

**STATE OF HAWAII**

**DEPARTMENT OF HUMAN SERVICES  
MED-QUEST DIVISION  
KAPOLEI, HAWAII**

**Legal Ad Date: June 30, 2007  
REQUEST FOR PROPOSAL**

**No. RFP-MQD-2008-005**

**COMPETITIVE SEALED PROPOSAL**

**To Provide Behavioral Health Services  
For Medicaid Eligible Adults who are Seriously Mentally Ill**

**Will be received up to 2:00 p.m., Hawaii Standard Time  
(H.S.T.)  
On August 16, 2007**

**In the Department of Human Services  
Med-QUEST Division  
1001 Kamokila Boulevard, Suite 317  
Kapolei, Hawaii 96707**

Note: If this RFP was downloaded from the State Procurement Office RFP Website each applicant must provide contact information to the RFP contact person for this RFP to be notified of any changes. For your convenience, an [RFP Interest form](#) may be downloaded to your computer, completed and e-mailed or mailed to the RFP contact person. The State shall not be responsible for any missing addenda, attachments or other information regarding the RFP if a proposal is submitted from an incomplete RFP.

## TABLE OF CONTENTS

<b>SECTION 10</b>	<b>ADMINISTRATIVE OVERVIEW.....</b>	<b>7</b>
10.100	PURPOSE OF THE REQUEST FOR PROPOSAL (RFP) .....	7
10.200	AUTHORITY FOR ISSUANCE OF RFP .....	7
10.300	ISSUING OFFICER .....	8
10.400	USE OF SUBCONTRACTORS .....	8
10.500	ORGANIZATION OF THE RFP.....	9
<b>SECTION 20</b>	<b>RFP SCHEDULE AND REQUIREMENTS.....</b>	<b>10</b>
20.100	RFP TIMELINE.....	10
20.200	ORIENTATION .....	10
20.300	SUBMISSION OF WRITTEN QUESTIONS.....	11
20.400	NOTICE OF INTENT.....	11
20.500	TAX CLEARANCE.....	11
20.600	CERTIFICATE OF GOOD STANDING .....	12
20.700	DOCUMENTATION.....	13
20.800	ORAL PRESENTATIONS .....	14
20.900	RULES OF PROCUREMENT.....	14
20.910	<i>Contingent Fees</i> .....	14
20.920	<i>Discussion with Applicants</i> .....	15
20.930	<i>RFP Amendments</i> .....	15
20.940	<i>Cost of Preparing Proposal</i> .....	15
20.950	<i>Provider Participation in Planning</i> .....	15
20.960	<i>Disposition of Proposals</i> .....	15
20.970	<i>Rules for Withdrawal or Revision of Proposals</i> .....	16
20.980	<i>Independent Price Determination</i> .....	16
21.100	CONFIDENTIALITY OF INFORMATION .....	17
21.200	ACCEPTANCE OF PROPOSALS.....	17
21.300	SUBMISSION OF PROPOSALS .....	17
21.400	DISQUALIFICATION OF OFFERORS .....	18
21.500	IRREGULAR PROPOSALS .....	19
21.600	REJECTION OF PROPOSALS.....	19
21.700	CANCELLATION OF RFP .....	20
21.800	OPENING OF PROPOSALS.....	20
21.900	ADDITIONAL MATERIALS AND DOCUMENTATION .....	20
22.100	NOTICE OF AWARD .....	21
22.200	PROTESTS .....	21
<b>HEAD OF STATE PURCHASING AGENCY.....</b>	<b>.....</b>	<b>22</b>
<b>SECTION 30</b>	<b>BACKGROUND.....</b>	<b>23</b>
30.100	MEDICAL ASSISTANCE IN HAWAII.....	23
30.200	DEPARTMENT OF HUMAN SERVICES.....	23
30.300	MEDICAL ASSISTANCE ELIGIBILITY .....	24
30.310	<i>Basic Criteria</i> .....	24
30.400	AGED, BLIND AND DISABLED (ABD) .....	24
30.500	HAWAII QUEST (QUEST).....	25
30.510	<i>Asset Limits</i> .....	25
30.520	<i>Income Limits</i> .....	25
30.530	<i>Categorical Requirements</i> .....	26
30.540	<i>Employer-Based Health Coverage</i> .....	26
30.550	<i>Additions to the Household</i> .....	26
30.560	<i>Eligibility Determination</i> .....	26

30.570	<i>QUEST Medical Plan: Behavioral Health Coverage</i> .....	27
30.600	QUEST-NET .....	29
30.610	<i>QUEST-Net: Health Coverage Benefits</i> .....	29
30.700	QUEST- ACE .....	30
30.800	QUEST EXPANDED ACCESS (QEXA).....	30
30.900	ESTIMATED ENROLLMENT IN MANAGED CARE PROGRAMS.....	31
31.100	ELIGIBLE BHTPA MEMBERS.....	31
31.110	<i>Seriously Mentally Ill</i> .....	32
31.120	<i>Evaluation and Referral to the BHTPA</i> .....	33
31.130	<i>Enrollment into the BHTPA</i> .....	34
31.140	<i>Re-Enrollment into the BHTPA</i> .....	36
31.150	<i>Optional Enrollment</i> .....	36
31.160	<i>Involuntary Commitment</i> .....	36
31.170	<i>Criminal Commitment</i> .....	37
31.200	TRANSITION OF CARE.....	37
<b>SECTION 40</b>	<b>PROVISION OF SERVICES.....</b>	<b>39</b>
40.100	OFFEROR’S ROLE IN MANAGED CARE.....	39
40.200	QUALIFICATION OF THE BEHAVIORAL HEALTH THIRD PARTY ADMINISTRATOR.....	39
40.300	REIMBURSEMENT .....	39
40.400	PROVIDER NETWORK.....	41
40.410	<i>Required Services</i> .....	41
40.420	<i>Availability and Accessibility of Providers</i> .....	43
40.430	<i>Department of Health – Adult Mental Health Division (DOH-AMHD)</i> .....	44
40.440	<i>State Mental Health Hospital</i> .....	45
40.450	<i>Assertive Community Treatment (ACT)</i> .....	45
40.500	CARE COORDINATION/CASE MANAGEMENT SYSTEM.....	46
40.510	<i>Care Coordination/Case Management (CC/CM)</i> .....	47
40.520	<i>Individualized Treatment Plan (ITP)</i> .....	49
40.600	BHTPA PERSONNEL.....	51
40.610	<i>Medical Director</i> .....	51
40.620	<i>Supporting Staff and Systems</i> .....	51
40.700	SCOPE OF BEHAVIORAL HEALTH SERVICES.....	52
40.710	<i>Covered Behavioral Health Services</i> .....	53
40.720	<i>Department of Health Alcohol and Drug Abuse Division (DOH-ADAD)</i> .....	56
40.800	OUT-OF-STATE AND OFF-ISLAND COVERAGE .....	57
40.900	OTHER SERVICES TO BE PROVIDED.....	58
41.100	ON-SITE VISITS .....	62
41.200	GEOGRAPHIC AREAS TO BE SERVED.....	62
<b>SECTION 50</b>	<b>ADMINISTRATIVE REQUIREMENTS .....</b>	<b>63</b>
50.100	NOTIFICATION OF ENROLLMENT.....	63
50.110	<i>Responsibilities of the BHTPA</i> .....	63
50.120	<i>Collection of Member’s Share of Premiums and Spenddowns</i> .....	65
50.130	<i>Eligibility Verification</i> .....	65
50.200	DISENROLLMENT .....	65
50.210	<i>Members Who No Longer Meet the Criteria for SMI</i> .....	67
50.220	<i>Option to Disenroll upon Medicaid Fee-For-Service or Medicare Eligibility Determination</i> .....	67
50.300	ROOM AND HOSPITAL ADMISSIONS .....	68
50.310	<i>Determination of Eligibility</i> .....	68
50.320	<i>Emergency Room</i> .....	68
50.400	ASSESSMENT AND COLLECTION OF FEES AND PENALTIES .....	71
50.500	THIRD PARTY LIABILITIES .....	71
50.510	<i>Definition</i> .....	71
50.520	<i>Reimbursement from Third Parties</i> .....	71

50.530	<i>Responsibilities of DHS and the BHTPA</i> .....	72
50.600	QUALITY IMPROVEMENT .....	72
50.610	<i>Importance of Quality Improvement</i> .....	72
50.620	<i>Quality Improvement Programs</i> .....	74
50.630	<i>Responsibilities of the Plan</i> .....	79
50.700	MONITORING AND EVALUATION .....	79
50.710	<i>Internal QIP Monitoring</i> .....	79
50.720	<i>External Monitoring</i> .....	80
50.730	<i>Conduct Surveys</i> .....	80
50.740	<i>Conduct Case Study Interviews</i> .....	81
50.750	<i>CMS Contracted Review Organization</i> .....	81
50.800	REPORTING REQUIREMENTS .....	82
50.810	<i>Purpose for Data to be Collected</i> .....	82
50.820	<i>Timeliness of Data Submitted</i> .....	82
50.830	<i>Compliance with the Health Insurance Portability and Accountability Act</i> .....	82
50.840	<i>Chain of Trust Partner Agreement</i> .....	82
50.900	MQD INFORMATION SYSTEMS .....	83
51.100	ENCOUNTER DATA REQUIREMENTS .....	85
51.110	<i>Accuracy, Completeness and Timeliness of Encounter Data</i> .....	85
51.200	QUALITY ASSURANCE REPORTING .....	87
51.210	<i>Required Quality Improvement Program Activities Reports</i> .....	87
51.220	<i>HEDIS and Other State Required Reports</i> .....	88
51.300	FINANCIAL INFORMATION .....	88
51.400	NOTIFICATION OF CHANGES IN MEMBER STATUS .....	89
51.410	<i>Member and Plan Responsibilities</i> .....	89
51.420	<i>Changes in Member Status</i> .....	89
51.500	EDUCATIONAL MATERIALS .....	90
51.510	<i>DHS Responsibilities</i> .....	90
51.520	<i>Plan's Responsibilities</i> .....	90
51.530	<i>DHS Review of Materials</i> .....	91
<b>SECTION 60</b>	<b>TERMS AND CONDITIONS.....</b>	<b>92</b>
60.100	GENERAL.....	92
60.200	TERM OF THE CONTRACT.....	93
60.210	<i>Availability of Funds</i> .....	94
60.300	CONTRACT CHANGES .....	94
60.400	GENERAL AND SPECIAL CONDITIONS OF CONTRACT .....	95
60.500	OFFEROR PROGRESS .....	95
60.510	<i>Offerors Reporting</i> .....	95
60.520	<i>Inspection of Work Performed</i> .....	95
60.530	<i>Subcontracts/Provider Agreements</i> .....	96
60.600	REINSURANCE .....	97
60.700	APPLICABILITY OF HAWAII REVISED STATUTES .....	97
60.710	<i>Wages, Hours and Working Conditions of Employees Providing Services</i> .....	97
60.720	<i>Standards of Conduct</i> .....	97
60.730	<i>Campaign Contributions by State and County Contractors</i> .....	98
60.800	FRAUD AND ABUSE/NEGLECT .....	98
60.900	CONFIDENTIALITY OF INFORMATION .....	98
61.100	SERVICES.....	99
61.110	<i>Services to be Provided</i> .....	99
61.120	<i>Financial Sanctions</i> .....	100
61.130	<i>Plan Invoice</i> .....	101
61.140	<i>Payment to Providers and Subcontractors</i> .....	101
61.150	<i>Use of Funds</i> .....	101
61.200	ACCEPTANCE.....	102

61.300	DISPUTES.....	102
61.400	WARRANTY OF FISCAL INTEGRITY .....	102
61.500	FULL DISCLOSURE.....	103
61.510	<i>Litigation.....</i>	103
61.600	TERMINATION OF THE CONTRACT .....	103
61.610	<i>Termination for Expiration of QUEST by CMS .....</i>	104
61.620	<i>Termination for Bankruptcy or Insolvency .....</i>	104
61.630	<i>Procedure for Termination .....</i>	104
61.700	TERMINATION CLAIMS .....	105
61.800	FORCE MAJEURE .....	106
61.900	PROHIBITION OF GRATUITIES .....	107
62.100	AUTHORITY .....	107
<b>SECTION 70</b>	<b>TECHNICAL PROPOSAL .....</b>	<b>108</b>
70.100	INTRODUCTION .....	108
70.200	TRANSMITTAL LETTER .....	109
70.300	EXECUTIVE SUMMARY .....	110
70.400	COMPANY BACKGROUND AND EXPERIENCE.....	110
70.410	<i>Background of the Company.....</i>	110
70.420	<i>Company Experience .....</i>	111
70.500	ORGANIZATION AND STAFFING .....	112
70.510	<i>Organization Charts .....</i>	112
70.520	<i>Staffing (Personnel Resumes) .....</i>	113
70.600	FINANCIAL STATEMENTS.....	113
70.610	<i>Per Member Financial Data .....</i>	114
70.700	PROVIDER NETWORK.....	114
70.710	<i>Provider Listing .....</i>	114
70.720	<i>Map of Behavioral Health Providers and Hospitals.....</i>	116
70.800	QUALITY IMPROVEMENT PROGRAM .....	116
70.900	CARE COORDINATION/CASE MANAGEMENT .....	116
70.910	<i>Quality Assurance.....</i>	117
71.100	OUTREACH AND EDUCATION PROGRAMS .....	117
71.200	BIDDERS FEE SCHEDULE .....	117
71.300	GAIN LIMIT.....	118
<b>SECTION 80</b>	<b>EVALUATION AND SELECTION .....</b>	<b>119</b>
80.100	INTRODUCTION .....	119
80.200	TECHNICAL PROPOSAL EVALUATION AND SCORING .....	119
80.210	<i>Step I – Merits of the Bidder and the Bidder’s Technical Proposal (100 possible points).....</i>	119
80.300	STEP I – MERITS OF THE BIDDER AND THE BIDDER’S PROPOSAL .....	120
<b>APPENDIX A</b>	<b>PROPOSAL APPLICATION FORM (SPO-H-200) .....</b>	<b>123</b>
<b>APPENDIX B</b>	<b>GLOSSARY .....</b>	<b>124</b>
<b>APPENDIX C</b>	<b>GENERAL CONDITIONS.....</b>	<b>125</b>
<b>APPENDIX D</b>	<b>BUSINESS ASSOCIATE LANGUAGE.....</b>	<b>126</b>
<b>APPENDIX E</b>	<b>STANDARDS OF CONDUCT .....</b>	<b>127</b>
<b>APPENDIX F</b>	<b>WRITTEN QUESTIONS FORMAT.....</b>	<b>128</b>
<b>APPENDIX G</b>	<b>MINIMUM PROVIDER REQUIREMENTS .....</b>	<b>129</b>
<b>APPENDIX H</b>	<b>SERVICES &amp; MISC ITEMS NOT COVERED BY HAWAII QUEST PROGRAM .....</b>	<b>130</b>

**APPENDIX I    DISCLOSURE STATEMENT .....131**  
**APPENDIX J    QIP .....132**  
**APPENDIX K    SMI CRITERIA .....133**  
**APPENDIX L    SMI EVALUATION PROCESS .....134**  
**APPENDIX M    BEHAVIORAL HEALTH PROVIDER NETWORK MATRIX .....135**  
**APPENDIX N    BLANK.....136**  
**APPENDIX O    HAWAII STATE HOSPITAL POLICY AND PROCEDURE .....137**

## **SECTION 10 ADMINISTRATIVE OVERVIEW**

### **10.100 Purpose of the Request for Proposal (RFP)**

This Request for Proposal (RFP) solicits participation by a qualified Behavioral Health Third Party Administrator (BHTPA) to provide required behavioral health services to Medicaid eligible adults who are seriously mentally ill (SMI). The services shall be provided statewide through a single BHTPA.

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

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

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

### **10.200 Authority for Issuance of RFP**

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

### **10.300 Issuing Officer**

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

Ms. Lois Lee, Acting Med-QUEST Division Administrator  
Department of Human Services/Med-QUEST Division  
601 Kamokila Boulevard, Suite 518  
Kapolei, HI 96707

**Telephone: (808) 692-8050**

**Fax: (808) 692-8155**

### **10.400 Use of Subcontractors**

In the event of a proposal submitted jointly or by multiple organizations, one organization shall be designated as the primary offeror and shall have responsibility for not less than 40 percent of the work to be performed. The project leader shall be an employee of the prime offeror and meet all the required experiences. All other participants shall be designated as subcontractors. Subcontractors shall be identified by name and by a description of the services/functions they will be performing. The prime offeror shall be wholly responsible for the entire performance whether or not subcontractors are used. The prime offeror shall sign the contract with DHS.

## 10.500 Organization of the RFP

This RFP is composed of eight sections plus appendices:

- ❑ Section 10 – Administrative Overview – Provides general information on the purpose of the RFP, the authorities relating to the issuance of the RFP, and the organization of the RFP.
- ❑ Section 20 – RFP Schedule and Procurement Requirements – Provides information on the rules and schedules for procurement of behavioral services.
- ❑ Section 30 – Background - Describes the current medical assistance programs, including Medicaid, QUEST, and QUEST Net, and the role of DHS.
- ❑ Section 40 –Provision of Services - Provides information on the medical and behavioral health services to be provided under this RFP and contract
- ❑ Section 50 – Administrative Requirements – Provides information on the eligibility and disenrollment of members, quality improvement and utilization review requirements, collection of co-payments and third party liability payments, data to be provided by the plan, DHS notification requirements, procedures for emergency admissions and the DHS monitoring procedures
- ❑ Section 60 – Terms and Conditions - Describes the terms and conditions under which the work will be preformed
- ❑ Section 70 – Technical Proposal – Describes the required content and format required for submission of a proposal.
- ❑ Section 80 – Evaluation and Selection – Defines the evaluation criteria and explains the evaluation process.

Various appendices are included to support the information presented in Sections 10 through 80.

## **SECTION 20 RFP Schedule and Requirements**

### **20.100 RFP Timeline**

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

Issue RFP	June 30, 2007
Orientation	July 10, 2007
Submission of Written Questions	July 16, 2007
Written Responses to Questions	July 23, 2007
Notice of Intent to Propose	July 27, 2007
Receipt of Proposals	August 16, 2007
Contract Award	September 17, 2007
Implementation	November 1, 2007

### **20.200 Orientation**

An orientation for offerors in reference to this RFP will be held on June 10, 2007. Time and place to be determined at a later date.

