crafted a program focusing on members' cultural needs. We collaborate intensively with members, family members, providers and social support systems to promote a strengths-based approach to recovery. Our efforts deliver a highly tailored network of culturally appropriate resources.

- Program innovations serving 260,000 Medicaid beneficiaries in the state of Kansas. We have expanded our initial management of the state's Medicaid and Block Grant Substance Abuse Program to include the Kansas Medicaid Ambulatory Mental Health Program. Our successes under this expansion include implementing detailed information interfaces to update the state's aging systems.

- As the Maryland Administrative Services Organization for Maryland's Public Mental Health System, we serve as both the state's administrative services organization and its fiscal agent for the Substance Abuse Mental health Services Administration Access to Recovery grant. Through this dual role, we cover 900,000 Medicaid enrollees and an additional 40,000 uninsured members.

- As one of the Regional Care Collaborative Organizations (RCCO) for the Southeast Region of Colorado, we promote an "accountable care organization" model. This is one of the first programs to shift the responsibility of key utilization management functions, including both the quality and cost of care, to providers.

If the Company operates a variety of businesses, the offer shall identify for each operation, the type of business, the date the business was established and began operations, the related gross revenues and total number of employees.

ValueOptions' sole focus is, and always has been, managed behavioral health care.

70.420 COMPANY EXPERIENCE

The details of company experience including subcontractor experience, relevant to the proposal shall include but not be limited to the following:

Length and quality of previous experience in providing the required behavioral health services to a Medicaid population or low-income group

A consistent, member-focused, and outcomes-driven approach to quality case management is what sets ValueOptions apart.

We offer unmatched length and quality of experience providing behavioral health services to Medicaid and low-income populations, spanning Medicare, Medicaid, dual-eligible, and medically complex memberships. These include youth and adult members, the severely mentally ill, chronically homeless, chronic substance abusers, and other high needs populations.

We have provided groundbreaking solutions in a wide variety of settings. For example, ValueOptions developed the first system dedicated to managing complex, statewide Medicaid contracts with diverse memberships spanning multiple funding streams. ValueOptions' system assigns each member with a unique eligibility code, and then automatically designates and tracks applicable funding sources for that member. We are also the first behavioral health organization to provide a nationwide, telebehavioral health network, with telehealth resources available to all of our providers.

A chart outlining our Medicaid experience across the country is an addendum to this section, Company Background and Experience, **Attachment 1**. Following are a few examples of our achievements:

- **Texas**
  - Reduced cost per enrollee from $2,563 to $1,830
  - 46 percent improvement in appropriate access
  - $72,000 reduction in per member per year costs for severe outlier populations
  - Saved the state $60 million in administrative costs
- **Florida**
  - Reduced the administrative rate from 22 percent in 1996 to less than 13 percent in 2010
  - Operational efficiencies, economies of scale, program innovations such as telehealth, and a new provider contracting/funding model
  - Served nearly 340,000 Medicaid members
- **Kansas**
  - 35 percent reduction in substance abuse care costs
  - 20 percent more people receiving care
  - 28 percent improvement in administrative costs (PMPM)

- **Massachusetts**
  - 50 percent reduction in Emergency Room visits
  - 68 percent reduction in inpatient hospitalizations
  - 60 percent reduction in medication refill gaps
  - 19 percent reduction in average total medical costs

Length and quality of previous experience with managed care, including experience in working with behavioral health agencies and behavioral health agencies as subcontractors

For 17 years, ValueOptions has implemented Medicaid networks, serving adults and children, with a wide variety of forms and structures. We have developed partnerships with provider organizations in urban, suburban, and rural areas in every region of the country. Many of these programs have required large and multi-faceted networks including subcontracted peer and provider organizations. And we have deep experience working with local provider networks, facilities, peer-run organizations, pharmacy benefits managers and other behavioral health agencies to deliver the most effective care possible. As an innovator of accountable care organization models, we have contracted extensively with local provider networks. We provide highlights of our experience below, and include additional experience within our addendum, Company Background and Experience, **Attachment 1**.

- In **Florida:**
  - ValueOptions first began working with both fee-for-service (FFS) and at-risk provider service networks starting in **2008**, serving as their capitated, full-risk behavioral health carve-out.
  - ValueOptions was also chosen as the MBHO partner for Star Health Plan (a Medicaid HMO), which will become operational on or before January 1, 2013. The provider managed health plans managed and administered by ValueOptions represent a true partnership with community mental health care providers.
- In **Colorado**, we have partnered with regional organizations, including FQHCs and CMHCs to promote a regional care collaborative organization, since **1995**.
- Working with the state of **Texas** since **1999**, we have partnered with pharmacy benefits managers to reduce pharmacy costs by nearly ten percent, per patient.
- In **New York** we have worked with our co-located health plan partner, EmblemHealth, in response to New York's state plan amendment to develop health homes. Through a partnership begun in **1994**, we have jointly developed a model that was selected as a designated health home provider to deliver member centric services.

Outline of existing behavioral healthcare packages offered that are similar to the package described for this RFP

We have a wide range of experience with existing behavioral healthcare packages similar to that described for Hawaii's QUEST membership, including:

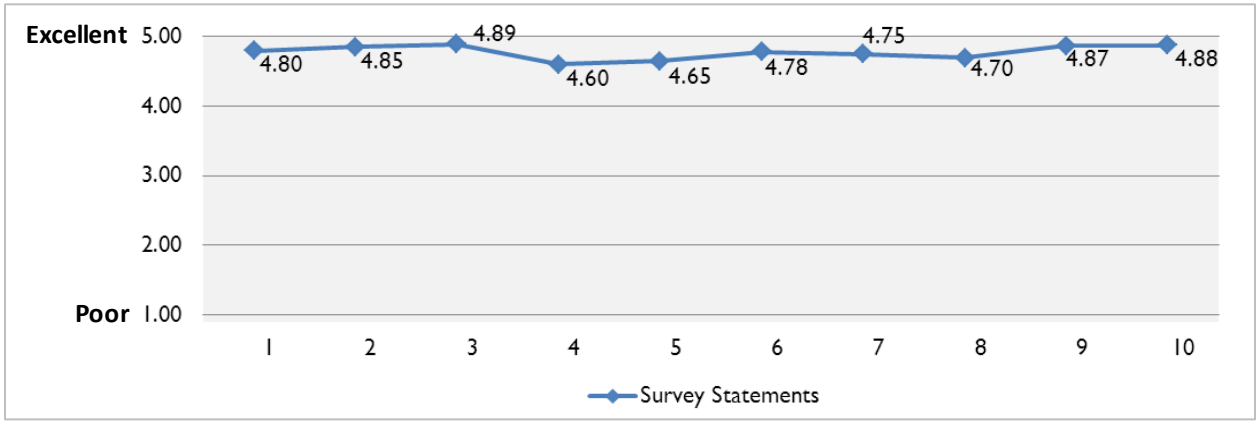
- **effectively managing services for complex SMI and substance abuse populations**
- **enhancing access to geographically dispersed members**
- **creating culturally appropriate care networks**
- **collaborating with local provider networks and peer run organizations**
- **forming unique partnerships with affiliated health plans**
- **administering federal, state, and grant funded resources**

We provide a chart detailing our complete, state Medicaid experience as an addendum to this section, Company Background and Experience, **Attachment 1**. In addition, we provide the following summaries:

ValueOptions of Illinois, & the Illinois Mental Health Collaborative for Access & Choice

As the Administrative Services Organization we provide the clinical and administrative infrastructure that delivers more than $380 million of mental health services to children, adults and families. As the statewide, contracted systems administrator for the Illinois Department of Human Services, the Collaborative is enhancing recovery and resilience initiatives for children and adults who have mental illnesses.

This program uses a high level of peer support services, including a peer-run warm line available for members 24 hours a day. Staffed with trained, credentialed peer professionals who have experienced their own mental health recovery, the warm line provides emotional support, recovery education, and self-advocacy support. This service has resulted in extremely high member satisfaction.



Our use of customized peer service supports has resulted in excellent member satisfaction.

The Collaborative operates two Illinois offices, each with a unique function. The Chicago office is the main site for clinical, administrative and reporting staff. The Springfield office is the main site for administrative, recovery and resilience, provider relations and information technology staff. Peer and family support specialists work out of both of these offices, providing peer and family support by telephone, and developing recovery education materials and events. Regional liaisons travel throughout the state, collaborating with regional department staff to support providers in their assigned areas.

Connecticut Behavioral Health Partnership

ValueOptions delivers an integrated public behavioral health service system for children and families, as well as adults. The partnership provides enhanced access to, and coordination of, a more complete and effective system of community-based behavioral health services. As the Administrative Services Organization, we support and improve individual outcomes, while effectively managing state resources and increasing federal financial participation in the funding of behavioral health services. ValueOptions manages approximately $500 million in services via a Braided Funding model. In addition, through our status as a Quality Improvement Organization the state of Connecticut receives a 75 percent federal match for administrative expenses associated with utilization management.

The partnership's service system includes core services (benefits currently covered under Connecticut's Medicaid program) as well as grant-funded community services such as residential care and intensive home-based services. Since 2006, the partnership has decreased:

- discharge delay (the time members spend in the emergency department waiting for service) by 60 percent
- inpatient discharge delay (time members spend in care that is not necessary) by 39 percent
- residential discharge delay by seven percent
- sub-acute discharge delay by 13 percent

We have also contributed to developing a consortium between existing advocacy organizations. This consortium, known as Faces and Voices of Recovery, comprises the National Alliance on Mental Illness (NAMI), Families United for Children's Mental Health (a chapter of the National Federation of Families for Children's Mental Health), Padres Abriendo Puertas and African Caribbean American Parents of Children with Disabilities. Faces and Voices of Recovery works collaboratively with Connecticut Behavioral Health Partnership, NAMI and Connecticut Community for Addiction Recovery in many ways, including providing information and expertise that shape policy and practice. A Connecticut Behavioral Health Partnership contract with NAMI and Connecticut Community for Addiction Recovery enables these entities to work hand-in-hand to provide training and access to non-traditional community services.

Texas NorthSTAR

Traditionally, Texas behavioral health services were limited to a small number of state-contracted local providers who received state block funding. Under NorthSTAR, ValueOptions introduced competition and negotiated contracts with multiple providers. As a result, six new community mental health providers emerged to offer crucial specialty services, such as rehabilitation and Assertive Community Treatment teams, and providers now compete for customers. ValueOptions also trained providers on new billing systems to speed claims payments.

To address widespread denial of services and waiting lists, ValueOptions removed the county-of-residence restriction so that there is "no wrong door" to eligibility, increased choice of providers from a larger seven-county provider network and introduced ombudsman services to help consumers to access services and resolve problems.

Consumers and advocates were involved from the very beginning and participated in shaping the design and development of the NorthSTAR program. The NorthSTAR authority's governing board is made up of appointees of the commissioners' courts of the seven counties and serves as a vehicle for holding ValueOptions accountable for resolving consumers' complaints, concerns and systems issues. In addition, a strong prevention, education and outreach department employs consumer and family advocates to act as internal change agents and bring consumer and advocate perspectives to the organization.

Positive program evaluation by the Texas Health and Human Services Commission:

The State agency examined three Medicaid managed care models, STAR, STAR+PLUS and NorthSTAR, in the areas of access, quality, integration and cost. The study concluded, "NorthSTAR does a better job of collecting data and managing behavioral health services than STAR or STAR+PLUS. Comparative data available on several indicators such as timely provision of care after hospitalization, timely claims payment and satisfaction also indicate that it may be performing better than the other two models." (Behavioral Health in Managed Care: A Review of Texas Medicaid Models, Texas Health and Human Services Commission, December 2002, Executive Summary, page 6.).

Maryland Administrative Organization

Since contract inception, ValueOptions Maryland has provided services to 8,100 more members on average each month while lowering the state's administrative costs. This represents a 13 percent increase in the number of individuals served, with only a 9.3 percent increase in the total cost of care. This is a savings of approximately $23.2 million annually compared to the previous run rate. The additional funds not only paid for care for more individuals, but also paid for case management and RTC (residential treatment center) waiver services, two services not previously provided. ValueOptions facilitated a decrease of $3.16 in cost per member served, a savings of $2.7 million over eight months, or $4.1 million on an annualized basis.

Colorado Health Partnerships

The Colorado Partnership behavioral health organizations are focused on creating a strong community-based system of services which provide effective treatment in a safe setting. Since the program's creation in 1995, mental health spending has shifted from 70 percent to 80 percent of Medicaid funding going to institutional care (i.e., hospitals and congregate residential settings), to more than 90 percent of funding going to community-based care.

Increased Access In Rural & Frontier Communities

To meet the needs of rural counties, the Partnerships developed an extensive network of crisis and alternative services, enabling people to be treated in the communities where they live and work, instead of driving hundreds of miles to an urban area. School-based treatment and after-school programs, respite homes for adults and children, in-home, crisis support and homeless outreach services all improve access for persons most at risk. Less than one-half of one percent of the Partnership's eligible members now has to travel more than 30 miles to see a provider.

Consumer Involvement in Program Design and Implementation

The Colorado Partnership BHOs became the first managed care organizations in Colorado to have an Office of Consumer and Family Affairs. Currently, our Partnerships have collectively trained more than 200 peer and family peer specialists. Advocates and peer specialists provide direct services and participate in program design, quality studies and system advocacy. The Colorado Partnerships have also established many informal self-help support groups and 18 consumer-run programs, such as drop-in centers, club houses and empowerment centers.

AT A GLANCE

Client: Colorado Dept. of Health Care Policy and Financing

Covered Lives: More than 280,000 adults and children

Covered Services: Broad range of mental health services

Type of Contract: Capitated

Employees: 65

Location: Colorado Springs, CO

Date Started: 1995

National Recognition: NAMI Heroes in the Fight Award, 2006; Psychiatric Services Achievement Award, Silver Award, 2003; Lilly Reintegration Award, 2nd Place, 2002; USA Today Quality Cup Finalist, 1996; NAMI Outcomes Roundtable award, 1996

Increased Access to Care

The Partnerships have eliminated wait times of up to 30 days for a routine outpatient appointment, to appointments within seven days. Currently, routine appointments have been scheduled within our access standards 98 percent of the time, urgent appointments (within 24 hours) 100 percent of the time, and Emergent appointments (within one hour urban and two hours rural) 100 percent of the time. In addition, the Partnerships have significantly improved the number of appointments kept within seven days of a client's discharge from an inpatient facility.

Existing volume of current non-Medicaid members receiving SMI services broken down by age and sex

We provide this information in the following chart:

Age / Sex	Non-Medicaid
Total Covered Membership	431,169
SMI Adult (>18) Male	16,250
SMI Adult (>18) Female	16,085
SED Youth (<18) Male	7,518
SED Youth (<18) Female	7,056
Total Adult SMI (>18)	34,074
Total Youth SED (<18)	15,423

Existing volume of Medicaid recipients receiving SMI services broken down by age and sex

We provide this information in the following chart:

Age / Sex	Medicaid
Total Covered Membership	7,730,059
SMI Adult (>18) Male	128,010
SMI Adult (>18) Female	198,227
SED Youth (<18) Male	266,264
SED Youth (<18) Female	252,842
Total Adult SMI (>18)	337,603
Total Youth SED (<18)	360,059

Any instances of sanctions, corrective action or oversight, or findings of fraud or abuse related to activities of the offeror, the offer's parent organization or its subsidiaries, or the offeror's subcontractors or agents. (Describe the event, findings, agency bringing the action, outcome, and any other relevant facts that relate to the matter listed.)

Our administrative audit chart, regarding all sanctions, corrective action or oversight is an addendum to this section, Company Background and Experience, **Attachment 2**. We have no incidents of fraud or abuse to report.

70.500 ORGANIZATION AND STAFFING

The organization and staffing section shall include organization charts of current personnel and resumes of selected management, supervisory and key personnel. The information should provide the State with a clear understanding of the organization and functions of key personnel.

70.510 ORGANIZATION CHARTS

The organization charts shall show:
-Relationships of the offeror to related entities
-Organizational structure, lines of authority, functions and staffing of the offeror or proposed entity

We provide an organizational chart for both our national support and proposed Hawaii office on the following pages. ValueOptions deploys a centralized matrix structure to oversee the organization as a whole. Leaders of each matrix function report directly to the ValueOptions Chief Executive Officer and make up the National Leadership Team seen in the first chart. Specific matrix functions include Clinical and Quality, Networks, Information Technology, Claims, Call Center and Customer Service Operations, and Legal and Compliance. These functions in turn support a de-centralized operational structure based on the unique needs—and locations—of our clients.

The overall Hawaii office structure links directly to ValueOptions' national Medicaid leadership team of clinical, quality and strategic experts, with the Hawaii-based Executive Director reporting to Mary Mastrandrea, LCSW, Senior Vice President of the Public Sector Division. Our broad national scope of experience provides our Hawaii-based staff with a sophisticated team of national support.

The proposal shall include a brief discussion of the development of full time equivalent (FTE) estimates for the following positions:
- Member Services
- Provider Services, including monitoring of subcontractor services
- Case Management Services
- Information Systems
- Fraud and Abuse Investigation
- Administrative support

Our program structure and staffing model includes an Oahu-based, primary office and engagement center. This location serves as the home office of our Executive Director, Medical Director, Clinical Director, Quality Management Director, Pharmacy Director and other key staff roles.

Our geographically based teams (Geo Teams) establish a local presence and collaborative relationship with key administrators, providers and state agency staff. Geo Teams will include our Intensive Care Coordinators as well as provider relations specialists and a recovery and wellness liaisons to manage and assist our network of community-based case managers. Each Geo Team is assigned to a specific region of the State to foster local relationships.

The Geo Teams can flex to include other regional/local staff from the DHS and other local resources such has vocational, housing, and social support systems to enhance members' long-term recovery. This transparency allows us to gather feedback and information from other interested stakeholders, ensuring that all available data is viewed through multiple lenses. We have successfully implemented Geo Teams in other Medicaid programs with measurable success.

Member Services

In determining the optimal number of member engagement staff for the state, we assumed the number of contacts per business day to equals approximately 45 and balanced these assumptions with the following factors:

- the state's commitment to member service as evidenced by the telephone hotline requirements
- because of the strong program of outreach and education we envision for this option, we increased the number of member engagement staff and embedded a peer wellness and recovery specialist in anticipation of significant call volume from members, family members, and providers.

Based on our model calculation, we propose two, full-time engagement specialists for clinical intake and triage, administrative functions, and member questions. In addition, we have proposed staff in our 24/7 central night service to triage any afterhours calls and will staff an on-call Intensive Care Coordinator in Hawaii for 24 hour crisis support.

Provider Services, Including Monitoring of Subcontractor Services

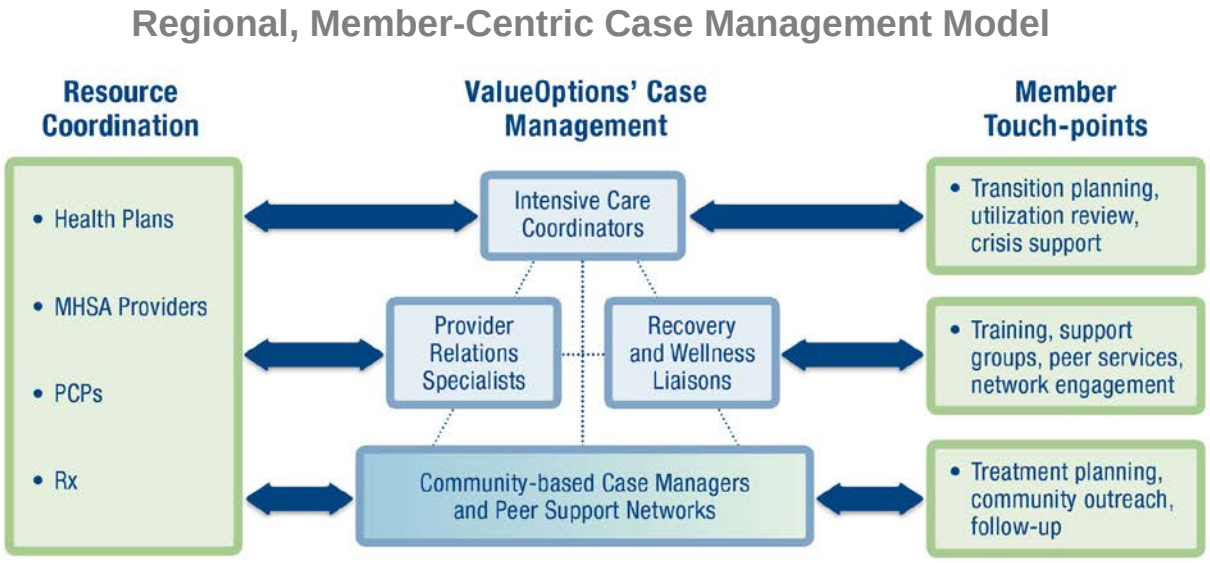
In support of our regionally based Geo Team model, a Provider Relations Specialist will implement provider trainings, augment community support networks and assist the regional Intensive Care Coordinators in monitoring all contracted, community-based case managers.

We also propose additional peer, Wellness and Recovery Liaisons to provide training, technical assistance, and support to providers working to embrace a recovery-driven system of care. Our certified peer staff will give voice to the recovery movement and encourage member and family resiliency. By hiring individuals with a lived experience as staff to support our membership, we are empowering both the members we serve and the individuals we hire. The Recovery and Wellness Liaison will receive rigorous training and credentialing assistance.

Case Management Services

For case management services, we will staff two distinct types of individuals:

- **Intensive Care Coordinators:** We will staff three, full-time home-based Intensive Care Coordinators at strategic locations across the islands. These staff members will be Registered Nurses (RNs), Licensed Practical Nurses (LPNs), or social workers with master's degrees in social work (MSW). The Intensive Care Coordinators will be responsible for assistance in case reviews and treatment/transition planning, service authorization and monitoring community-based case managers.
- **Community-based Case Managers:** These full-time staff members will be contracted from provider agencies statewide. Our initial staffing of community-based case managers is based on the assumption of 820 initial members and a maximum case load of no more than 40 members to any one case manager. We will adjust the number of contracted FTEs based on increase in members served.

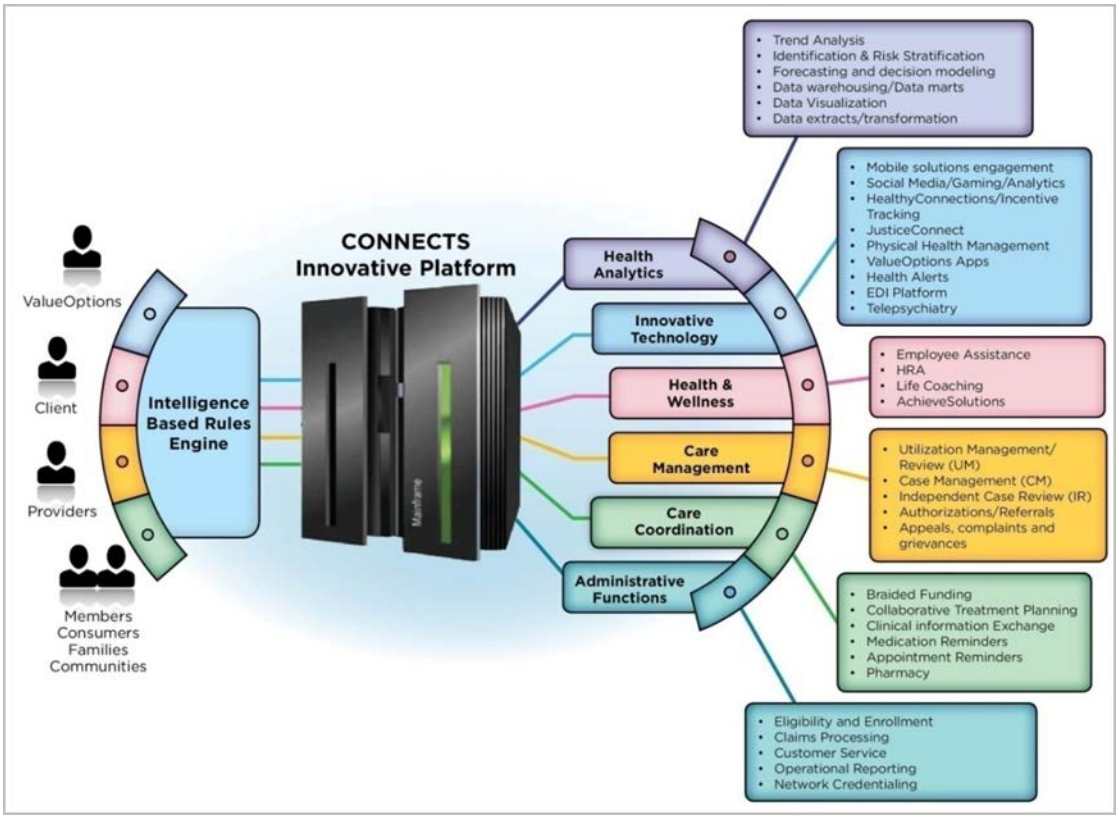


Our case management staffing model supports the member at every step.

Information Systems

We dedicate one full-time IT staff in Hawaii, who will receive support from our national IT team. Together, ValueOptions' IT experts will ensure that all stakeholders have ready access to our integrated, proprietary information management platform. This technology enhances coordination among all members of the regional Geo Teams, treating PCPs, and other medical and mental health providers.

Our integrated system is the only of its kind, for managing complete clinical, administrative, claims and reporting processes. It is fully capable of meeting all requirements included in sections 50.700 and 50.800 of the RFP. A key role of our Hawaii-based IT staff will be lending support and guidance for this unique interface.



Our national and local level IT staff will fully support the implementation of our uniquely integrated IT system.

Compliance/Program Integrity Manager (Fraud and Abuse Investigation)

We offer you a proactive fraud, waste and abuse program, with one Hawaii-based, full-time staff member backed by our national Legal and Compliance department. We structure our prevention efforts on provider education, training, communication, and industry partnerships. Our national Legal and Compliance department administers corporate-wide compliance and anti-fraud programs operations. It is led by a compliance director, who reports directly to ValueOptions' national director of compliance and program integrity, as well as the program's director.

Our compliance program comprises four major functions: prevention, audit and detection, investigation, and resolution. Leveraging our internal systems capabilities, our fraud and abuse program will meet all of the state's reporting requirements as outlined in section 40.370 of the RFP.

Administrative Support

We integrate administrative service functions with the provider services functions, member service functions, and national level supports. We will provide one full-time staff member to support this role.

Current or proposed key personnel, including an indication of their major areas of responsibility and position within the organization. At a minimum the following positions should be detailed. Medical Director

- Executive Director
- Financial Officer
- Pharmacist
- Plan contact
- QA/UR coordinator
- Grievance Coordinator
- Compliance Coordinator
- Geographic location of the key personnel

We have adjusted our staffing model to build a leadership team to best serve Hawaii's members. This includes making the leadership of our Quality Department a full time dedicated staff member, making the leadership of our Clinical Department a full time dedicated staff member responsible for all utilization review, and assigning our Executive Director as your plan contact. She will have a significant amount of day to day contact overseeing the Community Care Services program.

