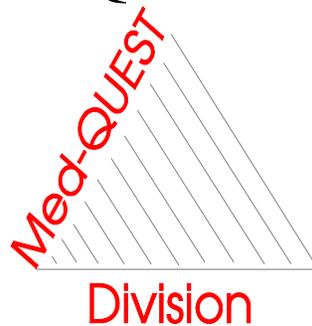


STATE OF HAWAII
Department of Human Services

REQUEST FOR PROPOSAL

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

RFP-MQD-2013-007



Med-QUEST Division- Finance Office
Issued August 20, 2012

STATE OF HAWAII

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

**Legal Ad Date: August 20, 2012
REQUESTS FOR PROPOSAL**

No. RFP-MQD-2013-007

COMPETITIVE SEALED PROPOSAL

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

**Will be received up to 2:00 p.m., Hawaii Standard Time
(H.S.T.)
On September 17, 2012**

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

Table of Contents

TABLE OF CONTENTS.....	2
SECTION 10 ADMINISTRATIVE OVERVIEW.....	7
10.100 PURPOSE OF THE REQUESTS FOR PROPOSAL (RFP).....	7
10.200 AUTHORITY FOR ISSUANCE OF RFP.....	8
10.300 ISSUING OFFICER	8
10.400 USE OF SUBCONTRACTORS.....	8
10.500 CAMPAIGN CONTRIBUTIONS BY STATE AND COUNTY CONTRACTORS	9
10.600 ORGANIZATION OF THE RFP	9
SECTION 20 RFP SCHEDULE AND REQUIREMENTS	11
20.100 RFP TIMELINE.....	11
20.200 ORIENTATION.....	11
20.300 SUBMISSION OF WRITTEN QUESTIONS	12
20.400 NOTICE OF INTENT	12
20.500 REQUIREMENTS TO CONDUCT BUSINESS IN THE STATE OF HAWAII.....	13
20.600 HAWAII COMPLIANCE EXPRESS (HCE)	13
20.700 DOCUMENTATION.....	14
20.800 RULES OF PROCUREMENT.....	14
20.810 <i>No Contingent Fees</i>	14
20.820 <i>Discussion with Offerors</i>	14
20.830 <i>RFP Amendments</i>	15
20.840 <i>Costs of Preparing Proposal</i>	15
20.850 <i>Provider Participation in Planning</i>	15
20.860 <i>Disposition of Proposals</i>	15
20.870 <i>Rules for Withdrawal or Revision of Proposals</i>	16
20.900 CONFIDENTIAL INFORMATION	16
20.910 <i>Confidentiality of Personal Information</i>	16
21.100 ACCEPTANCE OF PROPOSALS.....	17
21.200 SUBMISSION OF PROPOSALS	17
21.300 DISQUALIFICATION OF OFFERORS.....	18
21.400 IRREGULAR PROPOSALS.....	19
21.500 REJECTION OF PROPOSALS.....	19
21.600 MULTIPLE OR ALTERNATE PROPOSALS	20
21.700 CANCELLATION OF RFP	20
21.800 OPENING OF PROPOSALS.....	20
21.900 ADDITIONAL MATERIALS AND DOCUMENTATION.....	20
22.100 FINAL REVISED PROPOSAL	21
22.200 NOTICE OF AWARD	21
22.300 PROTESTS.....	21
SECTION 30 BACKGROUND.....	23
30.100 BEHAVIORAL HEALTH IN MQD.....	23
30.200 DEPARTMENT OF HUMAN SERVICES	24
30.300 BHO ENROLLED POPULATION	24
30.310 <i>Basic Criteria</i>	24
30.320 <i>QUEST Expanded Access (QExA)</i>	25
30.330 <i>Hawaii QUEST (QUEST)</i>	27
30.340 <i>Exclusions</i>	27
30.400 ESTIMATED ENROLLMENT IN MANAGED CARE PROGRAMS.....	27
30.500 ELIGIBLE BHO MEMBERS.....	27

30.510	<i>Serious Mental Illness or Serious and Persistent Mental Illness</i>	28
30.520	<i>Evaluation and Referral to the BHO</i>	28
30.600	ENROLLMENT INTO THE BHO	30
30.610	<i>Referral process</i>	30
30.620	<i>Involuntary Commitment</i>	31
30.700	RE-ENROLLMENT INTO THE BHO	31
30.800	DISENROLLMENT	32
30.810	<i>Criminal Commitment</i>	32
30.820	<i>State Mental Health Hospital</i>	32
30.900	BHO POLICY MEMORANDUMS	32
SECTION 40	PROVISION OF SERVICES	34
40.100	BHO'S ROLE IN MANAGED CARE.....	34
40.200	CASE MANAGEMENT SYSTEM.....	35
40.210	<i>System Description</i>	35
40.220	<i>CM Policies</i>	37
40.230	<i>Individualized Treatment Plan (ITP)</i>	40
40.300	PROVIDER NETWORK.....	41
40.310	<i>General Provisions</i>	41
40.320	<i>Provider Credentialing, Recredentialing and Other Certification</i>	43
40.330	<i>Provider Contracts</i>	44
40.340	<i>Review of Medical Records</i>	49
40.350	<i>Provider Availability</i>	51
40.360	<i>Geographic Access of Providers</i>	52
40.370	<i>Fraud & Abuse</i>	53
40.370.1	<i>Reporting and Investigating Suspected Provider Fraud and Abuse</i>	54
40.370.2	<i>Employee Education About False Claims Recovery</i>	55
40.370.3	<i>Adult Abuse Reporting Requirements</i>	55
40.380	<i>Provider and Subcontractor Reimbursement</i>	55
40.400	AUTHORIZATION OF SERVICES	57
40.500	MEMBER GRIEVANCE SYSTEM.....	59
40.510	<i>General Requirements</i>	59
40.520	<i>Recordkeeping</i>	60
40.530	<i>Grievance Process</i>	60
40.540	<i>State Grievance Review</i>	62
40.550	<i>Appeals Process</i>	62
40.560	<i>Continuation of Benefits During an Appeal or State Administrative Hearing</i>	64
40.570	<i>Notice of Action</i>	65
40.600	BHO PERSONNEL	67
40.610	<i>Medical Director</i>	67
40.620	<i>Supporting Staff and Systems</i>	67
40.700	DAILY ROSTERS/BHO REIMBURSEMENT	68
40.800	SCOPE OF BEHAVIORAL HEALTH SERVICES.....	69
40.810	<i>Covered Behavioral Health Services</i>	70
40.820	<i>Department of Health Alcohol and Drug Abuse Division (DOH-ADAD)</i>	73
40.900	OUT-OF-STATE AND OFF-ISLAND COVERAGE.....	73
41.100	OTHER SERVICES TO BE PROVIDED.....	74
41.200	TRANSITION OF CARE.....	78
41.300	ON-SITE VISITS	79
41.400	GEOGRAPHIC AREAS TO BE SERVED	79
SECTION 50	ADMINISTRATIVE REQUIREMENTS	80

50.100	NOTIFICATION OF ENROLLMENT.....	80
50.110	<i>Responsibilities of the BHO</i>	80
50.120	<i>Eligibility Verification</i>	82
50.200	DISENROLLMENT	82
50.210	<i>Members Who No Longer Meet the Criteria for SMI</i>	83
50.300	ASSESSMENT AND COLLECTION OF FEES AND PENALTIES	84
50.400	QUALITY IMPROVEMENT	84
50.410	<i>Importance of Quality Improvement</i>	84
50.420	<i>Quality Improvement Programs</i>	85
50.430	<i>Responsibilities of the BHO</i>	89
50.500	PERFORMANCE INCENTIVES	89
50.600	MONITORING AND EVALUATION	90
50.610	<i>Internal QIP Monitoring</i>	90
50.620	<i>External Monitoring</i>	90
50.630	<i>Conduct Surveys</i>	91
50.640	<i>Conduct Case Study Interviews</i>	91
50.650	<i>CMS Contracted Review Organization</i>	91
50.700	REPORTING REQUIREMENTS.....	92
50.710	<i>Purpose for Data to be Collected</i>	92
50.720	<i>Timeliness of Data Submitted</i>	92
50.730	<i>Reports</i>	92
50.740	<i>Provider Network and Service Reports</i>	94
50.740.1	<i>Provider Network Adequacy and Capacity Report</i>	94
50.740.2	<i>GeoAccess (Or Similar Program) Reports</i>	95
50.740.3	<i>Provider Suspensions and Termination Report</i>	96
50.740.4	<i>Provider Complaints and Claims Report</i>	96
50.750	<i>Member Services Reports</i>	97
50.750.1	<i>Member Complaints, Grievances and Appeals Report</i>	97
50.750.2	<i>Behavioral Health Services Report</i>	98
50.760	<i>Administration and Financial Reports</i>	98
50.760.1	<i>Quality Improvement Program (QIP) Report</i>	98
50.760.2	<i>Prior Authorization Requests Denied/Deferred</i>	99
50.760.3	<i>Fraud and Abuse Summary Reports</i>	99
50.760.4	<i>BHO Financial Reporting Guide</i>	100
50.770	<i>BHO Certification</i>	100
50.780	<i>Follow-Up by BHOs/Corrective Action Plans/Policies and Procedures</i>	101
50.800	INFORMATION TECHNOLOGY.....	102
50.810	<i>General Requirements</i>	102
50.820	<i>Expected Functionality</i>	102
50.830	<i>Method of Data Exchange with MQD</i>	102
50.840	<i>Chain of Trust Agreement</i>	103
50.850	<i>Compliance with the Health Insurance Portability and Accountability Act (HIPAA)</i>	103
50.860	<i>Possible Audits of BHO Information Technology</i>	104
50.870	<i>BHO Information Technology Changes</i>	104
50.880	<i>Disaster Planning and Recovery Operations</i>	104
50.900	ENCOUNTER DATA REQUIREMENTS	104
50.910	<i>Accuracy, Completeness and Timeliness of Encounter Data Submissions</i>	104
51.100	NOTIFICATION OF CHANGES IN MEMBER STATUS.....	105
51.110	<i>Member and BHO Responsibilities</i>	105
51.120	<i>Changes in Member Status</i>	106
51.200	EDUCATIONAL MATERIALS.....	106
51.210	<i>BHO's Responsibilities</i>	106
51.220	<i>Requirements for Written Materials</i>	107

51.300	READINESS REVIEW	108
51.310	<i>Required Review Documents</i>	108
51.320	<i>Updated GeoAccess Reports</i>	111
51.330	<i>BHO Provider Network</i>	111
SECTION 60	TERMS AND CONDITIONS	112
60.100	CONTRACT DOCUMENTS	112
60.200	CONFLICT BETWEEN CONTRACT DOCUMENTS, STATUTES AND RULES.....	112
60.300	SUBCONTRACTS AGREEMENTS.....	113
60.400	RETENTION OF MEDICAL RECORDS.....	115
60.500	RESPONSIBILITY FOR TAXES.....	115
60.600	FULL DISCLOSURE	116
60.610	<i>Business Relationships</i>	116
60.620	<i>Litigation</i>	117
60.700	FISCAL INTEGRITY.....	117
60.710	<i>Warranty of Fiscal Integrity</i>	117
60.720	<i>Performance Bond</i>	117
60.800	TERM OF THE CONTRACT.....	118
60.900	INSURANCE.....	119
60.910	<i>Liability Insurance Requirements</i>	119
60.920	<i>Reinsurance</i>	121
61.100	MODIFICATION OF CONTRACT.....	121
61.200	CONFORMANCE WITH FEDERAL REGULATIONS.....	122
61.300	TERMINATION OF THE CONTRACT.....	122
61.310	<i>Termination for Default</i>	122
61.320	<i>Termination for Expiration or Modification of the Programs by CMS</i>	123
61.330	<i>Termination for Bankruptcy or Insolvency</i>	123
61.340	<i>Procedure for Termination</i>	124
61.350	<i>Termination Claims</i>	125
61.400	CONFIDENTIALITY OF INFORMATION	126
61.500	BHO'S PROGRESS.....	128
61.510	<i>BHO Reporting</i>	128
61.520	<i>Inspection of Work Performed</i>	128
61.600	DISPUTES	129
61.700	LIQUIDATED DAMAGES, SANCTIONS AND FINANCIAL PENALTIES.....	129
61.710	<i>Liquidated Damages</i>	129
61.720	<i>Sanctions</i>	130
61.800	ACCEPTANCE.....	133
61.900	COMPLIANCE WITH LAWS.....	133
61.910	<i>Wages, Hours and Working Conditions of Employees Providing Services</i>	133
61.920	<i>Compliance with other Federal and State Laws</i>	133
62.100	MISCELLANEOUS SPECIAL CONDITIONS	134
62.110	<i>Use of Funds</i>	134
62.120	<i>Prohibition of Gratuities</i>	135
62.130	<i>Publicity</i>	135
62.140	<i>Force Majeure</i>	135
62.150	<i>Attorney's Fees</i>	136
62.160	<i>Time is of the Essence</i>	136
62.170	<i>Authority</i>	136
62.180	<i>Health plan request for waiver of contract requirements</i>	136
SECTION 70	TECHNICAL PROPOSAL	137