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

### **20.300 Submission of Written Questions**

Offerors shall submit questions in writing, and/or on diskette in Word 2000 format, or lower to the following mailing address or e-mail address:

Ms. Lois Lee, c/o Dona Jean Watanabe  
Med-QUEST Division-Finance Office  
1001 Kamokila Boulevard, Suite 317  
Kapolei, Hawaii 96707  
Fax: (808) 692-7989

Email address: [dwatanabe@medicaid.dhs.state.hi.us](mailto:dwatanabe@medicaid.dhs.state.hi.us)

The written questions shall reference the RFP section, page and paragraph number in the format provided in Appendix F. Offerors must submit written questions by 2:00 p.m., (H.S.T.) on July 16, 2007. DHS shall respond to the written questions no later than July 23, 2007. No verbal responses shall be considered as official.

### **20.400 Notice of Intent**

Potential offerors shall submit a Notice of Intent to Propose to the Issuing Officer no later than July 27, 2007, 4:30 p.m. (H.S.T.). Submission of a Notice of Intent to Propose is not a prerequisite for the submission of a proposal, but it is necessary that the Issuing Officer receive the letter by this deadline to assure proper distribution of amendments, questions and answers and other communication regarding this RFP.

Notice of Intent can be mailed or faxed to:

Ms. Lois Lee  
c/o Dona Jean Watanabe  
Med-QUEST Division-Finance Office  
1001 Kamokila Boulevard Room 317  
Kapolei, Hawaii 96707-2005

Fax Number: (808) 692-7989

### **20.500 Tax Clearance**

A certified copy of a current valid tax clearance certificate issued by the State of Hawaii, Department of Taxation (DOTAX) and the Internal Revenue Service (IRS) will be required upon notice of award.

Tax clearance certificates are valid for a six (6)-month (not one hundred eighty (180) day) period beginning on the later dated DOTAX or IRS approval stamp.

The tax clearance submitted with the sealed offer must be valid on the solicitation's legal ad date or any date thereafter up to the offer due date. A valid tax clearance received with the offer will remain valid for the contract award.

The tax clearance certificate shall be obtained on the State of Hawaii, DOTAX Tax Clearance Application Form A-6 (rev.2006) which is available at the DOTAX and IRS office in the State of Hawaii or the DOTAX website, and by mail or fax:

DOTAX Website (Forms & Information):  
<http://www.state.hi.us/tax/tax.html>

DOTAX forms by mail: (808) 587-7572  
1-800-222-7572

DOTAX forms by fax: (on Oahu) (808) 587-7272  
(outside Oahu) (808) 678-0522

Contractor is also required to submit a tax clearance certificate for final payment on the contract

**20.600 Certificate of Good Standing**

Upon award of a contract, the Contractor will be required to obtain a Certificate of Good Standing from the Department of Commerce and Consumer Affairs (DCCA) Business Registration Division (BREG).

A business entity referred to as a "Hawaii business", is registered and incorporated or organized under the laws of the State of Hawaii. The Contractor shall submit a "Certificate of Good Standing" issued by the DCCA, BREG.

A business entity referred to as a "compliant non-Hawaii business," is not incorporated or organized under the laws of the State of Hawaii but is registered to do business in the State. Contractor shall submit a "Certificate of Good Standing" and may be obtained from [www.BusinessRegistrations.com](http://www.BusinessRegistrations.com). To register or to obtain a "Certificate of Good Standing" by phone, call (808) 586-2727 (M-F 7:45 to 4:30 HST). The "Certificate of Good Standing" is valid for six (6) months from date of issue and must be valid on the date it is received by the purchasing agency. There are costs associated with registering and obtaining a "Certificate of Good Standing" from the DCCA; these costs are the responsibility of the Contractor.

## **20.700 Documentation**

Offerors may review information describing Hawaii's Medicaid Program and QUEST by contacting at 808-692-8083 between 9:00 a.m. and 3:00 p.m. (H.S.T.) for an appointment. The documentation library contains material designed to provide the offerors with additional and supplemental information and shall have no effect on the requirements stated in this RFP.

The documentation library, maintained at the location of the issuing officer in Kapolei includes the following:

- QUEST Program Documentation
- Organization charts and functional statements
- QUEST Health Plan manual
- QUEST Policy Memorandum Manual
- EPSDT Manual
- Standards of internal quality assurance
- HEDIS
- QUEST Financial Reporting Guide
- Current QUEST Formulary
- Information on the development of the capitated rate ranges
- Memorandum of Agreement between DHS and DOH
- Health Intervention
- Grievance Policies and Procedures
- Other pertinent data

Offerors that request copies of documentation after visiting the documentation library shall be provided the documents at cost.

Packaging and shipping of documentation shall be the responsibility of the offerors.

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

**20.800 Oral Presentations**

Offerors who submit a proposal in response to this RFP may be required to make an oral presentation of their proposal. If an oral presentation is requested, the offeror shall send its key personnel. Such presentations provide an opportunity for an offeror to clarify its proposal to ensure a thorough and mutual understanding. The issuing officer shall notify a selected offeror if an oral presentation is required.

**20.900 Rules of Procurement**

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

**20.910 Contingent Fees**

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

20.920 Discussion with Applicants

A. Prior To Submittal Deadline:

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

B. After Proposal Submittal Deadline:

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

20.930 RFP Amendments

DHS reserves the right to amend the RFP any time prior to the closing date for the submission of the proposal. Amendments shall be sent to all offerors who requested copies of the RFP.

20.940 Cost of Preparing Proposal

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

20.950 Provider Participation in Planning

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

20.960 Disposition of Proposals

All proposals become the property of the State of Hawaii. The successful proposal shall be incorporated into the resulting

contract and shall be public record. The State of Hawaii shall have the right to use all ideas, or adaptations to those ideas, contained in any proposal received in response to this RFP. Selection or rejection of the proposal shall not affect this right. Written requests for an explanation of rejection shall be responded to in writing within five (5) working days of receipt.

Offerors who submit technical proposals that do not meet mandatory requirements or that do not meet all the threshold requirements during the technical evaluation phase, shall have their technical proposals returned.

#### 20.970 Rules for Withdrawal or Revision of Proposals

A proposal may be withdrawn or revised at any time prior to, but not after, the deadline for receipt of proposals August 16, 2007, provided that a request in writing executed by an offeror or its duly authorized representative for the withdrawal or revision of such proposal is filed with DHS before the deadline for receipt of proposals. The withdrawal of a proposal shall not prejudice the right of an offeror to submit a new proposal.

After the submittal deadline, all proposals timely received shall be deemed to be firm offers that are binding on the offerors for ninety days. During this period, offerors may neither modify nor withdraw their proposals without written authorization or invitation from the DHS.

#### 20.980 Independent Price Determination

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

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

## 21.100 Confidentiality of Information

If the offeror seeks to maintain the confidentiality of sections of the proposal, each page of the section(s) should be marked as "Proprietary" or "Confidential." An explanation to the DHS of how substantial competitive harm would occur if the information were released is required. If the explanation is sufficient, then to the extent permitted by the exemptions in section 92F-13, HRS, the affected section may be deemed confidential. Such information shall accompany the proposal, be clearly marked, and shall be readily separable from the proposal to facilitate eventual public inspection of the non-confidential sections of the proposal. The DHS will maintain the confidentiality of the information to the extent allowed by law. **Note that price is not considered confidential and will not be withheld.** Blanket labeling of the entire document as "proprietary;" however, will result in none of the document being considered proprietary.

## 21.200 Acceptance of Proposals

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

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

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

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

## 21.300 Submission of Proposals

Each qualified offeror may submit only one proposal. More than one proposal shall not be accepted from any offeror. The Proposal Application Identification (Form SPO-H-200) shall be completed and submitted with the proposal (Appendix A).

Five (5) bound copies and one (1) unbound copy of the technical proposal shall be received by the DHS Issuing Officer no later than August 16, 2007 at 2:00 p.m., H.S.T, or postmarked by the USPS no later than August 16, 2007 and received by the state purchasing agency no later than 10 days from the submittal deadline. All mail-ins postmarked by USPS after August 16, 2007, will be rejected. Hand deliveries will not be accepted after 2:00 p.m. H.S.T., August 16, 2007. Deliveries by private mail services such as FEDEX shall be considered hand deliveries and shall be rejected if received after the submittal deadline. Proposals shall be mailed or delivered to:

Attn: Ms. Lois Lee  
c/o Dona Jean Watanabe  
Department of Human Services  
Med-QUEST Division-Finance Office  
1001 Kamokila Blvd. Suite 317  
Kapolei, Hi 96707

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

Hawaii DHS/RFP-MQD-2008-005  
Behavioral Health Technical Proposal  
(Name of Offeror)

## **21.400 Disqualification of Offerors**

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

- Proof of collusion among offerors, in which case all bids involved in the collusive action shall be rejected and any participant to such collusion shall be barred from future bidding until reinstated as a qualified offeror.
- An offeror's lack of responsibility and cooperation as shown by past work of services.

- An offeror's being in arrears on existing contracts with the State or having defaulted on previous contracts.
- An offeror's lack of proper provider network and/or sufficient experience to perform the work contemplated, if required.
- An offeror shows any noncompliance with applicable laws.
- An offeror's delivery of proposal after the proposal due date.
- An offeror's failure to pay, or satisfactorily settle, all bills overdue for labor and material on former contracts with the State at the time of issuance of this RFP.
- An offeror's lack of financial stability and viability.
- An offeror's consistently substandard performance related to meeting the MQD requirements from previous contracts.

#### **21.500 Irregular Proposals**

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

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

#### **21.600 Rejection of Proposals**

The State reserves the right to consider as acceptable only those proposals submitted in accordance with all requirements set forth in this RFP and which demonstrate an understanding of the

problems involved and comply with the service specifications. Any proposal offering any other set of terms and conditions contradictory to those included in this RFP may be rejected without further notice.

A proposal may be automatically rejected for any one or more of the following reasons: (Relevant sections of the Hawaii Administrative Rules for Chapter 103F, HRS, are parenthesized)

- (1) Rejection for failure to cooperate or deal in good faith. (Section 3-141-201, HAR)
- (2) Rejection for inadequate accounting system. (Section 3-141-202, HAR)
- (3) Late proposals (Section 3-143-603, HAR)
- (4) Inadequate response to request for proposals (Section 3-143-609, HAR)
- (5) Proposal not responsive (Section 3-143-610(a)(1), HAR)
- (6) Applicant not responsible (Section 3-143-610(a)(2), HAR)

#### **21.700 Cancellation of RFP**

The RFP may be canceled and any or all proposals may be rejected in whole or in part, when it is determined to be in the best interests of the State.

#### **21.800 Opening of Proposals**

Upon receipt of proposal by a state purchasing agency at a designated location, proposals, modifications to proposals, and withdrawals of proposals shall be date-stamped and, when possible, time-stamped. All documents so received shall be held in a secure place by the state-purchasing agency and not examined for evaluation purposes until the submittal deadline.

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

#### **21.900 Additional Materials and Documentation**

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

## **22.100 Notice Of Award**

A statement of findings and decision shall be provided to all applicants by mail upon completion of the evaluation of competitive purchase of service proposals.

Any agreement arising out of this solicitation is subject to the approval of the Department of the Attorney General as to form, and to all further approvals, including the approval of the Governor, required by statute, regulation, rule, order or other directive.

No work is to be undertaken by the awardee prior to the contract commencement date. The State of Hawaii is not liable for any costs incurred prior to the official starting date.

## **22.200 Protests**

Any applicant may file a protest against the awarding of the contract. The Notice of Protest form, SPO-H-801, is available on the SPO website [www2.hawaii.gov/spoh](http://www2.hawaii.gov/spoh). Only the following matters may be protested:

- (1) A state purchasing agency's failure to follow procedures established by Chapter 103F of the Hawaii Revised Statutes;
- (2) A state purchasing agency's failure to follow any rule established by Chapter 103F of the Hawaii Revised Statutes; and
- (3) A state purchasing agency's failure to follow any procedure, requirement, or evaluation criterion in a request for proposals issued by the state purchasing agency.

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

considered submitted on the date of actual receipt by the state purchasing agency.

<b>Head of State Purchasing Agency</b>	<b>Procurement Officer</b>
Name: Lillian B. Koller	Name: Lois Lee
Title: Director of Human Services	Title: Acting MQD Administrator
Mailing Address: P.O. Box 339 Honolulu, Hawaii 96809-0339	Mailing Address: P.O. Box 700190 Kapolei, Hawaii 96709-0190
Business Address: 1390 Miller Street Honolulu, Hawaii 96813	Business Address: 1001 Kamokila Blvd, Suite 317 Kapolei, Hawaii 96707

## **SECTION 30            BACKGROUND**

### **30.100    Medical Assistance in Hawaii**

Medical assistance to qualified indigent, uninsured and underinsured is provided through the State administered Medicaid fee-for-service, QUEST and QUEST-Net programs. The Med-QUEST Division (MQD) under the DHS administers these medical assistance programs.

### **30.200    Department of Human Services**

MQD is the organizational unit within DHS that is responsible for the operation and administration of the medical assistance programs including QUEST, QUEST-Net, and fee-for-service. For purposes related to this RFP, the basic functions or responsibilities of MQD include:

- Defining the medical and behavioral health benefits to be provided by the managed care plans
- Developing the rules, policies, regulations, and procedures to be followed under the medical assistance programs administered by the department
- Negotiating and contracting with selected medical and behavioral health managed care plans
- Determining initial and continued eligibility of members
- Enrolling and disenrolling members
- Reviewing and ensuring the adequacy of the plan's provider networks
- Monitoring the quality of services provided by the plans and its providers
- Reviewing and analyzing utilization of services and reports provided by the plans
- Handling unresolved member grievances with the plans and providers
- Billing and collecting member premium share
- Monitoring the financial status of all medical assistance programs administered by the Department. Current programs include QUEST, QUEST-Net, and fee-for-service programs
- Analyzing the effectiveness of QUEST and QUEST-Net in meeting its objectives

- Managing the various information systems
- Providing member eligibility information to the participating plans
- Providing monthly capitation payments to the participating plans
- Imposing civil or administrative monetary penalties and/or financial sanctions for violations of specific contract provisions
- Refer to the organization charts and functional statement in the Bidder's Library for additional information on the functions of DHS and MQD

### **30.300 Medical Assistance Eligibility**

#### 30.310 Basic Criteria

All recipients must meet the following basic eligibility criteria:

- Be a U.S. citizen or legal resident alien entering the U.S. before August 22, 1996 or allowed to participate in Medicaid under provisions of the Personal Responsibility and Work Reconciliation Act of 1996 and subsequent amendments of those provisions
- Legal resident alien children (under 19) who entered the U.S. after August 22, 1996
- Intend to reside in the State of Hawaii
- Provide a verified Social Security Number (SSN)
- Not reside in a public institution, including correctional facilities and the Hawaii State Hospital

### **30.400 Aged, Blind and Disabled (ABD)**

The State's Medicaid fee-for-service (FFS) program provides medical assistance to eligible individuals under Title XIX of the Social Security Act. The Medicaid fee-for-service program is a state administered program, which receives federal funding for approximately 55% of its expenditures. The Medicaid FFS program is administered by the Med-QUEST Division (MQD) of DHS.

Hawaii's Medicaid fee-for-service program covers all mandatory Medicaid groups as well as several optional eligibility groups. Under the current Medicaid program for the aged, blind and

disabled, payments are made to providers based on the service(s) rendered (fee-for-service).

### **30.500 Hawaii QUEST (QUEST)**

In its efforts to increase access to health care and control the increase in health care expenditures, the State of Hawaii implemented Hawaii QUEST (QUEST) on August 1, 1994. QUEST is a statewide Medicaid demonstration project (Section 1115 waiver) that provides medical and behavioral health services through competitive managed care delivery systems. QUEST incorporates separate plans for the provision of medical services, specialized behavioral health services, and certain transplants for children and adults.

QUEST currently includes the individuals in the:

- Temporary Assistance to Needy Families (TANF) programs
- Foster Care
- General Assistance (GA) Program; and
- Others who meet QUEST eligibility requirements

The following briefly describes the eligibility for the QUEST program.

#### **30.510 Asset Limits**

Asset limits of \$2,000 for a household of one (1), \$3,000 for a household of two (2), and \$250 for each additional person in the household, have been established to qualify for QUEST. Pregnant women and Children under age 19 have no asset requirements.

#### **30.520 Income Limits**

An individual or family whose gross monthly income is less than the following income limits as a percentage of the federal poverty level (FPL) shall be financially eligible for participation in QUEST: pregnant women, whose countable family income does not exceed 185%, children under the age of 19 whose countable

family income does not exceed 200%, and all other individuals whose countable family income does not exceed 100% of FPL.

### 30.530 Categorical Requirements

Currently, QUEST includes the TANF and GA financial recipients, and other eligibles that are not aged, blind or disabled, that meet the financial asset and income limitations and are not eligible for employer-sponsored insurance.

### 30.540 Employer-Based Health Coverage

Working adults, except for recipients of DHS financial assistance, who have or are eligible for insurance coverage under the Hawaii Prepaid Health Care Act are excluded from participating in QUEST. Their dependents and spouses will be allowed to participate in QUEST.

### 30.550 Additions to the Household

An application is required for individuals requesting to be added to the medical assistance recipient household, including newborns. Although the newborn may be enrolled into a recipient household as of the date of birth, the newborn will be ineligible for continued assistance if an application is not submitted in a timely manner. If no application is received, the State will provide notification to the family and terminate coverage. The State will pay the medical plan at least one month's capitation for a newborn born to a QUEST eligible family.

### 30.560 Eligibility Determination

An applicant will be allowed to request coverage of appropriate emergency room or hospital costs incurred within the five (5) days immediately prior to the date of application. This will ensure that coverage can be requested for medical services received after normal State business hours, on holidays and on weekends. The DHS will cover these services on a fee-for-service basis. If a person is hospitalized during the fee-for-service period, the DHS will assume financial responsibility through discharge.

30.570 QUEST Medical Plan: Behavioral Health Coverage

The QUEST medical plans are required to provide an array of medically necessary behavioral health (mental health, drug abuse and alcohol abuse) preventive, diagnostic, therapeutic and rehabilitative services within established limits below to adult members, except for members who: 1) have been determined eligible for and have been transferred to the BHTPA, and/or 2) are the responsibility of the appropriate State agency pursuant to a criminal commitment for evaluation or treatment under the provisions of Chapter 706, HRS.