Name and Position	Major Area of Responsibility and Position within the Organization	Geographic Location
Executive Director	The Executive Director/CEO is responsible for overall management of the state of Hawaii contract, with ultimate responsibility for all program areas. As a member or ValueOptions' national leadership team, the executive director will maintain direct contact with the DHS throughout the contract. She reports directly to ValueOptions' Senior Vice President, Public Sector Division.	Oahu-based
Medical Director	Serves as the chief medical officer for the Service Center to ensure access and delivery of cost-effective, quality care and service to members. The Medical Director reports to the Executive Director and receives support from ValueOptions' corporate medical director.	Oahu-based
Clinical/Utilization Review Director (Case Management Supervisor)	The Clinical / Utilization Review Director is responsible for the overall clinical leadership of the CCS program including development of policy and procedures, setting and implementing utilization management goals supervision, education and training of case management staff. The Clinical/Utilization Review Director oversees the case management program and regionally-based Intensive Care Coordinators. The Clinical/Utilization Review Director interfaces with other operational units in regards to utilization management and clinical systems.	Oahu-based
Finance/Reporting Manager (Financial Officer)	The financial officer reports to the Executive Director, and is responsible for the strategic development and implementation of financial processes and systems in support of overall corporate business objectives.	Oahu-based
Pharmacist	Pharmacists are contracted as part of our provider network, and are responsible for formulary management and clinical/professional services. We will staff one Pharmacy Director to oversee contracted pharmacists. The Pharmacy Director reports to the Medical Director.	Oahu-based
Quality Assurance Director (QA/UR Coordinator)	Quality Assurance is responsible for the overall Quality Assurance/Improvement program including development of policy and procedures, developing and undertaking performance improvement projects, and supervision, education and training of quality management staff including the Grievance Coordinator and the Compliance Coordinator. The Quality Assurance Director interfaces with other operational units in regards to quality improvement and the quality management plan, and reports to the Medical Director.	Oahu-based

Name and Position	Major Area of Responsibility and Position within the Organization	Geographic Location
Complaints and Grievances Coordinator	The Complaints and Grievances coordinator will ensure compliance with all protocols as stated in section 40.500 of the RFP. This individual will work with the Intensive Care Coordinators, but will not have any involvement in case management activities, as required. The Grievance Coordinator reports to the Quality Assurance Director.	Oahu-based
Compliance/Program Integrity Manager (Compliance Coordinator)	ValueOptions lends the support of our national compliance and reporting team, comprising legal experts specializing in regulatory requirements and fraud and abuse. The Compliance Coordinator reports to the Quality Assurance Director.	Oahu-based

70.600 PROVIDER NETWORK

70.610 PROVIDER LISTING

The offeror shall have a provider network that complies with the requirements of section 40.300. The offeror shall identify its providers on each island by specialty. The offeror must provide the full range of behavioral health services to members included in their proposal statewide. All providers required in Section 40.310 shall be included in the proposal.

ValueOptions is currently engaged in a good faith effort to build a network that is fully compliant with all specialties, access, credentialing and other criteria outlined in section 40.300 of the RFP. Our network will be fully compliant no later than 60 days prior to commencement of services to members, and will include at minimum the following provider types:

- behavioral healthcare specialist services such as psychiatrist, psychologist, social workers, certified substance abuse counselors, and advance practice nurses trained in psychology
- case management
- inpatient behavioral health hospital services
- outpatient behavioral health hospital services
- mental health rehabilitation services
- day treatment programs
- psychosocial rehabilitation (PSR)/Clubhouse
- residential treatment programs
- pharmacists
- laboratory services
- crisis services: mobile crisis response and crisis residential services
- interpretation services
- transitional housing
- representative payee
- supported employment
- peer specialists

The provider network shall be based on either existing contracted providers or the offeror may provide its network based on providers' intent to contract with the BHO. The letter of intent (LOI) format provided in Appendix F shall be used to identify providers that are willing to contract with the BHO. A copy of each LOI shall be submitted in the proposal. Within one month of notice of award, the offeror must submit its preliminary network to the DHS. Failure to meet the requirements of the contract will result in a delay in implementation of the plan.

We include copies of each signed LOI, as well as documentation of our recruitment efforts using the provided Appendix F, as an addendum to this section of the proposal. Please see **Attachment 1.**

RECRUITMENT EFFORT AND OUTREACH TO DATE

At the heart of our success in network development and management is the fact that we design our solutions one state partner at a time. From broad networks to specialty providers, from the needs of the many to the needs of the vulnerable few, our most important work is to build systems of care for people who have few resources and little influence.

We develop each Medicaid program's provider network in response to its unique needs and design, maintaining the flexibility for it to evolve to meet future challenges.
Presently, most of Hawaii is designated as a mental health professional shortage area and demand for services outstrips current capacity. The result is that those seeking services often have to wait longer or may have inconsistent treatment due to staff changes. As they wait, the severity of their problems often worsens, which can lead to mental health crises. In order to meet the current and future unmet needs of those with behavioral health disorders in Hawaii, a large number of professional positions in behavioral health need to be filled. Additionally, those trained to become behavioral health clinicians require exposure to issues facing island residents.

ValueOptions has contracted with the Western Interstate Commission for Higher Education to develop a uniquely tailored network of providers and peer supports to meet the needs of Hawaii's most vulnerable Medicaid members.

For Hawaii, we will contract with all willing Medicaid providers, as well as attempt to expand the supply of behavioral health providers willing to serve the Medicaid population. When the original RFP was released in May, our network and provider relations staff began an extensive network analysis, discovery, and recruitment effort. With the re-release of the RFP, we have restarted these efforts to contract with provider organizations across the state. We are committed to developing a full network meeting all DHS requirements prior to readiness review.

We have contracted with the Western Interstate Commission for Higher Education (WICHE) whose primary goal is to advance the preparation of a qualified mental health workforce in the West. WICHE has access to a national cadre of content experts on policy, system improvement and practice issues in behavioral health, in areas such as public financing, health integration, health information exchanges, and economics to the use and development of evidence-based

practices. WICHE will provide a variety of workforce development opportunities to improve the competency of the behavioral health workforce in Hawaii, including peer support services, evidenced-based practices development and support, internship consortiums and community capacity-building.

We will continue these efforts with similar organizations to exceed the state's expectations, and identify additional, regional behavioral health agencies with which we have established contacts in the chart on the following page.

Established Behavioral Health Agency Relationships

Behavioral Health Agency/Affiliation	Contact
Proprietary and Confidential	
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

In Hawaii, as a continuation of our efforts begun in May, we have outreached to approximately 200 providers to date, including Community Mental Health Centers, Federally Qualified Health Centers, Psychiatrists, Psychologists, Advanced Nurse Practitioners and Masters Prepared clinicians to invite them to partner with us to serve these consumers. Recognizing that all of these providers will not only meet the networks requirements as defined, but will expand the availability of Medicaid providers across the islands, we included the providers currently participating in our current commercial network as well. We provide as an addendum to this section of our proposal, a list of all providers we have contacted, including those whom we have sent LOIs, with those who have returned LOIs highlighted. Please see **Attachment 2**.

Our outreach effort inviting these providers to join us has included telephonic, email, fax and USPS mailings. Although we are still in process of developing this network, it is important to note our expertise in quickly building and implementing networks in diverse settings—**we have never missed a deliverable or deadline in an implementation related to network development.**

ValueOptions will oversee all network and provider relations functions of this program, and will comply with all requirements specified in section 40.300 of the RFP. In subsequent years, we

will propose redesigns and other development initiatives to strengthen the network – all designed to enhance your goal of improving the value of behavioral health services without comprising vulnerable populations' access to them.

The offeror shall provide its provider listing (to include providers who have signed a LOI) for each island using the format in Appendix G. For each provider type, the offeror shall list the following information:

- *Provider type*
- *Specialty (i.e., psychiatrist, psychologist, psychiatric nurse practitioner, social workers, substance abuse counselors, etc.)*
- *Island/County (for Oahu, include the city)*
- *List the provider name (last name, first name, M.I.)*
- *Provider address (location where service is provided)*
- *City*
- *Zip code*
- *Indication as to whether the provider is accepting new BHO patients from the plan (Y/N)*
- *indication as to whether the provider has a limit on the number of BHO QUEST patients he/she will accept from the plan (Y/N)*

Separate the providers by provider type noted below:

- *Behavioral healthcare specialist services such as psychiatrist, psychologist, social workers, certified substance abuse counselors, and advance practice nurses trained in psychology*
- *Case management*
- *Inpatient behavioral health hospital services*
- *Outpatient behavioral health hospital services*
- *Mental health rehabilitation services*
- *Day treatment programs*
- *Psychosocial rehabilitation (PSR)/Clubhouse*
- *Residential treatment programs*
- *Pharmacies*
- *Laboratory Services*
- *Crisis services: mobile crisis response and crisis residential services*
- *Interpretation services*
- *Transitional housing*
- *Representative payee*
- *Supported employment*
- *Peer specialist*

Each provider should be listed only once.

For clinics serving in the capacity of a behavioral health provider, list the clinic and under the clinic name, identify each specific provider (e.g., psychiatrist, psychologist, psychiatric practitioner, etc.). The address of the clinic should be placed in the address field. The number of BHTPA members assigned to the clinic should be noted. Physicians serving as specialists should be listed on the specialty care matrix with the clinic's name. If the clinic also provides translation, it should be listed on the translation services matrix.

In addition to a hard copy of the provider listings, the offeror shall include with its proposal an electronic file of providers in
Excel format.

We include the requested provider listings, using the Appendix G template provided with the RFP and in Excel format, as requested, as an addendum to this section of our proposal. Please see **Attachment 2**.

Finally, the offeror shall describe in narrative format how it will reimburse for services for which there are either no contracted providers or the number of providers fail to meet the minimum requirement. Additionally, if the plan does not meet the required providers in its network, it should identify how it will enable its members to access these services. Please describe in this narrative portion how it will arrange to reimburse for meals and lodging for out-of-town medically necessary stays.

Reimbursement for Services for which There Are Either No Contracted Providers or the Number of Providers Fail to Meet the Minimum Requirement

If a Hawaii member needs treatment and there is no specialized provider already contracted in a particular service location, or if the network contracting process is incomplete at program start date, we will establish a single case agreement with a local, out-of-network provider. ValueOptions has specially trained administrative staff to issue single case agreements, and cases are reviewed by clinical staff on an ongoing basis to ensure that they meet medical necessity criteria. A record will be established within our system and the provider's credentials will be verified to allow payment for members in care, for a provisional period of up to 180 days following the transition.

Each case in progress at the time of transition will receive careful consideration focused on the member's needs. Treating providers eligible to join our network will be recruited, although our primary concern resides in sustaining each member's continuous, uninterrupted care. Single case agreements ensure this care continuity throughout the credentialing process.

How the Plan Will Enable Its Members to Access Services If It Does Not Meet the Required Providers in Its Network

As described immediately above, single case agreements enable members to receive services from non-contracted providers. In any instance where a member need requires a specialty not available in the ValueOptions network, a single case agreement can be employed to allow the member to receive care from an out-of-network provider. Single case agreements not only allow us to provide services on a temporary basis to members with unique needs and during transition planning—they also inform our ongoing recruitment efforts. All providers contracted under single case agreements will be invited to join our network.

We will maintain ongoing network support and development throughout the life of our contract to identify and address any provider gaps.

Measures to ensure that each member has access to the right care at the right time include:

- maintaining an open network recruitment policy —We will encourage non-network providers who are serving our membership to join our network.
- providing single case agreements even for those provider not in our network who do not want to join—We do not limit the provision of single case agreements with the contingency that providers must apply for network membership. Our focus resides with the member; we will

contract as necessary with the best possible providers to meet members' needs regardless of their disposition toward joining our network.

- developing alternative services such as peer support and ensure connections to non-funded community resources and natural supports—Through the joint efforts of our local and national staff, community providers and community organizations, we will continue to broaden the scope and depth of peer services, and local, culturally appropriate care.
- contracting with willing providers and clinics to reimburse their inter-island travel time
- providing access to a national telehealth network—the first of its kind in the nation, ValueOptions will offer members expanded access to specialists throughout the country via a live, interactive interface. Please see section 70.700 Case Management, for a full description of our eCare Access telehealth platform.

ValueOptions is the first in the industry to offer a national telebehavioral health network, via our eCare Access Telehealth platform

- transporting the member off-island, when other alternatives are unavailable—We recognize that transporting the member for treatment off-island may be the best, most supportive option in some cases. We will coordinate with transportation vendors and provide direct member supervision when this becomes a necessity.

Reimbursement for Meals and Lodging for Out-Of-Town Medically Necessary Stays

Our provider relations liaisons' and Intensive Care Coordinators' primary role is to develop strong, regional presences by forming trusted provider relationships. By embedding themselves within the regional care management structure, these staff will identify existing opportunities for travel and lodging arrangements currently utilized by the state's provider organizations.

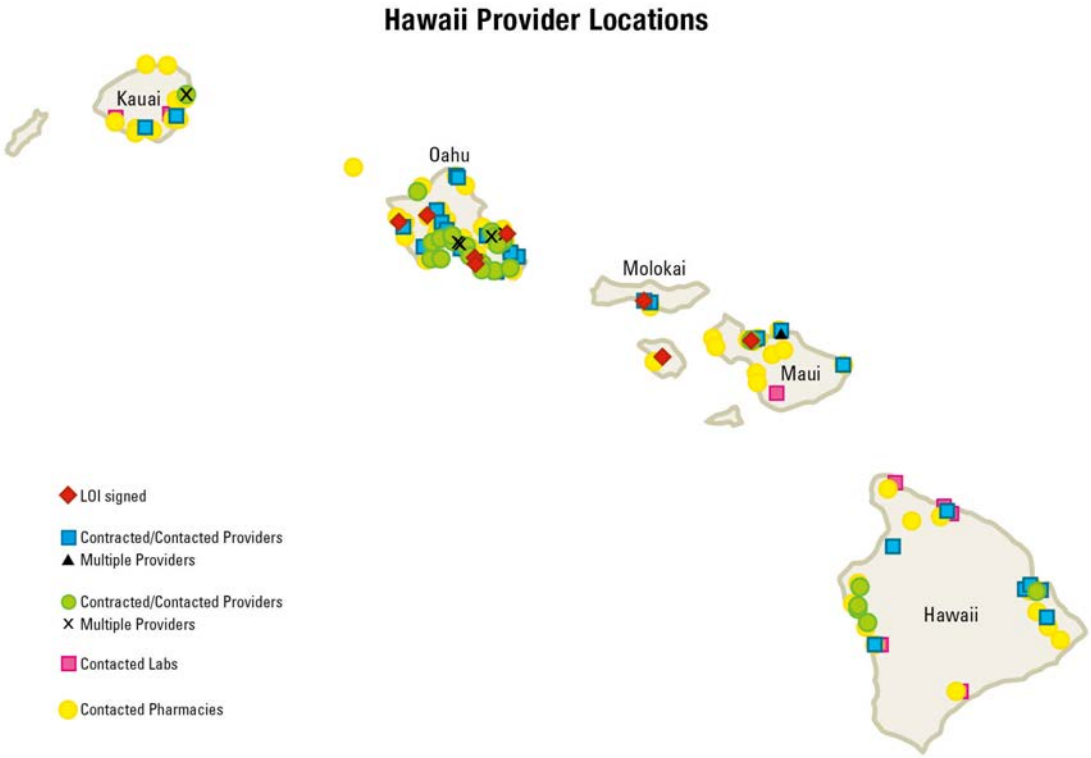
When ValueOptions identifies a service gap or need, we can provide travel services for providers. Providers required to travel out of town to render their services will be reimbursed for meals and lodging using available structures and resources. In other states, we have arranged for transportation services through stipends, using contracts with various types of transportation providers to achieve discounts on services.

For members required to travel for medically necessary stays, we will pay the costs of transportation, meals and lodging based on the Medicaid capitation rate. This may be accomplished through methods such as dispensing pre-paid debit cards, providing coupons or vouchers managed by ValueOptions, or in some cases, providing individual chaperone support.

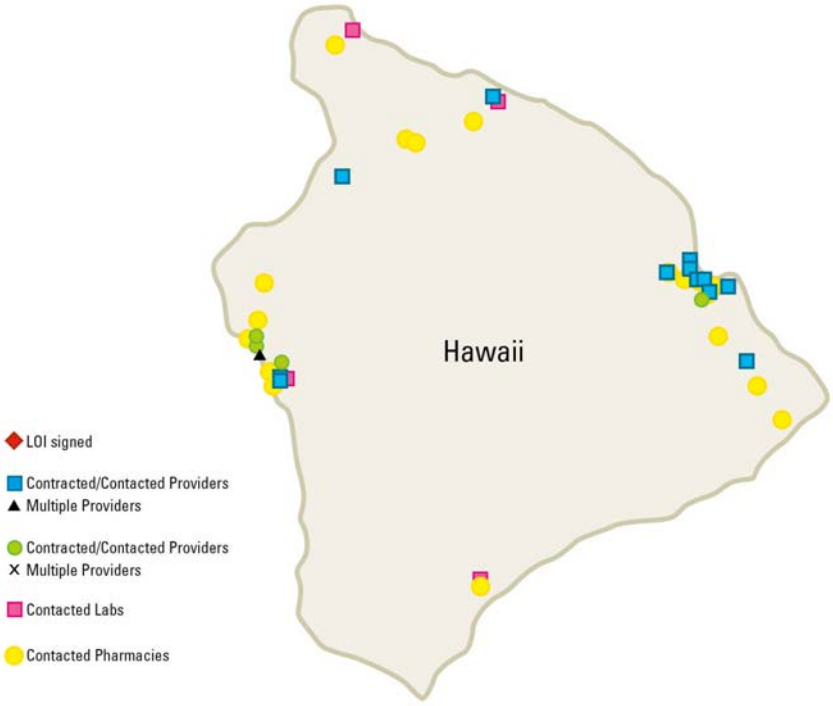
70.620 MAP OF BEHAVIORAL HEALTH PROVIDERS AND HOSPITALS

The offeror shall include in its proposal a map of each island indicating the locations of its behavioral health providers and acute psychiatric hospitals. The offeror shall include all providers that have signed a LOI in their maps as well as contracted providers.

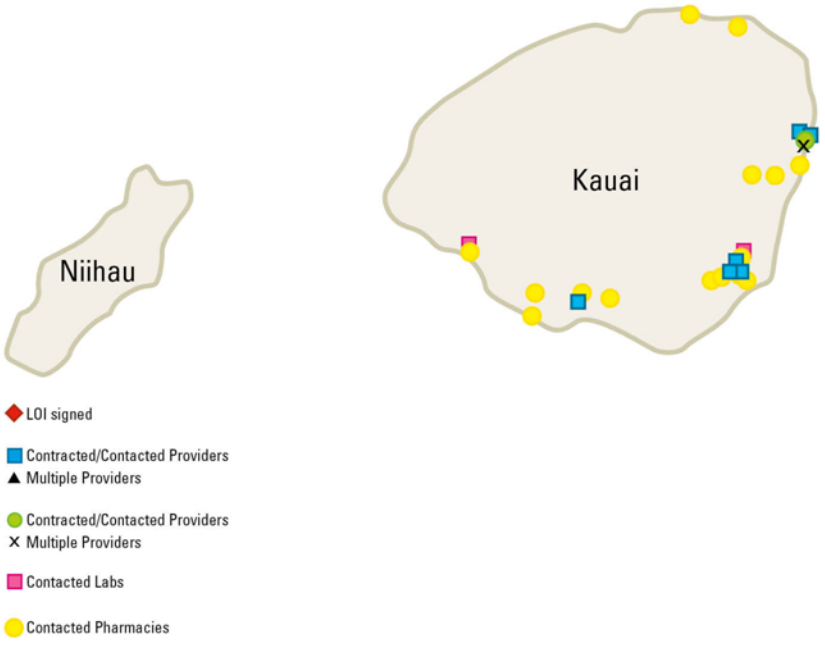
We include in the map below all currently contracted providers as well as those who have signed an LOI. For specific provider details, please see **Attachment 2**.



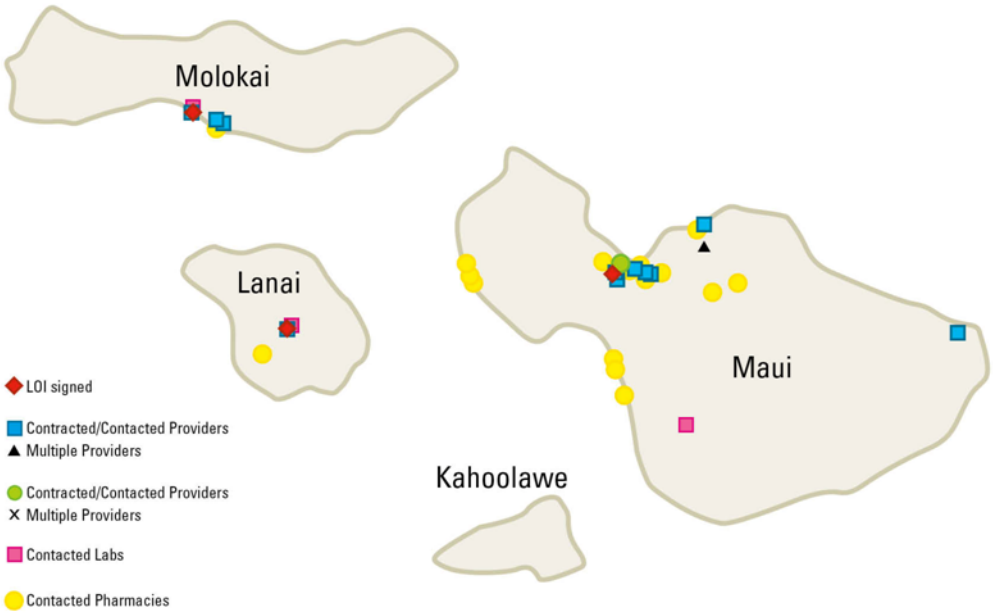
Hawaii – (Big Island) Provider Locations



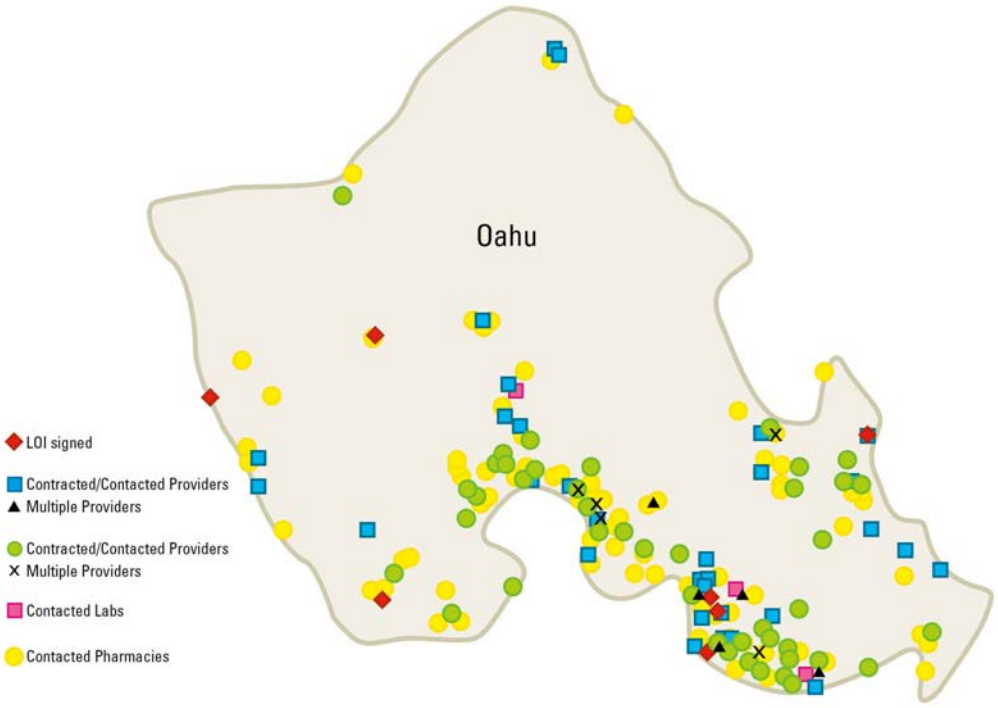
Hawaii – Kauai and Niihau Islands Provider Locations



Hawaii – Maui, Molokai, and Lanai Islands Provider Locations



Hawaii – Oahu Provider Locations



70.700 CASE MANAGEMENT

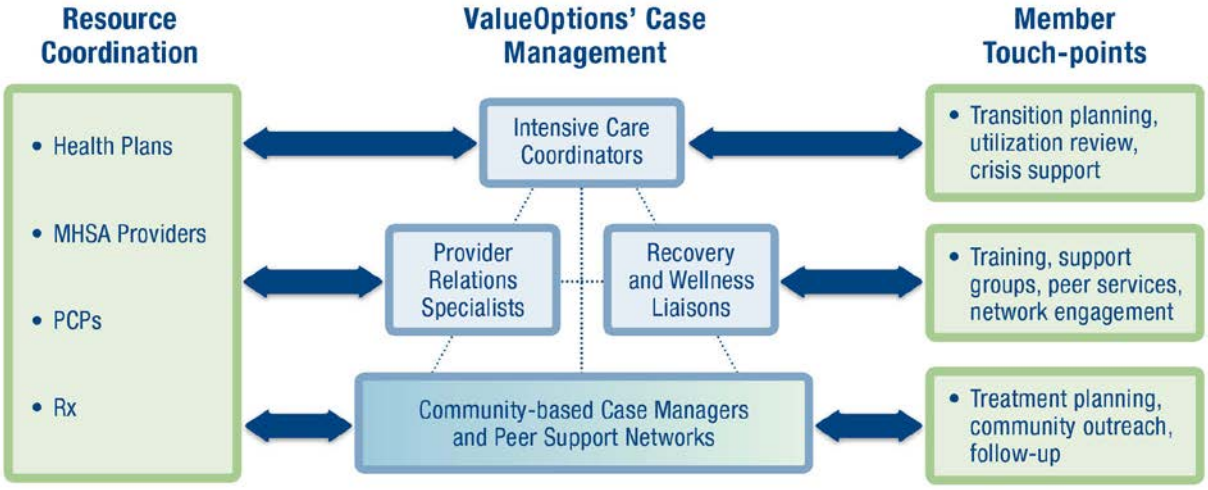
The offeror shall explain the following in their proposal:

Our Member-focused Case Management Model

Throughout our responses below, we describe how we will accomplish the state's goals through our **regional, member-centric Case Management Model,** emphasizing enhanced engagement, communications, and collaboration among all stakeholders. This model strengthens care coordination, network development, and member recovery and resiliency. At the model's core, our member-focused case management structure, with regional, geographically-based teams, or **Geo Teams**, coordinate member care. Our Geo Teams will include the following elements:

- a team of **regionally-based Intensive Care Coordinators** to provide case management oversight, coordination, and direct member support when needed
- a supporting team of **Recovery and Wellness Liaisons and Provider Relations Specialists** to grow and strengthen existing provider resources; ensure credentialed, community peer specialists and provider quality; and provide training to peers and case managers
- a network of **contracted case managers and credentialed peer services providers** throughout Hawaii to meet the diverse needs of your members. We intend to contract with Hawaii-based non-profit providers for case management services. These providers bring a local knowledge and familiarity with local, non-Medicaid funded resources, such as peer support services, transportation services, and other vital, community-based components of care.

Regional, Member-centric Case Management Model



Regionally-based Intensive Care Coordinators ensure that:

- members receive appropriate case management services and interventions
- treatment plans are completed and individualized
- services are authorized and coordinated across the member's entire spectrum of needs
- case managers work with physical health partners to deploy care coordination strategies for those individuals who are most at risk with chronic co-morbid conditions

Role and Function of Regional Geo Teams

Our regional Geo Teams will coordinate and supervise all face-to-face contact requirements for Community Care Services (CCS) members with local organizations and provider agencies, as set forth in the RFP. Led by ValueOptions' Intensive Care Coordinators, who are Licensed Clinical Social Workers (LCSWs), Registered Nurses (RNs), Licensed Practical Nurses (LPNs), or social workers with a master's degree in social work (MSWs), our team will also include dedicated peer Recovery and Wellness Liaisons and staff Provider Relations Specialists. Peer and provider relations staff supports provide both direct and community-based support to the Medicaid population, its providers, and the delivery system. This can include normalizing the recovery process for members and their families, helping members find traditional and non-traditional services in the community, and improving member engagement and treatment outcomes.

Our Intensive Care Coordinators will lead and supervise the efforts of each team's group of case managers who will serve as the local case management teams. Each of these highly specialized case managers will be a locally-based, licensed Hawaii practitioners trained and familiar with the islands' available community resources and overall care infrastructure. Through the case managers' critical support, members will receive outreach, coordination, and guidance to the best resources available by the most efficient means.

We will ensure the required level of CCS member engagement is achieved by placing our staff locally where our case management agency partners and members reside. Our embedded Geo Teams will participate actively in the local communities, forming strong bonds with local government officials, law enforcement, and social service agencies. Our regionally-based Geo Teams provide access to and coordination of a more comprehensive community-based behavioral health service and support system to meet the needs of the complex, high-need CCS population.