70.100	INTRODUCTION.....	137
70.200	TRANSMITTAL LETTER	138
70.300	PROPOSAL NARRATIVE.....	139
70.400	COMPANY BACKGROUND AND EXPERIENCE.....	139
70.410	<i>Background of the Company</i>	139
70.420	<i>Company Experience</i>	140
70.500	ORGANIZATION AND STAFFING	141
70.510	<i>Organization Charts</i>	141
70.520	<i>Staffing (Personnel Resumes)</i>	142
70.530	<i>References (professional and member)</i>	143
70.600	PROVIDER NETWORK.....	143
70.610	<i>Provider Listing</i>	143
70.620	<i>Map of Behavioral Health Providers and Hospitals</i>	145
70.700	CASE MANAGEMENT	146
70.800	OUTREACH AND EDUCATION PROGRAMS.....	147
SECTION 80	CAPITATION RATES	148
80.100	INTRODUCTION.....	148
80.200	OVERVIEW OF THE RATE STRUCTURE	148
80.300	RISK SHARE PROGRAM.....	149
80.400	RATE DEVELOPMENT	149
80.500	FUTURE RATE SETTING.....	149
SECTION 90	EVALUATION AND SELECTION	150
90.100	INTRODUCTION.....	150
90.200	EVALUATION PROCESS	150
90.300	MANDATORY PROPOSAL EVALUATION	150
90.400	PROPOSAL EVALUATION	150
90.500	EVALUATION CRITERIA	151
90.510	<i>Transmittal Letter (0 points possible)</i>	152
90.520	<i>Proposal Narrative (10 points possible)</i>	153
90.530	<i>Company Background and Experience (15 points possible)</i>	153
90.540	<i>Organization and Staffing (15 points possible)</i>	153
90.550	<i>Provider Network (20 points possible)</i>	154
90.560	<i>Case Management (25 points possible)</i>	154
90.570	<i>Outreach and Education Programs (15 points possible)</i>	154
APPENDIX A – WRITTEN QUESTIONS FORMAT.....		156
APPENDIX B – NOTICE OF INTENT TO PROPOSE FORMAT		157
APPENDIX C – PROPOSAL DOCUMENTS		158
APPENDIX D – CCS REFERRAL PROCESS.....		159
APPENDIX E - CONTRACT FORMS & GENERAL CONDITIONS.....		160
APPENDIX F – PROVIDER LETTER OF INTENT		161
APPENDIX G – PROVIDER LISTING		162
APPENDIX H – RISK SHARE PROGRAM		163

SECTION 10 ADMINISTRATIVE OVERVIEW

10.100 Purpose of the Requests for Proposal (RFP)

This Requests for Proposal (RFP) solicits participation by a qualified Behavioral Health Organization (BHO) to case manage, authorize, and facilitate the delivery of behavioral health services to Medicaid eligible adults who have serious mental illness (SMI) or serious and persistent mental illness (SPMI) who are in the QUEST Expanded Access (QExA) health plans. The services shall be provided statewide through a single Vendor and shall be collectively referred to as the Community Care Services Program (CCS).

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

At this time, the QUEST health plans are responsible for administering all behavioral health services for their members, unless court ordered to obtain services through the Department of Health- Adult Mental Health Division (DOH-AMHD). This population may be transitioned into the CCS program in the future.

Additionally, the AMHD provides services for many members that are in the QUEST Expanded Access (QExA) health plans or are uninsured. In addition, this population may be transitioned into the CCS program in the future.

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

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

10.200 Authority for Issuance of RFP

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

10.300 Issuing Officer

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

Patricia M. Bazin
Health Care Services Branch Administrator
Department of Human Services/Med-QUEST Division
601 Kamokila Boulevard, Suite 506A
Kapolei, HI 96707
Telephone: (808) 692-7739

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 Campaign Contributions by State and County Contractors

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

10.600 Organization of the RFP

This RFP is composed of nine sections plus appendices:

- Section 10 – Administrative Overview – Provides general information on the purpose of the RFP, the authorities relating to the issuance of the RFP, and the organization of the RFP
- Section 20 – RFP Schedule and Requirements – Provides information on the rules and schedules for procurement of behavioral services
- Section 30 – Background - Describes the current medical assistance programs, including QUEST and QUEST Expanded Access (QExA) and the role of DHS
- Section 40 –Provision of Services - Provides information on the medical and behavioral health services to be provided under this RFP and contract
- Section 50 – Administrative Requirements – Provides information on the eligibility and disenrollment of members, quality improvement and utilization review requirements, data to be provided by the plan, DHS notification requirements, and the DHS monitoring procedures
- Section 60 – Terms and Conditions - Describes the terms and conditions under which the work will be performed
- Section 70 – Technical Proposal – Describes the required content and format required for submission of a proposal
- Section 80- Capitation Rates- Defines the methodology that DHS uses for setting capitation rates.

- Section 90 – Evaluation and Selection – Defines the evaluation criteria and explains the evaluation process.

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

SECTION 20 RFP SCHEDULE AND REQUIREMENTS

20.100 RFP Timeline

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

Issue RFP	August 20, 2012
Orientation	August 27, 2012
Submission of Written Questions	August 27, 2012
Written Responses to Questions	August 30, 2012
Notice of Intent to Propose	August 31, 2012
Receipt of Proposals	September 17, 2012
Proposal Evaluation Period	September 17 - 30, 2012
Contract Award	October 1, 2012
Contract Effective Date	November 1, 2012
Commencement of Services	March 1, 2013

20.200 Orientation

An orientation for Offerors in reference to this RFP will be held on the date specified in Section 20.100, at 9:00 am (H.S.T.) at the Med-QUEST Office, Kakuhihewa Building at 601 Kamokila Boulevard, #577A, Kapolei, Hawaii.

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

20.300 Submission of Written Questions

Offerors may submit questions in writing in Word 2010 format, or lower to the following physical or e-mail address:

Ms. Dona Jean Watanabe
Med-QUEST Division-Finance Office
1001 Kamokila Boulevard, Room 317
Kapolei, Hawaii 96707-2005
Fax: (808) 692-7989
e-mail: dwatanabe@medicaid.dhs.state.hi.us

The written questions shall reference the RFP section, page and paragraph number in the format provided in Appendix A. Offerors must submit written questions by 12:00 p.m. (H.S.T.) on the date specified in Section 20.100. DHS shall respond to the written questions no later than the date specified in Section 20.100. No verbal responses shall be considered as official.

20.400 Notice of Intent

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

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

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

Fax Number: (808) 692-7989
e-mail: dwatanabe@medicaid.dhs.state.hi.us

20.500 Requirements to Conduct Business in the State of Hawaii

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

HRS Chapter 237, tax clearance

HRS Chapter 383, unemployment insurance

HRS Chapter 386, workers' compensation

HRS Chapter 392, temporary disability insurance

HRS Chapter 393, prepaid health care

One of the following:

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

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

20.600 Hawaii Compliance Express (HCE)

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

purposes. See website:
<https://vendors.ehawaii.gov/hce/splash/welcome.html>

20.700 Documentation

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

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

20.800 Rules of Procurement

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

20.810 No Contingent Fees

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

20.820 Discussion with Offerors

- 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 §3-143-403, Hawaii Administrative Rules.

20.830 RFP Amendments

DHS reserves the right to amend the RFP any time prior to the closing date for the final revised proposals.

20.840 Costs of Preparing Proposal

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

20.850 Provider Participation in Planning

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

20.860 Disposition of Proposals

All proposals become the property of the State of Hawaii. The successful proposal shall be incorporated into the contract. A copy of successful and unsuccessful proposal(s) shall be public record as part of the procurement file as described in Section 3-143-616, HAR, pursuant to Chapter 103F, HRS. The State of Hawaii shall have the right to use all ideas, or adaptations to those ideas, contained in any proposal received in response to this RFP. Selection or rejection of the proposal shall not affect this right. Written requests for an explanation of rejection shall be responded to in writing within five (5) business days of receipt.

Proposals that are rejected pursuant to RFP sections 21.300-21.700, below, may be retrieved by the Offeror from the purchasing agency within thirty (30) days after its rejection from the purchasing agency. After thirty (30) days, the purchasing agency may discard the rejected proposal.

20.870 Rules for Withdrawal or Revision of Proposals

A proposal may be withdrawn or revised at any time prior to, but not after, the deadline for receipt of proposals 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.

20.900 Confidential Information

If the offeror seeks to maintain the confidentiality of sections of the proposal, each page of the section(s) shall be marked as "Proprietary" or "Confidential." An explanation to the DHS of how substantial competitive harm would occur if the information were released is required. If the explanation is sufficient, then to the extent permitted by the exemptions in Section 92F-13, HRS, the affected section may be deemed confidential. Such information shall accompany the proposal, be clearly marked, and shall be readily separable from the proposal to facilitate eventual public inspection of the non-confidential sections of the proposal. The DHS shall maintain the confidentiality of the information to the extent allowed by law. Blanket labeling of the entire document as "proprietary," however, shall result in none of the document being considered proprietary.

20.910 Confidentiality of Personal Information

Act 10 relating to personal information was enacted in the 2008 special legislative session. As a result, the Attorney General's General Conditions of Form AG Form 103F, *Confidentiality of Personal Information*, has been amended to include Section 8 regarding protection of the use and disclosure of personal information administered by the agencies and given to third parties.

21.100 Acceptance of Proposals

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

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

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

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

21.200 Submission of Proposals

Each qualified offeror shall submit only one (1) proposal. More than one (1) proposal shall not be accepted from any offeror. The Proposal Application Identification (Form SPO-H-200) shall be completed and submitted with the proposal (Appendix C).

Technical proposal shall be submitted in the following manner: original proposal bound and three (3) additional bound copies and (1) complete electronic version in MS Word 2010 or lower or PDF, on a CD. The Issuing Officer shall receive the technical proposals no later than 12:00 p.m. (H.S.T.) on the Proposal Due date specified in Section 20.100 or postmarked by the USPS no later than the date specified in Section 20.100 and received by the Department within ten (10) days of the Proposal Due date. All mail-ins postmarked by USPS after the date specified in Section 20.100, shall be rejected. Hand deliveries shall not be accepted after 12:00 p.m., H.S.T., the date specified in Section 20.100. Deliveries by private mail services such as FEDEX shall be considered hand deliveries and shall not be accepted if received after 12:00 p.m., H.S.T., the date specified in Section 20.100. Proposals shall be mailed or delivered to:

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

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

Hawaii DHS/RFP-MQD-2013-007
Community Care Services (CCS)
Technical Proposal
(Name of Offeror)

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

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

21.300 Disqualification of Offerors

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

- Proof of collusion among offerors, in which case all bids involved in the collusive action shall be rejected and any participant to such collusion shall be barred from future bidding until reinstated as a qualified offeror
- An offeror's lack of responsibility and cooperation as shown by past work or services
- An offeror's being in arrears on existing contracts with the State or having defaulted on previous contracts
- An offeror's lack of 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

21.400 Irregular Proposals

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

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

21.500 Rejection of Proposals

The State reserves the right to consider as acceptable only those proposals submitted in accordance with all requirements set forth in this RFP and which demonstrate an understanding of the problems involved and comply with the 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 or more of the following reasons:

- Rejection for failure to cooperate or deal in good faith (HAR §3-141-201)
- Rejection for inadequate accounting system (HAR §3-141-202)
- Late Proposals (HAR §3-143-603)
- Inadequate response to request for proposals (HAR §3-143-609)
- Proposal not responsive (HAR §143-610(a)(1))
- Offeror not responsible (HAR §3-143-610(a)(2))

21.600 Multiple or Alternate Proposals

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

21.700 Cancellation of RFP

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

21.800 Opening of Proposals

Upon receipt of a proposal by the 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 to the public inspection after a contract has been awarded and executed by all parties.

21.900 Additional Materials and Documentation

Upon request from the state purchasing agency, each Offeror shall submit any additional materials and documentation

reasonably required by the state purchasing agency in its evaluation of the proposal.