The medical plan shall be responsible for providing comprehensive behavioral health services up to the benefit limits including the services below. A benefit year is defined as the period between July 1 of one year through June 30 of the next calendar year.

- ❑ Coverage will be limited to twenty-four hours of outpatient visits and thirty days of hospitalization per benefit year.
- ❑ Each day of inpatient hospital services may be exchanged for two days of non-hospital residential services, two days of partial hospitalization services, two days of day treatment, or two days of intensive outpatient services. Detoxification, whether provided in a hospital or in a non-hospital facility, shall be considered part of the inpatient benefit limit. The plan may substitute each inpatient day for two outpatient hours, if the 24 hours of outpatient benefit is exhausted.
- ❑ Diagnosis and treatment of substance abuse will be included in the inpatient and outpatient benefits for psychiatric treatment.
- ❑ A participating plan may, at the plan's option, exceed the limits on behavioral health services.

Based on established criteria (refer to Subsection 31.100, Eligible BHTPA Members) the member may be enrolled in the BHTPA for the continuing provision of behavioral health services once determined to be Seriously Mentally Ill (SMI). Upon enrollment into the BHTPA, the medical plan ceases to be responsible for the member's behavioral health services.

The medical plan shall be responsible for providing comprehensive behavioral health services up to the benefit limits including:

- Twenty-four hour care for acute psychiatric illnesses including:
  - Room and board
  - Nursing care
  - Medical supplies and equipment
  - Diagnostic services
  - Physician services
  - Other practitioner services as needed
  - Other medically necessary services
- Ambulatory services including 24-hour, 7 days per week crisis services
- Acute day hospital/partial hospitalization including:
  - Medication management
  - Prescribed drugs
  - Medical supplies
  - Diagnostic tests
  - Therapeutic services including individual, family, and group therapy and aftercare
  - Other medically necessary services
- Methadone treatment services which include the provision of methadone or a suitable alternative (i.e., LAAM), as well as outpatient counseling services
- Prescribed drugs (excluding Clozaril or Clozapine)
  - Medication management and patient counseling
- Diagnostic/laboratory services including:
  - Psychological testing
  - Screening for drug and alcohol problems
  - Other medically necessary diagnostic services
- Psychiatric or psychological evaluation
- Physician services
- Therapeutic services including:

- Other medically necessary therapeutic services

### **30.600 QUEST-Net**

QUEST-Net is a program implemented on April 1, 1996, providing limited medical, dental and behavioral health services. This program was developed primarily to serve as a safety net for persons who become ineligible for QUEST and ABD because their assets or income exceed the allowable retention limitations. Applicants with any type of medical coverage including Medicare, VA, or TriCare/Champus are not eligible for QUEST-Net.

QUEST-Net recipients are not eligible for the BHTPA services and are limited only to those covered under QUEST-Net as described in §30.610, QUEST-Net: Health Coverage.

### **30.610 QUEST-Net: Health Coverage Benefits**

QUEST-Net has limited medical and behavioral health coverage. The QUEST-Net coverage includes:

- Bona fide emergencies (including ground ambulance)
- 10 inpatient hospital days (there is no benefit for maternity, nursery, rehabilitation, or skilled nursing level of care)
- 12 outpatient medical visits
- 6 mental health outpatient visits (alcohol and substance abuse services are treated as mental health visits; 6 of the 12 outpatient medical visits may be substituted for 6 additional mental health visits)
- Diagnostic tests (laboratory tests, x-ray services, nuclear medicine) associated with the 12 outpatient medical visits
- Limited prescription drugs (One Cephalosporin agent, One Erythromycin agent, One Penicillin agent, Trimethoprim with Sulfamethoxazole, Sufacetamide, and Otic Polymixin/Neomycin/Hydrocortisone)

Refer to the DHS Administrative Rules for exclusions and other limitations on the QUEST-Net benefits. QUEST-Net members may be billed directly for any non-covered services and for covered services exceeding the established limits.

### **30.700 QUEST- ACE**

Uninsured adults with incomes not exceeding 100% of FPL who would be eligible for QUEST but are unable to enroll due to the enrollment cap, and are unable to enroll in QUEST-Net because they were not already QUEST or Medicaid fee-for-service recipients, are eligible for QUEST-ACE benefits.

Otherwise eligible persons from a Compact of Free Association country (Marshall Islands, Federated States of Micronesia, and Palau) who reside in Hawaii are enrolled in a QUEST-ACE health plan if the individual meets one of the criteria described above. All other QUEST-ACE health plan members must meet the citizenship requirements set forth in Sections 17-1714-28, HAR.

QUEST-ACE recipients are not eligible for the BHTPA services and are limited only to those covered under QUEST-Net as described in §30.610, QUEST-Net: Health Coverage.

### **30.800 QUEST Expanded Access (QExA)**

Hawaii is currently finalizing negotiations with the Centers for Medicare and Medicaid Services (CMS) to amend the current QUEST 1115 waiver program by integrating the ABD population into the managed care delivery system.

The program will be known as QUEST Expanded Access (QExA). The key elements of the proposed program design for the ABD include:

- Enrolling the ABD populations into a managed care plan.
- Folding all existing 1915© waiver programs into the QUEST program, with the exception of the waiver for the developmental disabilities or mental retardation (DD/MR) population, so that the contracted health plans will be responsible for the provision of home and community-based services (HCBS).

- Providing HCBS for individuals who have survived brain injury.
- Engaging the services of an independent Choice Counseling entity to assist the ABD population in selecting a health plan and understanding how to benefit from a managed care system.

### 30.810 Exclusions

Certain groups of Medicaid clients will continue to receive some services outside of the managed care system. The exceptions include:

- The population with DD/MR, currently covered under the DD/MR home and community-based waiver, will be enrolled in a managed care health plan for the primary and acute care services which are part of the QUEST health plan package. Case management, HCBS, and intermediate care facility/mental retardation (ICF/MR) benefits for this group will remain in the Fee-For-Service and carved out of the QExA health plan's capitated benefits package.
- Adults with serious mental illness (SMI) and severe and persistent mental illness (SPMI) will be enrolled in managed care health plans for the primary and acute care services which are part of the QUEST health plan package. Adults with a diagnosis and functional level that qualifies them as eligible for Adult Mental Health Division (AMHD) services will receive all mental health and substance abuse services through the DOH/AMHD system.

The DHS is currently assessing the feasibility of expanding the BHTPA to include the QExA SMI/SPMI adults.

### 30.900 **Estimated Enrollment in Managed Care Programs**

QUEST currently provides health services to approximately 160,000 individuals. QUEST-Net has approximately 2,200 members.

### 31.100 **Eligible BHTPA Members**

QUEST members, who meet criteria for the BHTPA, shall be eligible to receive the specialized behavioral health services

described in this RFP. In such a case, the medical plan shall be relieved of its responsibility for providing behavioral health services, but shall remain responsible for providing medical services.

If a QUEST member is determined to be SMI or provisionally SMI through the MQD evaluation process, the member is required to enroll into the BHTPA. Upon enrollment in the BHTPA, the QUEST medical plan is no longer responsible for the individual's behavioral health services.

ABD/fee-for-service individuals, who meet SMI or provisionally SMI eligibility criteria, may voluntarily choose to enroll into the BHTPA. The ABD member will generally be identified by their treating psychiatrist and referred to MQD for an evaluation and SMI determination.

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

A provider, on the behalf of a potentially eligible SMI applicant, will be allowed to request coverage of appropriate psychiatric-related emergency room or psychiatric inpatient hospital costs incurred within the five- (5) days immediately prior to the date of application. This will ensure that coverage can be requested for behavioral health services received after normal State business hours, on holidays and on weekends. The DHS will cover these services on a fee-for-service basis. If a person is institutionalized during the fee-for-service period, the DHS will assume financial responsibility through discharge.

### 31.110 Seriously Mentally Ill

Persons who are determined to be seriously mentally ill (SMI) are defined as adults who, as the result of a mental disorder; exhibit emotional, cognitive, or behavioral functioning which is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or services of a long-term or indefinite duration. In these persons, mental disability is severe and persistent resulting in a long-term limitation in their functional capacities for primary activities of daily living such as interpersonal relationships, self-care, homemaking, employment, and recreation. Criteria for designation of a person who is SMI can be found in Appendix K.

### 31.120 Evaluation and Referral to the BHTPA

Upon determination that a QUEST member or ABD recipient is potentially SMI, the medical plan, or the psychiatrist in the fee-for-service program, shall refer the member to MQD for an evaluation to determine eligibility for the BHTPA. Refer to Appendix L.

The MQD or its representatives shall conduct the evaluation. All necessary forms must be completed and documentation of illness (admission and discharge summaries, day hospital admission and discharge summaries, outpatient admission and discharge summaries, psychological test results, and other pertinent documents) must be submitted with the referral. If, after review of the documentation, no decision can be rendered, the member may be required to submit to an interview. The cost of completing the forms and obtaining documentation is the responsibility of the medical plan or the FFS provider.

If the member needs to be interviewed, and requires transportation to the evaluation site, the cost shall be borne by the referring medical plan or the DHS for FFS members. If all documents are completed and properly submitted on the initial referral, the determination will be made within 30 days from the receipt of the documents. If additional documentation is requested, the determination, if it can be made, will be done within 30 days of receipt of the additional documents. If an interview is required, the decision will be made within 1 week of the interview.

The evaluation results and the enrollment date into the BHTPA will be provided to the member's medical plan and the BHTPA or fee-for-service program. Five working days after notification of SMI determination, the BHTPA assumes responsibility for the member. The referring provider has the right to appeal any denial of SMI eligibility determination to the BHTPA. The BHTPA shall verify enrollment with DHS and the member's medical plan before providing services.

Dual eligible (Medicare/Medicaid) and Medicaid recipients who are not enrolled in a QUEST medical plan may voluntarily enroll in the BHTPA following determination that the person is SMI. For

dual diagnosis members, the most current ASAM placement criteria will be used as part of their evaluation for SMI eligibility.

### 31.130 Enrollment into the BHTPA

Applicants for the BHTPA may be:

- Referrals from the QUEST medical plan
- Referrals from the private practitioner in fee-for-service program (i.e., ABD, dual eligibles (Medicaid/Medicare))
- Referrals from the Hawaii State Hospital who are being discharged
- Referrals from the Department of Public Safety being discharged from their correctional facilities
- Referrals from the Department of Human Services for those young adults (18 years old) being discharged from the Hawaii Youth Correctional Facilities.

All referrals for potential BHTPA members will be subject to the SMI referral and evaluation process and must meet the criteria for the Severely Mentally Ill.

There is no enrollment cap for the BHTPA.

Once a member has been determined to meet the criteria for SMI determination, the member will be enrolled in the BHTPA. The enrollment date, which is five working days after notification of SMI determination, provided the applicant has met the QUEST or ABD eligibility requirements, shall be noted on the determination form. Upon enrollment into the BHTPA, the medical plan shall be relieved of its responsibility for providing all behavioral health services to the QUEST member. Similarly, the ABD Medicaid Program will not be directly billed for behavioral health services for a participant in the BHTPA.

Until the BHTPA enrollment date, the medical plan or fee-for-service provider retains responsibility for providing the behavioral health services. The medical plan shall not receive any additional compensation for maintaining the care coordination/case management functions as these services are expected to be performed as part of capitated rate.

Members who are enrolled in the BHTPA and who are later determined to no longer meet the criteria for SMI shall be

referred to the MQD by the BHTPA. A transition plan will be developed by the BHTPA and a copy forwarded to the MQD. The MQD shall determine whether the individual no longer meets the criteria using the same process described in Section 31.120, Evaluation and Referral to the BHTPA. The BHTPA will review the member's treatment status at least every six months to determine if SMI continued eligibility criteria are met.

If the member no longer meets the criteria for enrollment in the BHTPA, he/she shall be disenrolled from the BHTPA at the end of the month and responsibility for behavioral health services will revert to the medical plan or the fee-for-service program. The BHTPA transition plan will be given to the medical plan or fee-for-service provider in order to ensure continuity of care prior to disenrollment. The medical plan shall receive written notification from the MQD of the disenrollment from the BHTPA. Upon disenrollment from the BHTPA, the medical plan assumes responsibility for providing all medical and behavioral health services within the established QUEST benefit limits.

Covered behavioral health services provided by Medicaid providers to QUEST eligible behavioral health applicants from the determination date to the effective date of enrollment shall be paid by DHS on a fee-for-service basis. If the member is hospitalized at the time of enrollment, coverage under the fee-for-service system will continue until discharged from the hospital. The BHTPA shall, however, be responsible for care coordination coverage from the effective date.

### 31.140 Re-Enrollment into the BHTPA

Individuals, who are disenrolled from the BHTPA due to loss of eligibility for services and regain eligibility for services after an absence (of less than 6 months) are not required to be re-evaluated to be enrolled (unless the MQD or the BHTPA determines it is necessary, or a six-month re-evaluation is due).

Re-enrollment will be effective from the date the member is re-enrolled into the QUEST medical plan and/or the BHTPA. Re-enrollment will not be retroactive to the date of the last disenrollment.

### 31.150 Optional Enrollment

- ABD (determined SMI)
- Medicaid/Medicare members (dual eligibles)

Persons who are ABD and persons who are eligible for Medicaid and Medicare may enroll in the BHTPA on a voluntary basis. All ABD dual eligibles (Medicare and Medicaid) determined to be seriously mentally ill as defined in this section shall be eligible to receive the specialized behavioral health services described in this RFP. Dual eligibles that are determined SMI may elect to receive medical services on a fee-for-service basis and join the BHTPA for behavioral health services. QUEST members who become Medicare eligible during the contract period will have the option of remaining in the BHTPA for behavioral health services only, or reverting to the fee-for-service program for all health services.

- Medically Needy (with spenddown)

Medicaid eligible persons who are SMI and who meet spenddown criteria may be enrolled in the BHTPA. These individuals will receive medical and behavioral services on a fee-for-service basis.

### 31.160 Involuntary Commitment

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

#### **31.170 Criminal Commitment**

Adult members who have been criminally committed for evaluation or treatment in an inpatient setting under the provisions of Chapter 706, HRS, shall be disenrolled from all QUEST plans or fee-for-service program and become the clinical and financial responsibility of the appropriate State agency. The psychiatric evaluation and treatment of recipients who have been criminally committed to a mental health care setting shall be the clinical and financial responsibility of the appropriate State agency. The BHTPA shall be relieved of its responsibility for providing behavioral health services.

#### **31.200 Transition of Care**

The BHTPA shall coordinate the transition of behavioral healthcare services for newly enrolled members with the member's current fee-for-service behavioral health provider, DOH-CAMHD, and/or the QUEST medical plan, since many of the eligible members already have an established behavioral health care provider with the BHTPA. For some of these individuals, an abrupt change in therapy may be detrimental.

Individuals who are receiving services from DOH-CAMHD, and will no longer be eligible for services (age 21) with CAMHD, will also need to be transitioned to the BHTPA, if determined to be SMI, or back to their QUEST medical plan if they are determined to no longer meet the criteria to be SMI.

If the member is to be enrolled in the BHTPA from the QUEST medical plan, DOH-CAMHD, or the Fee-For-Service (FFS) Program, the disenrolling plan and the BHTPA shall equally assist the member in the transition process.

Similarly, if the member is to be disenrolled from the BHMO, the BHMO and the enrolling plan (QUEST medical plan) shall equally assist in the transition process. If the member no longer meets SMI criteria, and is enrolling into the FFS program, the BHTPA shall assist the member to locate an appropriate FFS behavioral health provider.

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

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

## **SECTION 40                      PROVISION OF SERVICES**

### **40.100      Offeror's Role in Managed Care**

One (1) BHTPA plan shall perform statewide administrative functions and provide case management services for behavioral health members who are seriously mentally ill (SMI). The BHTPA shall provide each member with a care coordinator or case manager who is responsible for the direction, coordination, monitoring and tracking of the behavioral healthcare services (mental health, drug abuse, and alcohol abuse services) needed by the members. The BHTPA shall develop and maintain a provider network capable of providing the required individualized behavioral health services needed by the members. Providers and BHTPA plan personnel should be knowledgeable about and sensitive toward the behavioral health care needs of the QUEST members.

The BHTPA shall also provide each member with a behavioral healthcare practitioner (BHP) who assesses the member's behavioral healthcare needs and provides the clinical services to meet these needs. Since the BHTPA members will retain their primary care provider (PCP) from the QUEST medical plan or FFS provider for coordination of medical services, the BHTPA shall ensure that the PCP or FFS provider is regularly updated on the member's diagnosis, medication, treatment plans, and ongoing care and that close coordination with the member's medical care is maintained.

### **40.200      Qualification of the Behavioral Health Third Party Administrator**

The participating BHTPA shall be properly licensed in the State of Hawaii (see Chapter 431 and 432 and 432D, HRS). At the time of bid submittal, the offeror shall have either received approval or filed an application with the Insurance Division of the Department of Commerce and Consumer Affairs, to operate as a health plan in the State.

### **40.300      Reimbursement**

The method of payment from DHS to the BHTPA shall be a set fee per month for administrative services. The fee shall be set

based on the number of members enrolled in the BHTPA in a given month. The following compensation schedule will apply.

**COMPENSATION AND PAYMENT SCHEDULE**

The administrative rate(s) for SMI recipient's services paid monthly on a total enrollment basis.

1 to 500 active members per month	\$ 75, 000.00
501 to 1,000 active members per month	\$131,367.00
1,001 to 1, 500 active members per month	\$187,467.00
1,501 to 2,000 active members per month	\$251,067.00
2,001 to 2,500 active members per month	\$308,000.00
2,501 to 3,000 active members per month	\$364,933.00
3,001 to 3,500 active members per month	\$421,867.00
3,501 to 4,000 active members per month	\$478,800.00
4,001 active members and more per month	\$535,733.00

In addition to the above administrative fees, payment for direct services and case management services will be reimbursed based on a fee schedule submitted by the contractor and approved by the MQD. The offeror shall include the fee schedule in the proposal. Reimbursement for direct services, with the exception of care coordination services, shall not exceed 60% of Medicare year 2006 base year rates. Facility reimbursement fees shall not exceed current Medicaid base rates by more than 10%. Payments will be made by DHS based on receipt of appropriate encounter data submitted by the BHTPA. Reimbursement for care coordination /case management services shall not exceed \$375 per member per month.