The state will further benefit from a single-platform, integrated IT solution trusted by more Medicaid programs than any other vendor. This will include our member-centric record, Spectrum®, and case management platform utilized by our case management partners, our advanced care gap analytics and pharmacy management modules to identify and risk-stratify high needs members, and our unique telehealth solutions to ensure that every member has access to needed care.

How persons (members, family members, community providers and providers) may access the case management system

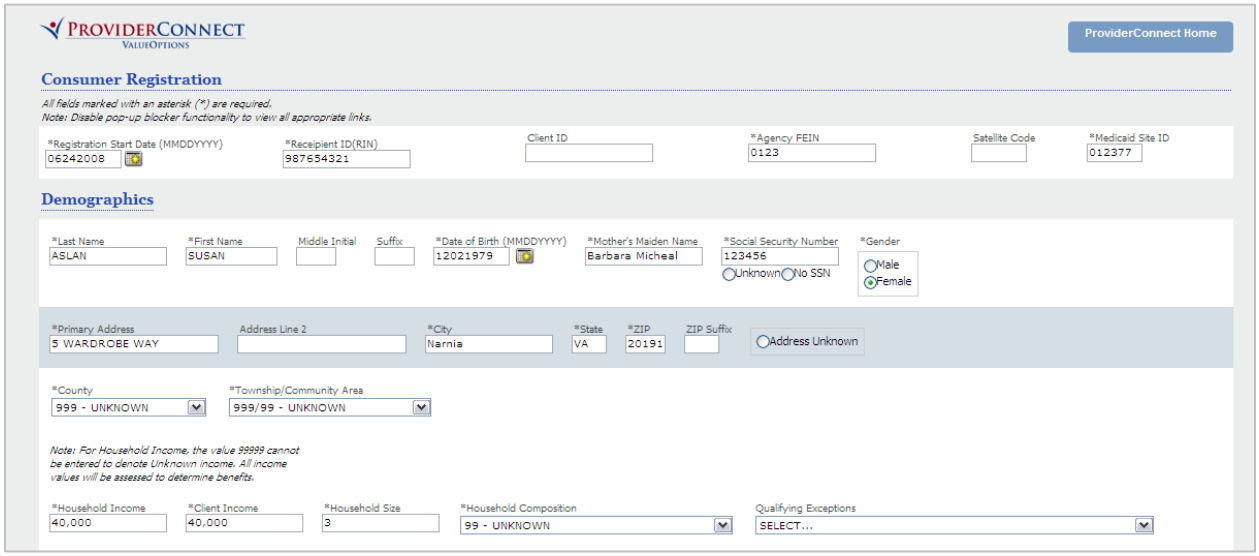
Members, family members, behavioral health providers, primary care physicians, and health plan resources will access and engage in our case management system through a wide network of Web-based interfaces, on-the-ground support, technological innovations, 24-hour in-state telephonic support, and peer support agencies' services that are fully compliant with section 40.200 of the RFP. Our model focuses on member engagement at each and every step. We describe some of our processes and access channels below, including:

- **Referral from the State and Health Plans**
- **Face-to-face, Comprehensive Assessments**
- **24-hour Hotline for Members and Providers**
- **Embedded Peer Support Networks**
- **Member and Provider Website and Online Resources**

Referrals from the State and Health Plans

We provide an integrated information system and shared member-centric health records to ensure coordinated and smoothly executed enrollments for all QExA members determined to be severely mentally ill (SMI) or provisionally SMI through the MQD evaluation process. Our system can incorporate information from the member's health plan and be made available to medical providers to enhance the efficacy of coordinated treatment and transition planning.

This is particularly useful for cases where members are disenrolled and then re-enrolled due to eligibility fluctuations within a relatively short timeframe. Our system will allow these members' continued eligibility for periods up to six months, without requiring additional evaluations. We will provide case managers with an automated enrollment module that can track each member's status, relevant timelines, updates, and other information. All enrollment data is captured within Spectrum, our member-centric record, so that health plan providers can access complete behavioral health treatment histories when the member is transitioned to a lower level of care, or for joint treatment planning for co-morbid cases.



Enrollment is part of our integrated management information system.

Our registration and enrollment module incorporates information gathered from the health plan's clinical assessment, as well as required eligibility verification business rules, clinical parameters and standard assessment tools. We will partner with you to develop clinical assessment reviews and outreach protocols that ensure engagement and the most appropriate treatment options available.

Recognizing the significant, compounded costs for members with co-morbid medical and behavioral health disorders, we engage in multiple strategies to maintain communication and coordination with the health plans once the member has been enrolled for behavioral health case management. These include:

- including the health plan care manager, and the member's somatic medical providers and PCPs in treatment planning and reviews
- direct, case manager outreach to medical providers for consultation in conducting comprehensive assessments
- including somatic medical information in the member record and individualized treatment plan
- coordinated tracking of medications for both physical and behavioral health conditions, including member and provider health alerts for non-adherence
- offering telephonic provider support for both behavioral health and medical providers for claims inquiries, information tracking and updates, policy information, and related consultations—this includes our physician consult line staffed by a licensed psychiatrist who provide assistance with medical treatment planning.

In addition, as part of our comprehensive, integrated system, member enrollment and assessment data can easily be shared with treating medical providers. Our Intensive Care Coordinators further ensure coordination among all stakeholders, including medical and behavioral health providers.

Face-to-Face, Comprehensive Assessments

Once enrolled, members are targeted for outreach. By contracting with local, community-based provider agencies and peer organizations, members will be able to seek direct access to case management services within their communities, from providers they know and trust. We have already begun extensive efforts to contract with multiple case management entities across the state, to offer members the greatest variety and availability of providers and peers possible.

For those members not able to access provider locations due to transportation, mobility, or other issues, our regional Geo Teams will coordinate on-the-ground outreach efforts with community case managers to ensure comprehensive assessments of all members within 30 days of enrollment, and reassessments annually, at minimum.

Case management is the backbone of effectively ensuring that members experiencing a severe mental illness are receiving the services they need to advance in their recovery. Case managers act as conduits for all care coordination and transition efforts, member education, outreach, and information on how to obtain services and make informed decisions about their behavioral health needs. Each member will be assigned a case manager upon enrollment. In addition to ensuring adequate outreach to conduct a comprehensive, face-to-face assessment, the case manager will also work with the member, family members and peers, and treating providers to develop the individualized treatment plan (ITP) within 30 days of completing the assessment, and update the plan as required.

Customized clinical assessments will support targeted methods of identifying the needs of CCS members, such as screening of claims and eligibility files to stratify members according to risk level, to facilitate the most assertive and effective interventions for the this severely mentally ill population. With our [redacted] at their disposal, members and the medical and behavioral resources in their individualized system of care, will experience an enhanced level of administrative continuity and ease of communication.

24-Hour, Hawaii-based Hotline

For additional assistance, our dedicated toll-free number provides CCS members, providers, and other stakeholders a single point of access to Hawaii's behavioral health system 24 hours a day, seven days a week.

Members and providers can access the hotline to:

- identify and connect members to their case manager or behavioral health provider
- direct members in crisis to the nearest, most appropriate behavioral health delivery site
- provide required approvals
- have their questions related to behavioral health problems and minor emergency care answered

All member calls at all times will be answered by our Member Engagement Specialists. We will also provide a team of locally-based Intensive Care Coordinators to handle clinical assessments, referrals, and inquiries. Members in crisis require easy and immediate access to a clinician who can assist them in obtaining the necessary services. For this reason, our Intensive Care Coordinators are available on a 24-hour, 7 day a week basis.

Our state-of-the-art telephony structure will immediately direct crisis calls to an Intensive Care Coordinator without placing the member on hold. All of our Member Engagement Specialists are trained to identify emergency situations and immediately warm-transfer such calls to an Intensive Care Coordinator. We are committed to member engagement and satisfaction and have proven processes in place to ensure consistent operational success.

Embedded Peer Support Services

To best achieve the DHS' goals for effective outreach and amplify ease of access, we recommend embedded peer support staffs located at key provider agencies and/or embedded service models whereby peer run organizations provide direct services. To coordinate these efforts, we will include dedicated, Recovery and Wellness Liaisons as part of our Geo Teams, to assist in the coordination of all peer-provided services and peer network development.

We have extensive experience working in partnership with community supports such as peer run organizations, churches, schools, universities, and local governments to provide education, training, research, and outreach to broaden the channels of access to our services—all further supporting members in achieving better health.

To illustrate:

- In Illinois, we offer a warm line service staffed with credentialed peer specialists who have experienced mental health recovery in their own lives. The warm line provides members with emotional support, recovery education, and self-advocacy support, and has resulted in exceedingly high member satisfaction.
- In Tennessee, TennCare, along with ValueOptions of Tennessee, supports non-traditional peer service for the region's culturally diverse needs.
    - Another model from our Tennessee experience, the Emotional Fitness Centers (EFC), is a faith-based provider of behavioral health services.

Our solutions and contractual arrangements are designed to meet the unique needs of our programs. Non-traditional delivery sites, such as those utilizing our telehealth solutions or culturally-specific practices have also proven greatly effective.

Peer Certification Assistance

We propose to further build upon current peer support development efforts in Hawaii by developing and expanding the training available to peers and their supervisors through Hawaii's Certified Peer Specialist (HCPS) program. The 'lived experiences' of peers offer a unique perspective and understanding of the challenges faced by many individuals with behavioral health disorders, while at the same time the outcomes of these experiences provide hope for others to live and thrive successfully in their community. Additionally, the training, support, and supervision of peer support specialists are vital to the success of such services. ValueOptions has a longstanding partnership with the Western Interstate Commission for Higher Education (WICHE). WICHE has more than 55 years of experience supporting the improvement of public behavioral health services and the preparation of the behavioral health workforce in the West and across the nation. For decades, the State of Hawaii has been a member of WICHE. ValueOptions intends to position WICHE's proven experience in Hawaii and other western states in targeting the development of peer specialists in Hawaii, as well as providing training and supports for the supervisors of peer specialists.

Recovery and resiliency are the fundamentals to the fabric of our approach to business and services. ValueOptions will ensure that every aspect from outreach to outcomes is conducted in a manner that supports and encourages recovery and resiliency. Our approach is built around supporting a culture of recovery by empowering members and families in every interaction with us, their providers, and their natural supports to achieve their fullest potential.

eCare Access: Telehealth Solutions to Reach Remote Members

In Hawaii, providers are already using our Online Care system, ECareAccess Telehealth Solution. Currently enrolled provider counts across the state include:
- ***11 psychiatrists***
- ***5 child psychiatrists***
- ***42 psychologists***
- ***2 APRN psychologists***

Tackling the challenges of Hawaii's rural and underserved areas will require a great deal of collaboration with all existing providers, agencies and stakeholders. We offer our ability to plot and evaluate access for each covered service, targeting areas for recruitment and initiatives that have proven successful in our other state Medicaid programs. Telehealth provides a secure solution in high definition, real-time images and proven efficiency to providers' offices. We are currently expanding our telehealth network to a national scope—the first of its kind in the industry.

The integrated web- and smartphone-based platform, eCare Access, allows providers to have clinically meaningful encounters, via high-quality video, audio and secure text chat. The platform includes e-prescribing, a diagnosis and procedure tool to properly code each visit, follow-up items such as referral functionality and educational tools, and documentation of the encounter that persists in perpetuity for both the patient and provider. Our platform also allows the member to choose a practitioner based on his or her online profile, from previous patient history reporting and satisfaction ratings.

We feel our telehealth solution will bring much-needed psychiatric services, in particular, to areas of Hawaii that have been underserved for many years.

The Online Care platform simplifies member and provider access.

Member and Provider Website and Online Resources

Web resources provide an additional avenue to member engagement. As part of our embedded, regional model of care, we will host a customized, user-friendly website with general information about Hawaii's program, as well as educational, clinical and transactional information for members, family members and providers. The website will provide access to informational resources for members and to a wide range of provider case management resources, including our enrollment module, online case management module and treatment

plans. The website will serve as the informational hub for sharing information among members, behavioral health providers, case managers, certified peers and medical providers.

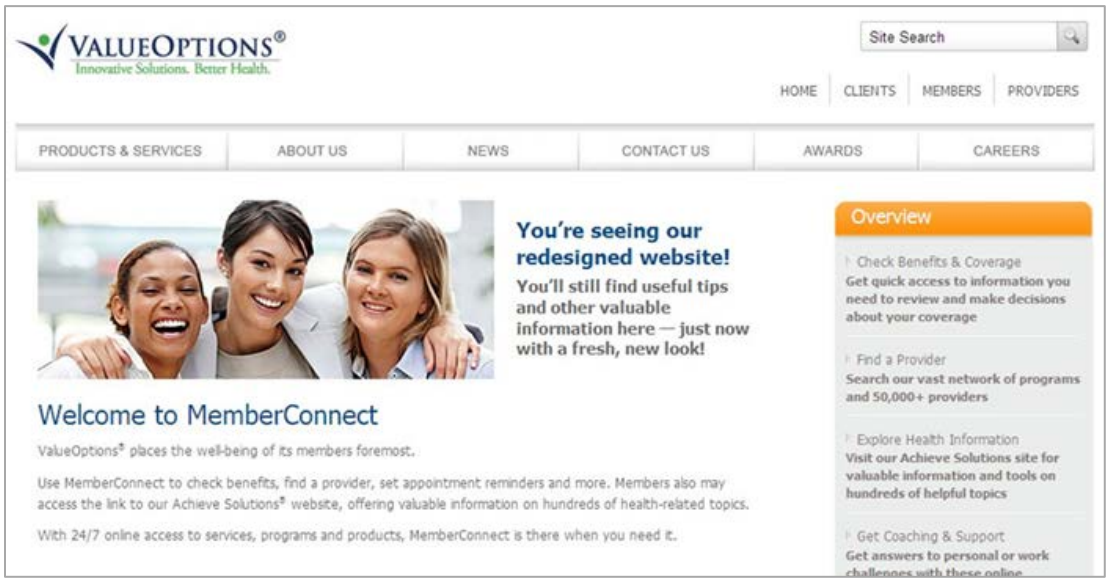
Our guiding design principles will enable maximum access, as well as efficient ways to update information. Our member and provider web portals and websites are utilized in our Medicaid programs across the county and have proven to be an addition avenue for member access to information. Our site will include:

- simplified access to a wide range of information, applications, people, and processes
- personalized spaces to support each member's and provider's role in a security-rich, standards-based, enterprise-wide framework
- our toll-free call center telephone number and hours of operation
- member services contact information, including e-mail addresses
- eligibility information and an explanation of requirements and benefits of the plan
- information on accessing behavioral health services
- a link to our provider directory
- crisis response information and toll-free telephone numbers
- emergency preparedness and response
- holistic health information and links to related articles
- information about community forums, volunteer activities and more
- information about advocacy organizations, including instructions for accessing services for children, youth, young adults and other family members/caregivers
- a hyperlink to the DHS website
- instructions on filing a grievance or appeal
- instructions on reporting suspected provider fraud and abuse, including DHS's toll-free telephone number and website address
- information to assist providers with billing and/or service authorization issues, as well as access to their manual
- other documents or resources required by DHS

We design our websites with easily navigable links to our member and provider portals. They also include other resources, such as our online provider training modules.

Member Portal

Your members and their families will have access to a dedicated Web portal, which offers a wide range of secure options for round-the-clock online service requests. The first time members visit the portal, they are prompted to register with a user name and password. That allows them to submit Web-based inquiries that our integrated information system automatically captures and makes available for staff follow-up and resolution.



Members and family members have access to a dedicated portal 24 hours a day, providing culturally appropriate resource information at a 6th grade reading level.

The member portal also enables members and family members to:

- verify eligibility
- check benefits
- search for network providers and their locations
- view authorizations, including services used
- view and print authorization letters, explanation of benefits and other correspondence
- check claims history and payment
- view our-of-pocket expenses for individuals or family
- submit an inquiry to customers services via our virtual messaging center
- view individualized treatment plans
- set up health alert reminders for medication and appointments
- modify their online profiles
- access information on benefits and how to obtain services

The member portal presents comprehensive, easy-to-read (6th grade level) information within seconds. It includes links to specific information and resources to assist members and families with their behavioral health needs. They include the Member Handbook, the provider directory, newsletters and articles written by members, information about community services and advocacy organizations, as well as instructions for contacting Member Services.

We include all required content, such as the Member Handbook, containing information about understanding and using benefits. But our website will also provide access to Achieve Solutions, our public award-winning online wellness and health information resource. This information is all readily accessible to members, families, system partners and providers, who can easily download, print, e-mail or make a PDF of any articles they want.

Provider Portal

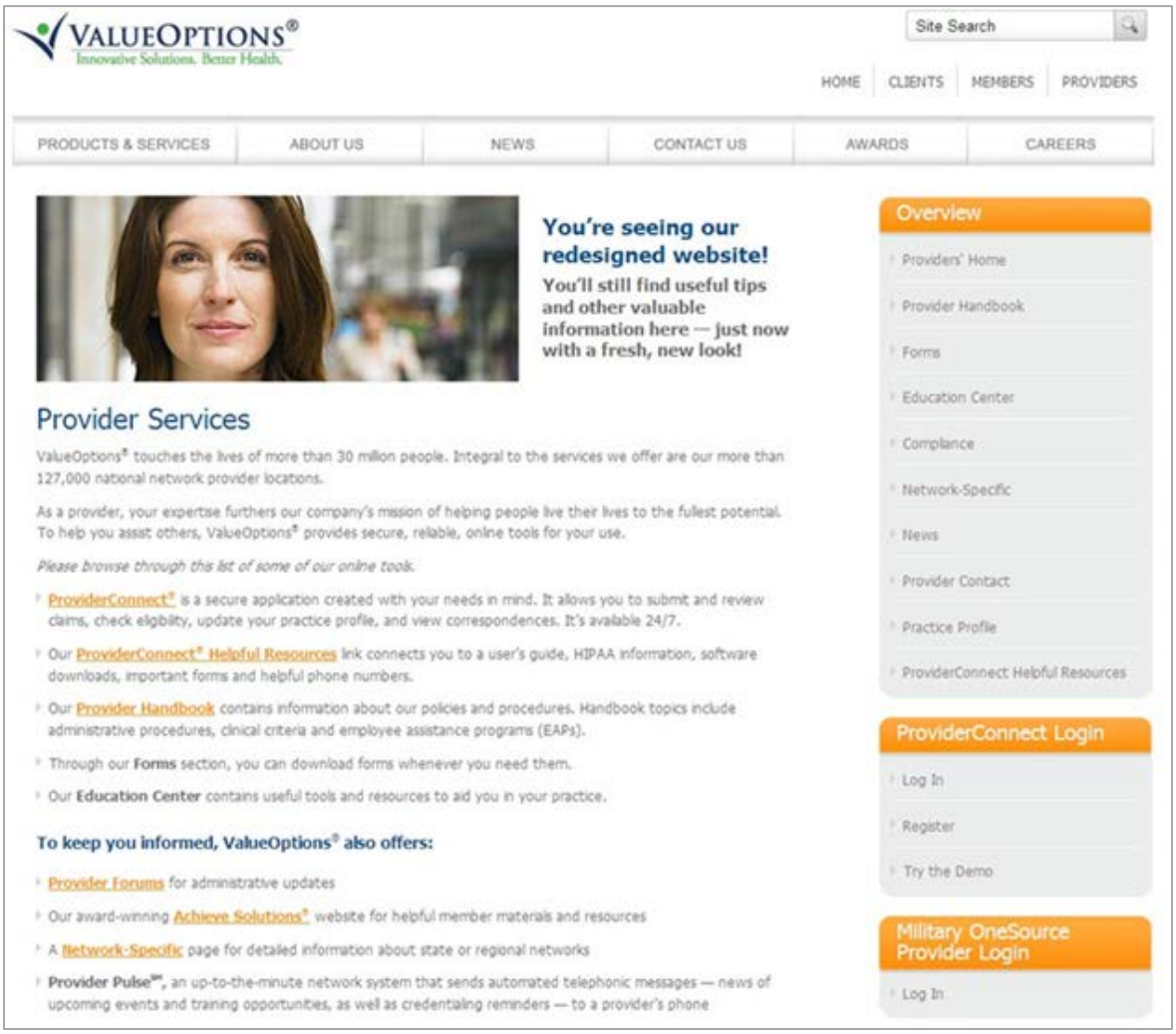
Our provider portal enables providers to view, submit and execute case management transactions online via a secure, scalable, and trusted Web portal. It is a robust and highly intuitive website that offers providers real-time access to tools necessary to answer most of their administrative or care questions, as well as request services for members.

We offer a comprehensive website that incorporates industry best practices, and is customized to address the unique needs of all providers. Our architecture enables on-demand access to pertinent information through intuitive menus and a three-click navigation scheme. It puts a full array of information resources at providers' fingertips.

Through our provider portal, we can electronically process both single and batch claims submissions, with instantaneous online adjudication at no charge to our providers.

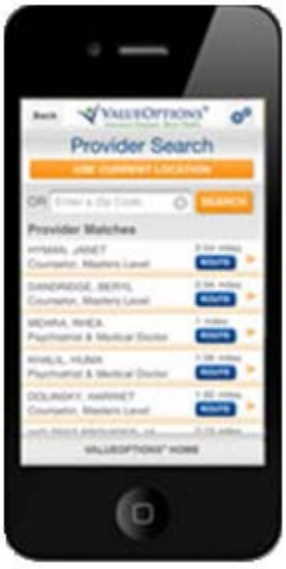
The provider portal enables providers to:

- check a member's enrollment status
- register a member for services
- check a member's benefit information
- review and submit authorization requests for all levels of care
- review and submit treatment plans
- view and submit demographic data updates
- attach documents to all submissions
- view/print authorization letters, summary vouchers and other documents
- create and view other types of inquiries through our message center
- view authorization/letter history
- directly submit claims or upload HIPAA-compliant files (providers can elect to register for EFT)
- view provider handbooks, obtain training information, current clinical articles and workshops
- enter health alerts to remind members of appointments or when to take their medications
- access on-demand reporting solutions to support their own practice management
- access client-specific network information
- download and print standard forms



The online provider portal provides central access to administrative and clinical resources.

Online, Searchable Provider Directory



We ensure your members have a choice of network providers who meet their cultural and linguistic preferences, as well as their behavioral health care needs. We are committed to offering members convenient access to all levels of care.

We actively recruit providers who meet one or more areas of need in a given demographic area to ensure a diverse network of highly qualified providers that meet members' care needs, as well as their cultural and linguistic preferences. Our online, searchable provider directory promotes informed choice by offering providers, and members and their families a comprehensive resource for available services, either online or in hard copy. And our **free, downloadable Mobile Referral Application** enables members to search for a provider, view specialties, and other demographic information about providers.

Our staff can also access the same information to assist with referrals. Members will find a choice of providers meeting their specific requirements, such as geographic location, hours of service, cultural and language competencies, ethnicity, professional degree, and gender.

Our goal is maintaining convenient access to all levels of care. We use our mapping technology to evaluate each level of service at least monthly and make determinations regarding recruitment needs. We know from experience that providers continuously evaluate and tweak their service offerings, so we also engage in provider data validation to ensure that the service locations we map are current and accurate.

How the BHO intends to perform assessments and develop individual treatment plans (ITP) for their members

Performing Assessments

Upon referral, all members meeting the enrollment and eligibility requirements outlined in sections 30.500 will receive an appointment for a comprehensive assessment with an assigned case manager. The assessment will occur no more than 30 days after member enrollment. For members needing more urgent contact with a case manager or provider, the assessment and planning process will begin earlier. For example, for emergency medical situations requiring immediate care, case managers and Intensive Care Coordinators will conduct the initial assessment as soon as the member is stabilized.

Comprehensive assessments will be conducted in walk-in clinics and other provider locations by licensed case managers. For those members unable to present at provider locations, the contracted case management organizations will provide face-to-face assessments at the member's home or other locations as appropriate.

Our community based case managers perform assessments and provide ongoing monitoring and evaluation of the members under their assigned case load. Members requiring more detailed follow-up assessment to ensure the appropriate level of service will receive a follow-up contact by our Intensive Care Coordinator who can address and assist barriers to care access issues. In addition, the Intensive Care Coordinator ensures that all pertinent information gathered is transmitted to the health plan's treating medical providers, PCPs and other medical professionals.

We coordinate the completion of the comprehensive needs assessment, and review the results prior to referrals to ensure a holistic view of the member's behavioral health, physical health, and psychosocial status and needs. CCS members requiring more intensive rehabilitation services (i.e., intensive in-home, therapeutic day treatment, and mental health support services) will be referred for additional clinical assessment.

Our comprehensive needs assessment includes a focus on the following key functional areas:

- treatment history
- current safety and health issues
- co-occurring substance abuse
- medications
- psychosocial issues
- cultural/linguistic needs
- service request/information needs
- benefit/resource knowledge

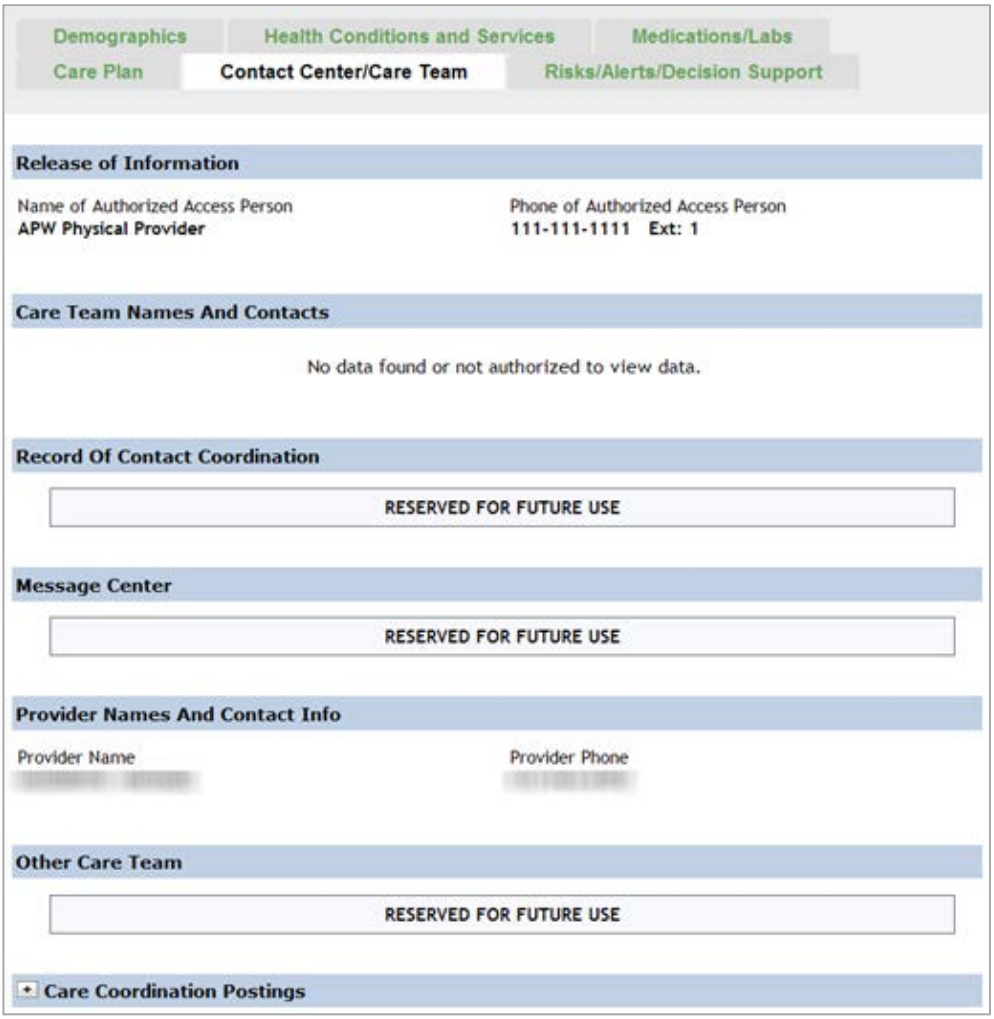
Developing Individual Treatment Plans for Members

We offer a member-centered Individual Treatment Plan (ITP) that exceeds the requirements laid out in section 40.230 of the RFP. Treatment planning is member-centric, and involves input from members as well as their provider teams, family members, peer specialists and case managers. We consider members fully engaged when they participate actively in care planning, are fully educated regarding the programs and resources available, and take the necessary steps to achieve their goals. Our approach to case management is member-driven to support the member's role. We involve both members and their families in the interdisciplinary team responsible for treatment planning and throughout the case management/review process.