22.100 Final Revised Proposal

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

22.200 Notice of Award

A statement of findings and decision shall be provided to all offerors 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 Attorney General as to form, and to all further approvals, including the approval of the Governor as required by statute, regulations, 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.

22.300 Protests

Any Offeror may file a protest against the awarding of the contract. The Notice of Protest form, SPO-H-801, is available on the SPO website under the SPO Forms for Vendors, Contractors and Service Providers for Health Care Services Providers at <http://hawaii.gov/spo/>. Only the following matters may be protested:

1. The DHS's failure to follow procedures established by Chapter 103F of the Hawaii Revised Statutes;
2. The DHS's failure to follow any rule established by Chapter 103F of the Hawaii Revised Statutes; and

3. The DHS's failure to follow any procedure, requirement, or evaluation criterion in a request for proposals issued by the state purchasing agency.

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

Head of Purchasing Agency	Procurement Officer
Name: Patricia McManaman	Name: Kenneth S. Fink, MD
Title: Director of Human Services	Title: Administrator, Med-QUEST Division
Mailing Address: P.O. Box 339 Honolulu, HI 96809-0339	Mailing Address: P.O. Box 700190 Kapolei, HI 96709-0190
Business Address: 1390 Miller Street Honolulu, HI 96813	Business Address: 1001 Kamokila Blvd, Ste 317 Kapolei, HI 96707

SECTION 30 BACKGROUND

30.100 Behavioral Health in MQD

Medical assistance to eligible beneficiaries is provided through the State administered QUEST, QUEST-ACE, QUEST-Net, Basic Health Hawaii (BHH), QUEST Expanded Access (QExA), and fee-for-service programs. The Med-QUEST Division (MQD), under the DHS, administers these medical assistance programs.

In Hawaii, those with a behavioral health diagnosis of Severe Mental Illness (SMI) or Severe and Persistent Mental Illness (SPMI) may have difficulty in accomplishing their activities of daily living (ADL) and thus require additional services beyond the basic behavioral health services utilized by individuals without SMI or SPMI. Currently, individuals with SMI or SPMI who are less than 65 years and not blind or disabled (non-ABD) receive their additional behavioral health services through their QUEST health plan. Individuals with SMI or SPMI who are 65 or older, blind or disabled (ABD) are enrolled in QExA and receive the additional behavioral health services through either the CCS or AMHD programs. Uninsured individuals with SMI or SPMI receive services through AMHD. This procurement presents a significant change to the CCS program; previous contracts have not required the selected vendor to be or function as a BHO, and MQD has not considered the previously selected vendors to be BHOs.

The initial population served under this contract will be those currently receiving additional behavioral health services through the CCS program. DHS anticipates phasing in other populations that may include ABDs currently receiving additional behavioral health services through AMHD, non-ABDs receiving such services through their QUEST health plan, and possibly the uninsured population currently eligible to receive such services through AMHD or other populations that may include but not be limited to discharges from the Hawaii State Hospital or releases from prison. In the future, a program could be established for the BHO to administer in which certain individuals receiving benchmark benefits under a new program established under the Affordable Care Act of 2010 (ACA) would pay premiums and have other cost-sharing to receive additional behavioral health

services. The ACA is Federal legislation that, among other things, puts in place comprehensive health insurance reforms.

The DHS and DOH are working closely and collaboratively to decrease the fragmentation and improve the quality of the behavioral health system.

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-ACE, QUEST-Net, BHH, QExA, and fee-for-service (FFS). For purposes related to this RFP, the basic functions or responsibilities of MQD include:

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

30.300 BHO Enrolled Population

30.310 Basic Criteria

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

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

30.320 QUEST Expanded Access (QExA)

The QExA program provides medical assistance to all individuals aged 65 years or older and disabled of all ages in both mandatory as well as several optional eligibility groups. The QExA program is part of the QUEST Expanded statewide Medicaid demonstration project (Section 1115 waiver) that provides medical and behavioral health services through competitive managed care delivery systems. QExA provides medical assistance to eligible individuals under Title XIX of the Social Security Act. QExA currently includes the following individuals:

- ABD individuals living in the community including:
 - SSI recipients;
 - ABD individuals whose countable household income is less than or equal to 100 percent of FPL; and
 - ABD individuals receiving state supplemental payments (SSP).
- ABD individuals residing in long-term care institutions (e.g., nursing facilities or long-term care hospitals), including those who are subject to post-eligibility treatment of income (or patient share-of-cost or “payability” provisions). This category of ABD individuals includes the Medically Needy with Spend-down eligibility group in long-term care institutions (i.e., those who have countable incomes greater than 100 percent of FPL but who incur substantial long-term care and other medical expenses).
- ABD individuals receiving long-term care services in their home or community.

- ABD individuals enrolled in the Developmental Disabilities and/or Intellectual Disabilities (DD/ID) 1915c waiver for ABD individuals of all ages who meet an ICF/MR LOC.
- Other relatively small, specialized ABD populations who previously received SSI cash payments, including:
 - Enrollees deemed to be receiving SSI for purposes of Medicaid but who may not receive actual SSI cash benefits because of earnings (including those eligible under § 1619(a) and (b), the PASS program, etc.);
 - “Pickle” enrollees who lost SSI cash benefits because of the cost-of-living adjustment (COLA) increase in their OASDI benefits;
 - Disabled adult children (DACs) who lost SSI cash benefits because they became eligible for OASDI payments or an increase in benefits; and
 - Disabled widow/widower beneficiaries (DWBs) who lost SSI cash benefits because they became eligible for OASDI payments.
- Other populations who meet QExA eligibility criteria, including:
 - Children age nineteen (19) or younger who are wards of the State (including but not limited to those whom the State has placed in foster care) and meet QExA eligibility criteria;
 - Children age twenty-one (21) or younger who have a subsidized adoption agreement and meet QExA eligibility criteria;
 - Women eligible for Medicaid only by virtue of their need for treatment of breast and cervical cancer;
 - Terminally ill individuals of any age eligible for Medicaid by virtue of their need for hospice services (and who would be eligible for Medicaid if in a medical institution);
 - Individuals not in receipt of Retirement, Survivors and Disability Insurance (RSDI) and Social Security Insurance (SSI) disability benefits who have been determined disabled by the State’s Aid to Disabled Review Committee (ADRC);
 - Disabled children under age twenty-one (21) who meet the criteria in this section; and
 - Disabled and aged parents (and caretakers) of minor children who meet the criteria in this section.

30.330 Hawaii QUEST (QUEST)

Currently, individuals who participate in the QUEST program receive their behavioral health services through their QUEST health plan. The BHO shall not be responsible for provision of behavioral health services to those members at this time.

30.340 Exclusions

Certain groups of Medicaid members will continue to receive their behavioral health services outside of the BHO. The exceptions include:

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 MQD reserves the right to expand the services covered under the CCS program to other populations, aside from what is set forth in this RFP. This includes, but is not limited to, the QUEST SMI/SPMI population and the adult population currently served by the DOH-AMHD.

30.400 Estimated Enrollment in Managed Care Programs

The MQD currently provides health care services to approximately 286,600 members as of February 2012. The programs that MQD provides services include QUEST, QExA, and FFS. Those in these programs are listed below:

QUEST	238,000 members
QExA	44,600 members
FFS	100 members
Medicare Beneficiaries	3,900 members

Note: Medicare Beneficiaries do not receive Medicaid benefits.

30.500 Eligible BHO Members

QExA members, who meet criteria for the BHO, shall be eligible to receive the specialized behavioral health services described in this RFP [see Section 40.800]. All BHO members shall be in a medical assistance program. In such a case, the health plan shall be relieved of its responsibility for providing behavioral health services including psychotropic medications, but shall remain responsible for providing medical services.

If a QExA member is determined to be SMI or provisionally SMI through the MQD evaluation process, the member will be enrolled into the BHO. Upon enrollment in the BHO, the QExA health plan is no longer responsible for the individual's behavioral health services.

Potentially eligible individuals who have not been enrolled but call the hotline and require crisis services shall receive such services, and the BHO shall provide assistance with eligibility and enrollment.

If the program is expanded to QUEST members, a similar process shall apply. If the program is expanded to include other populations, a process will be established by the Department to determine eligibility that will minimally require meeting clinical criteria in 30.520.

For the purpose of this RFP, an adult is defined as an individual who is age 19 years and older.

30.510 Serious Mental Illness or Serious and Persistent Mental Illness

Persons who are determined to have a diagnosis of serious mental illness (SMI) or Serious and Persistent Mental Illness (SPMI) are defined as adults who, as the result of a mental disorder; exhibit emotional, cognitive, or behavioral functioning which is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or services of a long-term or indefinite duration. In these persons, their mental disability is 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 has a diagnosis of SMI/SPMI can be found in Section 30.520.

30.520 Evaluation and Referral to the BHO

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

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

- Demonstrates the presence of a qualifying diagnosis for at least twelve (12) months or is expected to demonstrate the qualifying diagnosis (as found in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for the next twelve (12) months, and
- Meets at least one of the criteria demonstrating instability and/or functional impairment:
 - GAF < 50; or
 - Clinical records demonstrate that member is unstable under current treatment or plan or care; or
 - Requires protective services or intervention by housing/law enforcement officials
- Members that do not meet the eligibility criteria, but still felt by the MQD's medical director or designed that additional service are medically necessary for the member's health and safety, should be evaluated on a case by case basis for provisional eligibility.

Eligible Diagnoses:

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

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

The QExA health plan 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, it is unclear if the member would benefit from BHO services, the referral will be denied. The cost of completing the forms and obtaining documentation is the

responsibility of the health plan. The DHS may allow a FFS provider to submit a referral packet under extenuating circumstances.

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

The evaluation results and the enrollment date into the BHO will be provided to the member's health plan and the BHO. Five working days after notification of the SMI determination, the BHO assumes responsibility for the member. The referring provider has the right to appeal any denial of SMI eligibility determination to the BHO. The BHO shall submit any appeals to the MQD contract liaison for disposition within 72 hours of receipt. The BHO shall verify enrollment with DHS and the member's health plan before providing services.

30.600 Enrollment into the BHO

30.610 Referral process

Potential members of the BHO may be:

- Referrals from the QExA health plan
- Referrals from the Hawaii State Hospital who are being discharged
- Referrals from the Department of Health, AMHD or CAMHD
- Referrals from the Department of Public Safety being discharged from their correctional facilities
- Referrals from the Department of Human Services for those young adults (19 years old) being discharged from the Hawaii Youth Correctional Facilities.
- Individuals self-referring to the BHO or making first contact with the BHO through crisis services.

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

There is no enrollment cap for the BHO.

Once a member has been determined to meet the criteria for SMI/SPMI determination, the member will be enrolled in the BHO. Only the DHS may enroll members into the BHO.

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

Members who are enrolled in the BHO and who are later determined to no longer meet the criteria for SMI/SPMI shall be referred to the MQD by the BHO. A transition plan will be developed by the BHO 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 30.520, Evaluation and Referral to the BHO. The BHO will review the member's treatment status at least every six months to determine if SMI/SPMI continued eligibility criteria are met.

30.620 Involuntary Commitment

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

30.700 Re-Enrollment into the BHO

Individuals, who are disenrolled from the BHO 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 BHO 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 QExA health plan and/or the BHO. Re-enrollment will not be retroactive to the date of the last disenrollment. The BHO will be expected to assist members with maintaining eligibility.

30.800 Disenrollment

If the member no longer meets the criteria for enrollment in the BHO, he/she shall be disenrolled from the BHO at the end of the month and responsibility for behavioral health services will revert to the QExA health plan. Only the DHS may disenroll members from the BHO.

The BHO transition plan will be given to the QExA health plan in order to ensure continuity of care prior to disenrollment. The QExA health plan shall receive written notification from the MQD of the disenrollment from the BHO. Upon disenrollment from the BHO, the QExA health plan assumes responsibility for providing all medical and behavioral health services within the established plan behavioral health benefit limits.

30.810 Criminal Commitment

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

30.820 State Mental Health Hospital

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

30.900 BHO Policy Memorandums

The DHS issues policy memorandums to offer clarity on policy or operational issues or legal changes impacting the BHO. The BHO

shall comply with the requirements of all the policy memorandums during the course of the contract and execute each memorandum when distributed by MQD during the period of the contract. The BHO shall acknowledge receipt of the memoranda through electronic mail.

SECTION 40 PROVISION OF SERVICES

40.100 BHO's Role in Managed Care

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

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

Since the BHO members will retain their primary care provider (PCP) from their health plan, the BHO shall ensure that the PCP is 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.