All reimbursements for direct services and case management shall be subject to review by the MQD or its agent(s) for medical

necessity and appropriateness, respectively. The MQD or its agent shall be provided access to medical records and documentation relevant to such a review and the offeror agrees to provide access to all requested medical documents/records. It is the responsibility of the BHTPA to ensure that its subcontractors also provide MQD and its agents access to requested behavioral health documents/records with or without patient consent. Reimbursement for services deemed not medically necessary by MQD or its agent shall be denied. Reimbursements for members with third party coverage (including dual eligible members with Medicaid and Medicare) will be based on the fee schedule less any TPL recovery. Any overpayments for services will be recouped by MQD from the BHTPA.

The BHTPA will allow the State's agent(s) (including a reinsurer) to review all medical records. The MQD has final determination in what is considered a medically necessary, reimbursable service.

40.310 Review of Medical Records

Per 42 CFR part 434.53, the BHTPA shall provide MQD or its agent's access to all behavioral health records deemed necessary in the performance of its (the MQD's) responsibilities, with or without the patient's consent. If the BHTPA is not compliant with this requirement, the BHTPA may be sanctioned as described in section 61.120 of this RFP.

**40.400 Provider Network**

40.410 Required Services

The BHTPA shall develop and maintain a statewide provider network capable of providing 24-hours a day, 7 days a week statewide, comprehensive behavioral health, substance abuse, case management, crisis service and emergency telephone consultation services to eligible BHTPA members. The BHTPA must ensure a sufficient number of appropriately credential or otherwise qualified providers to furnish the required behavioral health services needed by the members in a timely manner (breakdown of current and estimate of potential ABD members will be given at a later date).

All providers of service must meet applicable State and Federal regulations, licensing, certification, and recertification requirements. It is expected that all providers in the BHTPA network shall comply with subcontracting, appointment standards, documentation and other provider related requirements in this document.

The following is a listing of required service components of the BHTPA provider network. It is not meant to be an all-inclusive listing of the components of the network and additional components may be required based on the needs of the members:

- Hospital services
- Outpatient hospital services
- 24-hour, 7 days per week emergency/crisis services
- Mental health rehabilitation services
- Behavioral healthcare specialist services such as psychiatrists, psychologists, social workers, certified substance abuse counselors, and advanced practice nurses trained in psychiatry
- Day treatment programs
- Residential treatment programs
- Care coordination/Case management services
- Pharmacy services
- Laboratory services
- Substance abuse services including Methadone treatment
- Pre-vocational programs
- Social/recreational services
- Occupational therapy
- Interpretation services
- Transportation services including emergency ground and air for patient and if medically appropriate for attendant(s)
- Lodging and meals associated with obtaining necessary care for patient and if medically appropriate for attendant(s)

The BHTPA shall notify the providers who provide service to its members that payment by the BHTPA is considered as "payment-in-full" and they cannot "balance bill" the members for these services. The unwillingness of the providers of services to comply with the BHTPA does not relieve the BHTPA from providing all medically necessary covered benefits.

Residents, interns, and students must work under the direct supervision of a licensed or certified professional of the same discipline that they are training in. The BHTPA must inform the DHS if unlicensed providers are used. The DHS has the right to review what education, training, and experience it will allow an unlicensed provider and for which specific provider types and levels of services.

#### 40.420 Availability and Accessibility of Providers

The BHTPA shall have a sufficient statewide provider network to ensure that members can access needed behavioral health services consistent with the member's degree of risk, as set forth below:

- Emergent services are available immediately
- Urgent problem visits are available within 48 hours
- Non-urgent office visits are offered within ten (10) business days or fourteen (14) days

The BHTPA shall adjust the member's assignments to a BHP as necessary to ensure timely access to behavioral health care and to maintain quality of care.

The BHTPA shall submit a copy of its scheduling guidelines in its proposal to clarify various types of appointments including specialty referrals and routine follow-up appointments. These guidelines shall be communicated in writing to all providers in the plan's network at the time of provider contracting or implementation of the program. The BHTPA shall monitor compliance with its stated appointment standards and shall have a corrective action plan when appointment standards are not met.

Providers should be knowledgeable about and sensitive toward the behavioral health care needs of the ABD population. The BHTPA proposal shall demonstrate the Offeror's ability to serve all the special populations (i.e., homeless individuals, persons who are dually diagnosed, and geriatric members). The proposal shall describe the mechanism the member will use to access available services, including any restrictions. The proposal shall also describe what will happen if a service is needed and is unavailable in the areas where the member resides.

The BHTPA shall ensure that at a minimum, 90% of the members have access to all covered services utilizing the standards below:

- ❑ Non-emergency inpatient services – located within 60 miles or 60 –70 minutes travel time
- ❑ All other covered services (urban) – located within 20 miles or 30 minutes travel time
- ❑ All other covered services (rural) – located within 50 miles or 60 minutes travel time

Access problems may be especially severe in rural areas and on the neighbor islands. The offeror shall describe its provider network in detail using Appendix M and submit in its proposal. In addition, the offeror shall describe how the special problems of access particular to rural areas and neighbor islands will be addressed.

In general, the BHTPA shall make the services it provides to Medicaid (QUEST and ABD) members as accessible as the services are to non-Medicaid clients within the BHTPA's service area, in terms of time, duration, amount, and scope.

#### 40.430 Department of Health – Adult Mental Health Division (DOH-AMHD)

Individuals participating in the BHTPA, and those who are receiving services under the fee-for-service ABD program, may currently be receiving services from one of the community mental health centers (CMHC) under AMHD or through the Medicaid Rehabilitation Option (MRO). The BHTPA will contract with the DOH/AMHD to continue these services with the member's approval, for continuity of care. \* See MOA between DHS and DOH.

The BHTPA will coordinate with the AMHD for medically appropriate admissions to the State Hospital and follow-up services with the ACT Team, if applicable and available. The BHTPA is encouraged to include the AMHD CMHC's in its provider network; however, they are not obligated to utilize all locations of CMHC's.

Referrals to DOH-AMHD will be consistent with the plan's policies and procedures for referral, and utilization reviews conducted on

clinical performance. All providers of services shall meet the BHTPA's qualifications and quality performance standards established for network providers.

40.440 State Mental Health Hospital

Members who meet admission criteria based on severity of illness and availability of facility beds, may be admitted to the State Mental Health Facility. Upon admission into the State Hospital, the individual shall be disenrolled from the BHTPA. See Appendix O for DOH criteria for State Hospital Admission.

40.450 Assertive Community Treatment (ACT)

The ACT Team provides 24-hour mobile crisis teams, assertive outreach for treatment in clients' own environments, individualized treatment, medication rehabilitation and supportive services.

The BHTPA may refer its members to the ACT Team (if available) for services if they meet the DOH criteria and severity of need. The BHTPA shall negotiate a contract with the DOH to access these services through DOH's designated provider when medically appropriate.

If the ACT Team accepts the BHTPA referral, the BHTPA is responsible for reimbursement to the ACT Team for the services provided. If the ACT Team is unable to accept the referral from the BHTPA, The BHTPA is responsible to provide the services.

#### 40.500 Care Coordination/Case Management System

Upon enrollment in the BHTPA, each member shall be assigned a care coordinator or a case manager. The BHTPA shall have a Care Coordinator/Case Management (CC/CM) system to:

- Provide the member with clear and adequate information on how to obtain services and make informed decisions about their own behavioral health needs;
- Provide comprehensive case assessment, case planning, ongoing quarterly monitoring of progress toward goals and support towards reaching those goals;
- Provide skills development in problem-solving and other skills to remain in/return to the community;
- Ensure crisis resolution;
- Coordinate and integrate the members' medical and behavioral health care and services with the QUEST medical plan or FFS provider, behavioral health provider, and primary care provider;
- Achieve continuity of members' care and cost effective delivery of services;
- Assist the member to obtain behavioral health interventions, prescribed by the interdisciplinary team as appropriate, and ensure that these services are received and provided in a timely manner;
- Ensure that an active, assertive system of outreach is in place to provide the flexibility needed to reach those members requiring services, such as the homeless or others, who might not access services without intervention due to language barriers, acuity of condition, dual diagnosis, physical/visual/hearing impairments, mental retardation, lack of transportation etc.;
- Facilitate member compliance with recommended medical and behavioral health treatment
- Assist members with DHS eligibility requirements (verifications, etc.) and compliance

In addition, the CC/CM system shall function to assist the providers in the plan's network to provide the care needed to bring the member to an optimum level of recovery/functioning with maximum autonomy, and to prevent relapse. Therefore, the system must be readily accessible to the member, not to place unnecessary burdens on the medical plan/FFS and BHTPA

providers, or compromise good behavioral health care. At a minimum, the plan shall have policies and procedures in place for:

- Providing care coordination
- Referring members to other programs or agencies
- Changing care coordinators/case managers
- Identifying levels of case management according to member needs and ensuring at least monthly face-to-face case manager contact.
- Outreach and follow-up activities, especially for members with special needs (i.e., homeless and homebound members)
- Provide documentation and data reporting of CC/CM services, encounters and outcomes.
- Providing continuity of care when members transition to other programs (i.e., medical plan, fee-for-service program, Medicare, new services in the treatment plan)

#### 40.510 Care Coordination/Case Management (CC/CM)

The BHTPA must demonstrate that it has a CC/CM system to ensure that all members receive all necessary covered behavioral health services. Specifically, the CC/CM services include member assessment, treatment planning, service linkage and coordination, monitoring and member advocacy (such as completing and filing an application for financial or housing assistance). The level of management will vary in scope and frequency depending on the member's intensity of need.

The BHTPA shall perform an initial comprehensive assessment of each enrolled member to determine the behavioral health and care coordination needs of the individual. The comprehensive assessment shall be conducted within thirty (30) days of enrollment into the BHTPA. If an individual loses eligibility and is re-enrolled into the BHTPA within six months, a comprehensive assessment does not need to be conducted upon re-enrollment unless it has been six months since the last assessment.

The offeror must include its policies and procedures for coordination and cooperation with community programs that provide services to eligible BHTPA members. In cases where the member has indicated that he/she is receiving services, which are behavioral health benefits, the BHTPA shall evaluate and determine whether the service is medically necessary.

The offeror shall describe in its proposal its CC/CM information to include:

- ❑ How persons (members, family members/guardians, community providers and providers) will access the care coordination/case management system for member services or inquiries.
- ❑ A description and a copy of the plan's assessment tool that will be used to gather information on the member as well as the frequency of review and updating of the tool (i.e., period of time between reassessment of tool). The assessment tool shall be subject to approval by DHS.
- ❑ How information will be exchanged between the BHTPA, the medical plan, the member's PCP, and other service providers, including non-contracted providers.
- ❑ How the CC/CM will coordinate with other providers to implement the Individual Treatment Plan (ITP) (see §40.520)
- ❑ A Description of CC/CM activities reporting plan to include:
  - Encounters
  - Outcomes
  - Notification to medical plans and FFS medical providers
  - Emergency room services
  - Hospital admissions
  - Discharge planning
  - Follow up to prevent hospital readmission.
- ❑ Definitions of the levels of CC/CM to be employed and a description of the standards for determining the level of CC/CM a member shall receive relative to a continuum

with classifications ranging from routine care coordination to intensive/complex case management including frequency and type of case management contact. CC/CM services that are considered appropriate to list as encounters include: face-to-face contact with member/family, other involved service providers, telephone calls involving direct communication with the person being called (does not include attempts to get in touch, leaving messages for call backs), and travel time (actual time spent in taking a member to/from places which must be treatment related).

- ❑ A description of proposed caseload assignments for each CC/CM classification, as well as policies and procedures for providing CC/CM as they relate to the member's needs
- ❑ A description of the CC/CM staffing including job descriptions of the care coordinator and the case manager, qualifications, and the type of initial and/or ongoing training and education that it will provide to its care managers
- ❑ If CC/CM services are to be subcontracted, submit to DHS for prior approval the proposed subcontract for the provision of CC/CM services. An oversight and training plan for subcontractors must also be submitted to DHS for prior approval.

#### 40.520 Individualized Treatment Plan (ITP)

An ITP shall be developed for each BHTPA member, requiring non-emergent treatment, within 30 days of the comprehensive assessment conducted upon enrollment. When inpatient treatment is required, the assessment and ITP shall be developed within the timeframes below:

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

The BHTPA shall develop the ITP to contain all necessary services identified by the interdisciplinary team, which includes

the medical plan or FFS provider, if applicable. These services shall include but not be limited to services provided by psychiatrists, psychologists, social workers, and advance practice nurses. The care coordinator/case manager is responsible for development and implementation of the ITP in coordination with the referring agency (i.e., DOH-CAMHD) PCP/FFS Provider and other involved persons as necessary.

The proposal shall describe the offeror's policies and procedures for the ITP process that shall include the forms to be used to document the ITP.

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

The BHTPA shall ensure the opportunity for meaningful participation by the member or their representative, and as appropriate, family members/significant others, and other informal caregivers, in the ITP development, modification, treatment, and the treatment plan meetings. (provided the member or their representative has provided written consent to allow these individuals to participate in the treatment and ITP activities described in this section).

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

## **40.600 BHTPA Personnel**

### **40.610 Medical Director**

The BHTPA shall have on staff a locally based Medical Director licensed to practice medicine with a specialty in psychiatry, in the State of Hawaii, to oversee the quality of behavioral healthcare furnished by the BHTPA and to ensure care is provided by qualified personnel. The Medical Director shall address any potential quality of care problems and direct the Quality Improvement Program (QIP). The Medical Director shall work closely with the MQD Medical Director when applicable, and participate in any committees relating to QUEST and/or the BHTPA when requested by DHS.

### **40.620 Supporting Staff and Systems**

The BHTPA shall have in place and identified adequate organizational and administrative systems that are capable of implementing contractual obligations. The staff (may be contracted) shall include but not be limited to:

- Care coordination/case management staff to ensure timely access to medically necessary services and to assist the member to understand and follow his/her treatment plan
- Coordinator to serve as the BHTPA's key contact for the contract
- Pharmacist either on staff with the BHTPA or on contract who is physically located in the State of Hawaii to address pharmacy needs of recipients
- QA/UR Coordinator who is a licensed R.N. in the State of Hawaii
- Staff who are responsible to answer questions and respond to complaints for both members and providers located in the State of Hawaii to address member needs or coordinate services
- Provider relations staff located in the State of Hawaii to confirm eligibility, interpret/explain plan policies, guidelines, and resolve complaints
- Grievance coordinator located in the State of Hawaii to investigate member and provider complaints
- Administrator to oversee the business systems

- Designated financial officer to oversee the budget and accounting system and to ensure timely and accurate submission of financial reports
- Information system staff capable of loading member tape information, and ensuring the timely and accurate submission of encounter data and other required information and reports including ad hoc reports as requested by DHS
- Support service staff to ensure the timely and accurate processing of other reports and coverage of the toll-free telephone hotline
- Clerical staff to conduct daily business

The BHTPA shall ensure that all staff has appropriate training, education, and experience to fulfill the requirements of the positions. The offer must include information on the number of FTE's that will be used and that the designated staff is adequate to meet the requirements and functions of this RFP..

#### **40.700 Scope of Behavioral Health Services**

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

The BHTPA shall provide a full range of psychiatric inpatient, outreach, treatment, rehabilitation and crisis response services needed by SMI adults. The BHTPA shall coordinate its services with the QUEST medical plan or the fee-for-service primary healthcare provider to avoid duplication of services and ensure that services are appropriately provided. Services may be provided or arranged for in a variety of ways such as through natural supports, mental health agencies, general hospitals, family members, consumer help approaches, or through the use of recovering consumers as paid or volunteer staff.

BHTPA services shall assist members to manage their illness, develop the appropriate and necessary living skills and acquire supports and resources they need to maximize their quality of life in the community. The BHTPA's services shall be guided by the following principles. Services shall:

- ❑ Be consumer-centered, based on the needs of the member rather than the needs of the system or the needs of the providers
- ❑ Empower members by incorporating consumer self-help approaches in a manner that promotes members retaining the fullest possible control over their own lives
- ❑ Be culturally appropriate
- ❑ Be flexible and available whenever and for as long as needed. They should be provided in a variety of ways, with members able to choose services and move in and out of system components as needed
- ❑ Focus on strengths, and build on the assets of the members to help them maintain a sense of identity, dignity, and self-esteem.
- ❑ Be normalized and incorporate natural supports and settings. Services shall be offered in the least restrictive, most natural setting possible.
- ❑ Be adaptable to meet the special needs of groups such as persons who are vision impaired, health impaired, hearing impaired, physically disabled, developmentally disabled, homeless, homebound, and those who have language barriers.
- ❑ Include meaningful participation by consumers and families in the member's ITP and on provider choice, service delivery and access to peer support groups.

#### 40.710 Covered Behavioral Health Services

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

The BHTPA shall submit a detailed plan describing the service delivery system including all current medically necessary services covered by the Hawaii Medicaid program and non-traditional services that will be in place to serve members. At a minimum, the BHTPA shall provide the services listed in this section below:

- ❑ Inpatient mental health services (twenty-four hour care). Services include:
  - Room and board
  - Nursing care
  - Medical supplies, equipment and drugs
  - Diagnostic services
  - Psychiatric services
  - Other practitioner services as needed
  - Physical, occupational, speech and language therapy
  - Other medically necessary services
  
- ❑ Ambulatory services includes 24-hour, 7 days/week emergency/crisis intervention
  - Mobile crisis response
  - Crisis stabilization
  - Crisis hotline
  
- ❑ All medically necessary alcohol and chemical dependency services
  
- ❑ Acute day hospital/partial hospitalization including:
  - Medication management
  - Prescribed drugs
  - Medical supplies
  - Diagnostic tests
  - Therapeutic services including individual, family, and group therapy and aftercare
  - Other medically necessary services
  
- ❑ Care Coordination/Case Management
  - Case assessment
  - Case planning (service planning, care planning)

- Outreach
- Ongoing monitoring and service coordination
  
- ☐ Methadone Management Services which include the provision of methadone or a suitable alternative (i.e. LAAM or bupernorphoine) as well as outpatient counseling services
  
- ☐ Prescribed Drugs
  - Medication evaluation, prescription and maintenance of psychotropic medications and medications to treat their side effects
  - Medication management
  - Medication counseling and education
  
- ☐ Diagnostic services including:
  - Psychological testing
  - Psychiatric or psychological evaluation (including neuropsychological evaluation)
  - Psychosocial history
  - Screening for and monitoring treatment of substance abuse and mental illness
  - Other medically necessary diagnostic services
  
- ☐ Behavioral health outpatient services also include:
  - Screening, Registration, and Referral
  - Treatment/service planning
  - Individual/group therapy and counseling
  - Family/collateral therapeutic support and education
  - Homebound services
  - Continuous treatment teams
  - Other medically necessary therapeutic services
  
- ☐ Other practitioner services
  - Other medically necessary practitioner services provided by licensed and/or certified healthcare providers

- ❑ Therapeutic services including:
  - Other medically necessary therapeutic services including services which would prevent institutionalization
- ❑ Bio-Psycho-Social Rehabilitation services including:
  - Work assessment service
  - Intensive day treatment
  - Day treatment
  - Residential treatment services
- ❑ Pre-vocational service including:
  - Work assessment service
  - Pre-employment service
- ❑ Social/Recreational therapy services

(Refer to Appendix H for a listing of specific exclusions from the program)

Adult members who have been designated as being SMI or provisionally SMI and who require alcohol abuse and/or drug abuse diagnosis, treatment and/or rehabilitative services shall receive these services from the BHTPA. The BHTPA shall make decisions regarding admission to treatment programs, continued stay, and discharge criteria based on the most recent edition of the American Society of Addiction Medicine (ASAM) Patient Placement Criteria.