The ITP serves as the basis of our online case management module which in turn, directs the care coordination efforts of the member's case manager or Intensive Care Coordinator and allows an interdisciplinary team to track the contributions of members, behavioral health and medical providers, PCP and other parties. The member's Intensive Care Coordinator coordinates the efforts of an interdisciplinary team, tracking the contributions of members, case managers, behavioral health and medical providers, PCP and other parties through the online case management module. The online case management module includes provisions for tracking and sharing information related to problems, goals, interventions, frequency and duration of services, and parties responsible for each intervention. All efforts are coordinated with the referring agency via the case manager or Intensive Care Coordinator and the internal capabilities of our integrated information platform.

All treatment plans for members will be completed within the timeframes outlined in section 40.230 of the RFP, with regular outreach and updates to the plan as determined by individual needs. Each plan identifies members' preferred outcomes, assessed strengths, current challenges, available and needed resources, and a response process for critical events. The plan addresses all areas identified in the comprehensive assessment, accounting for the roles of psychiatrists, psychologists, social workers, advance practice nurses, case managers, PCPs and other stakeholders, and initiates interventions based on priorities that members and/or caregivers agree on. Areas include:

- member goals for a better life
- safety/risk of harm
- treatment participation
- condition knowledge
- medication safety and reconciliation
- optimal function recovery skills
- physical health
- community resources access
- access to evidence-based treatment
- alcohol/substance abuse issues
- financial issues
- legal issues
- social/relationship issues
- cultural/linguistic resources
- housing support
- coordinated service delivery



Treatment planning focuses on coordination among all stakeholders.

The ease with which our community based case management team can input critical information into the online case management module creates unique records for each member that incorporate physical and behavioral health, as well as pharmacy claims information. The member-centric record, Spectrum, consolidates health information for a quick "at-a-glance" dashboard view of key data including:

- services received
- services authorized
- providers and provider contact information
- case management programs and contacts
- member-focused integrated care plan goals
- health conditions
- medication prescriptions
- at-risk crisis plan recommendations
- releases of information
- contact history

Subject to confidentiality guidelines, the record is available for members, family members, physical health providers, behavioral health providers, managed care organization case managers, and behavioral health case managers.

Implementation of Member-Level Interventions

Our individualized treatment plans ensure continuous monitoring of progress by requesting our provider partners to document members' movement toward their individual goals. The member-centric record includes:

- goal focus
- short-term objectives
- current status (e.g., initiated, revised, minimum and ongoing progress, achieved, discontinued)
- percent of goal/objective completed, anticipated date of goal completion and/or revision (based on progress)
- member participation in goal setting
- member engagement
- date reviewed

We conduct quality audits of all case management programs to ensure goal process updating is complete in the member record.

Ongoing Monitoring of Member Needs

At minimum, each plan will be reviewed and updated every six months; though for the highest intensity cases, we may outreach to members as frequently as multiple times a week. We continuously monitor member needs, with a minimum of monthly reviews for all case management care plan progress. Our utilization management process reviews clinical data at the point of service re-authorization to ensure that continued services are required per medical necessity criteria and whether transition to more appropriate service alternatives are indicated.

When the original assessment's areas of need are addressed, we re-evaluate the member for targeted case management discharge and transition to ongoing community care. When members continue targeted case management services for 12 months, we conduct a complete comprehensive assessment and re-define goals, as appropriate.

A description and inclusion of the health plan's assessment that was used to gather information on the member, when referred by a health plan, provider, DOH-CAMHD or others

Our member-centric record, Spectrum, incorporates all information available to provide a holistic view of the member, including all information provided in the health plan's assessment. The member-centric record assists both case managers in making utilization review determinations and other providers in delivering the most effective care throughout treatment.

We utilize all available information to deploy a tiered approach to case management, ranking members according to the intensity of their individual needs. These tiers correspond to the case management service requirements outlined in section 40.220 of the RFP, and in some instances, surpass the required level of contact required. The information gathered in the assessment, along

with the additional information gathered through the comprehensive needs assessment will assist the case manager in grouping the member within the proper tier, or alternatively, referring the member back to the health plan. The health plan's assessment will be carefully incorporated into our established and proven processes—not used as a tool to make automatic determinations. We incorporate a range of diagnostic tools and measures into our clinical assessments to ensure that each member meets SMI criteria and to hone each member's care to their individual needs.

How the BHO will interface with the member's PCP in the BHO and other service providers

We ensure effective, efficient care coordination for members with both behavioral and physical health special needs. This includes extensive measures to interface with members' PCPs and other service providers.

Coordination with Primary Care Providers (PCPs)

Successful coordination with a PCP occurs when we receive the consent through appropriate releases by the member. Then we are able to carry out necessary coordination activities, and enable our network providers to coordinate care directly with the member's primary care physician. We will work with the Hawaii DHS to receive claims information on the medications prescribed by our network providers, PCPs and specialists, and update it every 90 days. We will also use our clinical care alerts to screen pharmacy claims and alert providers to care gaps. We place special emphasis on notifying the member's PCP of any initiation or change in psychotropic medications.

Helping PCPs Screen for Behavioral Health Conditions

To help PCPs identify and accurately assess members who present with behavioral health conditions, we supply simple screening tools for use in recognizing the most frequent categories of co-morbid psychiatric and emotional conditions. ValueOptions provides screening procedures for affective disorders such as depression, delirium, and other mental health disorders. The use of screening questionnaires can facilitate the identification of members for an immediate referral to a specialty mental health/substance abuse disorder provider.

Medical and Behavioral Co-Morbidity

We coordinate with PCPs for members with certain behavioral health diagnoses, such as eating disorders, pervasive developmental disorders, complex neuropsychiatric disorders and substance use disorders (especially for prescription drug abuse and chronic pain). These diagnoses are typically associated with high levels of medical co-morbidity and/or utilization of medical services. Proper management of these cases usually requires coordination between the medical and behavioral health providers and vendors.

In these cases, our Intensive Care Coordinators facilitate the appropriate coordination between the PCPs and the behavioral health providers. These interventions may range from ensuring that a Release of Information exists to allow the appropriate exchange of information between

providers, to holding conference calls with providers, our Intensive Care Coordinators, the medical case manager, and a medical director.

Behavioral Health Education and Training for PCPs

In other programs we administer, we have provided a variety of informal opportunities for PCPs to interact with our behavioral health providers. A few examples include: making the Medical Director and Physician Advisors available for consultation; initiation of weekly "grand rounds," which offer the ability for PCPs to participate telephonically in case discussions; and actively involving PCPs in the resolution of complaints and grievances involving medical care issues. In addition, we develop ongoing training programs, including conducting provider forums, to which behavioral health and physical health providers have been invited.

Member-Centric Health Records - Spectrum

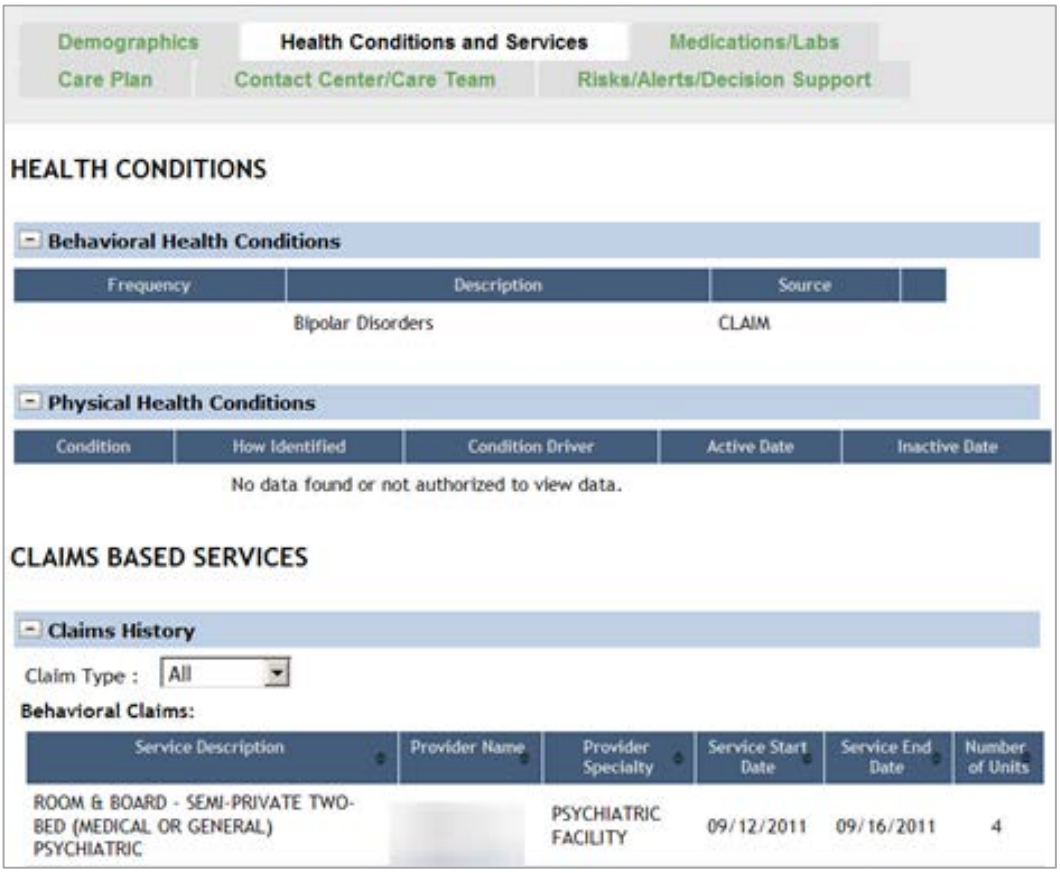
Our member-centric health record, Spectrum, serves as an easily accessed central hub to support information sharing between the member, behavioral health and physical health providers, PCPs and case managers. Our Intensive Care Coordinators and community-based case managers will provide a number of services to strengthen these interfaces, including:

- Our regional Intensive Care Coordinators and case management teams coach members on the skills of talking with their providers regarding their whole health needs. We systematically mine our data to identify at-risk, co-morbid members who may not be receiving optimal care.

- We outreach to the member and/or provider regarding possible care gap(s) and further screen, confirm, and implement actions to address these needs; we educate our providers regarding the importance of coordination and routine screening of physical health conditions as part of best practice care; and we monitor their compliance with best practice screenings and coordination as part of our quality audit process and through clinical reviews. This eliminates duplication of services, and establishes lead management in cases where physical and behavioral health needs are serious or complex. We also support primary care-based management of psychiatric medications, as appropriate.

- We document members' PCPs (and instances where a member has no PCP) into the clinical record maintained in our system. Part of our care coordination program includes follow-up on PCP referrals. Our case management procedures ensure that each member has an ongoing, need-appropriate source of primary care, as well as designated person or entity responsible for coordinating health services.

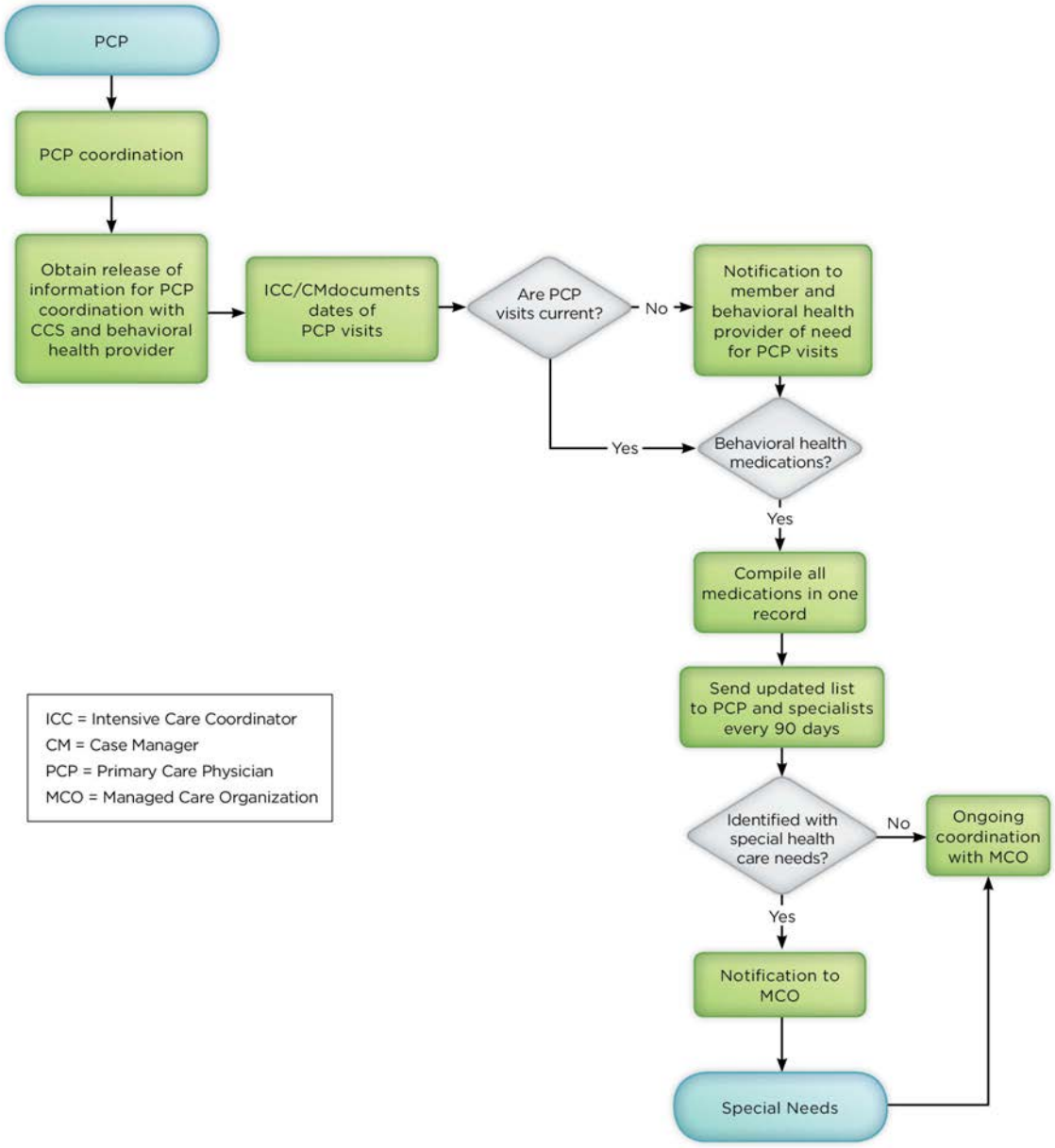
- Our information system documents medical visits, which can be tracked and reported for follow-up, which confirms that members have scheduled and kept their appointments.



The member-centric record stores and organizes complete member information.

The following workflow reflects our PCP coordination process, including medication reconciliation and contact with managed care organizations to assure that the member's treatment is properly and effectively managed:

Case Management – PCP Coordination Workflow



How the BHO will coordinate with the health plans

We will create effective partnerships with the health plans to coordinate members' behavioral and physical health care needs. Our coordination efforts include:

- **our integrated, regionally-based case management model**
- **joint treatment planning and medical rounds**
- **shared data among all stakeholders via the member-centric record**
- **joint systems protocols and electronic interfaces**
- **joint committees and meetings with health plans' administrators and key staff**

We will work closely QUEST Expanded Access and other health plans at all levels of leadership, network management, clinical and medical management to accomplish the goals of their acute, primary, and behavioral health programs. We will also work closely with the health plans and the medical community in Hawaii to recognize and replicate best practices, in all areas of practice and on all five islands where services are rendered. We will actively seek out providers and communities who have achieved integrated, coordinated systems of psychiatric care, and use their models and experiences to help create similarly strong systems in other communities. Additionally, we will share our experience from successful models in other states and programs, which may serve as best-in-class models.

Our Intensive Care Coordinators will serve as conduits and points of contact for the health plans. To effectively promote coordination of physical and behavioral health care, our staff will have primary responsibility for:

- determining which information is most important to health plans and what is the most effective way in which to share that information
- establishing regular meetings in which issues of coordination and communication can be discussed
- sharing policies, procedures, and guidelines for primary care-based screening and treatment of behavioral health disorders, including depression and anxiety, as well as indicators requiring a referral to a behavioral health provider
- ensuring referral and triage processes are effective and reviewing data to discern opportunities for joint quality of care initiatives
- contacting the health plans when co-management of a member is indicated and it will improve care and outcomes (with the member's permission, complying with HIPAA and Hawaii regulations on information exchange regarding a member's care between us and the health plans)
- responding to inquiries from the health plans about behavioral health and physical health co-morbidities
- coordinating management activities with the health plans, as requested
- promoting and supporting coordination between behavioral health care and health plan-contracted medical providers, as appropriate

- providing education to health plan-contracted providers on when and how to request specialty behavioral health services and/or consultation for members who are already receiving some level of behavioral health care in a primary care setting
- implementing collaborative quality management studies designed to determine best practices for coordinating care and ensuring optimum treatment outcomes

Member-Level Coordination

We will work with the health plans to develop joint operational protocols for shared membership and for co-morbid condition notifications. Additionally, we will focus our efforts on other aspects of a member's care that will benefit from our close coordination with the health plans. This includes:

- inpatient admission or discharge of a member with a behavioral disorder and co-morbid physical health diagnosis who is in care co-managed by ValueOptions and the health plan
- determination that the member is receiving psychotropics from more than one provider, identified by interaction with the member in case management, clinical reviews with the behavioral health provider or notice from the health plan (our care gap alert solution enhances this strategy)
- determination that a member in inpatient care has experienced clinically significant changes in physical status
- determination that a member in inpatient care has complicated medical or drug interactions overall health status concerns, such as new complex medical conditions

Best Practice Case Example
Monitoring Continuity of Care with MCOs

In Connecticut, we monitor and track the number and types of cases being co-managed by our organization and the three MCOs managing the medical benefits for members. Cases for co-management are referred either to us by the MCO or vice versa. We collaborated with the MCOs to develop a list of diagnoses that would warrant an automatic referral and co-management between our organization and the MCOs.

In 2010, approximately 240 cases were co-managed, which was a seven percent increase from 2009. The increase can be attributed to the improved process of monthly meetings with MCO representatives. We worked with the MCOs during 2010 to assist and educate them in identifying the cases that would benefit from care coordination. Many of the cases referred to us have been for social problems, such as a need for housing or childcare, rather than behavioral health diagnoses.

PROCESSES FOR IMPROVING COORDINATION AND COLLABORATION

Coordinating care at the interface of physical and behavioral health care for members, many of whom often have chronic health issues, requires both systems-level changes, as well as member- and provider-specific changes. Key to implementing these changes is an effective communication strategy at all levels. We propose a multi-level approach ranging from the systems level to the member level.

System-Level Coordination

Ongoing communication and coordination with health plans about the complex physical issues that may complicate behavioral treatment strategies is critical to our integrated process. We currently maintain a number of continuing communication and clinical support strategies with providers and agencies, such as:

- **Monthly Clinical Rounds Meetings:** We have monthly meetings with health plan clinical teams to review individual treatment planning for high-risk and complex cases, and to coordinate services that will improve outcomes. This includes participation in disease management programs, peer support, and wellness and recovery action plan service needs. We also encourage comprehensive consultation between MCO/case management program medical directors and our clinical staff.
- **Monthly MCO Operations Committee:** As a standard process, we also establish monthly meetings with health plans to discuss the following:
  - emergency room data to identify trends and opportunities for physical and behavioral health collaboration
  - pharmacy data review and recommendations
  - national trends regarding targeted populations, such as research or comparisons to our benchmarks and outlier management programs
- **Medical Advisory Committee:** Our advisory committee includes primary care physicians, pediatricians, psychiatrists, MCO medical directors, our state partners and our clinical staff. It supports the provision of behavioral health services in primary care settings, as well as psychiatric medication management by contracted primary care physicians. The committee discusses screening tools primary care physicians use, and barriers experienced while treating members with behavioral health diagnoses. It also reviews performance programs for targeted behavioral health providers and their primary care physician contacts.

Member Disenrollment Procedures

Leveraging the internal capabilities of our integrated information management system, we will provide a smooth interface for referring disenrolled members back to the health plan, and for notifying all providers and case managers. Our member-centric records accommodate the shared exchange of information among members, providers, case managers, and other stakeholders; and [redacted] further allows for customizations for interfaces and data exchanges. We are leaders in administrative efficiency and innovation for transitions of care.

Additional Geo Team Support for Integration

Co-morbid health conditions and substance abuse lead to spiraling costs. With instances of recurring substance abuse as high as 50 percent among Hawaii's Medicaid members, our embedded Geo Team model provides the additional support needed to coordinate complex care. As active participants in our regional Geo Teams, Intensive Care Coordinators will provide access to, and coordination of, a more complete and effective system of community-based behavioral health services and supports, managing and overseeing complex, chronic cases. In this capacity, they will collaborate with DHS and the health plans, providers, court systems, medical care providers, family service agencies, and our recovery and wellness liaisons to identify member-specific challenges as early as possible, identify and overcome obstacles to appropriate care, and ensure member-centered solutions that improve outcomes.

In our experience, these collaborations occur in a variety of settings, including:

- **Provider meetings:** Intensive Care Coordinators and case managers participate in treatment and discharge planning meetings with providers, family members, our state partners and other invested parties.
- **Regular communication with state and MCO partners:** Intensive Care Coordinators ensure effective, consistent communication and the designated clinical contact for each assigned member.
- **Hospital rounds:** Intensive Care Coordinators meet regularly with high-volume facility staff to identify members whose discharges may be delayed and work with those facilities and case managers to strategize solutions.
- **Collaborative peer review meetings:** Intensive Care Coordinators and case managers meet regularly to identify all members who may be stuck at a particular level of care by placement or disposition issues. Our state and MCO partners are invited to participate in these meetings.
- **Emergency Room (ER) calls:** Intensive Care Coordinators call every day to identify members who remain in the ER more than eight hours after medical clearance, and then work with our contracted case managers for those members requiring disposition assistance.
- **Monthly system of care meetings:** Intensive Care Coordinators meet monthly with health plan case management teams to review coordination protocols and discuss complex cases.
- **Authorizations of services:** Intensive Care Coordinators participate actively in all service authorizations, review process and treatment plan reviews.

Best Practice Case Example:
Collaborating with MCOs on Joint Initiatives

ValueOptions coordinates behavioral health and physical health care in Connecticut with three MCOs that manage medical benefits for our members. In 2008, we collaborated with the Community Health Network (CHN) on a joint Post-Partum Depression Study. It was designed to improve identification of members. A brochure describing the condition, an Edinburgh Post-Partum Depression survey tool, and a pre-paid envelope were mailed to all CHN members who had delivered a baby in the previous four to six weeks. All members who returned a completed survey, regardless of score, were contacted by one of our Intensive Case Managers or Peer Specialists and were offered behavioral health services and/or assistance obtaining access to community resources.

At the request of our client, we also consulted with Yale University, who was conducting its own grant-funded initiative with Connecticut medical providers to improve treatment of postpartum depression. To avoid duplication of our efforts, we met with Yale to discuss our project plan and additional opportunities to coordinate efforts. For example, Yale conducted several postpartum depression provider trainings, including one for behavioral health providers. We coordinated this training with them. While this formal study concluded in 2010, our Intensive Case Managers and Peer Specialists continue to be available for members receiving services as long as needed.

Coordination with Additional Entities

Our Geo Teams will strengthen our existing practice of coordination and partnerships with other state and community organizations to facilitate their care coordination responsibilities for members. Our Pharmacy Support Programs ensure we are coordinating our services across the entire array of Medicaid-funded services.

Consistent with our overall care coordination philosophy, we will cooperate with all external community and public agencies to ensure their participation in members' overall care plans. We expect state departments, provider agencies, schools, courts, and other community or public agencies to refer adults they believe will benefit from our care coordination services. Families may also request coordination.

Our Geo Teams will work with all entities that make up the affiliated delivery system in each of their assigned islands. Where possible, we will develop memoranda of understanding and agreements with high-contact community partners to facilitate collaboration and clarify their responsibilities.

All interfaces, integration support activities, and protocols will fully comply with all HIPAA and Medicaid confidentiality requirements, including those governing consent before discussion of any member information.

Best Practice Case Example
Coordinating Services with Community Agencies

In ValueOptions' Texas NorthSTAR program, we participate with multiple community providers, the sheriff's department, court system, and peer provider and family support organizations in a monthly outreach to drug-using prostitutes. These members are offered treatment instead of the endless cycle of abuse, arrests, and jail time.

The Bridge, a full service Homeless/Treatment and Education Facility in Dallas, consists of more than 19 health and human services organizations who provide a continuum of care, treatment, and support, including integrated behavioral and physical health care services. This case management program was developed to more effectively integrate services provided at the Bridge for those high-risk/high-cost individuals with a history of inappropriate use of emergency department resources. All case management interventions are provided by behavioral health providers who are trained in motivational interviewing, and are located in a shared physical health/behavioral health clinic on the "Bridge" grounds. The Bridge also serves as an interim clinical home to coordinate all services required to address the member's physical and behavioral health care needs.

The program has been extremely successful since its inception in June 2009. We have developed unique approaches to overcome the disadvantages/challenges described above, and the program has served an average of 21 percent of the daily shelter population, with promising outcomes. In fact, as of July 2009, 63 percent of case management participants had successfully completed the program, as evidenced by increased rates of housing stability, adherence to and compliance with community based treatment plans, and reduced visits to hospital emergency departments.

How the BHO will perform concurrent review during acute psychiatric hospitalization and perform safe and appropriate discharge planning

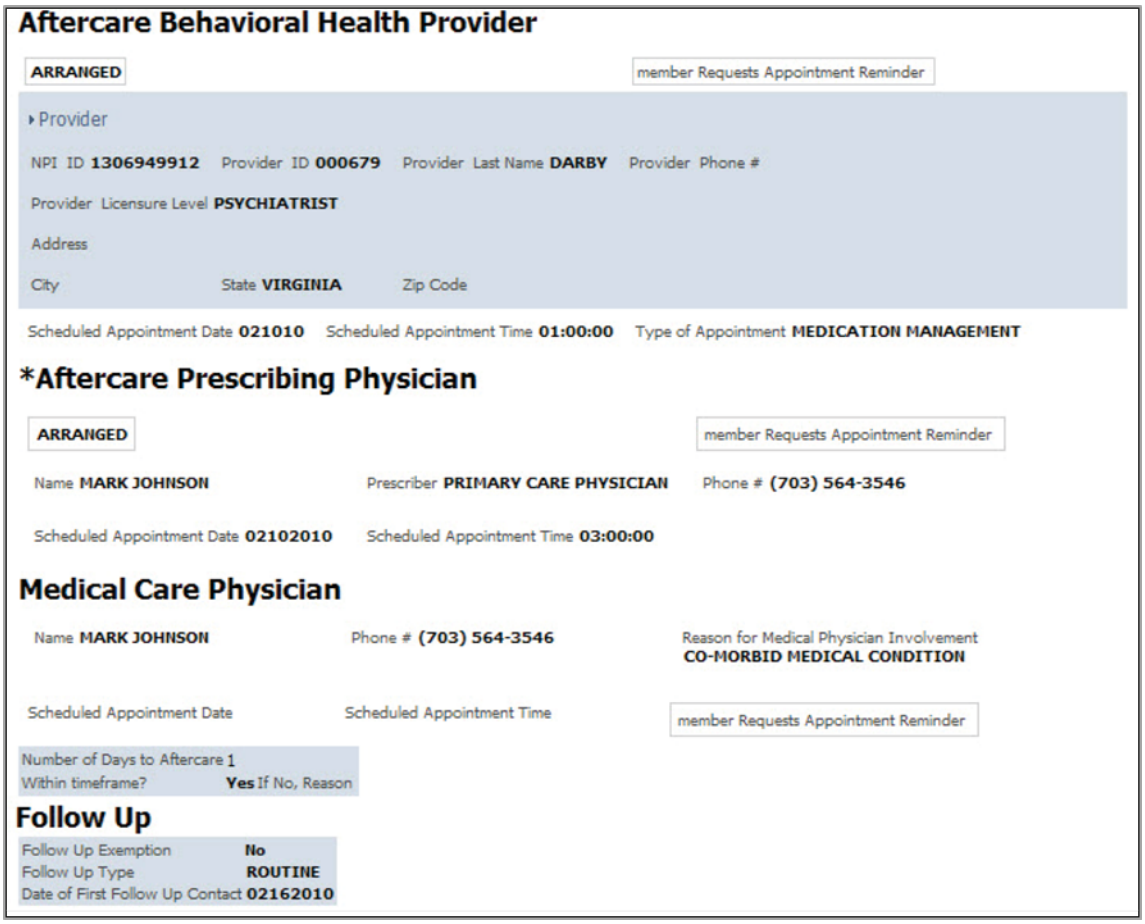
CONCURRENT REVIEW

Intensive Care Coordinators will conduct concurrent reviews as part of the authorization process. Through our integrated IT systems, Intensive Care Coordinators can manage the review process online, using our provider portal, described above. The integrated, online platform enables the Intensive Care Coordinator to review all treatment planning, member records and treating provider information necessary for adequate coordination and follow-up throughout the process. Whenever an inpatient admission occurs, intensive care coordinators will maintain close contact throughout all review processes.