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

The BHO shall ensure services are available. The BHO shall be responsible for ensuring there are sufficient providers to provide behavioral health services state-wide to meet the needs of the BHO's members.

40.200 Case Management System

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

40.210 System Description

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

- Provide the member with clear and adequate information on how to obtain services and make informed decisions about their own behavioral health needs;
- Provide comprehensive case assessment, case planning, ongoing quarterly monitoring of progress toward goals and support towards reaching those goals;
- Face-to-face comprehensive assessments on a new BHO member shall occur within thirty (30) days of enrollment into the program;
- Face-to-face reassessments shall be completed at least annually or sooner if medically necessary;
- Assure development of Individualized Treatment Plan (ITP);
- Initial ITP shall be developed within thirty (30) days of completing the face-to-face comprehensive assessment after enrollment into the program;

- ITPs shall be updated every six (6) months or sooner if medically necessary to include a significant change;
- Provide skills development in problem-solving and other skills to remain in/return to the community;
- Ensure crisis resolution;
- Coordinate and integrate the members' medical and behavioral health care and services with their health plan, 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; and
- Assist members with DHS eligibility requirements (verifications, etc.) and compliance.

The BHO must demonstrate that it has a CM system to ensure that all members receive all necessary covered behavioral health services. Specifically, the 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 BHO shall perform an initial face-to-face comprehensive assessment of each enrolled member to determine and document the behavioral health and case management needs of the individual. The comprehensive assessment shall be conducted within thirty (30) days of enrollment into the BHO. If an individual loses eligibility and is re-enrolled into the BHO 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.

40.220 CM Policies

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

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

- How persons (members, family members/guardians, community providers and providers) will access the case management system for member services or inquiries.
- How it will ensure continuity of care with existing case management agencies and ensure the BHO will be able to contract for these services.
- A description and a copy of the plan's assessment tool that will be used to gather information on the member as well as the frequency of review and updating of the tool (i.e., period of time between reassessment of tool). The assessment tool shall be subject to approval by DHS.
- How information will be exchanged between the BHO, the health plan, the member's PCP, and other service providers, including non-contracted providers.
- How the BHO will notify the member's PCP of significant changes, sentinel events or crisis situations within 72 hours or sooner.
- How the CM will coordinate with other providers to implement the ITP (see Section 40.230)
- A Description of CM activities reporting plan to include:
 - Encounters
 - Outcomes
 - Notification to health plans
 - Emergency room services

- Hospital admissions
- Discharge planning
- Follow up to prevent hospital readmission.
- A description of proposed caseload assignments for each CM classification, as well as policies and procedures for providing CM as they relate to the member's needs
 - Case managers shall have a maximum of forty (40) members in their case load.
 - Case managers with several members that are either High Intensive or Intensive shall have a lower case load than forty (40) based upon needs of their members.
- A description of the CM staffing including job descriptions of the case managers, qualifications, and the type of initial and/or ongoing training and education that it will provide to its care managers.
- Case managers shall be a Registered Nurse (RN), Licensed Practical Nurse (LPN), or a social worker with a masters degree in social work (MSW).
- If CM services are to be subcontracted, submit to DHS for prior approval, the proposed subcontract for the provision of CM services. An oversight and training plan for subcontractors must also be submitted to DHS for prior approval.

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

- Providing case management to include coordination of behavioral health service included in an individual's ITP, as well as coordination of behavioral health services with medical services

- Referring members to other programs or agencies
- Changing case managers
- Identifying levels of case management according to member needs and ensuring at least monthly face-to-face case manager contact.
- Definitions of the levels of CM to be employed and a description of the standards for determining the level of CM a member shall receive relative to a continuum with classifications ranging from routine to intensive/complex case management including frequency and type of case management contact. CM services that are considered appropriate to list as encounters include: face-to-face contact with member/family, other involved service providers, telephone calls involving direct communication with the person being called (does not include attempts to get in touch, leaving messages for call backs), and travel time (actual time spent in taking a member to/from places which must be treatment related). See chart below that provides additional description of CM levels.

Case Management Frequency Service Requirements

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

- Outreach and follow-up activities, especially for members with special needs (i.e., homeless, disabled, and homebound members)
- Provide documentation and data reporting of CM services, encounters and outcomes.
- Providing continuity of care when members transition to other programs (i.e., health plan, fee-for-service program, Medicare, new services in the treatment plan)
- Ensure continuity of care when members entering into the BHO have an established relationship with a case manager as described in the transition of care section.

40.230 Individualized Treatment Plan (ITP)

An ITP shall be developed for each BHO member, requiring non-emergent treatment, within 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 BHO shall develop the ITP to contain all necessary services identified by the interdisciplinary team, which includes the health plan, if applicable. These services shall include but not be limited to services provided by psychiatrists, psychologists, social workers, advance practice nurses, and case managers. The case manager is responsible for development and implementation of the ITP in coordination with the referring agency (i.e., DOH-CAMHD), PCP, and other involved persons as necessary.

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

The ITP shall also specify the level of CM services necessary (including minimum frequency of follow-up with the member) and shall minimally include: identification of all necessary

services according to the CM and other members of the interdisciplinary team, problems, goals, interventions/services to address each problem, frequency/amount and duration of services, and responsible person(s)/disciplines/agency(s) for each intervention.

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

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

40.300 Provider Network

40.310 General Provisions

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

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

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

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

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

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

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

The BHO shall ensure that the provider network is sufficient through the duration of the contract to meet all of the services required by its members. The BHO shall proactively ensure adequate access to services. This includes identifying any areas in the network of providers participating with the BHO where increased providers would further benefit members, and actively recruiting new providers to do so. The BHO will notify DHS of any provider that leaves the network, and the BHO shall fill any acquired deficiencies in the network. The BHO is encouraged to contract with the clinic from which the individual receives

medical care when possible to better integrate the delivery of medical and behavioral health care.

In accordance with 45 CFR Section 162.410, the BHO shall require that each applicable provider have a national provider identifier (NPI).

The BHO shall not include in its network any providers or providers whose owners or managing employees have been excluded from participation by the U. S. Department of Health and Human Services, Office of Inspector General (OIG), Section 1128 or Section 1128A of the Social Security Act, or have been excluded by the DHS from participating in the Hawaii Medicaid program and all other state Medicaid programs. The BHO shall be responsible for routinely checking Federal exclusion lists to include but not limited to the List of Excluded Individuals and Entities (LEIE) maintained by the OIG. The BHO shall immediately terminate any provider(s) or affiliated provider(s) whose owners or managing employees are found to be excluded. The BHO shall report provider application denials or termination to the DHS where individuals were on the exclusions list to include denial of credentialing for fraud related concerns as they occur. The BHO shall utilize the format provided by the DHS.

The BHO shall immediately comply if the DHS requires that it remove a provider from its network if: (1) the provider fails to meet or violates any State or Federal laws, rules, and regulations; or (2) the provider's performance is deemed inadequate by the State based upon accepted community or professional standards.

40.320 Provider Credentialing, Recredentialing and Other Certification

The BHO will follow the most current NCQA credentialing and recredentialing standards including delegation and provider monitoring/oversight, but reserves the right to require approval of standards and thresholds set by the organization (e.g. with regards to performance standards, office site criteria, medical record keeping, complaints triggering on-site visits). The BHO must also meet requirements of the RFP related to appointment availability (Section 40.350) and medical record keeping (Section 40.340).

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

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

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

The BHO shall require that all contracted laboratory testing sites providing services under this RFP have either a current Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver shall provide only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests. The BHO shall comply with the provisions of CLIA 1988.

The BHO shall submit its credentialing, recredentialing and other certification policies and procedures to MQD for review and approval by the due date identified in Section 51.300, Readiness Review.

40.330 Provider Contracts

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

1. Specify covered populations and specifically cite the CCS program;
2. Specify covered services;
3. Specify rates of payment;
4. Prohibit the provider from seeking payment from the member for any covered services provided to the member within the terms of the contract and require the provider to

look solely to the BHO for compensation for services rendered, with the exception of cost sharing pursuant to the Hawaii Medicaid State Plan;

5. Prohibit the provider from imposing a no-show fee for CCS program members who were scheduled to receive a Medicaid covered service;
6. Require the provider to cooperate with the BHO's quality improvement activities;
7. Require that providers meet all applicable State and Federal regulations, including but not limited to all applicable HAR sections, and Medicaid requirements for licensing, certification and recertification;
8. Require the provider to cooperate with the BHO's utilization review and management activities;
9. Not prohibit a provider from discussing treatment or non-treatment options with members that may not reflect the BHO's position or may not be covered by the BHO;
10. Not prohibit, or otherwise restrict, a provider from acting within the lawful scope of practice, from advising or advocating on behalf of a member for the member's health status, medical care, or treatment or non-treatment options, including any alternative treatments that might be self-administered;
11. Not prohibit, or otherwise restrict, a provider from advocating on behalf of the member to obtain necessary healthcare services in any grievance system or utilization review process, or individual authorization process;
12. Require providers to meet appointment waiting time standards pursuant to the terms of this contract and as described in Section 40.350;
13. Provide for continuity of treatment in the event a provider's participation terminates during the course of a member's treatment by that provider except in the case of adverse reasons on the part of the provider;
14. Require that providers comply and maintain the confidentiality of member's information and records as required by law, including but not limited to privacy and security regulations adopted under HIPAA and HRS;
15. Keep any records necessary to disclose the extent of services the provider furnishes the members;
16. Specify that CMS, the State Medicaid Fraud Control Unit, and the DHS or their respective designee shall have the right to inspect, evaluate, and audit any pertinent books, financial records, medical records, documents, papers, and

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

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

25. Require providers of transitioning members to cooperate in all respects with providers of other BHOs to assure maximum health outcomes for members;
26. Require the provider to comply with corrective action plans initiated by the BHO;
27. Specify the provider's responsibilities regarding third party liability;
28. Require the provider to comply with the BHO's compliance plan including all fraud and abuse requirements and activities;
29. Require that providers accept members for treatment, unless the provider applies to the BHO for a waiver of this requirement;
30. Require that the provider provide services without regard to race, color, creed, ancestry, sex, including gender identity or expression, sexual orientation, religion, health status, income status, or physical or mental disability;
31. Require that providers offer hours of operation that are no less than the hours of operation offered to commercial members or, if the provider has no commercial members, that the hours of operation are comparable to hours offered to recipients under Medicaid fee-for-service;
32. Require that providers offer access to interpretation services for members that have a Limited English Proficiency (LEP) at no cost to the member, and to document the offer and provision of interpreter services to the same extent as the BHO under the Contract;
33. Include a statement that the State and the BHO members shall bear no liability for the BHO's failure or refusal to pay valid claims of subcontractors or providers for covered services;
34. Include a statement that the State and the BHO members shall bear no liability for services provided to a member for which the State does not pay the BHO;
35. Include a statement that the State and the BHO members shall bear no liability for services provided to a member for which the plan or State does not pay the individual or healthcare provider that furnishes the services under a contractual, referral, or other arrangement to the extent that the payments are in excess of the amount that the member would owe if the BHO provided the services directly;

36. Require the provider to secure all necessary liability and malpractice coverage as is necessary to protect the BHO's members and the BHO;
37. Require that the provider use the definition for emergency medical condition included in the Medicaid provider manual;
38. Require that the provider provides copies of medical records to requesting members and allows them to be amended as specified in 45 CFR Part 164;
39. Require that the provider provide record access to any authorized DHS personnel or personnel contracted by the DHS without member authorization so long as the access to the records is required to perform the duties of the contract with the State and to administer the CCS program;
40. Require that the provider complies with BHO standards that provide the DHS or its designee(s) prompt access to members' medical records whether electronic or paper;
41. Require that the provider comply with the advance directives requirements specified in 42 CFR Part 49, subpart I, and 42 CFR Section 417.436(d), if applicable;
42. Require that medical records be retained in accordance with Sections 622-51 and 622-58, HRS, for a minimum of seven (7) years after the last date of entry in the records;
43. Require that the provider complies with all credentialing and re-credentialing activities; and
44. Require that the provider is licensed in good standing, in the State of Hawaii.

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

The BHO shall submit to the DHS for review and approval a model for each type of provider contract by the due date identified in Section 51.300, Readiness Review, and at the DHS' request at any point during the contract period.

In addition, the BHO shall submit to the DHS, on the last day of every month, starting with the month after Contract Effective Date identified in Section 20.100 and concluding with the month prior to the date of Commencement of Services to Members,

identified in Section 20.100 the signature page of all finalized and executed contracts that have not been previously submitted.