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

DOH-ADAD will continue to fund within available resources certain substance abuse treatment programs that may be accessed by BHTPA members. These include specialized residential and day treatment for pregnant and parenting mothers. Eligibility for, and entry into these ADAD funded programs will be determined by the ADAD provider.

ADAD will also pay for residential treatment for BHTPA members within its available resources. ADAD contracts with residential treatment programs and as such, has a specific number of

"beds". The BHTPA member may obtain a "bed" by contacting the treatment program directly and upon determination by the ADAD provider (and availability of a bed); the member may be admitted. The ADAD provider will inform the plan of the admission and expected length of stay. Another way to obtain a "bed" would be for the plan to refer the member to a substance abuse residential treatment provider and arrange for the utilization of an ADAD "bed". The BHTPA remains responsible for providing appropriate medically necessary substance abuse treatment services while awaiting an ADAD "bed". If an ADAD "bed" is not available, the BHTPA is responsible for arranging and providing payment for residential treatment services if medically necessary.

While the member is in an ADAD "bed" the medical plan or FFS program remains responsible for all medical costs. The ADAD provider shall coordinate with the BHTPA for the patient's discharge from the residential treatment program. The BHTPA remains responsible for placing the member into other appropriate substance abuse treatment programs following discharge from the residential treatment program.

#### **40.800 Out-of-State and Off-Island Coverage**

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

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

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

serious impairment to body functions or serious dysfunction of any bodily organ or part.

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

If a BHTPA member is referred/authorized for out-of-state behavioral health services (i.e. residential) the fee-for-service program will be responsible for the medical services. These members will be temporarily disenrolled from the QUEST plan while residing out of the State (and in active treatment). It is the responsibility of the BHTPA to notify DHS when the member is transferred for out-of-state services.

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

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

#### **40.900 Other Services to be Provided**

In addition to the behavioral health services listed in Subsection 40.710, Covered Behavioral Health Services, the plan shall provide certain specialized services. This section lists the required other services:

- Member Education

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

Member education also includes educating the members on the concepts of managed care, the scope of behavioral health services available through the plan and how to obtain BHTPA services. At a minimum, the plan shall also provide members with information on the procedures which members need to follow related to the plan's prior authorization process, utilization of case manager/care coordinator services, informing the plan of any changes in the member status, changing providers, filing a grievance, and notice of off-island travel.

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

☐ Cultural/Linguistic Services

The BHTPA shall be responsible for identifying cultural/linguistic/communication needs (i.e. interpretation services, TDD, alternative formats for materials for persons with vision and hearing impairments) and shall assist the member to obtain needed services. These methods shall be available whenever needed by members. The BHTPA shall identify the health practices and behaviors of the members to design programs, interventions and services which effectively address cultural and language barriers to the delivery of appropriate and necessary health services.

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

condition including side effects. The BHTPA shall describe its approach to providing culturally appropriate and linguistically competent services in its proposal.

☐ Accessible Transportation Services

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

☐ Outreach

Outreach involves the provision of services wherever necessary to assure all eligible members receive needed behavioral health services, (i.e., outreach to the home, homebound, etc.). The proposal shall describe how the plan intends to establish and maintain contact with all eligible members, but especially these special need individuals.

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

☐ Appointment Follow-up

When the BHTPA refers the member to another practitioner or service provider for behavioral health services, the BHTPA shall follow-up to verify that the member received the needed services. If a behavioral health appointment is made but not kept by the member, the BHTPA shall contact the member to determine the reason and schedule another appointment. When the BHTPA member requires services provided by a medical plan specialist or other practitioner, the BHTPA's providers or CC/CM shall coordinate the referral with the medical plan PCP or the fee-for-service provider. The medical plan shall follow-up with the specialist or other practitioner to verify that the member received the needed services.

☐ Hotline

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

☐ Certification of Physical or Mental Impairment

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

The listing of specialized behavioral health related services will be reimbursed under the following guidelines.

Member Education--Considered a CM service

Cultural/Linguistic Services--Considered an encounter if the member requires the interpreter to be present in order to receive health services. If services are needed for a pamphlet or brochure interpretation, it is considered an administrative expense.

Transportation Services—Considered a transportation encounter only if provided by a Medicaid provider other than a case manager (i.e. taxicab). If a Case Manager transports a member to a medical appointment it is considered an administrative service.

Outreach-- Considered to be a CM service when a successful face to face or telephone engagement is performed.

#### **41.100 On-Site Visits**

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

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

#### **41.200 Geographic Areas to be Served**

The offeror shall be able to provide the full range of behavioral health services to members on a statewide basis.

## **SECTION 50 ADMINISTRATIVE REQUIREMENTS**

### **50.100 Notification of Enrollment**

DHS shall provide the member with written notification of the BHTPA in which the member is enrolled and the effective date of enrollment. This notice shall serve as verification of enrollment until the member from the BHTPA receives a membership/enrollment card.

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

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

### **50.110 Responsibilities of the BHTPA**

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

Upon receipt of the information from DHS, the plan shall enroll the member and perform the necessary procedures to ensure that the member is provided access to care. The following describes the responsibilities of the BHTPA upon enrollment of a member. The listing is not all-inclusive and DHS may require the plan to perform other tasks as determined necessary. The

BHTPA may also add steps based upon its experiences and the procedures already performed for its members.

- ❑ Assign a member number to the member
- ❑ Assign a care coordinator/case manager to each member on the date of enrollment
- ❑ Explain the role of the care coordinator/case manager to the member and the procedures to be followed to obtain needed services. Provide the member with a listing of the providers. Orient and familiarize, then provide each member with a member handbook which explains the operations of the plan including the procedures to follow to make an appointment, obtain emergency services, change BHTPA providers or prescribing psychiatrist, member rights and responsibilities, file a complaint and grievance procedures, etc.
- ❑ Assist the member in the selection of a BHTPA provider and explain the role and responsibilities of the BHTPA provider and/or the CC/CM, as applicable and the procedures to be followed to obtain needed services. If the member does not select a BHTPA provider from the BHTPA provider network within ten (10) days of enrollment, the BHTPA shall select a BHTPA provider for the member
- ❑ Explain the confidentiality policies related to the member's case documentation records (includes treatment records)
- ❑ Explain to the member the information that needs to be provided by the member to the BHTPA and DHS upon changes in the status of the member including marriage, divorce, birth of a child, adoption of a child, death of a spouse or child, acceptance of a job, obtaining other health insurance, etc.

- Issue membership card(s) to the enrolled members with adequate information for providers to identify the following:
  - Member number
  - Member name
  - Effective date
  - Benefit or other limits (if applicable) e.g. behavioral health services only
  - Crisis hotline
  - Toll-free telephone number
  - Third Party Liabilities (TPL's)

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

#### 50.120 Collection of Member's Share of Premiums and Spenddowns

Members shall present verification of their monthly premium share payments to DHS. Upon verification of the monthly share payment, a membership/enrollment card will be issued to the member for the remaining portion of the month.

#### 50.130 Eligibility Verification

DHS shall provide a Provider Hotline for eligibility verification. Providers may call (808) 692-7360 for a verbal verification, or fax a request for information to the Med-QUEST Call Center at (808) 692-7186.

A procedure will be developed after the contract award and before implementation to insure confidentiality of recipient eligibility information.

#### 50.200 Disenrollment

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

- Member no longer qualifies based on the eligibility criteria for the Medicaid program or voluntarily leaves the program
- Member no longer meets SMI eligibility determination criteria
- Member moves to another State
- Member does not pay the required QUEST medical, or catastrophic premiums
- Death of the member
- Incarceration of the member
- Transfer of the member to a long term care nursing facility or an ICF-MR facility when the behavioral health care needs of the member will be assumed by the facility
- Member is waitlisted at an acute hospital for a long term care bed and the behavioral health care needs of the member will be assumed by the facility.
- Member becomes a PACE participant
- Member becomes Medicare eligible and chooses to disenroll from the BHTPA.
- Member is sent out-of-state for medical treatment by DHS or a health plan and DHS or the health plan will assume responsibility for the behavioral health care needs of the member.
- Member is admitted to the State Hospital
- Member provides false information with the intent of enrolling in QUEST under false pretenses

Members disenrolled for non-payment of premiums shall not be eligible for re-enrollment until three (3) months have elapsed and shall be required to pay all delinquent premiums in arrears to qualify for re-enrollment.

In most cases, the eligibility workers become aware of a situation which required action (i.e., member moves to the mainland or person fails to pay his/her premium) and the person is disenrolled from the BHTPA. In other instances, the plan may become aware of circumstances that could affect a person's eligibility. The BHTPA is encouraged to bring these situations to the attention of the eligibility worker. Examples of such situations include the member's death, incarceration, State

Hospital admission, or eligibility for Medicare. DHS shall provide disenrollment data to the BHTPA via electronic media on a daily and monthly basis.

#### 50.210 Members Who No Longer Meet the Criteria for SMI

Members who are enrolled in the BHTPA and who the BHTPA determines to no longer meet the criteria for SMI shall be referred to the MQD. The MQD shall determine whether the member no longer meets the criteria using the same process described in Subsection 31.120, Evaluation and Referral to the BHTPA.

If the member no longer meets the criteria for enrollment in the BHTPA, they shall be disenrolled from the BHTPA at the end of the month in which the determination is made and responsibility for care is assumed by the QUEST medical plan or the fee-for-service program. The QUEST medical plan or the fee-for-service program shall receive written notification of the disenrollment from the BHTPA. Upon disenrollment from the BHTPA, the QUEST medical plan or the fee-for-service program assumes responsibility for providing the medically necessary mental health, drug abuse, and alcohol abuse services needed by the individual within the established limits specified in Subsection 30.570, QUEST Medical plan: Behavioral Health Coverage.

#### 50.220 Option to Disenroll upon Medicaid Fee-For-Service or Medicare Eligibility Determination

Individuals can be eligible for and participate simultaneously in Medicaid and Medicare. Currently, dually eligible Medicaid/Medicare members maintain the ability to receive services from any qualified Medicare service providers. At the time of conversion of the ABD population into QUEST, dual eligible persons who are SMI will retain the option of enrolling into the BHTPA. If the BHTPA is not selected, then the person will remain in the fee-for-service program.

Members of the BHTPA who become Medicare eligible will have the option of remaining in the plan or reverting to the Medicaid fee-for-service program. The BHTPA should routinely review their membership rolls to identify members who are close to being Medicare eligible. Shortly before a member reaches sixty-

five (65) years of age, DHS shall notify the member in writing of their option to disenroll, or remain in the BHTPA. The BHTPA shall treat Medicare as a third party liability and the DHS shall reimburse the BHTPA as described in Section 40.300.

If the member, after being informed of their option to disenroll, elects to remain in the BHTPA, the plan will not be held financially responsible for reimbursements to providers outside of the established/allowed provider network for services rendered to the dually eligible member. The BHTPA shall properly inform the member of proper use of the BHTPA services.

## **50.300 Room and Hospital Admissions**

### **50.310 Determination of Eligibility**

The BHTPA shall provide access for plans and providers to verify eligibility (for individuals in situations in which they are unable to provide such information i.e., when admitted to an emergency facility or hospital), 24-hours a day, 7 days a week, to confirm enrollment, identify care coordinator/case manager assignments, and provide other pertinent information.

For situations where a member is provided emergency psychiatric services or admitted, and access to the BHTPA hotline is not in service, the psychiatric facility or hospital shall ascertain eligibility verification on the first day when the systems are available.

If the emergency facility or hospital to which a BHTPA member is admitted is not a contracted provider with the member's plan, the facility or hospital shall inform the member's plan of the member's admission within 24-hours of identifying that the member is enrolled with the BHTPA.

### **50.320 Emergency Room**

The BHTPA is required to provide reimbursement for psychiatric emergency services regardless of contract status (i.e., whether or not the emergency room has a contract with the BHTPA). Section 4704 of the Balanced Budget Act (BBA) added

§1932(b)(2) to the Social Security Act. The definition of an emergency is defined in Subsection 40.800.

Emergency services includes inpatient and outpatient services that are needed to evaluate or stabilize an emergency behavioral health condition that is found to exist using a prudent layperson's standard. These services must be provided by a provider that is qualified to provide such services under Medicaid. Once the individual's condition is considered stabilized, the BHTPA may require authorization for hospital admission or follow-up care. Additionally, the BHTPA must comply with the guidelines for coordinating post-stabilization care established under Medicare Part C. If the BHTPA fails to cover emergency screening or stabilization services, it may be subject to intermediate sanctions or termination as outlined in Section 1932(e) of the Social Security Act.

Coverage of emergency services extends to coverage of services required in order to determine whether an emergency exists. Therefore, the BHTPA is required, at a minimum, to provide reimbursement for both facility and professional services associated with emergency room screening and assessment. The BHTPA may not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency behavioral health condition under the prudent layperson's standard, turned out to be non-emergency in nature. The BHTPA may not require prior authorization for emergency services. This applies to out-of-network as well as in-network services that a beneficiary seeks in an emergency.

When emergency services are provided to an enrollee, the BHTPA is liable for payment as follows:

#### Presence of a clinical emergency

If the screening examination leads to a clinical determination by the examining physician that an actual emergency behavioral health condition exists, the BHTPA must pay for both the services involved in the screening examination and the services required to stabilize the patient.

#### Emergency Services Continue Until the Patient Can Be Safely Discharged or Transferred

The BHTPA is required to pay for all emergency services, which are medically necessary, until the clinical emergency is stabilized. This includes all treatment that may be necessary to assure, within reasonable medical probability, that no material deterioration of the patient's condition is likely to result from, or occur during, discharge of the patient or transfer of the patient to another facility.

If there is a disagreement between a hospital and the BHTPA concerning whether the patient is stable enough for discharge or transfer, or whether the medical benefits of an unstabilized transfer outweigh the risks, the judgment of the attending physician(s) actually caring for the beneficiary at the treating facility prevails and is binding on the BHTPA. The BHTPA may establish arrangements with hospitals whereby the BHTPA may send one of its own physicians with appropriate ER privileges to assume the attending physician's responsibilities to stabilize, treat, and transfer the patient.

#### Absence of a Clinical Emergency

If the screening examination leads to a clinical determination by the examining physician that no actual emergency behavioral health condition exists, then the determining factor for payment liability should be whether the beneficiary had acute symptoms of sufficient severity at the time of presentation. In these cases, the BHTPA must review the presenting symptoms of a beneficiary including prescription medication and must pay for all services involved in the screening examination where the presenting symptoms (including severe pain) were of sufficient severity to have warranted emergency attention under the prudent layperson's standard. If under the prudent layperson's standard the services are determined to be non-emergent, the BHTPA is obligated, at a minimum, to pay for the emergency room screening and assessment services.

#### Referrals

When a beneficiary's behavioral health provider or other plan representative instructs the beneficiary to seek emergency care in-network or out-of-network, the BHTPA is responsible for payment for the behavioral health examination and for other medically necessary behavioral health services, without regard

to whether the patient meets the prudent layperson standard described above.

The BHTPA is responsible for educating its members on the appropriate use of the emergency room.

#### **50.400 Assessment and Collection of Fees and Penalties**

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

#### **50.500 Third Party Liabilities**

##### 50.510 Definition

Third Party Liability (TPL) means any individual, entity or program that is or may be liable for all or part of the expenditures for furnished medical assistance. The application of TPL's is based on §1902(a)(25) of the Social Security Act that requires that State Medicaid agencies take all reasonable measures to identify legally liable third parties and treat verified TPL's as a resource of the Medicaid applicant or member.

##### 50.520 Reimbursement from Third Parties

DHS shall be responsible for coordination and recovery of accident and workers' compensation subrogation benefits involving QUEST members. The BHTPA shall seek reimbursement from all other reliable third parties to the limit of legal liability for the behavioral health services rendered. The TPL amounts collected and retained by the BHTPA shall be offset from the reimbursement amount as described in Section 40.300.

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

## 50.530 Responsibilities of DHS and the BHTPA

DHS shall:

- Collect and provide member TPL information to the BHTPA
- Be responsible for coordination and recovery of accident and workers' compensation subrogation benefits

The BHTPA shall coordinate behavioral health care benefits with other TPL's or organizations, both public and private, which are or may be available to pay medical expenses on behalf of any members including:

- Continuing cost avoidance of the behavioral health services through Pursuit of accident and workers compensations benefits.
- Reporting all accident cases incurring behavioral health expenses in excess of \$500 to DHS
- Providing a list of behavioral health expenses, in the format requested by DHS, for recovery purposes
- Recovering behavioral health expenses incurred by members from all other TPL resources
- Informing DHS of TPL information uncovered during the course of normal business operations
- Providing DHS with monthly reports of the total cost avoidance and amounts collected from TPL's within 30 working days of the end of the month
- Developing procedures for determining when to pursue TPL recovery

## 50.600 Quality Improvement

### 50.610 Importance of Quality Improvement

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

compromised. The importance of the QIP is emphasized in federal regulations which require each health maintenance organization (HMO), Prepaid Health Plans (PHP's) and Health Insuring Organizations (HIO's) which contract with the State Medicaid agencies to have in place an internal QIP.