Intensive Care Coordinators work closely with inpatient providers, who are responsible for initiating the concurrent review process, and their local Case Management Entities, when necessary. Our Intensive Care Coordinators use automated reports to track the need for subsequent reviews, and may call the provider before an authorization expires to confirm the need for concurrent or discharge review. Intensive Care Coordinators must document all clinical information received and the basis for services authorized. If they cannot independently determine the appropriateness of continued treatment, if our review discovers questionable treatment or discharge plans, or issues on the quality and appropriateness of care, the case is referred for further peer review.

Safe and Appropriate Discharge Planning and Case Closure

Intensive Care Coordinators will ensure a safe discharge and refer members to a community-based case manager. Our case management model includes case managers located at key community not-for-profit mental health providers, ensuring coordination and timely follow-up for all inpatient admissions.



Discharge and follow-up procedures are included in our integrated, online system.

Discharge planning begins as soon as a member is admitted to an inpatient setting. The assigned case manager and Intensive Care Coordinator monitor all inpatient admissions closely, notifying and coordinating with other treating providers, PCPs, residential supports and other stakeholders as needed.

All discharge planning is stored in the members individualized treatment plan and member-centric record. As part of our integrated system, this information provides automated updated and flags to notify all stakeholders with access as discharge approaches. Members flagged for an upcoming discharge receive additional support and coordination to ensure success. Recovery and wellness liaisons and community-based case managers provide vital assistance to the member in coordinating linkages to family and community supports, the health plan, and PCPs. This includes coordinating follow-up planning with medical care providers and others. All follow-up is likewise tracked within our system; case managers track members and conduct outreach as necessary to ensure adequate follow-up within ten days of an inpatient discharge.

Following discharge to a lower level of care, the member remains eligible for readmission without prior assessment for six months. This information is also recorded and flagged in our system, so that case managers can conduct additional, proactive outreach and follow-up as members approach the six month threshold.

How the BHO will prioritize cases for case management (i.e., how it will address the various levels of complexity and intensity of members' behavioral health care needs);

Cases will be prioritized for case management using a tiered assessment process and effective data mining techniques. Our model focuses on connecting members to the most appropriate services at the right time and reducing barriers to care. We identify members for higher intensity levels of case management through referral and risk stratification. We use a variety of data sources to identify, stratify and segment members at the population level. These include, among others:

- claims data
- our health plan partners' health risk assessments
- historic treatment plans

Data from these sources are incorporated into our predictive modeling platform, described below, which incorporates the data with our predictive algorithms to highlight those members with the most severe needs for referral to case management. Our proactive interventions foster increased functioning and prevent exacerbation of symptoms and crises.

Predictive Modeling Identification of Vulnerable and High Risk Members

One of the most important means of identifying the most vulnerable and highest risk members includes our predictive modeling/risk stratification software.

[redacted]

Clinical Care Gap Alerts

In addition to our [redacted], our care gap analytics platform cross-references pharmacy claims with available physical and behavioral health claims to screen the entire population for care gaps. This system enables us to identify members with gaps in care such as poor adherence, medication conflicts, and sub-optimal therapy. Once a member has been identified, their care gaps are generated and flagged in individual members' electronic care records for follow-up by our intensive care coordinators. These flags enable us to automatically send a summary of each member's alerts to the member's trusted advisors (e.g., primary care physician, behavioral health provider) for interpretation and inclusion in their treatment plans.

Care gaps are flagged and recorded within the integrated, member-centric record and treatment plan, identifying members for appropriate interventions.

How the BHO intends to implement the different levels of CM services described in Section 40.220;

We will implement the different levels of case management services described in section 40.220 through:

- risk stratification through care gap alerts and predictive modeling
- our member-centric record and individualized treatment plans, which identify members' eligibility and enrollment status, frequency service requirements, and other details
- oversight provided by our Intensive Care Coordinators, who ensure that community-based case managers implement appropriate levels of care and follow-up

All clinical reviews, authorizations and case histories will be managed through our [redacted]. This means that all contracted, community-based case managers will use the same clinical management system as supervisory staff and treating providers, ensuring consistency throughout the system of care. Built-in system protocols will be backed by extensive training and regular case manager outreach via our provider specialists, who ensure meaningful, current and effective provider contacts.

Sharing our system also means that all contracted providers' practice patterns will be subject to review from our Intensive Care Coordinators. Integrated treatment planning involves these ValueOptions staff in treatment planning sessions for high needs members, clinical reviews and case audits. We employ a highly flexible provider outlier management program to monitor individual provider practice patterns and identify needs for additional training and other outreach efforts. Through our regional, Geo Team model, we ensure consistency in implementing tiered service delivery across islands.

How the BHO intends to assure that case load ratios described in Section 40.220 are met.

Based on the existing risk distribution of DHS members, we are confident that our existing and growing provider relationships can maintain the required staffing ration of no more than 40 cases per case management staff. By establishing relationships with a variety of provider organizations across the island, we ensure a wide range of options for members, and an adequate availability of case management staff to meet the prescribed staffing ratios.

These ratios are built into our staffing requirements, which we review with each contracted provider group. Individual group strategies to ensure the ratios are maintained are developed in consultation with ValueOptions provider relations leadership and added to the contracts. Maintaining on-the-ground provider specialist staff further augments the efficacy of our monitoring and quality assurance efforts. Finally, our Intensive Care Coordinators provide comprehensive, coordinated oversight across regions to ensure that appropriate staffing ratios are maintained; and our quality assurance/quality management staff, in collaboration with provider

relations staff, will regularly audit our case management partners to ensure compliance with State and ValueOptions contractual requirements.

A description of how the BHO will review cases suspected of not meeting SMI criteria

Our Intensive Care coordinators, fully-licensed, clinically-experienced professionals, will review all health plan assessments and service authorization requests. Determinations of completed and properly submitted documents will be made within 30 days. If, during that time, it is determined that we have received a referral from the health plan in error, we review the referral with our medical director and the state in compliance with section 30.600 of the RFP. If the determination is upheld upon further review, the member will be transitioned back to the health plan in accordance with DHS disenrollment procedures. In these instances all final denials will be fully compliant with regulatory standards.

Alternatively, when a member is suspected of not meeting SMI criteria due to improvement in functioning, we begin by reviewing the member's current treatment plan with the community-based case manager. During this review, any additional information is considered, and the member may be contacted for additional assessment. Pending review by the Intensive Care Coordinator, medical providers and the medical director, ValueOptions will notify the state and begin the transition process back to the health plan. Coordinated follow-up and care planning will proceed, with the Intensive Care Coordinator facilitating linkages between the state, ValueOptions, the member and all treating providers.

A description of the components of an ITP

Individual treatment planning is conducted via our online case management module. The module is integrated within Spectrum, our member-centric record, so that as the treatment plan is updated and revised, the changes automatically upload to the member-centric record.

The online planning module presents a complete care tracking environment, with individual components for:

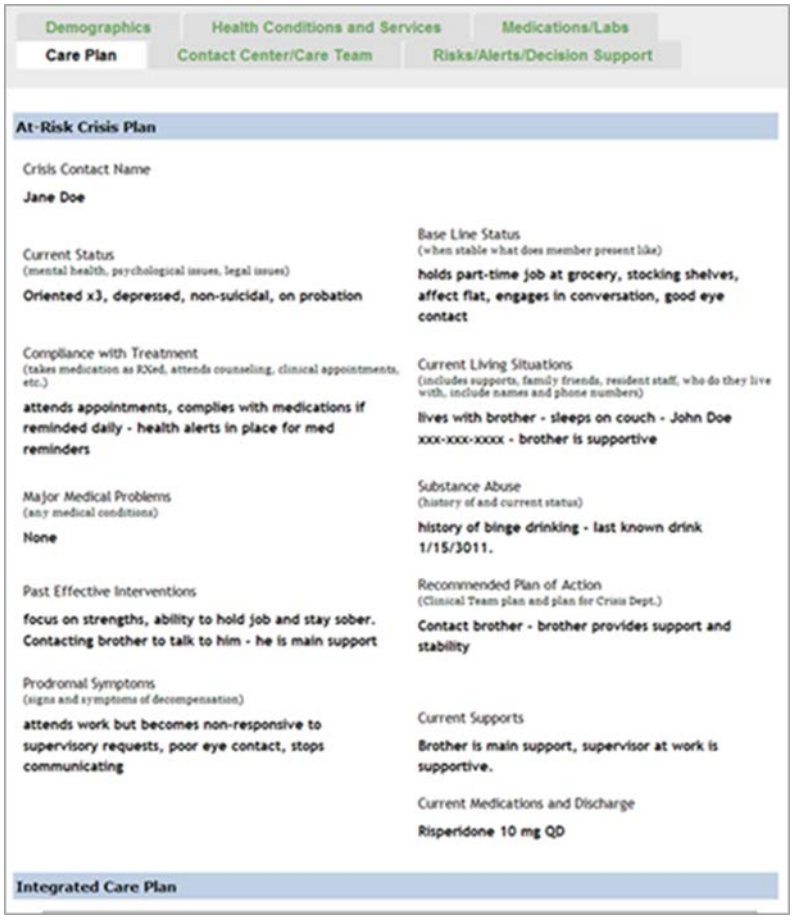
- referral information/enrollment
- acuity assessment/stratification
- clinical assessments
- contact coordination
- care planning
- case management contact activity
- outcomes surveys
- discharge

Case managers, in consultation with members, select pre-crafted goals and objectives tailored to the member's needs as determined from the Acuity Assessment. The design also allows customized, member-specific, customized goals. Additional fields allow goal status monitoring, refinement, and development participation. Historical goals are displayed and new goals may be added.

Drop down lists for a wide variety of both short and long-term goals include, among many others, fields for:

- addressing safety issues
- ensuring connection to treatment
- developing self-care strategies
- ensuring medication adherence
- maintaining stability
- promoting physical health
- connecting to community resources
- monitoring progress
- addressing barriers to participation

Goals and progress are tracked and updated throughout our system automatically. All information pertaining to establishing, reviewing, and revising goals are meticulously tracked, including both qualitative and quantitative measures for tracking progress. The plan also includes automated features for recording the degree of member, family member, provider and PCP involvement in the planning process.



The online ITP, Spectrum, provides a complete, member-centric interface

In accordance with the requirements set forth in section 40.230 of the RFP, all acute inpatient treatment plans will be generated or updated within 24 hours of admission, and all alternative inpatient admissions will have their plans generated our updated within 48 hours of admission. Our system maintains the flexibility to not only meet and exceed all requirements set forth for the individualized treatment plan in the RFP; but to accommodate changes as your requirements evolve over time.

A description of how the BHO will monitor CM services to report encounters, discharge planning and outcomes;

MONITORING AND REPORTING ENCOUNTERS, DISCHARGE PLANNING AND OUTCOMES

ValueOptions' case management module is able to accept and collect all data while leveraging a shared database that integrates member and provider information, clinical information, program information, and encounter/claims processing information in a single online record. The Web-based user interface optimizes delivering healthcare at the point-of-care by focusing on increasing quality of care, ensuring meaningful data is available for all stakeholders, enhancing consumer satisfaction, and streamlining communications.

As an integrated component of our [redacted], the case management module used to create individualized treatment plans communicates directly with the system's reporting components. All processes, from claims submissions to discharge plans, are integrated into our case management reporting.

Your Need
Flexible capability to monitor, track and report complete claims, eligibility, discharge and outcomes processes

Our Solution
A flexible, wholly integrated information platform with customized reporting capable of meeting these needs and fulfilling all reporting requirements outlined in section 50.700 of the RFP.

ValueOptions is recognized throughout the industry for working collaboratively with our state partners to design information delivery solutions that ensure access to information for all levels of users. We will deliver all required reports contained within section 50.700 of the RFP and will work with the Departments to develop other self-serve solutions such as dashboards, on-demand Web-based querying capabilities, and on-demand reports. We have successfully developed and delivered these Business Intelligence solutions to multiple Medicaid clients across the country and we view these products as collaborative efforts. We will do the same for Hawaii, creating innovative solutions, working closely with the DHS through all phases of development.

Some examples include:

- In Connecticut, we created a custom dashboard enabling in-network facilities to track their utilization patterns and compare results to others and to benchmark data.
- In Colorado, we created a customized financial dashboard for our provider partners to conduct ongoing trending/analysis of authorized claims dollars. This includes eligibility and revenue by eligibility category for each community mental health center/behavioral health organization entity.

Encounters

Each separate claim submitted or behavioral health encounter recorded is tracked in the individualized treatment plan. Enrollment information captured included the reason and source of each referral, criteria indicated, and contact turn-around times. The case management module also includes a dashboard summarizing the member's case management-related utilization events, including which triggers have been met based on systems information. This summary is updated monthly.

Discharge Planning

When a determination to discharge the member has been made, the case manager documents the following information:

- date of discharge
- discharge reason
- outcome survey competed (yes/no)
- narrative information

The module provides a range of drop-down options for the reason for member discharge, including:

- safely engaged in ongoing treatment
- returned to functional or symptomatic baseline
- member/family declines to accept the proposed treatment plan
- lack of adequate, consistent progress to qualify for continued case management services
- member enters long term residential or custodial care
- primary health insurance is no longer covered by ValueOptions
- ongoing case management services from another resource
- multidisciplinary team agrees member is ready for discharge
- member is not responsive to outreach attempts, supports or referrals

Outcomes

The case management module contains a built-in post service outcome survey and member satisfaction survey. When a member is discharged from the case management program, a satisfaction survey is completed to assess the member's experience with the program and with ValueOptions. This process is completed by either the Intensive Care Coordinator or community-based case manager.

Utilizing this data, our system produces standardized reports that are used for operational management and client deliverables.

We track a variety of additional utilization management metrics for inpatient and higher levels of care, as well as outpatient care. We conduct book-of-business comparisons of utilization data based on similar lines of business we manage, as well as regional and national benchmarks. Patterns outside the norm are followed up on, with action plans developed as needed.

A description of the case management staffing including a job description of the case manager and the type of initial and/or on-going training and education that it will provide to its case managers

CASE MANAGEMENT STAFFING

Intensive Care Coordinator

Our Intensive Care Coordinators will be Licensed Clinical Social Workers (LCSWs), Registered Nurses (RNs), Licensed Practical Nurses (LPNs) or social workers with master's degrees in social work (MSWs) who manage and oversee medically complex, co-morbid chronic cases, as well as work hand-in-hand with our regional support staff and community case managers, regional clinical care coordinators, and Geo Teams. They provide access and coordination of a more complete and effective system of community-based services and supports that improve overall outcomes. As part of our Geo Team's regional approach, Intensive Care Coordinators will collaborate with you, behavioral health and medical care providers, managed care organization health care managers, court systems, and Recovery and Wellness Liaisons to identify specific challenges as early as possible and overcome obstacles on behalf of each member.

Contracted, Community-based Case Managers

Our goal is to provide case management with the whole person in mind without creating artificial separation of responsibilities for behavioral health and physical health issues. For this reason, we will train community-based case managers who will have primary responsibility for care coordination and facilitation for all of a member's health needs and we will reimburse them for coordinating the member's entire care. Community-based case managers will have access to and be supported by a multi-disciplinary team of physical health, mental health, and substance abuse specialists and treatment providers, as well other community resources as required to meet the member's needs (e.g., housing, educational, entitlement, employment).

CASE MANAGEMENT SUPPORTING STAFF

Provider Relations Specialists

These dedicated staff members will serve to provide day to day provider customer service functions, coordinate trainings, liaise with health plans, and provided case management and peer support services, where applicable. Based in the state, these professionals provide a vital link between the regional Geo Teams and all contracted case managers and peer supports.

Recovery and Wellness Liaisons

Similar to our provider relations specialists, the recovery and wellness liaison's role is to facilitate communications and effective interfaces with peer run agencies throughout the state. Developing a supportive peer support network is vital to an effective system of care. Recovery and wellness liaisons are individuals who have self-identified as a person with lived experience and will be critical to building and maintaining this network or peer provided services. Working continuously to strengthen relationships with employment, transitional housing, transportation and other peer service providers, Recovery and Wellness Liaisons will help to develop a more culturally competent, supportive network of peer-level resources over time.

TRAINING AND EDUCATION FOR COMMUNITY-BASED CASE MANAGERS

Our Provider Relations department will support the provider network through the provision of ongoing training and technical assistance to ensure that providers are familiar with our systems. Furthermore, we will provide all new providers extensive and detailed technical support to assist in completing online services. We provide active, timely, and continuous communication, training, technical assistance, and quality management to ensure contract compliance, access, and quality. Through our experience managing large Medicaid contracts nationwide, we have learned that effective and continual trainings maximize positive provider practices. Targeted trainings are often necessary to ensure a provider's success in adapting to any new initiatives, best practices, programmatic changes, or technology advances.

Our proven methods of communication ensure transparency in our operations and provide access to meaningful information through multiple venues, including:

- **Web-based Education Forums**—This method enables providers to participate in educational forums without the expense of travel and disruptions to serving members.
- **Face-to-Face Educational Forums**—Using feedback from quality management and network management data to identify opportunities for focused "as needed" training supports providers in the use of our technology, not only streamlining key transactions on our end, but also allowing us to forge relationships that help promote best practices in clinical care.
- **Telephonic Support**—We provide telephonic support for providers who are in need of technical assistance or for those who have questions regarding our program or services. A Provider Relations Representative is always available to respond to provider calls and handle provider issues routinely, timely, and efficiently.
- **Provider Alerts**—To assure any key policy changes are quickly and appropriately communicated, we disseminate Provider Alerts through an email notification and posting of these Provider Alerts online. For ease of review, these are continuously available to the provider through the website and can be easily sorted by content or date.
- **Onsite, Individualized Support**—Onsite support will be available to all providers through our provider relations specialists and Intensive Care Coordinators
- **Newsletters**—In addition to our quarterly newsletter, The Valued Provider, covering both pertinent clinical and administrative topics, we disseminate monthly provider alerts in the form of e-mails to keep providers abreast of key topics or changes (e.g., the National Provider Identifier or other HIPAA Requirements).
- **Free and Discounted CEU/CMEs**—We have implemented a means for providers to obtain discounted continued education units/continuing medical education (CEU/CME) credits. This Learning Management System is an online library containing hundreds of accredited courses on mental health topics and is available 24 hours a day, seven days a week.

A description of how the BHO will monitor member's progress and continued need for enrollment in the BHO

Each member's plan is unique, and sets degree of family involvement, goals and timeframes specific to that member's needs. Outreach is likewise scheduled according to individual needs, with the frequency and duration subject to change with ongoing reassessments. For high needs members, outreach may occur bi-weekly or even daily, to review care planning and progress. In many instances, members and families are invited to join in conference calls with the community case manager, behavioral health provider and/or PCP for joint reviews and care planning sessions. At minimum, comprehensive assessments and updates to member treatment plans will occur annually, in accordance with the requirements set forth in the RFP.

As the member's treatment progresses, discharge to a lower level of care may become appropriate. In these instances, we will transition the member back to the referring health plan, through a coordinated process that informs all stakeholders, including all treating providers, PCPs and family-members in addition to DHS and the health plan. To ensure that these transitions are successful, we will provide each disenrolled member with added community-level and peer supports where appropriate and follow-up with health plan case managers and the member throughout the transition process. The member-centric record is maintained in our system and shared with the health plan, so that transition back to behavioral health case management can occur promptly and without disruption, should readmission become necessary. We can even treat case management for members who have multiple readmissions as a single episode, to alleviate added administrative burden on the health plans and stress on the members.

A description of how the BHO will coordinate enrollment and disenrollment with DHS description of the offeror's policies and procedures for the ITP process that includes the forms to be used to document the ITP.

Leveraging our industry exclusive, fully integrated IT platform, we can easily coordinate enrollment and disenrollment with the DHS' description outlined in the RFP. ValueOptions' information platform **maximizes current information technology** because it is the *only* platform built from the ground up to integrate and reliably maintain member eligibility/enrollment data. Eligibility status, including pending disenrollments, are flagged, so that members suspected of no longer meeting SMI criteria are identified well in advance.

Our proven experience with large Medicaid contract transitions enables us to anticipate issues and eliminate disruptions well in advance of implementation, and to effectively coordinate the transfer of all necessary data between ValueOptions and the QExA health plans.

Enrollment

Once the contract is awarded, we will work closely with you to develop a highly effective, automated enrollment/eligibility process that is fully compliant with all requirements outlined. Each group added to the system has date sensitive tiers and benefit packages assigned to the

contract period. The system allows for the maintenance of contract history for each group. Within our integrated eligibility module we are able to store as many effective and term dates as needed to indicate changes in coverage, group assignment, benefit packages, or coordination of benefits data. Our system displays eligibility history as well as the current status for each member to ensure services are approved or denied appropriately.

From the eligibility files, our system will automatically configure benefits based on CCS determinations. Our enrollment/registration model is extremely flexible and can be readily customized to the meet CCS needs.

Consumer Registration Confirmation

Registration Status: ********** APPROVED **********

Provider ID	Provider Last Name	Provider First Name	Provider Address
999999	PROVIDER	ILL TEST	, NORFOLK, VA 23502

Consumer ID	Last Name	First Name	Consumer Address
421326179	CONSUMER	TEST	123 FIRST ST , CHICAGO, IL 60290

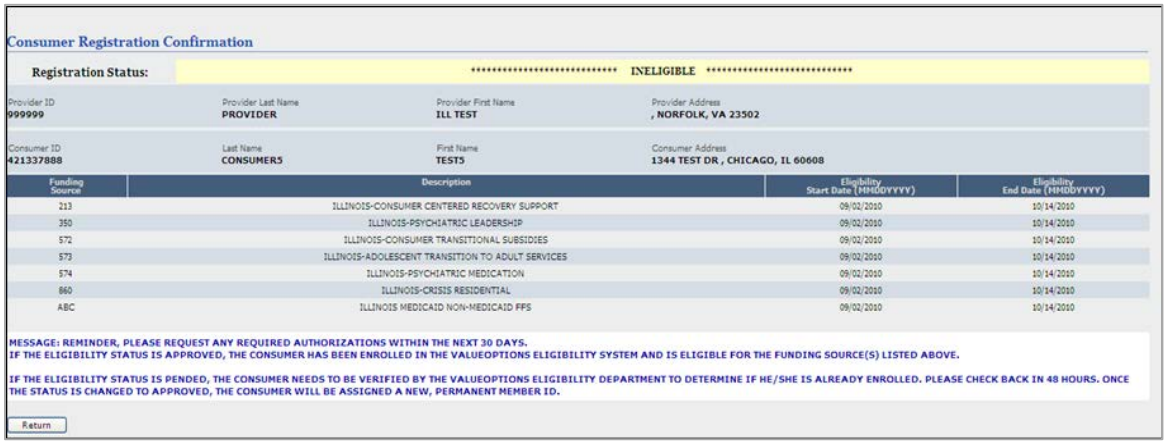
Funding Source	Description	Eligibility Start Date (MMDDYYYY)	Eligibility End Date (MMDDYYYY)
131	ILLINOIS-CHILD/ADOLESCENT FLEX FUNDS	06/01/2009	12/01/2009
213	ILLINOIS-CONSUMER CENTERED RECOVERY SUPPORT	06/01/2009	12/01/2009
350	ILLINOIS-PSYCHIATRIC LEADERSHIP	06/01/2009	12/01/2009
572	ILLINOIS-CONSUMER TRANSITIONAL SUBSIDIES	06/01/2009	12/01/2009
573	ILLINOIS-ADOLESCENT TRANSITION TO ADULT SERVICES	06/01/2009	12/01/2009
574	ILLINOIS-PSYCHIATRIC MEDICATION	06/01/2009	12/01/2009
860	ILLINOIS-CRISIS RESIDENTIAL	06/01/2009	12/01/2009
ABC	ILLINOIS MEDICAID FFS	06/01/2009	12/01/2009

MESSAGE: REMINDER, PLEASE REQUEST ANY REQUIRED AUTHORIZATIONS WITHIN THE NEXT 30 DAYS.
IF THE ELIGIBILITY STATUS IS APPROVED, THE CONSUMER HAS BEEN ENROLLED IN THE VALUEOPTIONS ELIGIBILITY SYSTEM AND IS ELIGIBLE FOR THE FUNDING SOURCE(S) LISTED ABOVE.

IF THE ELIGIBILITY STATUS IS PENDED, THE CONSUMER NEEDS TO BE VERIFIED BY THE VALUEOPTIONS ELIGIBILITY DEPARTMENT TO DETERMINE IF HE/SHE IS ALREADY ENROLLED. PLEASE CHECK BACK IN 48 HOURS. ONCE THE STATUS IS CHANGED TO APPROVED, THE CONSUMER WILL BE ASSIGNED A NEW, PERMANENT MEMBER ID.

Return

The confirmation screen includes an automatic reminder to make any authorization requests.



Consumer Registration Confirmation

Registration Status: ********** INELIGIBLE **********

Provider ID	Provider Last Name	Provider First Name	Provider Address
999999	PROVIDER	ILL TEST	, NORFOLK, VA 23502

Consumer ID	Last Name	First Name	Consumer Address
421337888	CONSUMER5	TEST5	1344 TEST DR , CHICAGO, IL 60608

Funding Source	Description	Eligibility Start Date (MMDDYYYY)	Eligibility End Date (MMDDYYYY)
213	ILLINOIS-CONSUMER CENTERED RECOVERY SUPPORT	09/02/2010	10/14/2010
350	ILLINOIS-PSYCHIATRIC LEADERSHIP	09/02/2010	10/14/2010
572	ILLINOIS-CONSUMER TRANSITIONAL SUBSIDIES	09/02/2010	10/14/2010
573	ILLINOIS-ADOLESCENT TRANSITION TO ADULT SERVICES	09/02/2010	10/14/2010
574	ILLINOIS-PSYCHIATRIC MEDICATION	09/02/2010	10/14/2010
860	ILLINOIS-CRISIS RESIDENTIAL	09/02/2010	10/14/2010
ABC	ILLINOIS MEDICAID NON-MEDICAID FFS	09/02/2010	10/14/2010

MESSAGE: REMINDER, PLEASE REQUEST ANY REQUIRED AUTHORIZATIONS WITHIN THE NEXT 30 DAYS.
IF THE ELIGIBILITY STATUS IS APPROVED, THE CONSUMER HAS BEEN ENROLLED IN THE VALUEOPTIONS ELIGIBILITY SYSTEM AND IS ELIGIBLE FOR THE FUNDING SOURCE(S) LISTED ABOVE.

IF THE ELIGIBILITY STATUS IS PENDED, THE CONSUMER NEEDS TO BE VERIFIED BY THE VALUEOPTIONS ELIGIBILITY DEPARTMENT TO DETERMINE IF HE/SHE IS ALREADY ENROLLED. PLEASE CHECK BACK IN 48 HOURS. ONCE THE STATUS IS CHANGED TO APPROVED, THE CONSUMER WILL BE ASSIGNED A NEW, PERMANENT MEMBER ID.

Return

Eligibility or ineligibility status appears at the top of the notification screen.