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

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

40.340 Review of Medical Records

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

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

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

- All medical records are maintained in a detailed and comprehensive manner that conforms to good professional medical practice;
- All medical records are maintained in a manner that permits effective professional medical review and medical audit processes;

- All medical records are maintained in a manner that facilitates an adequate system for follow-up treatment;
- All medical records shall be legible, signed and dated;
- Each page of the paper or electronic record includes the patient's name or ID number;
- All medical records contain patient demographic information, including age, sex, address, home and work telephone numbers, marital status and employment, if applicable;
- All medical records contain information on any adverse drug reactions and/or food or other allergies, or the absence of known allergies, which are posted in a prominent area on the medical record;
- All forms or notes have a notation regarding follow-up care, calls or visits, when indicated;
- All medical records contain the patient's past medical history that is easily identified and includes serious accidents, hospitalizations, operations and illnesses. For children, past medical history including prenatal care and birth;
- All pediatric medical records include a completed immunization record or documentation that immunizations are up-to-date;
- All medical records include the provisional and confirmed diagnosis(es);
- All medical records contain medication information;
- All medical records contain information on the identification of current problems (i.e., significant illnesses, medical conditions and health maintenance concerns);
- All medical records contain information about consultations, referrals, and specialist reports;
- All medical records contain information about emergency care rendered with a discussion of requirements for physician follow-up;
- All medical records contain discharge summaries for: (1) all hospital admissions that occur while the member is enrolled; and (2) prior admissions as appropriate;
- All medical records for members eighteen (18) years of age or older include documentation as to whether or not the member has executed an advance directive, including an advance mental health care directive;
- All medical records shall contain written documentation of a rendered, ordered or prescribed service, including documentation of medical necessity; and
- All medical records shall contain documented patient visits, which includes, but is not limited to:

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

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

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

The BHO shall submit its medical records standards to the State by the due date identified in Section 51.300, Readiness Review.

40.350 Provider Availability

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

- Emergency medical situations - Immediate care (twenty-four (24) hours a day, seven (7) days a week) and without prior authorization;

- Behavioral health provider visits (urgent) - Appointments within seventy-two (72) hours; and
- Behavioral health provider visits (standard) - Appointments within twenty-one (21) days.

The BHO shall ensure that:

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

The BHO shall establish policies and procedures to ensure that network providers comply with these acceptable wait times; monitor providers regularly to determine compliance; and take corrective action if there is a failure to comply. The BHO must post and maintain on the internet an accurate listing of participating providers and who is accepting new patients. The BHO shall submit these availability of providers policies and procedures as required in Section 51.300, Readiness Review.

40.360 Geographic Access of Providers

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

	Urban*	Rural
Hospitals	30 minute driving time	60 minute driving time
Emergency Services Facilities	30 minute driving time	60 minute driving time
Mental Health Providers	30 minute driving time	60 minute driving time
Pharmacies	15 minute driving time	60 minute driving time

24-Hour Pharmacy	60 minute driving time	N/A
------------------	------------------------	-----

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

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

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

40.370 Fraud & Abuse

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

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

provider and member to obtain services would be reported to MQD.

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

40.370.1 Reporting and Investigating Suspected Provider Fraud and Abuse

Within thirty (30) calendar days of discovering instances of suspected fraud or abuse, the BHO shall report all instances of suspected fraud or abuse to the MQD and the State of Hawaii, Department of the Attorney General, Medicaid Fraud Control Unit (MFCU). The BHO shall use the report form to be provided by the DHS to report or refer suspected cases of Medicaid fraud or abuse. At a minimum, this form shall require the following information for each case:

- Name;
- ID number;
- Source of complaint;
- Type of provider;
- Nature of complaint;
- Approximate dollars involved; and
- Legal and administrative disposition of the case.

As part of its report, the BHO shall include the results of its preliminary investigation. This includes, but is not limited to, providing any evidence it has on the member's services or provider's billing practices (unusual billing patterns, services not rendered as billed and same services billed differently or separately).

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

If the provider is not billing appropriately, but the BHO has found no evidence of fraud or abuse, the BHO shall provide education and training to the provider in question. The B shall maintain documentation of the education and training provided in addition to reporting the recovered amounts as income or revenues. A summary report shall be provided on a report form provided by the MQD.

40.370.2 Employee Education About False Claims Recovery

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

40.370.3 Adult Abuse Reporting Requirements

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

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

40.380 Provider and Subcontractor Reimbursement

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

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

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

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

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

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

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

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

40.400 Authorization of Services

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

The BHO shall submit these policies and procedures to MQD for review and approval by the due date identified in Section 51.300, Readiness Review.

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

The BHO shall not arbitrarily deny or reduce the required scope of services solely because of the diagnosis, type of illness or condition. The BHO may place appropriate limits on a service based on criteria such as medical necessity or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose.

The BHO shall not require prior authorization of emergency services.

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

- For standard authorization decisions, the BHO shall provide notice as expeditiously as the member's health condition requires but no longer than fourteen (14) days following the receipt of the written request for service from the provider on behalf of the member. An extension may be granted for up to fourteen (14) additional days if the member or the provider requests the extension, or if the BHO justifies a need for additional information and the extension is in the member's interest. If the BHO extends the time frame, it shall give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision. The BHO shall issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.
- In the event a provider indicates, or the BHO determines that following the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the BHO shall make an expedited authorization determination and provide notice as expeditiously as the member's health condition requires but no later than three (3) business days after receipt of the written request for service from the provider on behalf of the member. The BHO may extend the three (3) business day time frame by up to fourteen (14) calendar days if the member requests an extension, or if the BHO justifies to the DHS a need for additional information and the extension is in the member's interest. If the BHO extends the time frame, it shall give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to appeal if he or she disagrees with that decision. The BHO shall issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

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

As the BHO has authority to authorize direct services to its members, it shall refrain from provision of direct services or otherwise engage in activities that would constitute a conflict of interest.

40.500 Member Grievance System

40.510 General Requirements

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

The BHO shall develop policies and procedures for its grievance system and submit these to the DHS for review and approval by the due date identified in Section 51.300, Readiness Review. The BHO shall submit an updated copy of these policies and procedures within thirty (30) days of any modification for review and approval.

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

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

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

The BHO shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made and reviewed by a healthcare professional that has appropriate medical knowledge and clinical expertise in treating the member's condition or disease.

The BHO shall ensure that individuals who make decisions on grievances and appeals were not involved in any previous level of review or decision-making and are healthcare professionals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease. This requirement applies specifically to reviewers of:

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

40.520 Recordkeeping

The BHO shall maintain records of its members' grievances and appeals in accordance with this RFP's requirements for recordkeeping and confidentiality of members' medical records.

40.530 Grievance Process

A grievance may be filed about any matter other than an action. An action is defined as a termination, suspension, or reduction of a Medicaid covered service. Subjects for grievances include, but are not limited to:

- The quality of care of a provider;

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

- Rudeness of a provider or a provider's employee; or
- Failure to respect the member's rights.

A member or a member's representative may file a grievance orally or in writing. The member's representative does not need written consent from the member though the response to the grievance should be directed towards the member. A provider may file a grievance on behalf of the member orally or in writing with written consent from the member or their authorized representative. The BHO shall have in place written policies and procedures for processing grievances in a timely manner to include if a grievance is filed by a provider on behalf of the member or member's authorized representative and there is no documentation of a written form of authorization, such as an Authorization of Representation (AOR) form.

As part of the grievance system policies and procedures, the BHO shall have in effect mechanisms to: (1) ensure reasonable attempts were made to obtain a written form of authorization; and (2) consult with the requesting provider when appropriate. The BHO shall submit these policies and procedures as part of their Grievance System policies and procedures to MQD for review and approval by the due date identified in Section 51.300, Readiness Review.

In addition to meeting all requirements detailed in Section 40.510, in fulfilling the grievance process requirements the BHO shall:

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

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

40.540 State Grievance Review

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

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

Med-QUEST Division
Health Care Services Branch
PO Box 700190
Kapolei, HI 96709-0190
Telephone: 808-692-8094

- The MQD shall review the grievance and contact the member with a determination within thirty (30) days from the day the request for a grievance review is received; and
- The grievance review determination made by MQD is final.

40.550 Appeals Process

An appeal may be filed when the BHO issues a notice of action to a BHO member.

A member, provider, or authorized representative on behalf of the member with the member's consent, may file an appeal within thirty (30) days of the notice of action. An oral appeal may be submitted in order to establish the appeal submission date; however, this must be followed by a written request. The BHO shall assist the member, provider or authorized representative in this process.

In addition to meeting the general requirements detailed in Section 40.510, the BHO shall:

- Ensure that oral inquiries seeking to appeal an action are treated as appeals and confirmed in writing;
- As part of the grievance system policies and procedures, the BHO shall have in effect mechanisms to ensure reasonable attempts were made to obtain a written confirmation of the appeal;
- Send an acknowledgement of the receipt of the appeal within five (5) business days from the date of the receipt of the written or oral appeal;
- Provide the member or his or her representative a reasonable opportunity to present evidence, and evidence of allegations of fact or law, in person as well as in writing;
- Provide the member or his or her representative the opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the appeal process; and
- Include as parties to the appeal, the member and his or her representative, or the representative of a deceased member's estate.

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

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

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

- The results of the appeal process and the date it was completed; and
- For appeals not resolved wholly in favor of the member:
 - The right to request a State administrative hearing, and clear instructions about how to access this process;

- The right to request to receive benefits while the hearing is pending, and how to make the request; and
- A statement that the member may be held liable for the cost of those benefits if the hearing decision upholds the BHO's action.

The BHO shall notify the provider in writing within thirty (30) days of the resolution.

40.560 Continuation of Benefits During an Appeal or State Administrative Hearing

The BHO shall continue the member's benefits if:

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

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

- The member withdraws the appeal;
- The member does not request a State administrative hearing within ten (10) days from when the BHO mails a notice of adverse action;
- A State administrative hearing decision adverse to the member is made; or
- The authorization expires or authorized service limits are met.

If the final resolution of the State administrative hearing is adverse to the member, that is, upholds the BHO's adverse action, then the BHO may recover the cost of the services furnished to the member while the appeal was pending, to the

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

If the BHO or the State reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the BHO shall authorize or provide these disputed services promptly, and as expeditiously as the member's health condition requires.

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

40.570 Notice of Action

The BHO shall give the member and the referring provider a written notice of any action within the time frames specified below. The notice to the member or provider shall include the following information:

- The action the BHO has taken or intends to take;
- The reasons for the action to include but not limited to changes in regulation, Federal or State law that require the action;
- The member's or provider's right to an appeal with the BHO;
- The member's or provider's right to request an appeal;
- Procedures for filing an appeal with the BHO;
- Member may represent himself or use legal counsel or an authorized representative;
- Circumstances under which a hearing will be granted when action is based upon change in Federal or State law, as applicable; and
- The member's right to have benefits continue pending resolution of an appeal, how to request that the benefits be continued, and the circumstances under which a member may be required to pay the costs of these services.

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

- For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) days prior to the date the adverse action is to start except:
 - By the date of action for the following reasons:

- The BHO has factual information confirming the death of a member;
- The BHO receives a clear written statement signed by the member that he or she no longer wishes services or gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying that information;
- The member has been admitted to an institution that makes him or her ineligible for further services;
- The member's address is unknown and the post office returns BHO mail directed to the member indicating no forwarding address;
- The member has been accepted for Medicaid services by another local jurisdiction;
- The member's provider prescribes a change in the level of medical care;
- The period of advanced notice is shortened to five (5) days if there is alleged fraud by the recipient and the facts have been verified, if possible, through secondary sources.
- For denial of payment: at the time of any action affecting the claim.
- For standard service authorization decisions that deny or limit services: as expeditiously as the member's health condition requires, but not more than fourteen (14) days following receipt of request for service, with a possible extension of up to fourteen (14) additional days (total time frame allowed with extension is twenty-eight (28) days from the date of the request for services) if: (1) the recipient or provider requests an extension; or (2) the BHO justifies a need for additional information and how the extension will not adversely affect the member. If the BHO extends the time frame, it must: (1) give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision to extend the time frame; and (2) issue and carry out its determination as expeditiously as the member's health condition requires but no later than the date the extension expires.
- For expedited authorization decisions: as expeditiously as the member's health condition requires but no later than three (3) business days after receipt of the request for service.

For service authorization decisions not reached within the time frames specified above (which constitute a denial and, thus, an adverse action), on the date that the timeframes expire.