QIP's provide the BHTPA with a means of ensuring the best possible outcomes and functional health status of its members through delivery of the most appropriate level of care and treatment. QIP's include such important areas as utilization reviews, grievance procedures, and the maintenance of medical records. Quality care is defined as care that is accessible and efficient, provided in the appropriate setting, provided according to professionally accepted standards, and provided in a coordinated and continuous rather than episodic manner.

Quality care includes but is not limited to:

- Provision of services in a timely manner with reasonable waiting times for office visits and the scheduling of appointments
- Provision of services in a manner which is sensitive to the cultural differences of members
- Provision of services in a manner which is accessible for members
- Opportunities for members to participate in decisions regarding their care
- Emphasis on health promotion and prevention as well as early diagnosis, treatment, and health maintenance
- Appropriate use of services in the provision of care by providers
- Appropriate use of technology in the provision of care by providers
- Appropriate documentation, in accordance with defined standards, of the assessment and treatment of patients

- ❑ Provision of services in a manner which reflects standards of good practice
- ❑ Improved clinical outcomes and enhanced quality of life
- ❑ Consumer satisfaction
- ❑ User friendly grievance procedures which resolve issues in a timely manner

#### 50.620 Quality Improvement Programs

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

The BHTPA shall be required to submit written descriptions of its QIP including definitions of accepted standards of practice and established policies and procedures. The documentation shall be provided to DHS for review prior to selection of the BHTPA and upon request by DHS.

The QIP shall, at a minimum, be consistent with and incorporate the required components as specified in the "Standards for Internal Quality Improvement Programs of HMOs, HIO's, and PHP's Contracting with Medicaid" as published by the U.S. Department of Health and Human Services, Health Care Financing Administration, Medicaid Bureau. (Refer to a copy of the document in the Documentation Library)

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

- ❑ Written QIP Description – The QIP shall be a written document describing the following:
  - Goals and objectives
  - Scope of the QIP
  - Specific activities to be undertaken such as studies
  - Continuous activity and tracking issues
  - Provider review

- Focus on behavioral health outcomes
  - Systematic process of quality assessment and improvement
  - Evaluation of the continuity and effectiveness of the QIP
- ❑ Accountability of the Governing Body – The governing body of the organization, usually the Board of Directors, shall be responsible for the quality of care provided. The responsibilities of the governing body include oversight of the QIP, review of the progress of the QIP, and modifications to the program as needed.
  - ❑ Active QIP Committee – The Committee shall have regular meetings; document its activities, finding and recommendations and ensure follow-up; be accountable to the governing body, and have a cross section of BHTPA providers.
  - ❑ QIP Supervision – The QIP Committee should be the responsibility of a senior executive and the Medical Director should have substantial involvement
  - ❑ Adequate Resources – The QIP Committee should be provided with sufficient material resources to carry out its activities
  - ❑ Provider Participation in the QIP – Providers shall be kept informed about the written QIP and all subcontracts and agreements with providers shall require cooperation and access to medical records
  - ❑ Delegation of QIP Activities - The BHTPA shall remain responsible for the QIP even if portions are delegated to other entities. Any delegation of functions requires a written description of the delegated activities and written procedures for monitoring and evaluation
  - ❑ Credentialing and Recredentialing - The QIP shall contain provisions to assure that the behavioral healthcare practitioners are properly licensed and qualified to provide services to the BHTPA recipients. The credentialing and recredentialing policies and procedures shall be written and

approved by the governing body or designee and a credentialing committee shall be designated.

- Member Rights and Responsibilities – The QIP shall have written policies and procedures that state the plan’s commitment to treating members in a manner that respects their rights as well as its expectation of members’ responsibilities.

The policies and procedures shall include the plan’s internal grievance procedures. All grievances should be resolved within 30 days of the receipt of the complaint or grievance. Grievance procedures are mandated by State and Federal laws and help to ensure quality of care and an effective delivery system, therefore grievance procedures shall be user friendly and time sensitive. The procedures shall provide a process for disputes and disagreements between all parties to include, the member, the BHTPA, and the providers. The procedures shall be well documented and subject to the written approval of DHS, prior to its implementation.

The plan is responsible for providing written notification to the member of any adverse grievance decision and shall include notification to the member of his/her right to an administrative hearing with the Administrative Appeals Office (AAO) of DHS. Decisions of the AAO in favor of the member shall be binding upon the plan.

- Standards for Availability and Accessibility – The QIP shall have established standards for access to services, which are to be compared to the plan’s actual performance. Access and availability include standards for triage and travel time, telephone access and availability of appointments, which define the level of urgency and appropriate level of care.
- Case Documentation Records Standards – The QIP shall establish standards for the accessibility and availability of case documentation records and the information to be recorded and maintained in the records. A record review system to assess and assure conformance with standards shall be established.

- At a minimum, the treatment record shall be maintained by the BHTPA provider and include a record of the member's medical and treatment history, all behavioral healthcare services provided to the member, assessments (including telephone assessments), medication profile (current and historical), treatment plans, and goals for future clinical care. The treatment record shall indicate the current BHTPA provider, other service provider(s), and history of changes in psychiatrist and other providers, as well as referrals for related specialist care and behavioral health services authorized by the BHTPA provider and/or CC/CM.

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

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

Approval is also not needed for access by authorized DHS personnel or personnel contracted by DHS. (Refer to Subsection 60.900, Confidentiality of Information, for additional information)

- Utilization Review – The QIP shall include a written description of the plan’s utilization management (UM) program which outlines the program structure and accountability. The scope of UM may include formal preauthorization, triage, concurrent review, discharge planning, retrospective review and case management. The UM plan includes policies and procedures to evaluate care management, sites of service, level of care, triage, benefit coverage and cost of benefits to determine if they are clinically appropriate to the behavioral healthcare needs of the members.
  - The program should include evaluating medical necessity, the criteria used and the process used to review and approve the provision of clinical services. The focus of the UM program is to detect underutilization, overutilization, and inappropriate utilization.
  - The Plan shall have in place a prior authorization (PA) process that ensures timely determination for access to care/services. Individuals shall perform PA determinations with demonstrated competency and knowledge of appropriate treatment/services for conditions/illnesses. The Plan shall have a process with timeframes that address PA decision-making for behavioral health services/procedures that the BHP determines to be medically necessary. The Plan may have different processes for emergencies, urgent, or non-urgent services but in general, all PA's must be completed within 30 days. The PA and the related appeals process shall be documented and made available to all participating providers and submitted as part of this proposal.
  - Concurrent review requirements shall be documented and available to appropriate providers

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

#### 50.630 Responsibilities of the Plan

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

The plan shall conduct its own utilization reviews. DHS requires that data and information be submitted so that DHS can conduct its own internal audit and monitoring of the QIP of the BHTPA. Once the plan's QIP is approved by DHS, the internal review by DHS will primarily ensure the QIP is being administered and followed. DHS reserves the right to review the detailed records of the plan as it deems necessary. The plan shall also provide whatever records and information requested by the contractor selected by DHS to perform an independent external audit of the BHTPA.

### **50.700 Monitoring and Evaluation**

#### 50.710 Internal QIP Monitoring

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

DHS will evaluate specific aspects of the QIP by a variety of methods. It will review complaint and grievance logs, evaluate

complaints from advocacy groups, providers, agencies, and members/representatives, validate that QIP utilization management, concurrent review, and prior authorization procedures are being implemented with an understanding of the behavioral health benefits allowed under QUEST and taking into consideration the medical necessity of the services for the member. Also, DHS will evaluate whether procedures to ensure access to care, continuity of care and coordination of care and other QIP activities which are part of the plan's written QIP are being implemented.

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

#### 50.720 External Monitoring

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

#### 50.730 Conduct Surveys

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

The survey instruments shall be developed by DHS with input from the BHTPA. The DHS shall share the results of the survey

with the BHTPA. Participation in the DHS surveys will not preclude the plan from conducting its own surveys.

50.740 Conduct Case Study Interviews

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

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

50.750 CMS Contracted Review Organization

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

## **50.800 Reporting Requirements**

### 50.810 Purpose for Data to be Collected

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

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

### 50.820 Timeliness of Data Submitted

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

### 50.830 Compliance with the Health Insurance Portability and Accountability Act

It is expected that the implementation of the ASC X12N standard will occur during the contract period. The BHTPA shall implement the electronic transaction standards and other "Administrative Simplification" provisions of the Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-91, as specified by CMS.

### 50.840 Chain of Trust Partner Agreement

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

The Behavioral Health Managed Care plan shall institute chain of trust agreements, in compliance with HIPAA, with any parties with whom it will be providing or sharing electronic health information.

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

A Chain of Trust Agreement is a proxy for actual physical confirmation. Therefore it is important that the parties to these contracts agree to security mechanisms that:

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

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

## **50.900 MQD Information Systems**

To effectively and efficiently administer the programs, the DHS has implemented the Hawaii Prepaid Medicaid Management Information Systems (HPMMIS). HPMMIS is an integrated system that supports the administration of the program. The major functional areas of HPMMIS include:

- Receiving daily eligibility files from Hawaii Automated Welfare Information Systems (HAWI) and processing enrollment/disenrollment of members' into/from the health plans based on established enrollment/disenrollment rules;
- Processing member health plan choices submitted to the MQD enrollment call center;
- Producing daily enrollment/disenrollment rosters; monthly enrollment rosters; and TPL rosters;
- Processing monthly encounter submissions from health plans and generating encounter error reports for health plan correction. Accepting and processing monthly health

plan provider network submissions to assign QUEST provider IDs for health plan use. Errors associated with these submissions are generated and returned to the health plans on a monthly basis for correction;

- Monitoring the utilization of services provided to the members by the health plans and the activities or movement of the members within and between the health plans;
- Monitoring the activities of the health plans through information and data received from the health plans and generating management reports;
- Determining the amount due to the health plans for the monthly capitated rate for enrolled members;
- Producing a monthly provider master registry file for the health plans to use for assigning QUEST provider IDs to health plan providers for the purpose of submitting encounters to DHS;
- Generating the required CMS reports; and
- Generating management information reports.

Receiving/transmitting of data files between the health plans and HPMMIS is done via the MQD FTP file server. The MQD requires that health plans install the DHS approved Virtual Private Network (VPN) software that is provided to the health plan free of charge. The VPN software allows the MQD and health plans to securely transfer member, provider, and encounter data via the internet.

The MQD also operates the Premium Share Billing system that administers the billing and collection of the members' share of their monthly premium rate when applicable.

In addition, the MQD, through its fiscal intermediary, processes Medicaid fee-for-service payments in the Medicaid fee-for-service program utilizing HPMMIS.

The HPMMIS processes and reports on Medicaid fee-for-service payments. This includes dental services for the QUEST program population and Medicaid fee-for-service payments that are authorized under the program. The HPMMIS and reporting subsystems provide the following:

- Member processing (ID cards, eligibility, buy-in, etc.);

- Claims processing (input preparation, electronic media claim capture, claim disposition, claim adjudication, claim distribution, and payments);
  - Provider support (certification, edit and update, rate change, and reporting);
  - Management and Administrative Reporting Subsystem (MARS) and Surveillance and Utilization Reporting Subsystem (SURS) reports;
  - Reference files for the validation of procedures, diagnosis, and drug formularies; and
- Other miscellaneous support modules (TPL, EPSDT, DUR, MQC, etc.).

### **51.100 Encounter Data Requirements**

Based on the terms and conditions of CMS, the State will be required to submit reports on the utilization of health services. The BHTPA shall submit encounter data in accordance with the requirements and specifications defined in this RFP and in the QUEST Health Plan Manual. Payments for direct services and case management services costs are subject to review of appropriate encounter data as described in Section 40.300.

#### **51.110 Accuracy, Completeness and Timeliness of Encounter Data**

CMS is requiring in its terms and conditions that all information required from the BHTPA are accurate, complete, and provided by the deadlines specified. CMS authorizes the State to impose financial penalties or sanctions on the plans for inaccurate, incomplete, and late submissions of required data, information and reports. The State shall impose the specified sanctions to emphasize the importance and need for the data. Any financial sanctions imposed on the BHTPA shall be deducted from the subsequent month's payment to the plan. The amount of the total sanction for the month shall not exceed 10% of the monthly capitation payment.

- ❑ Timeliness – 80% of encounter data shall be received by DHS no more than 120 days from the date that services were rendered and 100% within 15 months.

Timeliness involves the period of time between the date of service and the provision of the encounter data to DHS and the period of time between the deadline for submission of

the data and the date the data is provided. The period of time allowed between the date of service and the provision of the encounter data to DHS is 80% within 120 days after the date the service is rendered and 100% within 15 months. Encounter adjustments will not be counted in the 120 days.

The plan may, in turn, sanction its subcontractors and providers if the required encounter data is not provided to the plan within the timeframe established by the plan. The required encounter data shall be provided to DHS by the specified deadline.

- Accuracy and Completeness – The data and information provided to DHS shall be reasonably accurate and complete. Data and reports shall be mathematically correct and present accurate information. An accurate encounter is one that reports a complete and accurate description of the service provided.

All requested data and information shall be complete with no material omissions. Encounter data is not complete if the data has missing or incomplete field information.

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

The BHTPA may file a written challenge to the sanctions with DHS not more than 30 days after the BHTPA receives written notice of the sanction. Challenges will be considered and decisions made by DHS no more than 60 days after the challenge is received by DHS. Sanctions are not refundable unless challenged by the BHTPA and decided in the favor of the BHTPA.

The BHTPA shall continue reporting encounter data beyond the term of the contract as processing and reporting of the data is

likely to continue due to lags in time in filing source documents by subcontractors and providers (refer to the Documentation Library for additional information on the sanctions).

## **51.200 Quality Assurance Reporting**

The QA reporting requirements provide 1) information on the activities and actions of the plan's QA and related programs and 2) performance measures. The objectives of the performance measures are: 1) to standardize how the plan specifies, calculates and reports information; and 2) to trend a plan's performance over time and to identify areas in need of improvement.

### **51.210 Required Quality Improvement Program Activities Reports**

The plan shall provide the following reports and information:

- Written notification of any QIP modifications, including personnel changes.
- Written notification of any delegation of QI activities to contractors
- Notification of lawsuits, license suspensions or other actions brought against the plan or a provider as soon as possible, but no later than five working days after the plan is made aware of the event.
- Report of the QIP evaluation reviews conducted at least annually. At a minimum, these reports shall include the following:
  - Number of cases selected for medical necessity review, and for quality of care review. Minimum data for each case selected for review shall include 1) date of service; 2) type of service; and 3) name, age, and diagnosis.
  - Results of the reviews as well as specific findings and recommendations must be included
  - Notice of any suspected member or provider fraud or abuse and the status of any investigations.
  - Participation with monitoring activities designated by DHS.

- Quarterly utilization reports as specified by the State (Refer to Appendix J). Reports are due within 90 days following the end of the prior quarter to the MOD Medical Director. Details on this information will be provided to the winning BHTPA bidder.
- Quarterly report on complaints, appeals, and grievances from members and providers and the number of adverse actions/decisions made, number of appeals and the outcomes of the appeals. The information shall be provided using the format established by DHS.
- Notice of any suspension and/or termination of a practitioner, and the reason(s) for such actions.
- The report on complaints and grievances are due quarterly and are due to DHS within 60 days of the close of the quarter/year. Any changes to the plan's QIP activities and reviews, and notices of any suspension and/or termination of a practitioner and the reason (s) for such actions shall be reported to the State as soon as possible.

#### 51.220 HEDIS and Other State Required Reports

The BHTPA is responsible for submitting reports as specified by DHS. State specified reports will be described to the plan.

#### **51.300 Financial Information**

The BHTPA shall submit financial information on a regular basis in accordance with the QUEST Financial Reporting Guide. DHS reserves the right to increase the frequency of financial reporting by the BHTPA. At a minimum, the BHTPA must submit all quarterly and annual reports in the formats prescribed in the QUEST Financial Reporting Guide. Additionally, other information specified in the QUEST Financial Reporting Guide must be submitted annually. The financial information shall be analyzed and compared to industry standards and standards established by DHS to ensure the financial solvency of the BHTPA. DHS may also monitor the financial performance of the BHTPA with on-site inspections and audits.

The QUEST Financial Reporting Guide is located in the Documentation Library.

## **51.400 Notification of Changes in Member Status**

### 51.410 Member and Plan Responsibilities

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

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

### 51.420 Changes in Member Status

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

- Death of the member or family member (spouse or dependent)
- Marriage
- Divorce
- Adoption
- Change in status (i.e., no longer meets the criteria for persons who are SMI)
- Change in address (i.e., moved out of state)
- Institutionalization (i.e. imprisonment or long term care facility)
- TPL coverage, especially employer-sponsored or Medicare

## 51.500 Educational Materials

### 51.510 DHS Responsibilities

DHS shall develop materials and presentations to education the members on the:

- Differences between the existing fee-for-service program and the new managed care program
- BHTPA services to be provided
- Eligibility criteria
- Enrollment criteria
- Payment of premium share
- Role of DHS and the BHTPA
- Appeals process

### 51.520 Plan's Responsibilities

A booklet or pamphlet shall explain in more detail the procedures to be followed by the member and the responsibility of the member. It shall be provided to each member.

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

- Role and selection of a BHTPA provider
- CC/CM system: role and selection of a CC/CM and how to access CC/CM services
- Changing behavioral health providers
- Making an appointment
- What to do in an emergency (regardless of service area)
- Reporting changes in status and family composition
- Reporting of a third party liability
- Reporting complaints or grievances
- Toll-free number to call for questions and assistance and 24 hour crisis line
- Using the membership card
- Penalties for fraudulent activities
- Out-of-state or off-island behavioral health services
- Confidentiality of member information
- Information on individuals rights as it pertains to the Health Care Privacy Act
- Failure to pay for non-covered services will not result in loss of Medicaid benefits

- Availability of Ombudsman Program services for ABD members

The booklets or pamphlets shall be prepared in at least the following languages. The plan shall certify that the transcription of the information to different languages has been reviewed by a qualified individual for accuracy:

- English
- Ilocano/Tagalog
- Chinese
- Samoan
- Vietnamese
- Korean
- Japanese

51.530 DHS Review of Materials

All printed materials, video presentations, and any other information prepared by the BHTPA that pertain to or reference the plan shall be reviewed and approved by DHS before use by the plan. The plan shall not advertise, distribute, or provide any materials relating to the BHTPA that have not been approved by DHS to the members. The plan shall not change the materials without the consent of DHS.