Disenrollment

We understand that ValueOptions will be responsible for the disenrollment of all members who no longer meet the criteria for enrollment at the end of each month. Disenrollment will proceed as outlined, with a coordinated and documented transition plan given to the QexA health plan to ensure continuity of care. Our system's unmatched integration capabilities combined with the dedicated efforts or our Geo Teams and administrative specialists will ensure a seamless transition from ValueOptions back to the health plan.

For data integrity purposes, when we upload your daily eligibility file, a batch process compares members on the inbound file to existing system records. If a member no longer exists in our system after the upload, we can write that record to a report to be validated and manually updated. The record can also be disenrolled based on pre-determined rules, such as those defined by DHS's rule on criminal commitment and additional criteria.

Our eligibility audit team will also randomly sample records and compare them to the source file. This ensures that our load process is converting data and performing accurately. Our standard load process includes a methodology to identify discrepancies and reports them internally or to our client as appropriate.

ITP Process, Forms and Policies

Once members are enrolled into the case management program through an automated interface with CCS, multiple avenues, including claims analysis of behavioral and physical health claims and pharmacy claims information, help to reevaluate and examine individual cases for further interventions. Care gap alerts inform case managers, behavioral health providers, pharmacists and PCPs of needed outreach and further planning efforts. All care gaps and other flags are automatically recorded in the integrated, member-centric record and online, individualized treatment plan.

Members are assessed and tiered into the program based on the information available at each stage. As new information is entered into the system, additional alerts for further review and plan adjustments update automatically. Case managers monitor plans carefully, ensuring provider coordination and member follow-up at each phase.

We take a collaborative approach to assess, plan, identify resources, coordinate and monitor care as members move through the tier levels toward recovery. The member is an active participant in this process with input into the goals and objectives that are most important to them.

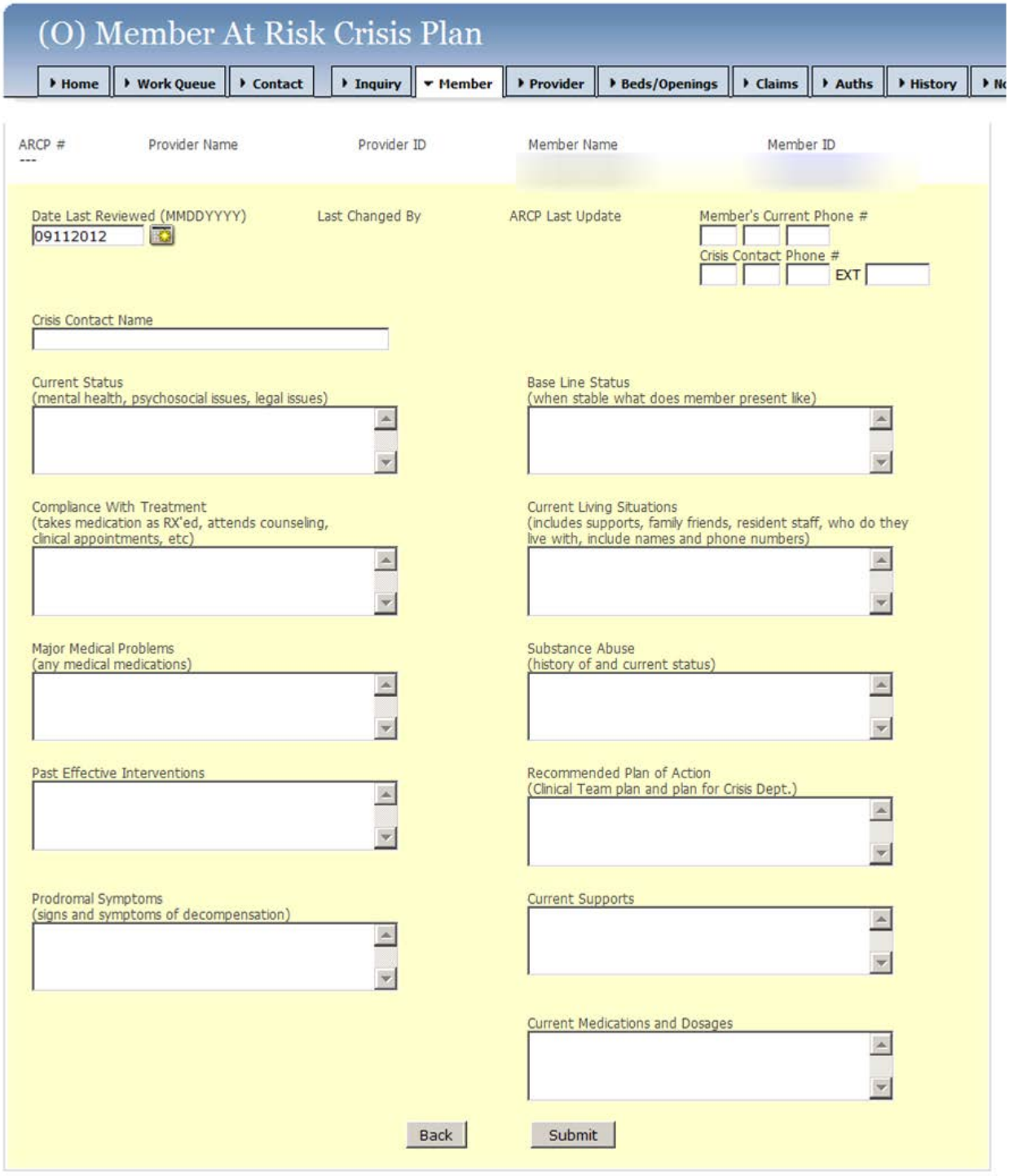
All policies and procedures for case management treatment planning will accord with industry best-practices and DHS criteria. ValueOptions' individualized treatment plans will be recorded within our integrated, online system, which captures all pertinent reporting data in addition to member data as each plan develops. We provide sample screen shots of some of the online templates used in the planning process on the following pages.

>> CASE MANAGEMENT ACUITY ASSESSMENT	
>> ASSESSMENT DATE	
>> MEMBER NAME	
>> ID #	
>> 1. BH IP & ER admits past 6 months	Not scored
>> 2. Danger to self/others (SI/HI) in past 6 months	Not scored
>> 3. Mental Health/Substance Use status	Not scored
>> 4. Treatment resources/coordination	Not scored
>> 5. Treatment participation	Not scored
>> 6. Medical condition	Not scored
>> 7. Medication safety	Not scored
>> 8. Current Health Status	Not scored
>> 9. Clinical History, including meds	Not scored
>> 10. Psychosocial status	Not scored
>> 11. BARRIERS TO CARE	
>> 11 a) Financial Issues	Not scored
>> 11 b) Legal Issues	Not scored
>> 11 c) Transportation	Not scored
>> 11 d) Cultural/ linguistic Issues	Not scored
>> 11 e) Social Support	Not scored
>> 11 f) Healthcare benefit availability	Not scored
>> 11 g) Other disabilities (vision, hearing, mobility)	Not scored
>> RECOMMENDED TIER PLACEMENT	

Automated forms similar to the one above will be incorporated into individualized treatment plans for Hawaii's members.

>>Date Established	>>Date Reviewed	>>Timeline for achieving goal	>>Current Status	>>% Complete	>>Member Involved	>>Provider Involved

Both short and long-term goals can be tracked and managed online.



Forms similar to the one above will enable detailed planning and ongoing management.

70.800 OUTREACH AND EDUCATION PROGRAMS

The offeror shall describe how they intend to perform all of the requirements described in Section 41.100, "other Services to be provided" (i.e., the offeror's efforts to contact persons who are homeless, homebound, and physically disabled, and the offeror's ability to provide cultural and linguistic services to meet the needs of the members). This section should include information on how the offeror intends to support members in maintaining their medical assistance eligibility.

In addition, the offeror shall describe how members will be transitioned and what safeguards will be put into place to ensure that there is no disruption of services and to avoid an abrupt change in treatment plan or service providers, especially for the members in high risk populations, i.e., the physically disabled, homeless, delinquent population and other persons who have a SMI/SPMI diagnosis with special needs. The proposal shall include the transition procedures for:

-Referral and coordination for members who have received behavioral health services from their health plan provider and/or DOH-CAMHD
-Inclusion of certain health plan providers into the behavioral health network to support and coordinate behavioral health services to high-risk members
-The BHO will resolve differences in treatment plans/approaches with the current PCP
-How the BHO intends to establish and maintain community linkages with other service providers, i.e., health plan , DOH-CAMHD, DOH-AMHD, DOH-ADAD, and other community-based providers

The ValueOptions regionally-based Geo Team model has been developed and perfected with outreach and engagement in mind. All outreach efforts are effectively managed through a tiered system of monitoring and support networks. Members are touched at each level:

- **Intensive Care Coordinators** provide oversight and coordination of provider networks, community case managers and supporting staff, and also work directly with high-needs members through joint treatment planning.

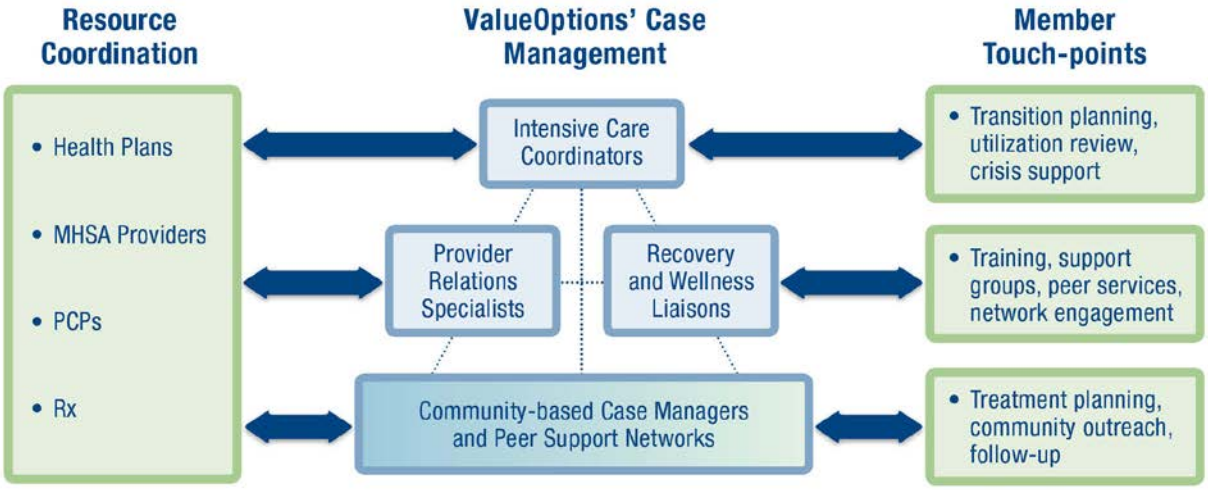
- **Staff peer specialists and provider specialists** coordinate member-provider/peer interactions, seek new opportunities and innovations for community outreach, and also meet members in their communities, at peer-run forums, clinics and related venues.

- **Community-based case managers and credentialed peer providers** conduct on-the-ground outreach in the members' local communities and facilitate coordinated, multidisciplinary treatment planning.

Through this vertically and horizontally integrated approach, members receive cross-sectional outreach linked through a progressive system of supervision and support. In addition, members of the Geo Team communicate cross-regionally, so that Intensive Care Coordinators on the Big

Island know and understand how the nuances of their members' needs compare and relate to those on Oahu, for example.

Regional, Member-centric Case Management Model



Below, we address each of the items listed in Section 41.100, describing how each benefits from our regional, member-centric case management model.

EFFORTS TO CONTACT PERSONS WHO ARE HOMELESS, HOMEBOUND, AND PHYSICALLY DISABLED

We specialize in coordinating targeted outreach for segments of the population with particularly challenging barriers to engagement, including the homeless, homebound, disabled, and those suffering from chronic substance abuse.

To contact persons who are homeless, homebound or physically disabled, we will implement a statewide peer navigation model to maximize available peer resources. We have a long history of promoting and developing services delivered by peers. Several prominent national programs were created and expanded with the support of ValueOptions, including the Recovery Empowerment Network (REN), Recovery Learning Communities, Transformation Centers, Recovery Innovations, and the Family Involvement Center (FIC).

Building on these successes and through the use of our national and local resources, we will design and implement innovative strategies to increase peer and family support services.

We will work to help promote Hawaii Certified Peer Support Services (HCPS) to include:

- engaging in a comprehensive assessment of the current state of peer support services, including demographic, concentration and comparative service utilization of peer services; in addition we will conduct an analysis of current training and service provision opportunities
- working with the Adult Mental Health Division (AMHD) and the Hawaii Certified Peer Specialist Advisory Committee (HCPS) to review service definitions, provider utilization , and practice guidelines for services available to be provided by peers, including mental health support services, crisis supports, and crisis respite services
- begin a process of promoting the statewide HCPSs
- develop trainings and provider communications focused on certification of new peer resources, and recertification of existing peers within the first two years, including face-to-face trainings, Webinars, ongoing, and annual/semi-annual trainings
- work with AMHD/HCPS to promote peer support services across the state, providing trainings and provider communications including service definitions, provider workforce development, supervision and practice guidelines
- conduct a comparative analysis of models providing the state with both practice-level and system-level recommendations

Our national support of peer services includes:

- award winning Web-based member and family resources
- our National Office of Wellness and Recovery, which includes a dedicated staff of peer services and monthly support calls recovery and wellness liaisions annual face-to-face recovery symposium featuring national recovery spokespersons and noted experts in the field
- Vice President of Wellness and Recovery and National Director of Peer and Recovery Services
- National Cultural Competency Committee and Office of Grants Management to provide sustainability of non-Medicaid emerging best practices. ValueOptions offers a wealth of grants management experience, including:
    - The Recovery Services Development Snapshot tool, developed in our Illinois program, is a strengths-based assessment of the recovery orientation of a large provider through parallel member and staff focus groups. This program supports key providers and peer-led recovery through dedicated Micro-Grant funding.
    - From our Tennessee experience, the Emotional Fitness Centers (EFC) is a faith-based provider of behavioral health services. Funding for operational support and staff development is provided through a special grant from the Tennessee Department of Mental Health and Substance Abuse Services. Billing for care is provided through TennCare and State Block Grant dollars.

To help maintain individuals' certification we will sponsor and conduct annual wellness and recovery forums, and offer a minimum of eight face-to-face contact hours. In accordance with the guidelines, standards and procedures of the Hawaii Certified Peer Specialist Support Program, training will cover the HCPS Code of Ethics, HCPS Scope of Activities and additional, pertinent information. In addition, peers will receive assistance in the administrative process for filing their applications.

We will achieve this level of peer training through our long-standing behavioral health systems expert partner, the Western Interstate Commission for Higher Education (WICHE), who has provided guidance to ValueOptions on a variety of behavioral health strategies for many western states. WICHE has decades of experience in working with western states, including ongoing work in Hawaii, to meet the challenges of changing environments through regional research and evaluation, policy analysis, program development, workforce development technical assistance, and information sharing. WICHE Mental Health staff collaborate with behavioral health policy makers, administrators, educators, consumers, family members and providers to improve services, training, and research in public behavioral health, and routinely contract with state behavioral health executive and legislative agencies to provide technical assistance on various initiatives based on their needs (e.g., program evaluation; management, policy and financing reviews; grant-writing; workforce development; training; and research and data analysis).

With WICHE's guidance, we will build upon current peer support development efforts in Hawaii by developing and expanding the training available to peers and their supervisors. WICHE has experience in targeting peer specialist development for indigenous populations, as well as providing training and supports for the supervisors of peer specialists. WICHE will provide these enhanced workforce development opportunities for peer specialists and their supervisors, which will augment the current training available in Hawaii.

Our protocols and initiatives effectively improve the quality and efficiency of care to high needs persons who are homeless, homebound, and physically disabled. Our work has focused on coordinating with governmental entities, local law enforcement and justice systems, health plans, foster care providers, hospitals and mental health providers, and increasingly with health homes. By engaging all affiliated groups in an open, regular and ongoing dialogue from the earliest stages of implementation, we ensure consistent strategies that target key issues and population segments, and enhance the value of each dollar spent.

Below, we review a few replicable examples from our experience coordinating with external entities to improve care for high needs populations in other states.

Massachusetts

The Commonwealth of Massachusetts annually negotiates specific improvement projects with ValueOptions called Performance Incentives (PIs). PIs emerge from consensus building with a wide variety of stakeholders, including members and families, advocates, state agencies, and providers. Examples of very successful PIs that have evolved into ongoing programs include the Massachusetts Child Psychiatry Access Project (MCPAP), the Community Support Program for People Experiencing Chronic Homelessness (CSPECH), Coordinated Family Focused Care (CFFC), and Recovery Learning Communities (RLCs). To date, hundreds of such PIs have been successfully completed. To highlight just a few examples:

- ValueOptions' staff worked with homeless providers and detoxification facilities to identify uninsured individuals with multiple detoxification admissions. Shelter and detoxification facility staff was trained to identify these high risk individuals and assist them in applying for Medicaid benefits, thereby ensuring their access to needed care management services and supports.

- ValueOptions collaborated with the Commonwealth's mental health and substance abuse treatment authorities to develop an Acute Treatment Service (ATS) model, designed to improve access to detoxification services for homeless individuals with co-occurring disorders. Building upon the work of the Community Consensus-Building Collaborative, ValueOptions developed program specifications for these prioritized, high-risk populations. Access to ATS services was further improved by our website that tracks the real-time availability of acute beds, for both psychiatric inpatient services and ATS services. Emergency Service Program (ESP) providers under contract with ValueOptions and care managers utilize this website to facilitate the admission process for acute care services.

Other cross systems successes include:

- working with authorities who serve the developmentally disabled to develop specialized inpatient psychiatric units dedicated to persons with developmental disabilities, who historically experienced inordinately long inpatient and emergency room lengths of stay
- working with county corrections to implement a [redacted] that electronically targets Medicaid recipients entering the criminal justice system who are appropriate for pre-arraignment diversion, offering an efficient and effective avenue to seamlessly refer mentally ill offenders to viable alternatives to incarceration

Massachusetts Community Support Program for People Experiencing Chronic Homelessness (CSPECH)

The Massachusetts Behavioral Health Partnership helped start a community-based system of care, CSPECH, that provides case management services and housing to more than 100 displaced adults across the Commonwealth. In operation since September 2006, MBHP's CSPECH program has touched the lives of many people in need by helping them focus on recovery and self-sufficiency. "It got me off the street – put a roof over my head. I really, really appreciate the people who helped me," said a member of the CSPECH program. Recognized by the Massachusetts Housing and Shelter Alliance (MHSA) for its commitment to helping homeless people get back on their feet, the MBHP was granted the 2007 MHSA Cornerstone Award. "I was proud to be one of the team leaders of this project and to have the privilege of working with such a great group of MBHP staff," said George Smart, Vice President of Clinical Operations. "We were all inspired by the success stories of members who had previously spent years living on the streets, and once having a place to live, began to express how much this program helped them feel like human beings again. CSPECH truly embodies the core values of ValueOptions and MBHP of clinical excellence, compassion, and respect and innovation."

Consistent with these standard operating protocols, we plan to work diligently to include all relevant government, provider, and other health related organizations in the systems strengthening processes in Hawaii, and look forward to developing innovative solutions to minimize administrative burden, bureaucratic inefficiencies, and adverse incidents, while reducing costs and streamlining the overall management of care.

New York Chronic Illness Demonstration Projects (CIDP)

We also developed and maintain a unique collaboration with New York City and Nassau County-based not-for-profit providers. Through this relationship, we manage the medical care coordination for the region's highest risk, multiple co-morbid Medicaid beneficiaries, and are responsible for all of the related data management, analysis and reporting deliverables for two of the State's CIDPs. CIDP beneficiaries are high-risk, high-cost, fee-for-service Medicaid beneficiaries who have one or more chronic illnesses, and often suffer from a chronic behavioral health condition.

The unique program design ensures the outreach to, and enrollment of, individuals with complex medical and psycho-social service needs. These individuals have historically been out of the reach of conventional health care systems. Eligible enrollees, identified through the application of a predictive modeling program, are often homeless, medically underserved, and wary of traditional health care providers. The program's goal is to improve access to primary care and preventive services, to enhance care coordination and quality of care, to improve health status and outcomes, and to decrease associated health care costs. Our Clinical Care Coordinators are partnered with provider-based care managers and peers to provide clinical support to the medical homes willing to work with these individuals. This experience, along with our experience customizing services in states and counties nationwide, serves as the foundation for us to adapt and provide the additional services that have been requested.

ValueOptions of Kansas

ValueOptions manages mental health and substance abuse services provided through Medicaid, as well as through Substance Abuse Prevention and Treatment block grant funds, for 320,000 Medicaid beneficiaries and persons eligible for block grant services. ValueOptions of Kansas (VO-KS) ensures access to Kansans who have Medicaid- and SAPT-funded mental health and substance abuse treatment.

We first began managing addiction services for the Kansas Medicaid and Block Grant Substance Abuse Program in 2007. This program encompasses substance abuse rehabilitation and prevention, problem gambling, and driving under the influence (DUI) offender programs. The contract is under the authority of the Kansas Department of Aging and Disability Services (KDAD). ValueOptions manages approximately $36 million in Medicaid, grant and DUI funds that have distinct administrative allowances attached to them. Medicaid represents $21.5 million of the total amount of funds. By coordinating the SAPT block grant and the Medicaid funds jointly, we have demonstrated a cost savings of $1 million a year in Kansas while also reducing the state's administrative cost of administering the SAPT grant.

We implement a wide range of utilization management and care coordination strategies to effectively reduced costs while improving care to the state's most vulnerable Medicaid members. We also have used a variety of strategies to improve access to services, such as:

- VO-KS works collaboratively with the Regional Alcohol & Drug Assessment Centers (RADACs) to consistently screen all applicants for services and ensures that other sources of payment—including private insurance—are fully utilized.
- We support the process already underway in Kansas to expand community-based treatment services, reserving 24-hour treatment beds for those members whose conditions require 24-hour care.
- We work with providers and our state client to identify and implement evidence-based practices consistent with Kansas' approach to treatment that improve the effectiveness of treatment provided with SAPT and Medicaid dollars, reducing recidivism and treatment duration as appropriate.
- We have implemented a Provider Excellence Program, which recognizes providers whose programs show the best treatment outcomes by minimizing the requirements for authorization of services they provide.
- We provide forums—through our Quality Management program, Kansas Recovery Conference, and through our Kansas Substance Abuse Summit—in which excellent providers and programs present their treatment approach so others can adapt those strategies as appropriate.
- Through our contacts with the Substance Abuse and Mental Health Services Administration we complement Kansas' efforts to assure continuation of substance abuse block grant funds, with increases as possible.

MEMBER EDUCATION

The backbone of our outreach and engagement strategy is making sure members have access to the information they need to make informed decisions about their healthcare. For CCS members, we will provide a wide variety of educational resources to assist them in recovery. Our materials are customized to address the nuances of Hawaii's system of care and member cultures. All written materials will be produced with the SMI population's needs in mind, and all will be produced at a sixth grade reading level in accordance with the RFP. We accomplish member education through a variety of outreach strategies and mediums, including:

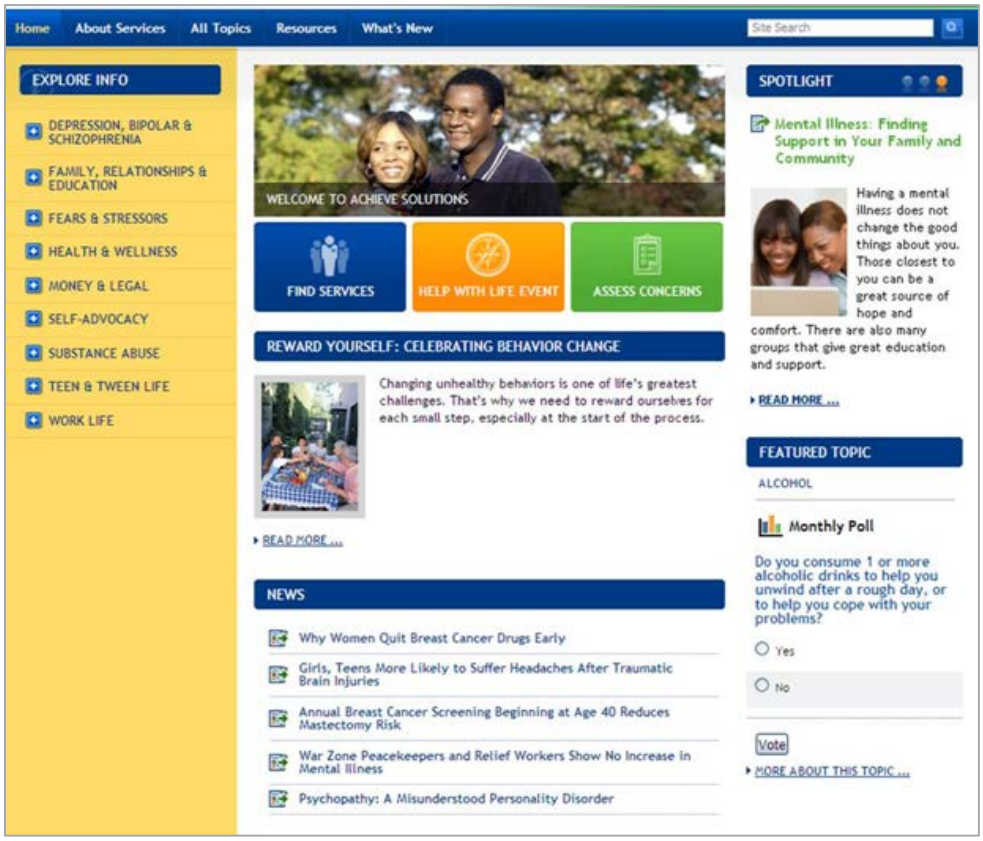
- **Member Handbook:** We will produce a handbook for members than will help them understand their behavioral health benefits and how to access them, how to obtain emergency care, how to file a grievance or appeal, and how to find a provider.

- **Website:** Our Web-based member portal will provide members comprehensive information about their care and services. This will include information about our quality programs, preventions services and programs, member rights and responsibilities, and additional educational materials. Members will also have access to our award-winning, online behavioral health resource, Achieve Solutions, which includes more than 2,500 articles on 125 health and wellness topics.

- **Member Newsletters:** Created with the assistance of members, their families and advocates across Hawaii, newsletters will include information on prevention topics, forthcoming education programs and changes in the program. Members and family members will be invited to write articles about their own experiences, as well as act as editors and reviewers.

- **Behavioral Health Providers and Staff Peer Specialists:** We have found these stakeholders to be more than willing to participate in educating members about services and health information. Members are receptive to receiving information from their providers, such as health educational materials. We will make written materials and brochures available throughout the behavioral health network, and through the recovery and wellness liaisons we will establish relationships with.

- **Recovery and Resiliency Forums:** We will partner with member leaders and advocacy organizations, such as NAMI and ADAD, to develop and conduct regional wellness and recovery forums annually. These forums bring together members, families, advocates, providers, and state agencies to learn and discuss important recovery topics and issues involved in supporting people in recovery and their families. The forums also address important topics such as the integration of peer services, trauma-informed care, and culturally- and linguistically-informed care.



The Member website is a quick source for information and a wide range of member resources.

Cultural Interpretation Services (Cultural and Linguistic Services)

Our top priority is ensuring that all citizens of Hawaii receive exceptional customer service in their native language and dialects, whether it is English or another language. We recognize that Hawaii has a unique array of cultural and language diversities, and we will position our local staff resources to ensure our program outreach and communications are relevant to each participant's individual preferences. To meet this need, we will ensure that all written materials are available in alternative formats, taking into consideration members with special needs, such as the visually or hearing impaired. Our printed materials, Web content, and other written materials are written at a 6th grade reading level to ensure accessibility to all members. In accordance with the requirements set forth in section 51.220 of the RFP, all written communications will include a language block informing members that the document/email/webpage contains important information and direct them to translation services. At minimum, this information will be provided in the following languages:

- English
- Ilocano
- Vietnamese
- Chinese (traditional)
- Korean

Needs for written materials in additional languages can also be accommodated, and all translated written materials will be vetted by a qualified individual for accuracy.