40.600 BHO Personnel

40.610 Medical Director

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

40.620 Supporting Staff and Systems

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

- Case management staff to ensure timely access to medically necessary services and to assist the member to understand and follow his/her treatment plan
- Executive Director that serves as the BHO's key contact employed at 1.0 FTE for this contract
- Pharmacist either on staff with the BHO or on contract (at least 0.5 FTE) 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 employed at least 0.5 FTE
- 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 to assure that members have access to behavioral health providers

- Grievance coordinator located in the State of Hawaii to investigate member complaints employed at least 0.5 FTE
- Information system staff capable of loading member tape information, and ensuring the timely and accurate submission of encounter data and other required information and reports including ad hoc reports as requested by DHS
 - Support service staff to ensure the timely and accurate processing of other reports and coverage of the toll-free telephone hotline
 - Clerical staff to conduct daily business

The BHO shall ensure that all staff have 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 Daily Rosters/BHO Reimbursement

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

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

The DHS shall pay the established capitation rate to the BHO for members enrolled for the entire month. Capitation payments for members enrolled/disenrolled on dates other than the first or last day of the month shall be prorated on a daily basis based on the number of days in a month.

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

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

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

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

40.800 Scope of Behavioral Health Services

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

The BHO shall assure provisions of a full range of psychiatric inpatient, outreach, treatment, rehabilitation and crisis response services needed by adults with a diagnosis of SMI/SPMI. The BHO shall coordinate its services with the member's health plan to avoid duplication of services and ensure that services are appropriately provided. Services may be provided or arranged for in a variety of ways such as through natural supports, mental health agencies, general hospitals, family members, consumer help approaches, or through the use of recovering consumers as paid or volunteer staff. The BHO may make arrangements with the member's health plan to assume responsibility for medical case management in order to provide a patient centric approach of a single case manager for both medical and behavioral health needs and services.

BHO services shall assist members to manage their illness, develop the appropriate and necessary living skills and acquire supports and resources they need to maximize their quality of

life in the community. The BHO shall ensure it may facilitate the provision of the following services:

- a. Inpatient behavioral health hospital services;
- b. Ambulatory Behavioral Health Services and crisis management;
- c. Medications and Medication Management;
- d. Diagnostic services and treatment to include psychiatric or psychological evaluation and treatment;
- e. Medically necessary alcohol and chemical dependency services;
- f. Methadone management services;
- g. Intensive Case Management;
- h. Partial hospitalization or intensive outpatient hospitalization;
- i. Psychosocial Rehabilitation/Clubhouse;
- j. Therapeutic Living Supports (or Specialized Residential Treatment centers);
- k. Transitional housing;
- l. Representative payee;
- m. Supported employment; and
- n. Peer specialist.

40.810 Covered Behavioral Health Services

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

The BHO shall submit a detailed plan describing the service delivery system including all current medically necessary behavioral health services covered by the Hawaii Medicaid program and non-traditional services that will be in place to serve members. The plan shall be submitted to the DHS for review and approval by the date specified in Section 51.300, Readiness Review. At a minimum, the BHO shall describe how it shall ensure access to the services listed in this section below:

- Inpatient Psychiatric Hospitalization services (twenty-four hour care). Services include:

- Room and board
 - Nursing care
 - Medical supplies, equipment and drugs
 - Diagnostic services
 - Psychiatric services
 - Other practitioner services as needed
 - Physical, occupational, speech and language therapy
 - Other medically necessary services
- Ambulatory behavioral health services includes 24-hour, 7 days/week emergency/crisis intervention
 - Mobile crisis response
 - Crisis stabilization
 - Crisis hotline
 - Crisis residential services
- Medication Management
 - Medication evaluation
 - Medication counseling and education
 - Psychotropic medications
- Diagnostic services including:
 - Psychological testing
 - Psychiatric or psychological evaluation and treatment (including neuropsychological evaluation)
 - Psychosocial history
 - Screening for and monitoring treatment of substance abuse and mental illness
 - Other medically necessary behavioral health diagnostic services to include labs
- All medically necessary alcohol and chemical dependency services
- Methadone Management Services which include the provision of methadone or a suitable alternative (i.e. LAAM or bupernorphoine) as well as outpatient counseling services
- Intensive Case Management

- Case assessment
- Case planning (service planning, care planning)
- Outreach
- Ongoing monitoring and service coordination
- Coordination with member's health plan and PCP
- Partial hospitalization or intensive outpatient hospitalization including:
 - Medication management
 - Prescribed drugs
 - Medical supplies
 - Diagnostic tests
 - Therapeutic services including individual, family, and group therapy and aftercare
 - Other medically necessary services
- Psycho-Social Rehabilitation/Clubhouse services including:
 - Work assessment service
 - Intensive day treatment
 - Day treatment
 - Residential treatment services
 - Social/recreational therapy services
- Therapeutic Living Supports to include specialized residential treatment facilities
- Transitional housing
- Representative Payee
- Supported employment services including:
 - Work assessment service
 - Pre-employment service
- Peer Specialist
- Behavioral health outpatient services also include:
 - Screening, Registration, and Referral
 - Treatment/service planning
 - Individual/group therapy and counseling
 - Family/collateral therapeutic support and education

- Continuous treatment teams
- Other medically necessary therapeutic services
- Other services
 - Other medically necessary practitioner services provided by licensed and/or certified healthcare providers
 - Other medically necessary therapeutic services including services which would prevent institutionalization
 - Maintenance of member's medical assistance eligibility

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

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

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

40.900 Out-of-State and Off-Island Coverage

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

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

Out-of-state emergency behavioral health services for members are covered under the BHO, if approved by the DHS. Emergency services are defined in §1932(b)(2) to the Social Security Act as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent

layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to body functions or serious dysfunction of any bodily organ or part.”

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

If a BHO 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 QExA plan while residing out of the State (and in active treatment). It is the responsibility of the BHO 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 BHO shall pay for such services. If the BHO has agreements with certain providers, the providers are in close proximity to the member, and the member can be safely transferred, the BHO may require that the member obtain the services from the specified providers.

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

41.100 Other Services to be Provided

In addition to the behavioral health services listed in Subsection 40.810, Covered Behavioral Health Services, the plan shall provide certain specialized services. This section lists the required other services:

- Member Education

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

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

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

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

- Cultural/Interpretation Services

The BHO shall provide oral interpretation services to individuals with Limited English Proficiency (LEP), sign language services and TDD services at no cost to the individual. The BHO shall notify its members and potential members of the availability of free interpretation services, sign language and TDD services, and inform them of how to access these services.

The BHO shall meet the following oral interpretation special requirements:

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

- Document the offer of an interpreter, and whether an individual declined or accepted the interpreter service.

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

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

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

- Accessible Transportation Services

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

- Outreach

Outreach involves the provision of services wherever necessary to assure all eligible members receive needed behavioral health services, (i.e., outreach to the home, homebound, homeless, etc.). The BHO shall establish and

maintain contact with all eligible members, but especially these special need individuals.

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

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

- Appointment Follow-up

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

- Hotline

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

hotline services may be on-line or provided through other means, such as pagers, with a maximum response time of 30 minutes.

- Adverse Events Policy/Reporting

The BHO shall have policies and procedures in place to identify and address adverse events that occur to their members. Adverse events include but are not limited to death, suicide attempts, altercations with law enforcement personnel including incarceration, involvement with Adult Protective Services, homicide or attempted harm to others, medication errors, and injuries requiring medical attention. The BHO shall submit to the DHS, for review and approval, policies and procedures relating to adverse events by the due date identified in Section 51.300, Readiness Review.

- Certification of Physical or Mental Impairment

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

41.200 Transition of Care

The BHO shall coordinate the transition of behavioral healthcare services for newly enrolled members with the DOH-CAMHD, DOH-AMHD, QUEST health plans and the QExA health plans, since many of the eligible members already have an established behavioral health care provider with the BHO. For some of these individuals, an abrupt change in therapy may be detrimental.

Upon commencement of services to members identified in Section 20.100, members receiving medically necessary behavioral health services the day before enrollment into the BHO, the BHO shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided by contract or non-contract providers. The BHO shall provide continuation of such services for ninety (90) days for all members or until the member has had an assessment from his

or her case manager, had an ITP developed and has been seen by his or her behavioral healthcare specialist. All non-contract providers shall be reimbursed at the Medicaid FFS rates in effect at the time of service delivery.

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

The BHO shall submit to the DHS, for review and approval, policies and procedures relating to transition of care by the due date identified in Section 51.300, Readiness Review.

41.300 On-Site Visits

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

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

41.400 Geographic Areas to be Served

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

SECTION 50 ADMINISTRATIVE REQUIREMENTS

50.100 Notification of Enrollment

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

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

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

50.110 Responsibilities of the BHO

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

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

- Assign a member number to the member. This may be the member's Medicaid ID number.
- Assign a case manager to each member on the date of enrollment. For members that already have a case manager in the community, the BHO shall maintain this relationship. If the member or case manager in the community is not interested in continuing this relationship, then the BHO shall perform transition of care as described in Section 41.200.
- Explain the role of the case manager to the member and the procedures to be followed to obtain needed services. Provide the member with a listing of the providers. Orient and familiarize, then provide each member with a member handbook which explains the operations of the plan including the procedures to follow to make an appointment, obtain emergency services, change BHO providers or prescribing psychiatrist, member rights and responsibilities, file a complaint and grievance procedures, etc.
- Assist the member in the selection of a provider and explain the role and responsibilities of the behavioral health provider and/or the CM, as applicable and the procedures to be followed to obtain needed services. The BHO shall maintain the member with their current provider, if applicable. If the member does not select or does not have their own behavioral health provider from the provider network within ten (10) days of enrollment, the BHO shall identify a provider for the member.
- Explain the confidentiality policies related to the member's case documentation records (includes treatment records).
- Explain to the member the information that needs to be provided by the member to the BHO and DHS upon changes in the status of the member including marriage, divorce, birth of a child, adoption of a child, death of a spouse or child, acceptance of a job, obtaining other health insurance, etc.
- Issue membership card(s) to the enrolled members with adequate information for providers to identify the following:
 - Member number
 - Member name
 - Effective date
 - Benefit, e.g. behavioral health services only
 - Crisis hotline
 - Toll-free telephone number
 - Third Party Liabilities (TPL's)

- Eligibility renewal date

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

50.120 Eligibility Verification

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

50.200 Disenrollment

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

- Member no longer qualifies based on the eligibility criteria for the Medicaid program or voluntarily leaves the program
- No contact with member established for over four (4) months
- Member refuses services and requests disenrollment from the program
- Member no longer meets SMI eligibility determination criteria
- Member moves to another State
- Member becomes a member in the QUEST program
- Death of the member
- Incarceration of the member
- Transfer of the member to a long term care nursing facility or an ICF-MR facility and 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 is sent out-of-state for medical treatment by DHS or a health plan and DHS or the health plan will assume responsibility for the behavioral health care needs of the member.
- Member is admitted to the State Hospital

- Member provides false information with the intent of enrolling in a DHS program under false pretenses

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

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

50.210 Members Who No Longer Meet the Criteria for SMI

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

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

Members who have not maintained contact for a period of four (4) months with the BHO, despite the continuing efforts of the BHO to reach out to the member, shall be placed on a disenrollment list submitted to the MQD the first week of each month. If, by the end of the fifth month, the member has not responded to Certified Mail (intended to re-establish contact) from the BHO, they shall be disenrolled from the BHO.

50.300 Assessment and Collection of Fees and Penalties

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

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

50.400 Quality Improvement

50.410 Importance of Quality Improvement

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

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

- Provision of services in a timely manner with reasonable waiting times for office visits and the scheduling of appointments
- Provision of services in a manner which is sensitive to the cultural differences of members
- Provision of services in a manner which is accessible for members

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

50.420 Quality Improvement Programs

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

The BHO shall be required to submit written descriptions of its QIP including definitions of accepted standards of practice and established policies and procedures. The documentation shall be provided to DHS as part of Readiness Review described in Section 51.300 and upon request by DHS.