## **SECTION 60                    TERMS AND CONDITIONS**

### **60.100      General**

This RFP, appendices, any amendments to the RFP and/or appendices, and the offeror's proposal submitted in response to this RFP form an integral part of the contract between the offeror and DHS. In exchange for services, payment from DHS for monthly administration costs (claims payment, enrollment, TPL), will be paid to the BHTPA. The BHTPA shall also be reimbursed for costs of direct services and case management services as described in Section 40. 300. The Contractor agrees to provide behavioral health care benefits as described in this RFP. The Contractor shall perform all of the services and shall develop, produce and deliver to DHS all of the data requirements described in this RFP. DHS shall make payment as described in this RFP.

QUEST Policy Memoranda are issued primarily to clarify policy or operational issues with the plans. The Contractor shall comply with the requirements of the policy memoranda and sign each memorandum as it is issued to acknowledge receipt and intention to implement.

In the event of a conflict between the language of the contract, and applicable statutes and regulations, the latter shall prevail. In the event of a conflict among the contract documents, the order of precedence shall be as follows: (1) Agreement (form AG Form 103F-Comp (9/06)), including all general conditions, special conditions, attachments, and addenda; (2) the RFP, including all attachments and addenda; and (3) Offeror's proposal. In the event of a conflict between the General Conditions and the Special Conditions, the Special Conditions shall control. The sections of the rules and regulations cited in this RFP may change as the rules and regulations are amended for MQD. No changes shall be made to this RFP due to changes in the section numbers. The documents in the documentation library shall be changed as needed. The availability and extent of the materials in the documentation library shall have no effect on the requirements stated in this RFP.

The Contractor shall comply with all laws, ordinances, codes, rules and regulations of the federal, state and local governments

that in any way affect its performance under this contract. The standard State general conditions found in Appendix C shall be incorporated into and become part of the contract between the contractor and DHS.

The Contractor shall pay all taxes lawfully imposed upon it with respect to the contract or any product delivered in accordance herewith. DHS makes no representations whatsoever as to the liability or exemption from liability of an offeror to any tax imposed by any governmental entity.

An offer shall be executed by the Hawaii Department of Human Services in accordance with Chapter 103F, HRS.

## **60.200 Term of the Contract**

This is a multi-term contract solicitation that has been deemed to be in the best interest of the State by the Director of the DHS. The contract is for the initial period of November 1, 2007 and shall continue until June 30, 2010.

The contract period shall be for a period of two years and eight months to provide for continuity of services to the recipients. In addition, DHS shall have the option to extend the contract beyond the initial term without the necessity of re-bidding, for not more than one (1) additional twelve (12) month period upon mutual agreement in writing, at least sixty (60) days prior to expiration of the contract, provided that the contract price for the extended period shall remain the same or lower than the initial bid price or as adjusted in accordance with the contract price adjustment provision herein. Funds are available for only the initial term of the contract, and the contractual obligation of both parties in each fiscal period succeeding the first initial term is subject to the appropriation and availability of funds to DHS.

The Offeror acknowledges that other unanticipated uncertainties may arise that may require an increase in the original scope of services from the Contractor awarded this contract. In the event that additional services may be required, the Contractor agrees to enter into a supplemental agreement upon request by the State for the additional work. The supplemental agreement may also include an extension of the period of performance and a respective increase in the compensation.

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

**60.210 Availability of Funds**

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

**60.300 Contract Changes**

Any modification, alteration, amendment, change or extension of any term, provision, or condition of the contract shall be made by written amendment signed by the contractor and the State. No oral modification, alteration, amendment, change or extension of any term, provision or condition shall be permitted, except as otherwise provided within this RFP.

All changes to the scope of services for behavioral health services to be provided by the contractor shall be negotiated. If the parties reach an agreement, the contract terms shall be modified accordingly by a written amendment signed by the Director of the DHS and an authorized representative of the contractor. If the parties are unable to reach an agreement within thirty (30) days of the contractor's receipt of a contract change, the MQD Administrator shall make a determination as to the revised price, and the contractor shall proceed with the work according to a schedule approved by the DHS, subject to the contractor's right to appeal the MQD Administrator's determination of the price.

The State may, at its discretion, require the contractor to submit to the State, prior to the State's approval of any modification, alteration, amendment, change or extension of any term, provision, or condition of the contract, a tax clearance from the Director of DOTAX, State of Hawaii, showing that all delinquent taxes, if any, levied or accrued under State law against the contractor have been paid.

#### **60.400 General and Special Conditions of Contract**

The general conditions found in Appendix C will become part of the contract between the contractor and the State. Special conditions may also be imposed contractually by the state purchasing agency, as deemed necessary.

#### **60.500 Offeror Progress**

##### 60.510 Offerors Reporting

On-site reviews will be conducted by DHS to verify the accuracy and appropriateness of information provided by offerors in their proposals. If awarded a contract, the contractor shall submit a plan for implementation of behavioral health services and shall provide progress/performance reports every two weeks beginning two weeks after the notification of contract award. The format to be used shall be approved by DHS. The purpose of the reports is to ensure that the BHTPA will be ready to enroll recipients as of November 1, 2007, and that all required elements such as the QIP are in place.

##### 60.520 Inspection of Work Performed

DHS, CMS, the State Auditor of Hawaii, the U.S. Department of Health and Human Services (DHHS), the General Accounting Office (GAO), the Comptroller General of the United States, the Office of the Inspector General (OIG), Medicaid Fraud Control Unit of the Department of the Attorney General or their authorized representatives shall, during normal business hours, have the right to enter into the premises of an offeror and/or all subcontractors and providers, or such other places where duties under the contract are being performed, to inspect, monitor, or otherwise evaluate the work being performed. All inspections and evaluations shall be performed in such a manner as to not unduly delay work. The Contractor(s), Subcontractor(s) and

Providers shall provide information and data, upon demand, to the DHS, any of the above named agencies, and their authorized representatives. The requested information or data shall be provided to the requesting agency(s) within a reasonable timeframe that will be determined by the DHS, but which shall be no less than five (5) calendar days.

60.530 Subcontracts/Provider Agreements

The contractor is allowed to negotiate and contract or enter into contracts or agreements with providers and other subcontractors (with prior written consent of the State) to the benefit of the offeror as long as the providers and subcontractors meet all established criteria and provide the services in a manner consistent with the minimum standards specified. All such agreements shall be in writing and shall specify the activities and responsibilities delegated to the subcontractor. The contracts must also include provisions for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. Certain subcontracts, including but not limited to Quality Assurance activities, must be approved by DHS prior to implementation. DHS reserves the right to inspect all subcontract and provider agreements at any time during the contract period. Any subcontract may be subject to the DHS's prior review and approval. The contractor's subcontractor shall submit to the contractor a tax clearance certificate from the Director of the Department of Taxation, State of Hawaii, showing that all delinquent taxes, if any, levied or accrued under State law against the subcontractor/provider have been paid.

No subcontract or agreement that an offeror enters into with respect to the performance under this contract shall in any way relieve an offeror of any responsibility for any performance required of it by this contract. The contractor shall provide DHS immediate notice in writing by registered or certified mail of any action or suit filed against it by any subcontractor or provider, and prompt notice of any claim made against an offeror by any subcontractor or provider which in the opinion of the offeror may result in litigation related in any way to the contract with the State of Hawaii. The contractor shall designate itself as the sole point of recovery for any subcontractor or provider.

The contractor shall notify DHS at least fifteen days prior to adding or deleting provider or subcontractor agreements or

making any change to any provider or subcontractor agreements which may materially affect the offeror's ability to fulfill the terms of this contract.

All agreements or contracts with the subcontractors or providers shall be finalized and fully executed within 30 days of the contract award. DHS reserves the right to review any subcontractor or provider contracts or agreements prior to the notification of award of the contract.

All subcontracts shall require that the subcontractors/providers agree to comply with the confidentiality requirements imposed by this RFP, to the extent subcontractors or providers render services or perform functions that make such provisions applicable to such agreements.

**60.600 Reinsurance**

The BHTPA may obtain reinsurance for its costs for BHTPA members.

**60.700 Applicability of Hawaii Revised Statutes**

60.710 Wages, Hours and Working Conditions of Employees Providing Services

Services to be performed by the contractor and its subcontractors or providers shall be performed by employees paid at wages or salaries not less than the wages paid to public officers and employees for similar work. Additionally, the contractor shall comply with all applicable laws of Federal and State government relative to workers compensation, unemployment compensation, payment of wages and safety. The contractor shall complete and submit the Wage Certification as provided in Appendix I pursuant to §103-55, HRS.

60.720 Standards of Conduct

The contractor shall execute the Provider's Standards of Conduct Declaration, a copy of which is found in Appendix E, and which shall become part of the contract between the contractor and the State

60.730 Campaign Contributions by State and County Contractors

Contractors are hereby notified of the applicability of Section 11-205.5, HRS, which states that campaign contributions are prohibited from specified State of county government contractors during the term of the contract if the contractors are paid with funds appropriated by a legislative body. For more information, Act 203/2005 FAQs are available at the Campaign Spending Commission webpage. See [www.hawaii.gov/campaign](http://www.hawaii.gov/campaign).

**60.800 Fraud and Abuse/Neglect**

Through its monitoring activities, the BHTPA should identify providers who may be committing fraud and/or abuse. The plan activities may include, but are not limited to, monitoring the billings of its providers to ensure members receive services for which the contractor is billed; investigating all reports of suspected fraud and over-billings (upcoding, unbundling, billing for services furnished by others and other over-billing practices), reviewing providers for over or under-utilization, verifying with members the delivery of services as claimed, and reviewing and trending consumer complaints on providers.

The BHTPA shall promptly report to the Med-QUEST Division, Medical Standards Branch instances in which suspected fraud has occurred. The BHTPA should provide any evidence it has on the providers' billing practices (unusual billing patterns, services not rendered as billed, same services billed differently and/or separately). If the provider is not billing appropriately, but the BHTPA does not believe the inappropriate billing meets the definition of fraud (i.e., no intention to defraud), the BHTPA should provide education and training to its provider.

**60.900 Confidentiality of Information**

An Offeror agrees that all information, records and data collected in connection with this contract shall be protected from unauthorized disclosures. In addition, an Offeror agrees to guard the confidentiality of applicant and recipient information. The contractor shall not disclose confidential information to any individual or entity except in compliance with:

- CFR Part 431, Subpart F;
- the Administrative Simplification provisions of Title II of the Health Insurance Portability and Accountability Act of 1996, Pub. Law 104-191 (HIPAA) and the regulations promulgated thereunder, including but not limited to the Security and Privacy requirements set forth in 45 C.F.R. Parts 160 and 164, and the Administrative Requirements set forth in 45 C.F.R. Part 162 (if applicable);
- HRS §346-10; and,
- All other applicable Hawaii statutes and administrative rules.

The Contractor is cautioned that federal and state Medicaid rules, and some other Federal and State statutes and rules, are often more stringent than the HIPAA regulations. Moreover, for purposes of this contract, the Contractor agrees that the confidentiality provisions contained in HAR Chapter 17-1702 shall apply to Contractor to the same extent as they apply to MQD.

Any other party shall be granted access to confidential information only after complying with the requirements of State and Federal laws and regulations pertaining to such access. The DHS shall determine if and when any other party has properly obtained the right to have access to this confidential information. Nothing herein shall prohibit the disclosure of information in summary, statistical or other form which does not identify particular individuals, provided that deidentification of protected health information must be in compliance with the HIPAA Privacy Rule.

Contractor is a business associate of the DHS as that term is defined in 45 C.F.R. §160.103, and agrees to the terms of the Business Associate agreement provisions attached as Appendix D, which shall become part of the contract between the Contractor and the State.

**61.100 Services**

61.110 Services to be Provided

As of the effective date of enrollment, in acknowledgment of payment of a negotiated amount for DHS eligible BHTPA members, the contractor agrees to provide all required

administrative and behavioral health services as specified in this RFP and a resulting contract.

The contractor shall be reimbursed monthly for the following services:

A. Administrative

Administrative costs will be paid monthly at an established rate based on the number of members enrolled in the BHTPA. The contractor will be responsible to provide administrative duties to include claims payment, eligibility verification, coordination of benefits, third party liability recovery, outreach and other duties specified in this RFP.

B. Direct Services and Care Coordination/Case Management

The contractor will be paid an advance, based upon 2 weeks of estimated services cost, at the beginning of the contract period. Thereafter, the contractor will invoice the actual service payments made each week to the MQD. The contractor shall include one original and one copy of the weekly invoice and should be mailed or delivered to:

Department of Human Services  
Med-QUEST Division  
Finance Office  
1001 Kamokila Blvd. # 317  
Kapolei, Hawaii 96707

61.120 Financial Sanctions

DHS may impose civil or administrative monetary penalties not to exceed the maximum amount established by Federal statutes and regulations if the BHTPA: (1) fails to provide medically necessary items and services that are required under law or under contract; (2) imposes upon beneficiaries excess premiums and charges; (3) acts to discriminate among enrollees; (4) misrepresents or falsifies information; or (5) violates other contract provisions and requirements.

DHS may also impose financial sanctions for encounter data that does not satisfy the accuracy, timeliness and completeness requirements as described in Sections 50.820 and 51.110 of this RFP. The financial sanctions determined for the month shall be deducted from the payment for the upcoming month's administrative rates.

61.130 Plan Invoice

The BHTPA shall submit monthly invoices to the State for administrative payment. The State shall adjust the invoice for the prior month's adjustments (e.g., additions/deletions of members, etc.).

61.140 Payment to Providers and Subcontractors

The contractor shall be responsible for paying its subcontractors and providers in a timely and accurate manner for benefits provided to members. Payments to providers shall be consistent with the claims payment procedures described in §1902(a)(37)(A) of the Social Security Act unless a health care provider and the organization agree to an alternative payment schedule. This section requires that "90% of claims for payment (for which no further written information or substantiation is required in order to make payment) are paid within 30 days of the date or receipt of such claims and that 99% of claims are paid within 90 days of the date of receipt of such claims." The BHTPA shall be financially responsible for any interest payments incurred as a result of non-compliance with the Hawaii Clean Claims Act , Section 431: 13-108, Hawaii Revised Statutes (HRS). In no event shall the subcontractors and providers look directly to the State for payment. The State and plan members shall bear no liability for the contractor's failure or refusal to pay valid claims of subcontractors or providers. The contractor shall indemnify and hold the State and the plan members harmless from any and all liability arising from such claims and shall bear all costs in defense of any action over such liability, including attorney's fees.

61.150 Use of Funds

The contractor shall not use any public funds for purposes of entertainment perquisites and shall comply with any and all conditions applicable to the public funds to be paid under this

contract, including those provisions of appropriate acts of the Legislature or by administrative rules adopted pursuant to law.

**61.200 Acceptance**

The offeror shall comply with all of the requirements of this RFP and DHS shall have no obligation to enroll any members in the BHTPA until such time as all of said requirements have been met.

**61.300 Disputes**

Any dispute concerning a question of fact arising under the contract, which is not disposed of by an agreement, shall be decided by the Director of DHS or his/her duly authorized representative who shall reduce his/her decision in writing and mail or otherwise furnish a copy to the contractor within ninety (90) days after written request for a final decision by certified mail, return receipt requested. The decision shall be final and conclusive unless determined by a court of competent jurisdiction to have been fraudulent, capricious, arbitrary, or so grossly erroneous as necessary to imply bad faith. In connection with any dispute proceeding under this clause, the contractor shall be afforded an opportunity to be heard and to offer evidence in support of his/her dispute. The contractor shall proceed diligently with the performance of the contract in accordance with the disputed decision pending final resolution by a circuit court of this State.

Any legal proceedings against the State of Hawaii regarding this RFP or any resultant contract shall be brought in a court of competent jurisdiction in the City and County of Honolulu, State of Hawaii.

**61.400 Warranty of Fiscal Integrity**

The offeror warrants that it is of sufficient financial solvency to assure DHS of its ability to perform the requirements of this contract. The offeror shall provide sufficient financial data and information to prove its financial solvency and shall comply with the solvency standards established by the State Insurance Commissioner for private health maintenance organizations.

## **61.500 Full Disclosure**

The offeror warrants that it has fully disclosed all business relationships, joint ventures, subsidiaries, holding companies, or any other related entity in its proposal and that any new relationships shall be brought to the attention of DHS as soon as such a relationship is consummated. The terms and conditions of CMS require full disclosure on the part of all contracting offerors and providers.

The offeror shall not knowingly have a director, officer, partner, or person with more than 5% of the entity's equity, or have an employment, consulting, or other agreement with such a person for the provision of items and services that are significant and material to the entity's contractual obligation with the State, who has been debarred or suspended by the Federal government, and shall not, without DHS' prior approval, lend money or extend credit to any related party. The offeror shall fully disclose such proposed transactions and submit a formal written request for review and approval.

The offeror shall include such provisions in any contract or agreement made with subcontractors or providers.

The offeror shall complete and provide all information required in the Disclosure Statement in Appendix I and include the forms in the Technical Proposal. The offeror shall ensure that each form is completed and that full disclosure is made.

### **61.510 Litigation**

The offeror shall disclose any pending litigation to which they are a party, including the disclosure of any outstanding judgment. If applicable, please explain.

## **61.600 Termination of the Contract**

This contract may terminate or may be terminated by DHS for any or all of the following reasons:

- For expiration of QUEST by CMS
- In the event of the insolvency of or declaration of bankruptcy by the offeror

Prior to termination of a contract, DHS must provide a hearing for the BHTPA . DHS may notify members of the hearing and allow them to disenroll without cause.

61.610 Termination for Expiration of QUEST by CMS

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

61.620 Termination for Bankruptcy or Insolvency

In the event that the contractor shall cease conducting business in the normal course, become insolvent, make a general assignment for the benefit of creditors, suffer or permit the appointment of a receiver for its business or its assets or shall avail itself of, or become subject to, any proceeding under the Federal Bankruptcy Act or any other statute of any State relating to insolvency or the protection of the rights or creditors, DHS may, at its option, terminate this contract. In the event DHS elects to terminate the contract under this provision it shall do so by sending notice of termination to the contractor by registered or certified mail, return receipt requested. The date of termination shall be deemed to be the date such notice is mailed to the contractor, unless otherwise specified.

In the event of insolvency of the BHTPA, the BHTPA enrollees shall not be liable for the debts of the BHTPA.

61.630 Procedure for Termination

The offeror shall:

- Stop work under the contract on the date and to the extent specified in the notice of termination.
- Notify the members of the termination and arrange for the orderly transition to the new BHTPA.