Through our regional, peer-supported case management model and experience crafting culturally appropriate networks of care, CCS members will receive unmatched attention to their cultural needs. Our experience in other states includes working with faith-based organizations in Tennessee, contracting with traditional Native American agencies in the southwest, and working with a variety cultural advocacy groups throughout the country.

ValueOptions brings a proven track record of providing effective access to non-English speaking members and their families, and we are keenly aware of our role in providing a culturally-relevant program for each CCS participant. Years of experience managing state Medicaid programs have given us a strong appreciation of the variety of nationalities, ethnic backgrounds, and diverse cultures of the members we serve. Because we are sensitive to the barriers that language and cultural backgrounds can present for members who need behavioral health services, we have led the way in developing a multi-cultural staff and provider network. It is also the reason we have designed programs tailored to meet the unique needs of all the members, families, organizations and communities we serve.

Our first step in meeting the cultural and language needs of members is hiring multi-lingual member engagement center staff from the local community. In Hawaii, we will focus on recruiting native speakers who have also lived in relevant cultural/linguistic environments. We will make all messages on our automatic call distributor line available in the key languages bulleted above, as well as English.

Additionally, all staff will have access to Language Line Services, comprising highly skilled interpreters, each with more than 20 years of experience. When our employees receive a call from a non-English speaker, they dial a toll-free number that connects them—in one ring—to the Language Line Services. Within moments, the caller and employee are connected to an

appropriate professional interpreter. Through this service, members who speak Ilocano, Vietnamese, traditional Chinese and Korean, in addition to nearly 200 additional languages, will receive prompt, effective services without frustration.

Language Line Services ensures that we can communicate effectively with members to resolve their question or concern and make the most appropriate referral. Speaking our members' language is just one more way we provide the exceptional customer service they deserve (and will come to expect). This dedicated, HIPAA-compliant translation service offers more than 170 languages, and is available at no charge to our members.

Communicating with the Hearing Impaired

We have a demonstrated commitment to overcoming the barriers to care faced by people with hearing loss or speech impairments. We take full advantage of available technology to ensure that all our members have complete, prompt access to behavioral health services they need. Options include confidential Telecommunication Devices for the Deaf/Text Telephone (TDD/TTY) services, and relay services.

We thoroughly train all call center staff on use of TDD/TTY and relay services so that members who are deaf, hard-of-hearing or speech impaired can talk to us without a translator. Callers can directly connect to the TDD line or be promptly transferred to speak with a customer service representative. This confidential service is available to our members 24 hours a day.

Culturally Appropriate Services

We ensure your members have a choice of network providers who meet their cultural and linguistic preferences, as well as their behavioral health care needs.

We actively recruit providers who meet one or more areas of need in a given demographic area to ensure a diverse network of highly qualified providers that meet members' care needs, as well as their cultural and linguistic preferences. Our online, searchable provider directory promotes informed choice by offering members and their families a comprehensive resource for available services, either online or in hard copy. Our staff can also access the same information to assist with referrals. Members will find a choice of providers meeting their specific requirements, such as geographic location, hours of service, cultural and language competencies, ethnicity, professional degree, and gender.

In addition, through our extensive peer network development efforts outlined above, we will seek culturally appropriate peer service providers to help member preserve their traditions. This includes seeking peer supports from non-conventional peer providers who can provide traditional healing services and/or religious supports. Adding this level of support can be extremely effective, especially among diasporic communities where a lack of member engagement results from a cultural disconnect.

ACCESSIBLE TRANSPORTATION SERVICES

We will contract with transportation providers throughout the islands to provide accessible transportation services. If there are no providers in the area for the requested level of service, we will coordinate the member's care accordingly. This includes accessing telehealth solutions,

developing single case agreements with non-participating providers, coordinating transportation to the closest provider, or referring the member to another appropriate clinical level of care available within the designated area. If the need is more acute, we will approve a combination of services and supports to sustain the member until the target service can be made available.

Our regional case management teams will make every possible effort to provide accessible transportation services, and locate designated transportation specialists to provide transportation services when necessary. ValueOptions will also provide necessary arrangements to allow travel between islands for practitioners or members, with reimbursable discounts on transportation services or prepaid services for members.

OUTREACH

Our outreach activities focus on three important principles:

1. ensuring members have the information they need to identify and access services in a timely and appropriate manner
2. providing members and families with information to enhance their ability to prevent the onset or worsening of behavioral health issues
3. improving access and kept appointments, especially for hard-to-reach members, such as those with special problems (the poor and persons with physical disabilities)

We use a variety of methods to meet members where they are and engage them as active program participants so they receive individualized care to meet their unique needs. Methods for engaging members include:

- **hotline** staffed with member engagement specialists and peers with lived experience who will serve as guides to assist members in navigating the Hawaii behavioral health delivery system
- **education and information resources** available through multiple modalities including online, print, and telephonic
- **regionally-based Geo Teams** anchored with community based case managers and staff peer specialists to ensure active outreach to members through a coordinated effort

We will ensure that members know how to contact us—upon program implementation and on an ongoing basis. We will host multiple community meetings to ensure that all interested individuals have an opportunity to learn about the program and how to access available services.

We will ensure awareness and access via comprehensive contact information provided at every possible member touch point: our website, provider offices, member and advocacy organizations, and peer groups. For example, materials will be available post-assessment to guide members to the member engagement center for information on referrals and next steps.

Processes to Address the Special Problems of the Poor and Persons with Physical Disabilities

We realize that for those members most in need, additional outreach measures are required, including, on-the-ground, face-to-face outreach efforts to effectively engage these members and

ensure that they maintain their medical assistance eligibility. Our staff peer specialists will be vital to fulfilling this need, working with local peer service providers to strategize effective, localized outreach campaigns to contact members directly at clinics, residential centers, homeless shelters, and other locations within the member community. The staff peer specialists additional responsibilities will include ensuring that all members receive the assistance they need, whether providing coordination with living assistance, explaining benefits, identifying needed family contacts, or through similar measures.

APPOINTMENT FOLLOW-UP

We have a demonstrated, nationwide track record of success helping members get and keep appointments, including measures for following-up with members to ensure continued engagement.

Appointment follow-up for CCS members will be conducted on an individual basis, as needed. For the state's most vulnerable members, measures will include face-to-face follow-up meetings with members to track their progress and adherence to treatment planning. We will use our member engagement specialists, our website and educational materials, and our Geo Teams to follow up with all member appointments, as well as to assist them with obtaining and keeping appointments for needed care.

For all missed appointments, at minimum, our member engagement specialists will contact the member to determine the reason the appointment was missed and to schedule another. Additional outreach measures may be necessary, up to and including face-to-face interventions or use of peer supports in contacting members without access to conventional resources. Coordination with health plan or PCP referrals will include sharing all pertinent data with health plan care management staff for specialist referrals, via our member-centric, integrated health records, and through direct case manager outreach to the health plan.

We use multiple methods and tools to ensure members can schedule appointments, keep their scheduled appointments, and can access needed services, including the following:

- **Warm Transfers to Providers and Peers:** Our telephone system enables a seamless and undetectable warm transfer, whereby our staff member stays on the line with the member until he or she is connected to a staff person at the provider's office. This ensures timely connections and coordination to improve member satisfaction and decrease the likelihood of non-compliance with treatment or engagement in care.

- **Call Reminder to Decrease Appointment "No-Shows":** Our Health Alert application is an outreach tool developed to facilitate and ensure timely and effective continuity of care for members. Health Alert is a component of our information platform that automates appointment reminders to increase compliance with scheduled appointments. Members can access Health Alert to set up and manage all of their appointments, through their member portal. Additionally, providers can also set up reminders for members through our provider Web portal.

- **Web-Based Provider Search Functionality:** Members will have access to our online provider directory through our website. The directory enables members to find a provider in their area 24 hours a day, seven days a week, at their own convenience. Members simply enter their location, the distance they are willing to travel, and the type of provider they are seeking. Based on specified search criteria, the directory will return the requested provider information and a map. It is very user-friendly, and features a "help" function that enables members to make full use of the system.

HOTLINE

All CCS members and providers will have access to a toll-free, Hawaii-based hotline 24 hours a day, seven days a week, staffed by member engagement specialists who can transfer to case managers as needed. Members and providers can access this line to:

- identify the individual's case manager or provider
- direct members to the nearest most appropriate behavioral health delivery site in cases of crisis, urgent, or emergency care
- provider required prior approvals
- answer other questions related to treatment of common behavioral health problems and minor emergency care

Members in crisis require easy and immediate access to a clinician who can assist them in obtaining the necessary services. When calling our toll-free number, the first option on our automatic call distributor menu is the emergency option. When selected, the call is immediately routed to an Intensive Care Coordinator, a licensed behavioral health professional, for immediate triage.

Our telephone technology enables the case manager or Intensive Care Coordinator to maintain open contact with the member at all times. Through an internal messaging system and/or three-way conference calling, the Intensive Care Coordinator is able to access identified crisis response systems, suicide hotlines, and 911 emergency services. This system ensures that the member has telephonic contact with a staff member at all times. **The caller is never put on hold in an emergency situation**.

On call Intensive Care Coordinators are available 24 hours a day via the toll-free number to respond to all crisis calls. When available, wellness recovery action plans and crisis plans are accessible within our system to ensure member-specific needs are identified and resolved according to their specific plans.

Additionally, our member engagement specialists are trained to identify emergency situations. This includes behavioral health clinical sensitivity training, which provides the groundwork for recognizing and identifying the different types of calls generated to a behavioral health line. This training provides our staff with key phrases and indicators which signal when a warm or "no-hold" transfer to an Intensive Care Coordinator is required.

All crisis calls are transferred with the no-hold feature enabling our staff to remain engaged until the Intensive Care Coordinator is on the line. Once this occurs, the member engagement specialist is released from the call.

When a member identifies the situation as an emergency, it is always treated as such. If the member and our staff define the situation differently, the more urgent definition will take precedence.

ADVERSE EVENTS POLICY/REPORTING

As part of our [redacted], we maintain a secure, web-based Adverse Incident Tracking System (AITS) used for reporting, tracking and investigation of all adverse incidents company-wide. Our system ensures accurate, timely reporting to DHS in compliance with all requirements set forth in the RFP. All policies and procedures regarding adverse incidents will be submitted to DHS in accordance with all readiness review activities.

Access level is controlled. Users are assigned a role level that determines what information can be accessed on a "need-to-know" basis. The application has embedded features which assign a severity index that classifies adverse incidents according to their severity in relation to the actual safety of ValueOptions' members or others. Recommended investigation guidelines, standard response expectations and variables are established for each severity index category to ensure member safety.

The benefits of our application include:

- a complete database that houses incidents where a ValueOptions member may have been harmed or a ValueOptions member harmed someone else
- a form-driven application, where based on answers given, correct questions pop up and drive determinations of the type and severity of the incident
- a role based application, where based on data and severity, the case is routed to the correct person for review

All information regarding the investigation of an adverse incident and the details of the incident are captured in the electronic forms. Within our system, a navigation bar contains options to generate reports. Users with access rights can generate several types of reports, including:

- incident reports
- suicide reports
- critical incident reports
- adverse incident reports
- list of incidents that still need the Part A form completed

ASSISTANCE WITH CERTIFICATION AND CONTINUED ELIGIBILITY

ValueOptions will provide members with the needed support to assist them to successfully complete the disability paperwork required for certification and continued eligibility, and to connect with the evaluating DHS panel provider. We will coordinate these efforts using the interfaces described above, such as our integrated information platform and extensive outreach

protocols. Community-based case managers will work with member to ensure that all timeframes are met, and that information is completed as required, including any additional outreach efforts that may be necessary.

We understand the current difficulties facing providers in determining eligibility for CCS members. Our experience managing multiple eligibility streams simultaneously, and our integrated IT solutions, will streamline this process and eliminate confusion. To assist providers in making accurate, timely and effortless determinations, we provide:

- notification calls from case managers at the pointe of enrollment to all known behavioral health providers associated with each member
- member ID cards for quick verifications by phone, and a non-denial-based authorization system for members without ID cards—we realize that many members, especially those suffering from a severe mental illness, will not always be able to present their ID cards at the time of contact. To ensure that these members receive the urgent care they need, we do not automatically deny care if eligibility cannot be immediately verified.
- Spectrum, our member-centric record, and our fully integrated information management platform automatically tracks all claims, authorizations and denials, and treatment progress. Our system also accommodates batch eligibility feeds, with automated adjudications and edits for superior quality and accuracy.

Members' continued eligibility will be incorporated into care and treatment planning, providing regular, timely reviews to ensure that eligibility criteria are being met. Case managers will assist members with all necessary administrative tasks as part of the case management process. Our integrated, member-centric records will record histories of outreach and contact with DHS providers, outcomes and the status of these interactions, and any flagged concerns regarding continued eligibility.

TRANSITION PROCEDURES

Continuity of care is our foremost concern. Our goal will be to assist members in receiving care without disrupting their therapy and without compromising positive therapeutic results.

Referral and Coordination for Members Who Have Received Behavioral Health Services from Their Health Plan Provider and/or DOH-CAMHD

As outlined in section 41.200 of the RFP, all members receiving medically necessary behavioral health services the day before enrollment will continue to receive services without any form of prior approval, and without regard to whether such services are being provided by contracted or non-contracted providers. ValueOptions will provide continuation of these services for 90 days, as prescribed, for all members or until members have an assessment from the case manager, have had an individualized treatment plan developed, and been seen by a behavioral healthcare specialist.

We ensure this continuity of service to members in treatment at the time of transition through targeted recruitment and individual, case rate provider contracts (single case agreements). Our single case agreements enable members to continue their care through the change in vendors, even if their providers are not part of ValueOptions' current network. Each case in progress at

the time of transition will receive careful consideration focused on the member's needs. Treating providers eligible to join our network will be recruited, although our primary concern resides in sustaining each member's continuous, uninterrupted care. Single case agreements ensure this care continuity throughout the credentialing process.

Inclusion of Certain Health Plan Providers into the Behavioral Health Network to Support and Coordinate Behavioral Health Services to High-Risk Members

ValueOptions is committed to ongoing recruitment of our network, and welcomes nominations from health plans, providers and Hawaii's members.

Our recruitment plan guides our efforts to build a network with enhanced availability and to deliver a smooth program implementation. The plan details our efforts and activities in meeting providers across the state, and obtaining their support and intent to contract with us.

We invite members and their families to nominate providers for inclusion in our network. We will identify key behavioral health care providers who are not currently members of ValueOptions' network, but who are currently treating Hawaii's members. Members who wish to nominate their providers for our network can request that the provider contact ValueOptions' national provider line. Providers who contact our national provider line are interviewed by our provider line specialists regarding their licensure, clinical specialties, and years of experience. The providers who meet ValueOptions' criteria receive an application.

Resolving Differences in Treatment Plans/Approaches with the Current PCP

As an experienced provider of behavioral health and technical services, ValueOptions has planned and executed many large and complex transitions for our clients. We establish an implementation team that includes an Implementation Director, departmental representatives and Implementation Leads from 20 different functional areas that are keys to ensuring a successful, error-free transition. As part of our implementation process, we will coordinate with current PCPs at the regional health plans to create effective systems interfaces, education and access to our member-centric record online environment. Our system is customizable to incorporate components unique to the health plans or data specific to PCPs. With the industry's only fully integrated platform, all PCP data can be included in treatment planning and reporting.

Intensive Care Coordinators further coordinate transition of care and services with the health plans' care management teams and PCPs. Integrated, joint treatment planning and record reviews provide additional opportunities to coordinate efforts and resolve discrepancies.

PCPs also have access to a variety of additional resources to better coordinate services. These include access to our website, our 24-hour Physician consult line offering support from live psychiatrists, diagnostic screening tools and additional educational materials mailed directly to PCPs. As part of our provider education initiatives during implementation, we will evaluate all existing PCP protocols for continuity with ValueOptions' approaches and methods, determine necessary measures to improve continuity, and conduct targeted outreach and education initiatives including onsite trainings, customized mailings, and Web content and additional resources as needed to provide a supportive environment for PCPs in the members' best interest.

How the BHO Intends to Establish and Maintain Community Linkages with Other Service Providers, i.e., Health Plan, DOH-CAMHD, DOH-AMHD, DOH-ADAD, and Other Community-Based Providers

Our case management services provide wraparound support, to include not only regular contact with case managers and clinicians, but also family, peer and community supports to keep the member engaged between clinical visits and follow-ups. We contract with community programs such as residential housing and treatment programs, coordinate with local legal and judicial systems, employment agencies and other resources to add layered support that assists members in making transitions necessary to recovery.

Our dedicated, Hawaii-based staff peer specialist and provider relations specialists will provide much needed support in establishing and maintaining community linkages with other service providers. Coordinating the efforts of contracted provider organizations and peer services within the communities served, our liaisons will ensure that:

- health plan, DHS, and other community-based providers' systems and protocols are consistent with ValueOptions' information systems
- adequate peer support networks exist for all members across islands, including providing outreach, training and adequate support to peer providers
- appropriate coordination with Intensive Care Coordinators is in place for clinical oversight and high intensity case reviews across provider organizations and health plans
- joint review procedures between various provider organizations and peer supports are in place and adequately tracked and monitored within our system
- opportunities for customized, integrated initiatives among various provider groups are identified, developed and implemented

Best-Practices Example: Peer-Run Crisis Respite

For members in crisis in the inpatient setting, our case managers initiate the discharge planning process early on, recognizing the importance of an appropriate plan of discharge and reintegration with the community to the member's overall success. We have direct experience crafting specialized opportunities for members in crisis to support this success, and can work with to develop customized programs.

For example, we can provide adult crisis respite programs offering peer-operated services. Crisis respite is typically viewed as an environment that meets immediate needs while avoiding the cost and disruption of inpatient admission. The longer stays and changes in medication that come with many inpatient admissions often result in a longer period before a person can return to normal activities of life.

People in crisis feel alone with their anxiety, panic, anger, frustrations and depression. A goal of peer-run crisis respite is to provide connections and relationships that can lessen the intensity of these feelings. These non-medical alternative programs offer a comfortable, non-judgmental environment where stresses can be processed and new options can be explored. The vision is that these interactions will result in fresh, short-term solutions and a wider array of options for handling future crises.

Peer-run respite can also provide an opportunity for immediate immersion into recovery through classes and interaction with peers who have progressed with their personal illness, symptoms, and triggers.

It is well understood that many members have co-occurring disorders. And it should also be understood that crisis respite would not meet the needs of substance abuse treatment or detoxification. In such situations, an individual admitted to crisis respite could be transferred to a substance abuse treatment program that deals with co-occurring disorders and that can assist in detoxification.

Recovery education is essential to peer-run crisis respite. Support groups and classes can be provided during the day and evenings to enable education of recovery concepts and development of potential mentoring relationships with other peers. Basic recovery concepts would be taught on an ongoing basis to all admitted members. Another key benefit of a peer-run crisis respite program is that staff members are educated in and participating in recovery and can teach and mentor basic recovery concepts.

"The peer support process allows and encourages development of mutual and reciprocal relationships between the givers and receivers of support. It is important to note that, in successful peer relationships, both individuals are givers and receivers of support, enabling both parties to feel valued and empowered. When people feel respected and valued, they become empowered and are more able to move toward recovery. It is believed that this helps to eliminate the institutionalization and potential trauma that frequently result from psychiatric hospitalizations."

--National Empowerment Center,
December 2010.

APPENDIX C

STATE OF HAWAII

STATE PROCUREMENT OFFICE

PROPOSAL APPLICATION IDENTIFICATION FORM

STATE AGENCY ISSUING RFP: Hawaii Department of Human Services

RFP NUMBER: RFP-MQD-2013-007

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

Check one:

☒ Initial Proposal Application

☐ Final Revised Proposal (Completed Items _____ - _____ only)

1. APPLICANT INFORMATION

Legal Name: ValueOptions, Inc.

Doing Business As: ValueOptions

Street Address: 240 Corporate Boulevard
Norfolk, VA 23502

Mailing Address: 240 Corporate Boulevard
Norfolk, VA 23502

Contact person for matters involving this application:
Name: Amy Grazer

Title: Vice President, Public Sector Development

Phone Number: (757) 323-9378

Fax Number: (757)892-5729

e-mail: amy.grazer@valueoptions.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: VA Date: April 6, 1987

3. PROPOSAL INFORMATION

Geographic area(s): State of Hawaii

Target group(s): Medicaid Eligible Adults Who Have a Serious Mental Illness

4. FUNDING REQUEST

FY	2013	Refer to Milliman CCS Data Book CY 2013 Capitation Rates (dated 8/24/2012)	FY		
FY	2014	TBD	FY		
FY	2015	TBD	FY		

Grand Total TBD

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

Scott M Tabakin — *Authorized Representative Signature*

9-13-12 — *Date Signed*

Scott M. Tabakin, Executive Vice President and Chief Financial Officer

Name and Title

STATE OF HAWAII

Department of Human Services

PROPOSAL LETTER

We propose to furnish and deliver any and all of the deliverables and services named in the attached Request for Proposals for 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.

Scott M Fuhrt — 9-10-12

Authorized Offeror's Signature/Corporate Seal — Date

CERTIFICATION FOR CONTRACTS, GRANTS, LOANS AND COOPERATIVE AGREEMENTS

1. The undersigned certifies, to the best of his or her knowledge and belief, that no Federal appropriated funds have been paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence 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: Scott M. Tabakin

Signature: Scott M Tabakin

Title: Executive Vice President and Chief Financial Officer

Date: 9-10-12

DISCLOSURE STATEMENT (CMS REQUIRED)

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

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

455.104 formation on Ownership & Control

(1) The name and address of each person with an ownership or controlling interest in the disclosing entity.
Please see attached.

(2) The name and address of each person with an ownership or controlling interest in any subcontractor in which the disclosing entity has direct or indirect ownership of five (5) percent or more.
None-N/A

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

(4) The names of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity also has an ownership or controlling interest.
None-N/A

455.105 Information Related to Business Transactions

(5) The ownership of any subcontractor with whom the offeror has had business transactions totaling more than $25,000 during the past 12-month period.
Please see attached.

(6) Any significant business transactions between the offeror and any wholly owned supplier or between the offeror and any subcontractor during the past five-year period.
Please see attached.

455.106 Information on Persons Convicted of Crimes

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

None-N/A

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

(1) Names and addresses of the Board of Directors of the disclosing entity.
Pleas see attached.

(2) Name, title and amount of compensation paid annually (including bonuses and stock participation) to the ten (10) highest management personnel.
Please see attached.

(3) Names and addresses of creditors whose loans or mortgages are secured by a five (5) percent or more interest in the assets of the disclosing entity. None-N/A

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

(1) Describe transactions between the disclosing entity and any related party in which a transaction or series or transactions during any one (1) fiscal year exceeds the lesser of $10,000 or two (2) percent of the total operating expenses of the disclosing entity. List property, goods, services, and facilities involved in detail. Note the dollar amounts or other consideration for each item and the date of the transaction(s). Also include justification of the transaction(s) as to the reasonableness, potential adverse impact on the fiscal soundness of the disclosing entity, and the nature and extent of any conflict of interest. This requirement includes, but is not limited to, the sale or exchange, or leasing of any property; and the furnishing for consideration of goods, services or facilities.
Please see attached.

(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.
Please see attached.

(3) As used in this section, "related party" means one that has the power to control or significantly influence the offeror, or one that is controlled or significantly influenced by the offeror. "Related parties" include, but are not limited to, agents, managing employees, persons with an ownership or controlling interest in the disclosing entity, and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any of such entities or persons.

42 CFR 456.101 DEFINITIONS

a) "Agent" means any person who has been delegated the authority to obligate or act on behalf of a provider.

b) "Convicted" means that a judgment of conviction, has been entered by a Federal, State or local court, regardless of whether an appeal from that judgment is pending.

c) "Disclosing entity" means a BHO.

d) "Other disclosing entity" means any other disclosing entity but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Social Security Act.

This includes:

(1) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII);

(2) Any Medicare intermediary or carrier; and

(3) Any entity that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XIX of the Social Security Act.

e) "Fiscal agent" means a contractor that processes or pays vendor claims on behalf of DHS.

f) "Group of practitioners" means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

g) 'Indirect ownership interest" means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

h) "Managing employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.

i) "Ownership interest" means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

j) "Person with an ownership or controlling interest" means a person or corporation that:

(1) Has an ownership interest totaling five (5) percent or more in a disclosing entity;

(2) Has an indirect ownership interest equal to five (5) percent or more in a disclosing entity;

(3) Has a combination of direct and indirect ownership interests equal to five (5) percent or more in a disclosing entity;

(4) Owns an interest of five (5) percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five (5) percent of the value of the property or assets of the disclosing entity;

(5) Is an officer or director of a disclosing entity that is organized as a corporation; or

(6) Is a partner in a disclosing entity that is organized as a partnership.

k) "Significant business transaction" means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and five (5) percent of an offeror's total operating expenses.

l) "Subcontractor" means:

(1) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or

(2) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the DHS agreement.

m) "Supplier" means an individual, agency, or organization from which a Provider purchases goods and services used in carrying out its responsibilities under its NHS contract (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

n) "Wholly owned subsidiary supplier" means a subsidiary or supplier whose total ownership interest is held by an offeror or by a person, persons, or other entity with an ownership or controlling interest in an offeror.

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
Please see attached document (next page).		

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-N/A		

Justification

DISCLOSURE STATEMENT

BHO NAME/NO. ValueOptions, Inc./ 54-1414194

DISCLOSURE STATEMENT FOR THE YEAR ENDED 12/31/2011

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.

9/10/12
Date Signed

Heyward Donigan, President and Chief Executive Officer
Chief Executive Officer (Name and Title Typewritten)

Karen J. Lester
Notarized

Heyward Donigan
Signature

KAREN J. LESTER
NOTARY PUBLIC
COMMONWEALTH OF VIRGINIA
NOTARY REGISTRATION NUMBER: 311922
MY COMMISSION EXPIRES: 10/31/14

DISCLOSURE STATEMENT
OWNERSHIP

BHO Name, BHO No.: ValueOptions, Inc., 54-1414194
Address (City, State, Zip): Norfolk, VA, 23502
Telephone: (757) 459-5100

For the period beginning: 1/1/2011 and ending 12/31/2011 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.
- ó IPA — A BHO that contracts with an association of doctors from various settings (some solo practitioners, some groups) to provide health services.
- o Network — A BHO that contracts with two or more group practices to provide health services.

Type of Entity:

[ ] Sole Proprietorship	[ ] For-Profit
[ ] Partnership	[ ] Not-For-Profit
[X] Corporation	[ ] Other (specify)
[ ] Governmental	[X] IPA

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
None-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
None-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
None-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
None-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
Please see attached.	

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 ALL:
Ronald I. Dozoretz, M.D./Chairman & Founder of FHC Health Systems (ValueOptions' parent company)	240 Corporate Boulevard Norfolk, VA 23502
Heyward R. Donigan/ President & CEO	
Harold A. Levine, M.D./Medical Director	
Paul M. Rosenberg/ EVP and General Counsel	
Scott M. Tabakin/EVP and Chief Financial Officer	
Kyle A. Raffaniello/EVP & Chief Strategy Officer	
Christopher R. Dennis, M.D./Chief Medical Officer and SVP, Regional Medical Director	
Alan J. Adkins, M.D./CMO Public Sector National Medical Director for Utilization Management	
John D. Tadich/ President, Public Sector Division	
Linton S. Holsenbeck, M.D./Service Center Vice President/ Medical Director, Colorado Service Center	

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
None-N/A			

ValueOptions' Board of Directors	
Name	**Addresses**
Ronald I. Dozoretz, M.D.	240 Corporate Blvd. Norfolk, VA 23502
Heyward R. Donigan**	240 Corporate Blvd. Norfolk, VA 23502
Kyle A. Raffaniello	240 Corporate Blvd. Norfolk, VA 23502
Paul M. Rosenberg	240 Corporate Blvd. Norfolk, VA 23502
Scott M. Tabakin	240 Corporate Blvd. Norfolk, VA 23502
Rebecca H. White	240 Corporate Blvd. Norfolk, VA 23502
Harold A. Levine	240 Corporate Blvd. Norfolk, VA 23502

Financial Reporting Guide Forms
Organization Structure and Financial Planning Form

1) If other than a government agency:
   a. When was your organization formed? April 6, 1987

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

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
Please see attached.		