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

- Written QIP Description – The QIP shall be a written document describing the following:
 - Goals and objectives

- Scope of the QIP
 - Specific activities to be undertaken such as studies
 - Continuous activity and tracking issues
 - Provider review
 - Focus on behavioral health outcomes
 - Systematic process of quality assessment and improvement
 - Evaluation of the continuity and effectiveness of the QIP
- Accountability of the Governing Body – The governing body of the organization, usually the Board of Directors, shall be responsible for the quality of care provided. The responsibilities of the governing body include oversight of the QIP, review of the progress of the QIP, and modifications to the program as needed.
 - Active QIP Committee – The Committee shall have regular meetings; document its activities, findings, and recommendations and ensure follow-up; be accountable to the governing body, and have a cross section of BHO providers.
 - QIP Supervision – The QIP Committee should be the responsibility of a senior executive and the Medical Director should have substantial involvement.
 - Adequate Resources – The QIP Committee should be provided with sufficient material resources to carry out its activities.
 - Delegation of QIP Activities - The BHO shall remain responsible for the QIP even if portions are delegated to other entities. Any delegation of functions requires a written description of the delegated activities and written procedures for monitoring and evaluation.
 - Member Rights and Responsibilities – The QIP shall have written policies and procedures that state the plan's commitment to treating members in a manner that respects their rights as well as its expectation of members' responsibilities.
 - Standards for Availability and Accessibility – The QIP shall have established standards for access to services, which are to be compared to the plan's actual performance. Access and

availability include standards for triage and travel time, telephone access and availability of appointments, which define the level of urgency and appropriate level of care.

- Case Documentation Records Standards – The QIP shall establish standards for the accessibility and availability of case documentation records and the information to be recorded and maintained in the records. A record review system to assess and assure conformance with standards shall be established.
 - At a minimum, the treatment record shall be maintained by the BHO provider and include a record of the member's medical and treatment history, all behavioral healthcare services provided to the member, assessments (including telephone assessments), medication profile (current and historical), treatment plans, and goals for future clinical care. The treatment record shall indicate the current BHO provider, other service provider(s), and history of changes in psychiatrist and other providers, as well as referrals for related specialist care and behavioral health services authorized by the BHO provider and/or CM.

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

- All case documentation records shall meet NCQA behavioral health guidelines for treatment record review. Records shall be maintained in a detailed, comprehensive, and organized manner which conform to good professional medical practice, permit effective professional medical review and medical audit processes and which facilitate an adequate system for follow-up treatment. All entries shall be legible, signed, and dated.
- Confidentiality of the records shall be maintained. Upon enrollment with the plan, the BHO shall ensure that confidential member records are accessible only to authorized persons, in accordance with written consent granted by a member or a member's representative or

with applicable State or Federal laws, rules or regulations. Subcontractors and other network providers are not required to obtain subsequent written consent from the member before providing access to the records, as long as access to the records is needed to perform the duties of this contract and to administer the program. Approval is also not needed for access by authorized DHS personnel or personnel contracted by DHS. (Refer to Section 61.400, Confidentiality of Information, for additional information)

- Utilization Review – The QIP shall include a written description of the BHO’s utilization management (UM) program which outlines the program structure and accountability. The scope of UM may include formal preauthorization, triage, concurrent review, discharge planning, retrospective review and case management. The UM plan includes policies and procedures to evaluate care management, sites of service, level of care, triage, benefit coverage and cost of benefits to determine if they are clinically appropriate to the behavioral healthcare needs of the members.
 - The program should include evaluating medical necessity, the criteria used and the process used to review and approve the provision of clinical services. The focus of the UM program is to detect underutilization, overutilization, and inappropriate utilization.
 - The BHO shall have in place a prior authorization (PA) process that ensures timely determination for access to care/services. Individuals shall perform PA determinations with demonstrated competency and knowledge of appropriate treatment/services for conditions/illnesses. The BHO shall have a process with timeframes that address PA decision-making for behavioral health services/procedures that the BHP determines to be medically necessary. The BHO may have different processes for emergencies, urgent, or non-urgent services but in general, all PA's must be completed within 30 days. The PA and the related appeals process shall be documented and made available to all participating providers. Refer to Section 40.400 regarding additional information for Authorization of Services.

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

50.430 Responsibilities of the BHO

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

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

50.500 Performance Incentives

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

The BHO may be eligible for performance incentives. The amount of incentive and measures shall be determined by the

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

50.600 Monitoring and Evaluation

50.610 Internal QIP Monitoring

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

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

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

50.620 External Monitoring

DHS may contract with a qualified entity to conduct an independent medical review or audit of the quality of services

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

50.630 Conduct Surveys

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

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

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

50.640 Conduct Case Study Interviews

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

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

50.650 CMS Contracted Review Organization

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

50.700 Reporting Requirements

50.710 Purpose for Data to be Collected

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

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

50.720 Timeliness of Data Submitted

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

50.730 Reports

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

All reporting data shall be submitted to the DHS in electronic format of either Word 2010 or lower (.docx), or Excel 2010 or lower (.xlsx). Reporting data shall not be submitted with read only or protected formatting.

As described in Section 50.720, the State may impose financial penalties for failure to produce accurate reports according to the time frames identified.

Data received from the BHO on quality, performance, patient satisfaction, or other measures shall be used for monitoring,

public reporting, and financial incentives. DHS shall also share information about the BHO to promote transparency and sharing of benchmarks/best practices. DHS shall publicly report measures in formats such as a consumer guide, public report, or otherwise, on MQD's website.

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

Category	Report	RFP Section	Due Dates
Provider Network and Services	Provider Network Adequacy & Capacity Report	50.740.1	April 30 July 31 October 31 January 31
Provider Network and Services	GeoAccess (or similar format) Report	50.740.2	April 30 July 31 October 31 January 31
Provider Network and Services	Provider Suspension & Termination Report	50.740.3	April 30 July 31 October 31 January 31
Provider Network and Services	Provider Complaints & Claims Report	50.740.4	April 30 July 31 October 31 January 31
Member Services	Member Complaints, Grievances & Appeals Report	50.750.1	April 30 July 31 October 31 January 31
Member Services	Behavioral Health Services Report	50.750.2	April 30 July 31 October 31 January 31
Administration & Financial Reports	QIP Description	50.760.1	September 30

Category	Report	RFP Section	Due Dates
Administration & Financial Reports	Prior Authorization Requests Denied/Deferred Report	50.760.2	April 30 July 31 October 31 January 31
Administration & Financial Reports	Fraud and Abuse Report	50.760.3	April 30 July 31 October 31 January 31
Administration & Financial Reports	BHO Financial Reports	50.760.4	April 30 July 31 October 31 January 31

50.740 Provider Network and Service Reports

50.740.1 *Provider Network Adequacy and Capacity Report*

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

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

- A listing of all providers and include the specialty or type of practice of the provider;
- The provider's location;
- Mailing address including the zip code;
- Telephone number;
- Professional license number and expiration date;
- Indication as to whether the provider has a limit on the number of the program patients he/she will accept
- Indication as to whether the provider is accepting new patients;
- Non-English language spoken (if applicable);
- Verification of valid license for in-state and out-of-state providers; and

- Verification that provider or affiliated provider is not on the federal or state exclusions list.

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

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

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

50.740.2 GeoAccess (Or Similar Program) Reports

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

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

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

In addition to the due date as identified in Section 50.730, these reports shall be submitted to the DHS at the following times:

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

50.740.3 *Provider Suspensions and Termination Report*

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

50.740.4 *Provider Complaints and Claims Report*

The BHO shall submit *Provider Complaints Reports* that include the following information from the previous quarter:

- The total number of resolved complaints by category (benefits and limits; eligibility and enrollment; member issues; BHO issues);
- The total number of unresolved complaints by category (benefits and limits; eligibility and enrollment; member issues; BHO issues) and the reason code explaining the status (i.e., complaint is expected to be resolved by the reporting

date, and complaint is unlikely to be resolved by the reporting date);

- Status of provider complaints that had been reported as unresolved in previous report(s);
- Status of delays in claims payment, denials of claims payment, and claims not paid correctly which includes the following:
 - The number of claims processed for each month in the reporting quarter;
 - The number of claims paid for each month in the reporting quarter;
 - The percentage of claims processed (at 30 and 90 days) after date of service for each month of the reporting quarter;
 - The number of claims denied for each month in the reporting quarter; and
 - The percentage of claims denied for each of the following reasons: (1) prior authorization/referral requirements were not met for each month in the reporting quarter; (2) submitted past the filing deadline for each month in the reporting quarter; (3) provider not eligible on date of service for each month in the reporting quarter; (4) member not eligible on date of service; and (5) member has another health insurer which shall be billed first.

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

50.750 Member Services Reports

50.750.1 *Member Complaints, Grievances and Appeals Report*

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

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

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

50.750.2 *Behavioral Health Services Report*

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

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

50.760 Administration and Financial Reports

50.760.1 *Quality Improvement Program (QIP) Report*

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

- Any changes to the QIP Program;
- A detailed set of QIP Program goals and objectives that are developed annually and includes timetables for implementation and accomplishments;
- A copy of the BHO's organizational chart including vacancies of required staff, changes in scope of responsibilities, changes in delegated activities and additions or deletions of positions;
- A current list of the required staff as detailed in Section 50.400 including name, title, location, phone number and fax number;
- An executive summary outlining the changes from the prior QIP;

- A copy of the current approved QIP Program description, the QIP Program work plan and, if issued as a separate document, the BHO's current utilization management program description with signatures and dates;
- A copy of the previous year's QIP Program, if applicable, and utilization management program evaluation reports; and
- Written notification of any delegation of QIP Program activities to contractors.

50.760.2 *Prior Authorization Requests Denied/Deferred*

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

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

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

50.760.3 *Fraud and Abuse Summary Reports*

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

- A summary of all fraud and abuse referrals made to the State during the quarter, including the total number, the administrative disposition of the case, any disciplinary action imposed both before the filing of the referral and after, the approximate dollars involved for each incident and the total approximate dollars involved for the quarter;

- A summary of the fraud and abuse detection and investigative activities undertaken during the quarter, including but not limited to the training provided, provider monitoring and profiling activities, review of providers' provision of services (under-utilization and over-utilization of services), verification with members that services were delivered, and suspected fraud and abuse cases that were ultimately not fraud or abuse and steps taken to remedy the situation; and
- Trending and analysis as it applies to: utilization management, claims management, post-processing review of claims, and provider profiling.

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

50.760.4 *BHO Financial Reporting Guide*

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

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

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

50.770 BHO Certification

The BHO shall certify the accuracy, completeness, and truthfulness of any data, including but not limited to, encounter data, data upon which payment is based, and other information required by the State, that may be submitted to determine the basis for payment from the State agency. The BHO shall certify that it is in substantial compliance with the contract and provide a letter of certification attesting to the accuracy, completeness, and truthfulness of the data submitted based on best knowledge,

information, and belief. The BHO shall submit the letter of certification to the MQD concurrent with the certified data and document submission. In the case of two (2) submissions in one month, the BHO shall submit two (2) letters of certification. The certifications are to be based on best knowledge, information, and belief of the following BHO personnel.

The data shall be certified by:

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

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

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

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

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

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

The BHO shall submit the most current copy of any policies and procedures requested. In the event the BHO has previously submitted a copy of a specific policy or procedure and there have

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

50.800 Information Technology

50.810 General Requirements

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

50.820 Expected Functionality

The DHS expects BHO information systems to facilitate and to integrate the following essential BHO case management and coordination of care functions: (1) member health status assessments; (2) determination of the optimal mix of health care services needed to improve the health status of said members; (3) coordination and oversight of the delivery of said services; and (4) the analysis and reporting of service utilization and outcomes data required to manage these functions effectively.

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

50.830 Method of Data Exchange with MQD

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

50.840 Chain of Trust Agreement

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

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

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

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

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

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

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

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

50.860 Possible Audits of BHO Information Technology

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

50.870 BHO Information Technology Changes

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

50.880 Disaster Planning and Recovery Operations

The BHO shall have in place disaster planning and recovery operations appropriate for the BHO industry, and comply with all applicable federal and state laws relating to security and recovery of confidential information and electronic data. The health plan shall provide the DHS with a copy of its documentation describing its disaster planning and recovery operations by the due date identified in Section 51.300, Readiness Review.

50.900 Encounter Data Requirements

The BHO shall submit encounter data to MQD once per month in accordance with the requirements and specifications defined by the State and included in the Health Plan Manual. Encounters shall be certified and submitted by the BHO as required in 42 CFR Section 438.606 and as specified in Section 50.770.

50.910 Accuracy, Completeness and Timeliness of Encounter Data Submissions

The following encounter data submission requirements apply:

- Accuracy and Completeness – The data and information provided to the DHS shall be accurate and complete. Data and reports shall be mathematically correct and present accurate information. An accurate and complete encounter is

one that reports a complete and accurate description of the service provided, and that passes the full edits/audits of the encounter processing cycle.