- ❑ Place no further orders or subcontracts for materials, services, or facilities, except as may be necessary for completion of the work under the portion of the contract that is not terminated.
- ❑ Terminate all orders and subcontracts to the extent that they relate to the performance of work terminated by the notice of termination.
- ❑ Assign to DHS in the manner and to the extent directed by the Med-QUEST Administrator of the right, title, and interest of the contractor under the orders or subcontracts so terminated, in which case DHS shall have the right, in its discretion, to settle or pay any or all claims arising out of the termination of such orders and subcontracts.
- ❑ With the approval of the Med-QUEST Administrator, settle all outstanding liabilities and all claims arising out of such termination of orders and subcontracts, the cost of which would be reimbursable in whole or in part, in accordance with the provisions of the contract.
- ❑ Complete the performance of such part of the work as shall not have been terminated by the notice of the termination.
- ❑ Take such action as may be necessary, or as the Med-QUEST Administrator may direct, for the protection and preservation of any and all property or information related to the contract which is in the possession of the contractor and in which DHS has or may acquire an interest.
- ❑ Within 30 working days from the effective date of the termination, deliver to DHS copies of all current data files, program documentation, and other documentation and procedures used in the performance of the contract at no cost to DHS. The contractor agrees that DHS or its agent shall have a non-exclusive, royalty-free right to the use of any such documentation.

## **61.700 Termination Claims**

After receipt of a notice of termination, the contractor shall submit to the Med-QUEST Administrator any termination claim in

the form and with the certification prescribed by the Med-QUEST Administrator. Such claim shall be submitted promptly but in no event later than six (6) months from the effective date of termination. Upon failure of the contractor to submit its termination claims within the time allowed, the Med-QUEST Administrator may, subject to any review required by the State procedures in effect as of the date of execution of the contract, determine, on the basis of information available to him/her, the amount, if any, due to the contractor by reason of the termination and shall thereupon cause to be paid to the contractor the amount to be determined.

Upon receipt of notice of termination, the contractor shall have no entitlement to receive any amount for lost revenues or anticipated profits or for expenditures associated with this or any other contract. The contractor shall be paid only the following upon termination:

- At the contract price(s) for the number of members enrolled in the BHTPA at the time of termination; and/or
- At a price mutually agreed by the contractor and DHS.

In the event of the failure of the contractor and DHS to agree in whole or in part as to the amounts with respect to costs to be paid to the contractor in connection with the total or partial termination of work pursuant to this article, DHS shall determine on the basis of information available the amount, if any, due to the contractor by reason of termination and shall pay to the contractor the amount so determined.

The contractor shall have the right to appeal, any such determination made by the DHS.

## **61.800 Force Majeure**

If the contractor is prevented from performing any of its obligations hereunder in whole or in part as a result of major epidemic, act of God, war, civil disturbance, court order or any other cause beyond its control, the contractor shall make a good faith effort to perform such obligations through its then-existing facilities and personnel; and such non-performance shall not be grounds for termination for default.

Neither party to this contract shall be responsible for delays or failures in performance resulting from acts beyond the control of such party.

Nothing in this section shall be construed to prevent DHS from terminating this contract for reasons other than default during the period of events set forth above, or for default if such default occurred prior to such event.

**61.900 Prohibition of Gratuities**

Neither the offeror nor any person, firm or corporation employed by the offeror in the performance of this contract shall offer or give, directly or indirectly to any employee or agent of the State of Hawaii, any gift, money or anything of value, or any promise, obligation, or contract for future reward or compensation at any time during the term of this contract.

**62.100 Authority**

Each party has full power and authority to enter into and perform this contract, and the person signing this contract on behalf of each party certifies that such person has been properly authorized and empowered to enter into this contract. Each party further acknowledges that it has read this contract, understands it, and agrees to be bound by it.

## SECTION 70 TECHNICAL PROPOSAL

### 70.100 Introduction

The following sections describe the required content and format for the technical proposal. These sections are designed to ensure submission of information essential to understanding and evaluating the proposal. There is no intent to limit the content of the proposal, which may include any additional information deemed pertinent. It is essential that the offeror provide the information in the following order separated by tabs:

- Transmittal letter
- Executive Summary
- Company background and experience
  - Background of the company
  - Company experience
- Organization and staffing
  - Organization charts
  - Personnel resumes
- Financial statements
  - Balance sheets, Statements of Income
  - Statements of Cash flow
  - Auditor's reports
  - Amounts associated with related party transactions
  - Management letters
  - Federal income tax returns
- Per member financial data
- Provider network
  - Provider listing (using format in Appendix M)
  - Map of providers and hospitals
- Quality improvement program (using format in Appendix J)
- Case management (using format in Appendix J8-J9)
- Outreach and education programs
- Approach to fraud and abuse detection and investigation
- Insurance certificate
- Disclosure statement (using forms provided in Appendix I)
  - Wage Certification
  - Insurance Certificate
- Federal and State tax clearance certificates
- Proof of application or license as an insurer in the State of Hawaii
- Appendices A, E

## 70.200 Transmittal Letter

The transmittal letter shall be on official business letterhead and shall be signed by an individual authorized to legally bind the offeror. It shall include:

- A statement indicating that the offeror is a corporation or other legal entity. All subcontractors shall be identified and a statement included indicating the percentage of work to be performed by the prime offeror and each subcontractor, as measured by percentage of total contract price.
- A statement that the offeror is/will be registered to do business in Hawaii and has/will obtain a State of Hawaii General Excise Tax License by the start of work Provide the Hawaii Excise tax number (if applicable).
- A statement identifying all amendments and addenda to this RFP issued by the issuing office and received by the offeror. If no amendments or addenda have been received, a statement to that effect should be included.
- A statement of affirmative action that the offeror does not discriminate in its employment practices with regard to race, color, religion, creed, age, sex, national origin or mental or physical handicap, except as provided by law.
- A statement that no attempt has been made or will be made by the offeror to induce any other party to submit or refrain from submitting a proposal.
- A statement that the person signing this proposal certifies that he/she is the person in the offeror's organization responsible for, or authorized to make, decisions as to the prices quoted, that the offer is firm and binding, and that he/she has not participated and will not participate in any action contrary to the above conditions.
- A statement that the offeror has read, understands, and agrees to all provisions of this RFP.

- ❑ A statement that it is understood that if awarded the contract, the offeror's organization will deliver the goods and services meeting or exceeding the specifications in the RFP and amendments.

### **70.300 Executive Summary**

The executive summary should provide DHS with a broad understanding of the entire proposal. The executive summary shall clearly and concisely condense and highlight the contents of the proposal.

### **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 businesses), and details of company experience relevant to the operation of managed care plans (type of plan, number of members, etc.). The key required information is provided below.

#### **70.410 Background of the Company**

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

- ❑ Provide a general description of the primary business of your organization and its client base
- ❑ 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 date 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
- ❑ Ownership of the company (names and percent ownership), including the officers of the corporation
- ❑ The home office location and all other offices (by city and state)

- The location of office from which any contract would be administered
- The name, address and telephone number of the contractor's point of contact for a contract resulting from this RFP
- The number of employees both locally and nationally
- The size of organization in assets, revenue and people
- The areas of specialization

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

#### 70.420 Company Experience

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

- Length and quality of previous experience in providing the required behavioral health services to a Medicaid population or low-income group.
- Length and quality of previous experience with managed care, including experience in working with behavioral health agencies and behavioral health agencies as subcontractors
- Outline of existing behavioral healthcare packages offered that are similar to the package for QUEST and the premiums or capitated rates charged
- Existing volume of current non-Medicaid members receiving SMI services broken down by age and sex
- Existing volume of Medicaid and QUEST recipients receiving SMI services broken down by age and sex

## 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

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

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

## 70.520 Staffing (Personnel Resumes)

Resumes should be provided for at least the Administrator or Executive Director, Financial Officer, Medical Director, Pharmacist, CC/CM Supervisor and QA/UR Director. The offeror shall identify an individual within the organization who will be the key contact person for the BHTPA. If this individual is not one of the positions for which resumes are required, the resume for this individual shall be included. Otherwise, the resume should identify which individual would be serving as the key contact person for the BHTPA.

The resumes of key personnel shall include, where applicable:

- Experience with the Medicaid and QUEST programs
- Experience in managed care systems
- Length of time with the BHTPA or related organization
- Length of time in the behavioral healthcare industry
- Previous relevant experiences
- Relevant education and training
- Names, positions titles and telephone numbers of at least two references who can provide information on the individuals' experience and competence.

## 70.600 Financial Statements

Financial statements for the applicable legal entity or each partner if a joint venture shall be provided for each of the last three years, including at a minimum:

- Balance Sheets
- Statements of Income
- Statements of Cash flow
- Auditor's reports

- ❑ Amounts associated with related party transactions
- ❑ Management letters
- ❑ Federal Income Tax returns

70.610 Per Member Financial Data

Information to be given at a later date

**70.700 Provider Network**

70.710 Provider Listing

The offeror shall identify its providers on each island by specialty. The offeror must provide the full range of behavioral health services to recipients included in their proposal statewide.

For the existing BHTPA, the provider network shall be based on existing contracted providers. If the offeror does not currently have a contract with DHS, the offeror may provide its network based on providers' intent to contract with the plan. The solicitation letter used by the plan to solicit provider names for the purpose of the proposal must be included in the proposal. Within one month of notice of award, the offeror must submit its preliminary network to the DHS. Failure to meet the requirements of the contract will result in a delay in implementation of the plan.

The offeror shall provide its provider listing for each island using the format in Appendix M. For each provider type, the offeror shall list the following information:

- number each provider
- list the provider name (last name, first name, M.I.)
- specialty (i.e., psychiatrist, psychologist, psychiatric nurse practitioner, social workers, substance abuse counselors, etc.)
- provider address (location where service is provided)
- city
- zip code
- number of the offeror's BHTPA members that are currently assigned to the provider

- indication as to whether the provider is accepting new BHTPA QUEST patients from the plan (Y/N)
- indication as to whether the provider has a limit on the number of BHTPA QUEST patients he/she will accept from the plan (Y/N)

Separate the providers by provider type noted below:

- Hospital services (indicate the specific services i.e., emergency room services or behavioral health outpatient services, being contracted for and note it in the specialty column.
- Urgent care services
- Ambulance (including ground and air ambulance) services
- Specialty services
- Pharmacy services
- Laboratory services
- Non-emergency transportation services
- Translation services

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 (i.e., psychiatrist, psychologist, psychiatric practitioner, etc.). The address of the clinic should be placed in the address field. The number of BHTPA members assigned to the clinic should be noted. Physicians serving as specialists should be listed on the specialty care matrix with the clinic's name. If the clinic also provides translation, it should be listed on the translation services matrix.

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

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

70.720 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.

**70.800 Quality Improvement Program**

The offeror shall submit with its proposal, the completed Quality Improvement Program matrix in Appendix J. Offerors not currently serving as a QUEST plan shall also submit a copy of its member handbook and provider manual. DHS reserves the right to perform an on-site review of any organization that submits a proposal.

**70.900 Care Coordination/Case Management**

The offeror shall submit with its proposal, the completed care coordination/case management system QIP section responses in Appendix J. The offeror shall explain the following in their proposal:

- How persons (recipients, family members, community providers and providers) may access the case management system;
- How the plan intends to use the assessment form completed by recipients
- A description and inclusion of the plan's assessment form that will be used to gather information on the patient, when referred by a QUEST plan, provider, DOH-CAMHD or others;
- How the BHTPA will interface with the recipient's PCP in the medical plan and other service providers;
- How the BHTPA 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);
- If the BHTPA elects to develop differing levels of CC/CM services, the criteria to be used in determining what level of services a member will receive;
- A description of how the BHTPA will review cases suspected of not meeting SMI criteria;
- A description of the components of a ITP;
- A description of how the BHTPA will monitor CC/CM services to report encounters, discharge planning and outcomes;

- ❑ A description of the care coordination/case management staffing including a job description of the care coordinator and the type of initial and/or on-going training and education that it will provide to its care coordinators/case managers;
- ❑ A description of how the BHTPA will monitor member's progress and continued need for enrollment in the BHTPA; and
- ❑ A description of how the BHTPA 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.

70.910 Quality Assurance

The offeror shall submit a copy of its UR criteria, credentialing criteria, and a description of their credentialing process

The offeror shall also submit a copy of its manual (if any) and any forms used to obtain information from patients for care coordination/case management and document care coordination provided to patients. An on-site readiness review will be conducted to validate the care coordination/case management system is operational before the implementation date.

**71.100 Outreach and Education Programs**

The offeror shall submit their policies and procedures of all elements provided for in Subsection 40.900, "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).

**71.200 Bidders Fee Schedule**

The offeror shall submit their fee schedule as part of their proposal. The fee schedule will require review and approval by the MQD.

The cost data should include information on the average unit costs for the services to be provided (i.e., claim payment, enrollment, etc.)

**71.300 Gain Limit**

The BHTPA is limited to no more than a 3% profit.

## **SECTION 80                    EVALUATION AND SELECTION**

### **80.100     Introduction**

The department shall conduct a comprehensive, fair, and impartial evaluation of proposals received in the response to this RFP. A Proposal Review Committee will evaluate the proposal based on the technical content and cost. Proposals will be awarded points based on meeting the specific requirements of the RFP. Each technical criterion shall receive a score not to exceed the maximum points assigned to that criterion.

The evaluation of proposals shall be conducted in the following step:

### **80.200     Technical Proposal Evaluation and Scoring**

The selection criteria for the Technical Proposal are as follows:

- Merits of the Bidder and the Bidder's Proposal–  
Detailed work plan

#### **80.210     Step I – Merits of the Bidder and the Bidder's Technical Proposal (100 possible points)**

The Offeror shall submit its proposal in response to Section 70 of this RFP. The proposal shall address the specified topics and provide the requested information in the order in which it is prescribed. The Offeror should address each topic as fully as possible yet be concise and succinct.

The Offeror shall be assigned a score based on the Offeror's experience, the personnel assigned to the project, and the proposed approach and Work Plan. MQD reserves the right to add, change or delete any of the criteria.

The scoring criteria will be based on the following points:

- Transmittal letter (5 points)
- Executive Summary (5)
- Approach (10)
- Data Processing Capabilities (10)
- Company Background and Experience (10)

- Project Organization and Staffing (10)
- Financial (5)
- Provider Network (20)
- Care Coordination/Case Management (15)
- QIP (10)

**80.300 Step I – Merits of the Bidder and the Bidder’s Proposal (100 Possible Points)**

The listing of criteria is not all-inclusive and MQD reserves the right to add, delete or modify any criteria.

- Transmittal Letter (5 points possible)

Transmittal letter must be on an official letterhead and signed by an individual authorized to legally bind the Offeror. Letter shall include all statements as specified in Section 70.200. If transmittal letter is incomplete no points will be awarded.

- Executive Summary (5 points possible)

Does the executive summary provide a broad understanding of the proposal?

- Approach (10 Points Possible)

The Offeror’s understanding of current program structure and the extent to which each proposed component will interact with existing program elements will be evaluated. The Offeror’s grasp of required or recommended changes and their implications for the Medicaid program will also be assessed.

The Offeror will include a logical, clear, and detailed statement of their methodology and overall organizational approach for successful completion of the project objectives. The rationale and methodology for achieving objectives will be considered as well as the Offeror's organizational approach to the project.

- Data Processing Capabilities (10 points possible)

Does the offeror have a data processing system and capabilities of processing and maintaining claims data? Does it explain the adequacy of the offeror's system to collect, maintain and process the required information? If there are modifications or expansions, will the system be able to continue to process and maintain claims data?

- Company Background and Experience (10 points possible)

Does the proposal describe the company background and experience? Has the company demonstrated that the scope of services under this RFP can be completed by the Offeror?

- Project Organization and Staffing (10 Points Possible)

Proposals will be evaluated on the basis of relevant experience and client references. MQD reserves the right to contact previous and current clients. The experience of the subcontractors, if applicable, will be evaluated as well. Included in this evaluation will be an assessment of past and current management experience for similar services of like projects in scope.

Proposals must demonstrate that Offeror has sufficient relevant program experience and has been successful in performing projects of similar scope to that described herein. The Offeror's provider network and QIP will be critically reviewed.

The competence of proposed key professionals and other employees in the project will account for all of the points. Qualifications of personnel will be evaluated according to education and Hawaii Medicaid experience. Resumes of all key personnel must be provided.

- Financial (5 Points Possible)

All required documents (Sec. 70.500) have been submitted. The Offeror's information demonstrates that it has the necessary financial means to support the extent of services and administrative support as stated in the RFP.

- Provider network (20 Points Possible)

Has the Offeror provided all of the data required in the RFP? Is the Offeror's network capable of providing the services set forth in the RFP in all areas statewide? Is the network of sufficient depth to meet the behavioral health needs of its members? Does the provider network provide access to all required services as set forth in the RFP?

- Care Coordination/Case Management (15 Points Possible)

Does the Offeror's Care Coordination/Case Management clearly describe a system that will provide for an adequate system of care coordination/case management for its members? Are the functions of the staff clearly stated and feasible? Are there adequate numbers of staff? Will care coordination/case management clearly provide the monitoring and coordination of needed clinical and other services to support the member in the community?

- QIP (10 Points Possible)

Has the Offeror provided responses to all requests/queries in Appendix J? Does the Offeror's QIP responses demonstrate a clear and satisfactory Quality Improvement Program?

**APPENDIX A  
200)**

**PROPOSAL APPLICATION FORM (SPO-H-**

## APPENDIX B

## GLOSSARY

**APPENDIX C**

**GENERAL CONDITIONS**

## APPENDIX D

## BUSINESS ASSOCIATE LANGUAGE

**APPENDIX E**

**STANDARDS OF CONDUCT**

**APPENDIX F**

**WRITTEN QUESTIONS FORMAT**

## APPENDIX G

## MINIMUM PROVIDER REQUIREMENTS

**APPENDIX H SERVICES & MISC ITEMS NOT COVERED  
BY HAWAII QUEST PROGRAM**

**APPENDIX I**

**DISCLOSURE STATEMENT**



**APPENDIX K      SMI CRITERIA**

## APPENDIX L

## SMI EVALUATION PROCESS

**APPENDIX M      BEHAVIORAL HEALTH PROVIDER  
NETWORK MATRIX**

**APPENDIX N**

**BLANK**

**APPENDIX O**

**HAWAII STATE HOSPITAL POLICY AND  
PROCEDURE**