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

   Yes _____ No X If yes, please explain:

3) Civil Rights Compliance Data

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

   Yes _____ No 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.

   Please see the attached policy and procedure for a description.

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.

N/A - no felony convictions

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:

ValueOptions, Inc.

Board of Directors

Positions

Position Type	Name	Title	Address—All Parties Listed
Director	Donigan, Heyward R.	Director	ValueOptions, Inc. 240 Corporate Boulevard Norfolk, VA 23502
Director	Raffaniello, Kyle A	Director	
Director	Rosenberg, Paul M	Director	
Director	Tabakin, Scott M	Director	
Officer	Donigan, Heyward R.	President and Chief Executive Officer	
Officer	Raffaniello, Kyle A	Vice President	
Officer	Rosenberg, Paul M	Secretary	
Officer	Tabakin, Scott M	Treasurer	
Officer	White, Rebecca H.	Assistant Secretary	

MASTER LICENSE LIST

	SERVICE COMPONENT	License/Requirement	Renewal Date
	UTILIZATION REVIEW	**THIRD PARTY ADMINISTRATOR**	**Annual**
1	Alabama	Arkansas	**Annual**
2	Arizona	California	**Annual**
3	Arkansas	Connecticut	**Annual**
4	Connecticut	Delaware	**Annual**
5	Georgia	Florida	**Annual**
6	Illinois	Georgia	**Annual**
7	Indiana	Idaho	**Annual**
8	Kansas	Illinois	**Annual**
9	Kentucky	Iowa	**Annual**
10	Louisiana(MNRO)	Kansas	**Annual**
11	Maine	Louisiana	**Annual**
12	Maryland	Maine	**Annual**
13	Minnesota	Maryland	**Annual**
14	Mississippi	Michigan	**Annual**
15	Missouri	Minnesota	**Annual**
16	Nebraska	Mississippi	**Annual**
17	Nevada	Montana	**Annual**
18	New Hampshire	Nebraska	**Annual**
19	New York	New Hampshire	**Annual**
20	North Dakota	New Jersey	**Annual**
21	Oklahoma	New York	**Annual**
22	Pennsylvania	North Carolina	**Annual**
23	Rhode Island	North Dakota	**Annual**
24	South Carolina	Ohio	**Annual**
25	South Dakota	Oklahoma	**Annual**
26	Tennessee	Pennsylvania	**Annual**
27	Texas	Rhode Island	**Annual**
28	Vermont	South Dakota	**Annual**
29	Virginia	Texas	**Annual**
30		Utah	**Annual**
31		West Virginia	**Annual**
	PPN/PPA		
32	Connecticut(PPN)		**Annual**
33	Illinois(PPA)		**Annual**

Updated: 9/14/2012

Licensed Preferred Provider Program Administrator (PPA)
Illinois

Licensed Preferred Provider Network (PPN)
Connecticut

CMS-QIO Like Entity Certification

ValueOptions, Inc. (Eligible to operate in all states; valid until 12/03/2015)

Regulated Entities –

Florida Behavioral Health –	FL –	(PLHSO) Pre-Paid Limited Health Service Organization
N. FL Behavioral Health Partners –	FL –	PLHSO
Value Behavioral Health – of Pennsylvania, Inc.	PA –	Risk Assuming Preferred Provider Organization Third Party Administrator
Value Health Reinsurance –	AZ –	Life and Disability Reinsurance
ValueOptions of California –	CA –	Knox Keene
ValueOptions of Kansas –	KS -	HMO
ValueOptions of Texas –	TX –	HMO
Wellington Life Insurance Company	AZ –	Life and Disability (Health Certificate of Authority in 32 states)
Colorado Health Partnership	CO –	Limited Service Licensed Provider Network
Northeast Behavioral Health Partners	CO –	Limited Service Licensed Provider Network
Foothills Behavioral Health Partners	CO -	Limited Service Licensed Provider Network

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? They are prepared quarterly.

   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 _____ No x

   d. If yes, provide a copy of the latest statements including all necessary data to support your answers in (a) through (c) above. Please see attached. We include both interim financial statements and our most recent, consolidated annual financial statements in the pages that follow.

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

   a. If yes, how often are audits conducted? Audits are conducted annually.

   b. By whom are they conducted? Price Waterhouse Coopers

   c. Did this auditor perform that offeror's last audit?
      Yes x No _____
      If no, provide the name, address, and telephone number of the firm that performed the offeror's last audit.

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 09/04/2012

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

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

PRODUCER MARSH USA, INC. THREE JAMES CENTER 1051 EAST CARY STREET, SUITE 900 RICHMOND, VA 23219 Attn: 804-344-8600	**CONTACT NAME:** **PHONE (A/C, No, Ext):** **FAX (A/C, No):** **E-MAIL ADDRESS:**
INSURED FHC HEALTH SYSTEMS, INC. 240 CORPORATE BLVD. NORFOLK, VA 23502	**INSURER(S) AFFORDING COVERAGE** — **NAIC #** **INSURER A :** Charter Oak Fire Insurance Company — 25615 **INSURER B :** Travelers Property Casualty Co. Of America — 25674 **INSURER C :** Travelers Indemnity Co Of CT — 25682 **INSURER D :** National Union Fire Ins Co Pittsburgh PA — 19445 **INSURER E :** **INSURER F :**

COVERAGES **CERTIFICATE NUMBER:** CLE-003350084-39 **REVISION NUMBER:** 29

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS		
A	**GENERAL LIABILITY** X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY PRO-JECT LOC			P-630-4359M993-COF-12	07/01/2012	07/01/2013	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ $ $ $ $ $	1,000,000 1,000,000 5,000 1,000,000 5,000,000 2,000,000
A	**AUTOMOBILE LIABILITY** X ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS X HIRED AUTOS X NON-OWNED AUTOS			P-810-4359M993-COF-12 Owned Physical Damage $5,000 Ded. Comp/Coll Hired Physical Damage $1,000 Ded. Comp/Coll	07/01/2012	07/01/2013	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ $ $ $	1,000,000
B	X **UMBRELLA LIAB** X OCCUR **EXCESS LIAB** CLAIMS-MADE DED RETENTION $			PSM-CUP-4359M993-TIL-12	07/01/2012	07/01/2013	EACH OCCURRENCE AGGREGATE	$ $	5,000,000 5,000,000
C	**WORKERS COMPENSATION AND EMPLOYERS' LIABILITY** Y / N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N **(Mandatory in NH)** If yes, describe under DESCRIPTION OF OPERATIONS below	N / A		PO-UB-3719M169-TCT-12	07/01/2012	07/01/2013	X WC STATU-TORY LIMITS OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ $ $	1,000,000 1,000,000 1,000,000
D	Commercial Crime			011794258	09/30/2011	09/30/2012	Each Claim		3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

CERTIFICATE HOLDER

"Evidence of Coverage"

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.

Susan B. Vignone — Susan B. Vignone

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 09/04/2012

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

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

PRODUCER MARSH USA, INC. THREE JAMES CENTER 1051 EAST CARY STREET, SUITE 900 RICHMOND, VA 23219 Attn: 804-244-8600	**CONTACT NAME:** **PHONE (A/C, No, Ext):** **FAX (A/C, No):** **E-MAIL ADDRESS:**
INSURED FHC HEALTH SYSTEMS, INC. 240 CORPORATE BLVD. NORFOLK, VA 23502	**INSURER(S) AFFORDING COVERAGE** — **NAIC #** **INSURER A :** Homeland Insurance Company Of New York — 34452 **INSURER B :** Illinois Union Insurance Co — 27960 **INSURER C :** National Union Fire Ins Co Pittsburgh PA — 19445 **INSURER D :** **INSURER E :** **INSURER F :**

COVERAGES **CERTIFICATE NUMBER:** CLE-003750538-02 **REVISION NUMBER:** 4

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	**GENERAL LIABILITY** COMMERCIAL GENERAL LIABILITY X CLAIMS-MADE [ ] OCCUR X MANAGED CARE E&O GEN'L AGGREGATE LIMIT APPLIES PER: POLICY [ ] PRO-JECT [ ] LOC			MCB535311	12/15/2011	12/15/2012	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ $ $ $ $ SEE NEXT PAGE $
	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS HIRED AUTOS SCHEDULED AUTOS NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ $ $ $
B	**UMBRELLA LIAB** [ ] OCCUR X **EXCESS LIAB** [ ] CLAIMS-MADE DED [ ] RETENTION $			XMSG21685008010	12/15/2011	12/15/2012	EACH OCCURRENCE AGGREGATE	$ 10,000,000 $
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y / N: N **(Mandatory in NH)** If yes, describe under DESCRIPTION OF OPERATIONS below	N / A					WC STATU-TORY LIMITS [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ $ $
C	Crime incl Fidelity Coveage			011794258	09/30/2011	09/30/2012	Limit	5,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

CERTIFICATE HOLDER

"Evidence of Coverage"

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.

Susan B. Vignone — Susan B. Vignone

AGENCY CUSTOMER ID: 101050
LOC #: Richmond

ADDITIONAL REMARKS SCHEDULE

AGENCY	NAMED INSURED
MARSH USA, INC.	FHC HEALTH SYSTEMS, INC. 240 CORPORATE BLVD. NORFOLK, VA 23502
POLICY NUMBER	
CARRIER / NAIC CODE	EFFECTIVE DATE:

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,
FORM NUMBER: 25 FORM TITLE: Certificate of Liability Insurance

MANAGED CARE ERRORS & OMISSIONS LIABILITY COVERAGE PROVIDED ON A CLAIMS MADE BASIS.
$15,000,000 EACH CLAIM
$15,000,000 AGGREGATE SUBJECT TO A RETENTION OF $2,500,000 EACH CLAIM

ACORD®

EVIDENCE OF PROPERTY INSURANCE

DATE (MM/DD/YYYY)
09/04/2012

THIS EVIDENCE OF PROPERTY INSURANCE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE ADDITIONAL INTEREST NAMED BELOW. THIS EVIDENCE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS EVIDENCE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE ADDITIONAL INTEREST.

AGENCY	PHONE (A/C, No, Ext): 866-966-4664	COMPANY
MARSH USA, INC. THREE JAMES CENTER 1051 EAST CARY STREET, SUITE 900 RICHMOND, VA 23219 Attn: Susan Vignone 804-344-8969		Charter Oak Fire Insurance Company
FAX (A/C, No): 212-948-0884	E-MAIL ADDRESS: Richmond.certrequest@marsh.com	
CODE:	SUB CODE:	
AGENCY CUSTOMER ID #:		

INSURED	LOAN NUMBER	POLICY NUMBER
FHC HEALTH SYSTEMS, INC. 240 CORPORATE BLVD. NORFOLK, VA 23502		P-630-4359M993-COF-12
	EFFECTIVE DATE: 07/01/2012 / EXPIRATION DATE: 07/01/2013	☐ CONTINUED UNTIL TERMINATED IF CHECKED
	THIS REPLACES PRIOR EVIDENCE DATED:	

PROPERTY INFORMATION

LOCATION/DESCRIPTION
ValueOptions of Tennessee, Inc. is recognized as a Named Insured

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS EVIDENCE OF PROPERTY INSURANCE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

COVERAGE INFORMATION

COVERAGE / PERILS / FORMS	AMOUNT OF INSURANCE	DEDUCTIBLE
BLANKET REAL AND PERSONAL PROPERTY, INCLUDING BOILER & MACHINERY	22,616,356	25,000
BLANKET BUSINESS INCOME INCL. RENTAL VALUE	18,933,647	24 Hours
BLANKET EDP EQUIPMENT	41,550,003	5,000
EARTHQUAKE ANNUAL AGGREGATE LIMIT - CA EARTHQUAKE DED. IS $100,000 MIN.	10,000,000	50,000
FLOOD ANNUAL AGGREGATE LIMIT - FLOOD ZONE "A" DED. IS $100,000	2,500,000	50,000
REPLACEMENT COST, SPECIAL PERILS FORM, NO COINSURANCE CLAUSE		

REMARKS (Including Special Conditions)

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

ADDITIONAL INTEREST

CLE-003128614-07

NAME AND ADDRESS		
Evidence of Coverage	☐ MORTGAGEE ☐ LOSS PAYEE	☐ ADDITIONAL INSURED
	LOAN #	
	AUTHORIZED REPRESENTATIVE of Marsh USA Inc. Susan B. Vignone *Susan B. Vignone*	

ACORD 27 (2009/12)

9) Are there any suits, judgements, tax deficiencies, or claims pending against the offeror?

Yes _____ No X

Briefly describe each item and indicate probable amount.

N/A

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

Yes _____ No X

If yes, when? N/A

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. Please see 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 X No _____

If yes, provide the following information:

Amount of Bond	$ See explanation below.
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.

Through its surety broker, AON, ValueOptions maintains a robust performance bond program. In accordance with section 60.720 of the RFP, a performance bond will be provided and maintained throughout the term of the contract. In accordance with the performance bond program, the amount of the bond can be adjusted on a periodic basis with membership and revenue changes, as required.

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. Please see attached.

d. Are data from open referrals and prior notifications used?
Yes x No _____ If so, how? See attached.

e. Are detailed written procedures maintained? Yes x
No _____

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. Please see 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). Please see attached.

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

Yes x No _____ If yes, enter name: Scott M. Tabakin

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.

a. The company receives no direct reimbursement from Medicare.

b. The company does not separately report third party recoveries on its financial statements. In terms of third party liability, the company's standard practice is to coordinate benefits in advance with other parties. As such, there are minimal recoveries that would occur when compared to a traditional pay-and-chase type system. The company's information system can produce a report of third party recoveries if required.

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
Ronald I. Dozoretz, M.D.	3005 45th Street NW Washington, DC 200016	Controller	Yes	

Background Check Information Form

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

Name**	Ever known by another name* Yes	No	Social Security Account #	Date of Birth (Da/Mo/Yr)	Place of birth City/County/State

Please see attached.

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

** For each person listed:

a. Give addresses for the last ten years

b. Ever suspended from any Federal program for any reason?

Yes _____ No X _____ If yes, please explain.

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 ail 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.

Scott M. Tuhl — 9-10-12

Signature — Date

Grievance System Form

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

I hereby certify that ValueOptions, 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 — Date: 9-10-12

Scott M. Tabakin — Executive Vice President and Chief Financial Officer
Printed Name — 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):

PHC/ValueOptions, Inc.'s Workers' Compensation policy prohibits the adding of additional insured. Additional insured on Errors and Omissions policy per contract requirement, will be added by endorsement.

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

ValueOptions, Inc.

Name of Offeror

Scott M. Tabakin

9-13-12

Authorized Representative Signature Date

Scott M. Tabakin, Executive Vice President and Chief Financial Officer

Print Name and Title

CERTIFICATE OF LIABILITY INSURANCE (COLI)
CHECKLIST & SAMPLE FORM (ACORD 25 Form (2009/09)[2])

This Checklist must accompany the completed COLI submitted with the proposal and subsequent contract. In the event of a conflict between this Checklist and the terms of the contract, the latter shall prevail.

If a requirement noted below is reflected in a current policy endorsement, a copy of the endorsement may be submitted in lieu of the statement on the COLI. Insurance requirements are subject to oversight by the State of Hawaii Department of Accounting and General Services, Risk Management Office.

NO.	CERTIFICATE OF INSURANCE LIABILITY REQUIRED ELEMENTS	✓
(1)	THE DATE THE COLI ISSUED SHOULD NOT BE MORE THAN 15 DAYS FROM THE DATE OF ITS REQUEST. THE COLI SHOULD NOT BE ISSUED OVER 30 DAYS FROM THE DATE OF SUBMISSION.	
(2)	THE NAME OF THE "INSURED" MUST MATCH THE NAME OF THE CONTRACTOR/PROVIDER.	
(3)	THE INSURER MUST BE LICENSED TO DO BUSINESS IN THE STATE OF HAWAII OR MEET THE REQUIREMENTS OF SECTION 431:8-301, HAWAII REVISED STATUTES.	
(4)	THE "COMMERCIAL GENERAL LIABILITY" COVERAGE SHOULD INDICATE COVERAGE ON A "PER OCCURRENCE" BASIS.	
(5)	A "POLICY NUMBER" OR BINDER NUMBER SHOULD BE INDICATED.	
(6)	THE "EFFECTIVE DATE" SHOULD BE NO LATER THAN THE CONTRACT DATE OR THE FIRST DATE THAT THE CONTRACTOR COMMENCES WORK FOR THE STATE.	
(7)	THE "EXPIRATION DATE" SHOULD BE AFTER THE EFFECTIVE DATE OF THE AGREEMENT OR SUPPLEMENTAL AGREEMENT, AS APPLICABLE, AND BE MONITORED TO ENSURE THAT RENEWAL COLI ARE RECEIVED ON A TIMELY BASIS.	
(8)	THE LIMITS OF LIABILITY FOR THE FOLLOWING TYPES OF COVERAGE SHOULD BE FOR AT LEAST AS MUCH AS REQUIRED BY THE CONTRACT, NORMALLY IN THE FOLLOWING AMOUNTS (CHECK CONTRACT LANGUAGE FOR SPECIFICS):	
	A. COMMERCIAL GENERAL LIABILITY $1 MILLION PER OCCURRENCE, AND $2 MILLION IN THE AGGREGATE	
	B. AUTOMOBILE – MAY BE COMBINED SINGLE LIMIT: BODILY INJURY: $1 MILLION PER PERSON, $1 MILLION PER ACCIDENT PROPERTY DAMAGE: $1 MILLION PER ACCIDENT	
	C. WORKERS COMPENSATION/EMPLOYERS LIABILITY (E.L.) E.L. EACH ACCIDENT: $1 MILLION E.L. DISEASE: $1 MILLION PER EMPLOYEE, $1 MILLION POLICY LIMIT E.L. $1 MILLION AGGREGATE	

[1] The Contractor should use the Acord form currently in use at the time of submission with the contract.

NO.	CERTIFICATE OF INSURANCE LIABILITY REQUIRED ELEMENTS	✓
	D. PROFESSIONAL LIABILITY $1 MILLION PER CLAIM, AND $2 MILLION ANNUAL AGGREGATE	
(9)	"ANY AUTO" COVERAGE IS REQUIRED, OR IF NOT MARKED, "HIRED AUTOS" AND "NON-OWNED AUTOS" SHOULD BE INDICATED. IF THERE ARE NO CORPORATE-OWNED AUTOS, THEN THE "HIRED & NON-OWNED AUTO" MAY BE ENDORSED TO THE COMMERCIAL GENERAL LIABILITY TO SATISFY THIS REQUIREMENT.	
(10)	IF THE LIMITS OF LIABILITY SHOWN FOR GENERAL LIABILITY OR AUTOMOBILE LIABILITY ARE LESS THAN REQUIRED BY CONTRACT, THEN UMBRELLA LIABILITY WITH COMBINED LIMIT MAY SATISFY THE MINIMUM REQUIREMENT AND THE STATE LISTED AS "ADDITIONAL INSURED" ON THE UMBRELLA POLICY OR THE UMBRELLA POLICY IS NOTED AS "FOLLOW FORM" ON THE CERTIFICATE.	
(11)	NOTE: THE STATE REQUIRES HIGHER LIMITS OF $1 MILLION, AS COMPARED TO THE BASIC LIMITS REQUIRED BY STATE LAW REGARDING WORKERS COMPENSATION COVERAGE.	
(12)	THE REQUIRED "PROFESSIONAL LIABILITY" COVERAGE SHOULD BE INDICATED IN THIS SECTION.	
(13)	THE "ADDL INSR" BOX SHOULD BE CHECKED TO INDICATE THAT THE STATE IS AN ADDITIONAL INSURED UNDER THE POLICY(IES), OR NOTED IN THE DESCRIPTION OF OPERATION BOX AT THE BOTTOM OF THE FORM.	
(14)	THE "CERTIFICATE HOLDER" SHOULD BE THE NAME AND ADDRESS OF THE DEPARTMENT OF HUMAN SERVICES/MED-QUEST DIVISION, 1001 KAMOKILA BOULEVARD, SUITE 317, KAPOLEI, HAWAII 96707	
(15)	THE COLI SHOULD BE SIGNED BY THE INSURANCE AGENT OR AN INSURANCE COMPANY REPRESENTATIVE.	
	DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES BOX: THIS SECTION SHOULD CONTAIN THE FOLLOWING LANGUAGE: THE STATE OF HAWAII IS AN ADDITIONAL INSURED WITH RESPECT TO OPERATIONS PERFORMED FOR THE STATE OF HAWAII. ANY INSURANCE MAINTAINED BY THE STATE OF HAWAII SHALL APPLY IN EXCESS OF, AND NOT CONTRIBUTE WITH, INSURANCE PROVIDED BY THIS POLICY.	

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) (1)

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

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

PRODUCER	CONTACT NAME:
	PHONE (A/C, No, Ext): FAX (A/C, No):
	E-MAIL ADDRESS:
	PRODUCER CUSTOMER ID #:

INSURED	INSURER(S) AFFORDING COVERAGE	NAIC #
(2)	INSURER A:	
	INSURER B: (3)	
	INSURER C:	
	INSURER D:	
	INSURER E:	
	INSURER F:	

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	(8) LIMITS	
	GENERAL LIABILITY	(13)		(5)	(6)	(7)	EACH OCCURRENCE	$
	☐ COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
	☐ CLAIMS-MADE ☐ OCCUR (4)						MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$ (10)
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
								$
	AUTOMOBILE LIABILITY	(13)					COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO (9)						BODILY INJURY (Per person)	$
	☐ ALL OWNED AUTOS						BODILY INJURY (Per accident)	$
	☐ SCHEDULED AUTOS						PROPERTY DAMAGE (Per accident)	$ (10)
	☐ HIRED AUTOS							$
	☐ NON-OWNED AUTOS							$
	UMBRELLA LIAB ☐ OCCUR	(13)					EACH OCCURRENCE	$
	EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DEDUCTIBLE							$ (10)
	☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY						WC STATU-TORY LIMITS ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y/N ☐ N/A						E.L. EACH ACCIDENT	$
	(Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ (11)
	(12)						E.L. DISEASE - POLICY LIMIT	$

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

CERTIFICATE HOLDER	CANCELLATION
(14)	SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.
	AUTHORIZED REPRESENTATIVE (15)

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 09/12/2012

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

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

PRODUCER
MARSH USA, INC.
THREE JAMES CENTER
1051 EAST CARY STREET, SUITE 900
RICHMOND, VA 23219
Attn: 804-244-8600

CONTACT NAME:
PHONE (A/C, No, Ext):
FAX (A/C, No):
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE		NAIC #
INSURER A :	Homeland Insurance Company Of New York	34452
INSURER B :	Illinois Union Insurance Co	27960
INSURER C :	N/A	N/A
INSURER D :		
INSURER E :		
INSURER F :		

INSURED
FHC HEALTH SYSTEMS/VALUEOPTIONS, INC.
240 CORPORATE BLVD.
NORFOLK, VA 23502

COVERAGES **CERTIFICATE NUMBER:** CLE-003864736-03 **REVISION NUMBER:** 4

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	**GENERAL LIABILITY**			MCB535311	12/15/2011	12/15/2012	EACH OCCURRENCE	$
	[ ] COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
	[X] CLAIMS-MADE [ ] OCCUR						MED EXP (Any one person)	$
	[X] MANAGED CARE E&O						PERSONAL & ADV INJURY	$
							GENERAL AGGREGATE	$ SEE NEXT PAGE
	GEN'L AGGREGATE LIMIT APPLIES PER:						PRODUCTS - COMP/OP AGG	$
	[ ] POLICY [ ] PRO-JECT [ ] LOC							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	[ ] ANY AUTO						BODILY INJURY (Per person)	$
	[ ] ALL OWNED AUTOS [ ] SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	[ ] HIRED AUTOS [ ] NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
B	[ ] **UMBRELLA LIAB** [ ] OCCUR			XMSG21685008010	12/15/2011	12/15/2012	EACH OCCURRENCE	$ 10,000,000
	[X] **EXCESS LIAB** [ ] CLAIMS-MADE						AGGREGATE	$
	[ ] DED [ ] RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N						WC STATU-TORY LIMITS [ ] OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [N]	N/A					E.L. EACH ACCIDENT	$
	(Mandatory in NH)						E.L. DISEASE - EA EMPLOYEE	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - POLICY LIMIT	$

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

T

CERTIFICATE HOLDER

Department of Human Services
Med-Quest Division
1001 Kamokila Boulevard, Suite 317
Kapolei, HI 96707

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.

Susan B. Vignone — Susan B. Vignone

AGENCY CUSTOMER ID: 101050

LOC #: Richmond

ADDITIONAL REMARKS SCHEDULE

AGENCY	NAMED INSURED
MARSH USA, INC.	FHC HEALTH SYSTEMS/VALUEOPTIONS, INC. 240 CORPORATE BLVD. NORFOLK, VA 23502
POLICY NUMBER	
CARRIER / NAIC CODE	EFFECTIVE DATE:

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,

FORM NUMBER: 25 FORM TITLE: Certificate of Liability Insurance

MANAGED CARE ERRORS & OMISSIONS LIABILITY COVERAGE PROVIDED ON A CLAIMS MADE BASIS.
$15,000,000 EACH CLAIM
$15,000,000 AGGREGATE SUBJECT TO A RETENTION OF $2,500,000 EACH CLAIM

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 09/12/2012

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

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

PRODUCER MARSH USA, INC. THREE JAMES CENTER 1051 EAST CARY STREET, SUITE 900 RICHMOND, VA 23219 Attn: 804-344-8600	**CONTACT NAME:** **PHONE (A/C, No, Ext):** **FAX (A/C, No):** **E-MAIL ADDRESS:**
INSURED FHC HEALTH SYSTEMS/VALUEOPTIONS, INC. 240 CORPORATE BLVD. NORFOLK, VA 23502	**INSURER(S) AFFORDING COVERAGE** — **NAIC #** INSURER A : Charter Oak Fire Insurance Company — 25615 INSURER B : Travelers Property Casualty Co. Of America — 25674 INSURER C : Travelers Indemnity Co Of CT — 25682 INSURER D : INSURER E : INSURER F :

COVERAGES **CERTIFICATE NUMBER:** CLE-003864733-02 **REVISION NUMBER:** 7

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	**GENERAL LIABILITY** X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY PRO-JECT LOC			P-630-4359M993-COF-12	07/01/2012	07/01/2013	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 1,000,000 $ 5,000 $ 1,000,000 $ 5,000,000 $ 2,000,000
A	**AUTOMOBILE LIABILITY** X ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS X HIRED AUTOS X NON-OWNED AUTOS			P-810-4359M993-COF-12 Owned Physical Damage $5,000 Ded. Comp/Coll Hired Physical Damage $1,000 Ded. Comp/Coll	07/01/2012	07/01/2013	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
B	X **UMBRELLA LIAB** X OCCUR **EXCESS LIAB** CLAIMS-MADE DED RETENTION $			PSM-CUP-4359M993-TIL-12	07/01/2012	07/01/2013	EACH OCCURRENCE AGGREGATE	$ 5,000,000 $ 5,000,000
C	**WORKERS COMPENSATION AND EMPLOYERS' LIABILITY** Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N **(Mandatory in NH)** If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		PO-UB-3719M169-TCT-12	07/01/2012	07/01/2013	X WC STATU-TORY LIMITS OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 1,000,000 $ 1,000,000 $ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

The State Hawaii is recognized as an Additional Insured with respect to operations performed for the state of Hawaii per written contract. This insurance is primary and non-contributory

CERTIFICATE HOLDER

Department of Human Services
Med-Quest Division
1001 Kamokila Boulevard, Suite 317
Kapolei, HI 96707

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.

Susan B. Vignone — Susan B. Vignone

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:	Scott M. Tabakin
Signature:	Scott M. Tabakin
Title:	Executive Vice President and Chief Financial Officer
Date:	9-10-12

CONTRACT NO. RFP-MQD-2013-007

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:

ValueOptions, 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).

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 Scott M. Tabakin
(Signature)

Print Name Scott M. Tabakin

Print Title Executive Vice President and Chief Financial Officer

Date 9-10-12

While not available as of submission of the proposal all, state and federal tax clearance certificates will be submitted in compliance with section 20.500.