- Timeliness – sixty percent (60%) of the encounter data shall be received by the DHS no more than one hundred twenty (120) days from the date that services were rendered. BHOs shall have the goal of submitting one hundred percent (100%) and shall submit no less than ninety-nine percent (99%) of encounter data within fifteen (15) months from the date of services. Adjustments and resubmitted encounters shall not be subject to the one hundred twenty (120) day submission requirement. In addition, TPL related encounters shall not be subject to the one hundred twenty (120) day submission deadline.

The BHO shall be notified by the DHS within thirty (30) days from the receipt date of the initial encounter submission of all encounters that have failed the accuracy and completeness edits. The BHO shall be granted a thirty (30) day error resolution period from the date of notification. If, at the end of the thirty (30) day error resolution period, fifteen percent (15%) of the initial encounter submission continues to fail the accuracy and completeness edits, a penalty amounting up to ten percent (10%) of the monthly (initial month's submission) capitation payment may be assessed against the BHO for failing to submit accurate and timely encounter data. In a case where the BHO contract is not continued, a penalty of up to ten percent (10%) may be assessed against all of the outstanding payments to the BHO for failing to submit accurate and timely encounter data.

51.100 Notification of Changes in Member Status

51.110 Member and BHO Responsibilities

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

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

51.120 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
- Enrollment into a QUEST health plan
- On conditional release or receiving services from AMHD
- Change in income

51.200 Educational Materials

51.210 BHO's Responsibilities

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

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

- Role and selection of a BHO provider
- CM system: role and selection of a CM and how to access 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

A copy of this booklet shall be submitted to DHS for review and approval in the timeframe described in Section 51.300, Readiness Review.

51.220 Requirements for Written Materials

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

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

The BHO shall make all written information for members available in English, Ilocano, Vietnamese, Chinese (Traditional) and Korean. When the BHO is aware that the member needs written information in one of these alternate languages, the BHO shall send all written information in this language to that member. The BHO may provide information in other prevalent non-English languages based upon its member population as required in Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d, 45 CFR Part 80.

All written materials distributed to members shall include a language block that informs the member that the document contains important information and directs the member to call the BHO to request the document in an alternative language or to have it orally translated. The language block shall be printed, at a minimum, in the non-English languages identified in paragraph 3 of this Section.

The BHO shall certify that a qualified individual has reviewed the translation of the information into the different languages for accuracy. The BHO shall submit certification and translation of information into different languages for review and approval by the due date identified in Section 51.300, Readiness Review.

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

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

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

51.300 Readiness Review

51.310 Required Review Documents

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

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

- Provider network composition and access;
- Quality Improvement program (QIP) standards;
- Utilization Management Program (UMP) strategies; and
- All required policies and procedures.

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

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

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

Document	RFP Reference Section	Due Date
Credentialing, recredentialing and other certification policies and procedures	40.320 Provider Credentialing, Recredentialing and Other Certifications	30 days after contract effective date
Model for each provider contract	40.330 Provider Contracts	10 days after contract effective date

Document	RFP Reference Section	Due Date
Medical records standards	40.340 Review of Medical Records	60 days after contract effective date
Provider availability policy and procedure	40.350 Provider Availability	30 days after contract effective date
Prior authorization/pre-certification policies and procedures	40.400 Authorization of Services	60 days after contract effective date
Grievance system policies and procedures	40.500 Member Grievance System	60 days after contract effective date
Detailed plan for service delivery system	40.810 Covered Behavioral Health Services	30 days after contract effective date
Behavioral Health Adverse Events policy and Procedure	41.100 Adverse Events Policy/Reporting	30 days after contract effective date
Transition of Care policies and procedures	41.200 Transition of Care	30 days after contract effective date
QI Program	50.420 QI Program	60 days after contract effective date
Documentation describing its disaster planning and recovery operations	50.880 Disaster Planning and Recovery Operations	90 days after contract effective date
Member booklet	51.200 Educational Materials	30 days after contract effective date
Translation Certification	51.220 Requirements for Written Materials	Within 30 days of DHS approval of English versions of documents

Document	RFP Reference Section	Due Date
A GeoAccess (or comparable program) report	51.320 Updated GeoAccess Reports	30 days after contract effective date
Subcontractor Agreements	60.300 Subcontracts Agreements	60 days after contract effective date

51.320 Updated GeoAccess Reports

The BHO shall submit, within thirty (30) days of the date of Contract Effective Date identified in Section 20.100, updated GeoAccess reports (or reports generated by a similar program) that include all providers who have signed a provider agreement. The BHOs shall submit additional reports to DHS every two (2) weeks thereafter until sixty (60) days prior to the date of Commencement of Services to Members identified in Section 20.100.

51.330 BHO Provider Network

The BHOs must meet provider network requirements outlined in Section 40.300 no later than sixty (60) days prior to date of Commencement of Services to Members as described in Section 20.100.

SECTION 60 TERMS AND CONDITIONS

60.100 Contract Documents

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

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

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

60.200 Conflict Between Contract Documents, Statutes and Rules

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

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

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

60.300 Subcontracts Agreements

Replace General Condition 3.2, Subcontracts and Assignments, with the following:

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

The BHO shall submit to the DHS for review and prior approval, all subcontractor agreements related to the provision of covered benefits and services and member services activities to members (e.g., call center) and provider services activities and payments to providers. The BHO shall submit these subcontractor agreements as required in Section 51.300, Readiness Review. In addition, the DHS reserves the right to inspect **all** subcontractor agreements at any time during the contract period.

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

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

Additionally, no assignment by the BHO of the BHO's right to compensation under the contract shall be effective unless and

until the assignment is approved by the Comptroller of the State of Hawaii, as provided in Section 40-58, HRS, or its successor provision.

All subcontractor agreements must, at a minimum:

- Describe the activities, including reporting responsibilities, to be performed by the subcontractor and require that the subcontractor meet all established criteria prescribed and provide the services in a manner consistent with the minimum standards specified in the BHO's contract with the State;
- Require that the subcontractor fulfill the requirements of 42 CFR Section 438.6 that are appropriate to the service delegated under the subcontract;
- Provide information regarding member rights and processes regarding the Member Grievance System found in Section 40.500, if applicable;
- Include a provision that allows the BHO to:
 - Evaluate the subcontractor's ability to perform the activities to be delegated;
 - Monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule (the frequency shall be stated in the agreement) established by the DHS and consistent with industry standards or State laws and regulations;
 - Identify deficiencies or areas for improvement; and
 - Take corrective action or impose other sanctions including, but not limited to, revoking delegation, if the subcontractor's performance is inadequate.
- Require that the subcontractor submits to the BHO a tax clearance certificate from the Director of the DOTAX, State of Hawaii, showing that all delinquent taxes, if any, levied or accrued under State law against the subcontractor have been paid;
- Fulfill the requirements of 42 CFR Section 434.6 that are appropriate to the service delegated under the subcontract;
- Include a provision that the BHO shall designate itself as the sole point of recovery for any subcontractor;
- Include a provision that neither the State nor the BHO members shall bear any liability of the BHO's failure or refusal to pay valid claims of subcontractors;
- Require that the subcontractor track and report complaints against them to the BHO;

- Require that the subcontractor fully adhere to the privacy, confidentiality and other related requirements stated in the RFP and in applicable federal and state law;
- Require that the medical records be retained in compliance with Section 60.400. The actual requirements shall be detailed in the agreement;
- Require that the subcontractor comply with all requirements related to confidentiality of information as outlined in Section 61.400. The actual requirements found in this section shall be detailed in the agreement.
- Require that the subcontractor notify the BHO and the MQD of all breaches of confidential information relating to Medicaid applicants and recipients, as BHO members. The notice to the State shall be within two (2) business days of discovery of the breach and a written report of the investigation and resultant mitigation of the breach shall be provided to the State within thirty (30) business days of the discovery of the breach.

60.400 Retention of Medical Records

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

The BHO and its providers shall retain all medical records, in accordance with Section 622-58, HRS, for a minimum of seven (7) years from the last date of entry in the records. For minors, the BHO shall retain all medical records during the period of minority plus a minimum of seven (7) years after the age of majority.

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

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

60.500 Responsibility For Taxes

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

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

60.600 Full Disclosure

60.610 Business Relationships

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

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

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

60.620 Litigation

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

60.700 Fiscal Integrity

60.710 Warranty of Fiscal Integrity

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

60.720 Performance Bond

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

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

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

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

Upon termination of the contract, for any reason, including expiration of the contract term, the BHO shall ensure that the performance bond is in place until such time that all of the terms of the contract have been satisfied. The performance bond shall be liable for, and the DHS shall have the authority to, retain funds for additional costs including, but not limited to:

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

60.800 Term of the Contract

This is a multi-term contract solicitation that has been deemed to be in the best interest of the State by the Director of the DHS in accordance with Section 3-149-302(c), HAR. The contract is for the initial term from the date of commencement of services to members as specified in Section 20.100 to June 30, 2015. Unless terminated, the contract shall be extended without the necessity of re-bidding, for not more than three (3) additional twelve (12) month periods or parts thereof, only upon mutual agreement of the parties in writing. The BHO shall not contract with the State of Hawaii unless safeguards at least equal to Federal safeguards (41 U.S.C. 423, section 27) are in place.

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

The contract will be terminated only if funds are not appropriated or otherwise made available to support continuation of performance in any fiscal period succeeding the initial fiscal period of the contract; however this does not affect either the State's rights or the BHO's rights under any termination clause of the contract. The State shall notify the BHO, in writing, at least sixty (60) days prior to the expiration of the contract whether funds are available or not available for the continuation of the contract for each succeeding contract extension period. In the event of termination, as provided in this paragraph, the BHO shall be reimbursed for the unamortized, reasonably incurred, nonrecurring costs. The award of a contract and any allowed renewal or extension thereof, is subject to allotments made by the Director of Finance, State of Hawaii, pursuant to HRD Chapter 37, and subject to the availability of State and/or Federal funds.

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

60.900 Insurance

60.910 Liability Insurance Requirements

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

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

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

The policy(ies) shall provide at least the following limit(s) and coverage:

Coverage	Limits
Commercial General Liability	Per occurrence, not claims made <ul style="list-style-type: none"> • \$1 million per occurrence • \$2 million in the aggregate
Automobile	May be combined single limit: <ul style="list-style-type: none"> • Bodily Injury: \$1 million per person, \$1 million per accident • Property Damage: \$1 million per accident
Workers Compensation / Employers Liability (E.L.)	<ul style="list-style-type: none"> • Workers Comp: Statutory Limits • E.L. each accident: \$1,000,000 • E.L. disease: \$1,000,000 per employee, \$1,000,000 policy limit • E.L. \$1 million aggregate
Professional Liability, if applicable	May be claims made: <ul style="list-style-type: none"> • \$1 million per claim • \$2 million annual aggregate

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

1. "The State of Hawaii is an additional insured with respect to operations performed for the State of Hawaii."

2. "Any insurance maintained by the State of Hawaii shall apply in excess of, and not contribute with, insurance provided by this policy."

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

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

Failure of the BHO to provide and keep in force the insurance required under this section shall be regarded as a material default under this contract, entitling the DHS to exercise any or all of the remedies provided in this contract for a default of the BHO.

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

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

60.920 Reinsurance

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

61.100 Modification of Contract

The following is added as General Condition 4.1.4:

All modifications of the contract shall be negotiated and accompanying capitated rates established. If the parties reach an agreement, the contract terms shall be modified accordingly

by a written amendment signed by the Director of the DHS and an authorized representative of the BHO. If the parties are unable to reach an agreement within thirty (30) days of the BHO's receipt of a contract change, the MQD Administrator shall make a determination as to the contract modifications and capitation rate, and the BHO shall proceed with the work according to a schedule approved by the DHS, subject to the BHO's right to appeal the MQD Administrator's determination of the contract modification and price under Section 61.600, Disputes.

61.200 Conformance with Federal Regulations

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

61.300 Termination of the Contract

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

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

61.310 Termination for Default

The failure of the BHO to comply with any term, condition, or provision of the contract or applicable requirements in Sections 1932, 1903(m) and 1905(t) of the Social Security Act shall constitute default by the BHO. In the event of default, the DHS shall notify the BHO by certified or registered mail, with return receipt requested, of the specific act or omission of the BHO, which constitutes default. The BHO shall have fifteen (15) days from the date of receipt of such notification to cure such default. In the event of default, and during the above-specified grace period, performance under the contract shall continue as though

the default had never occurred. In the event the default is not cured within fifteen (15) days, the DHS may, at its sole option, terminate the contract for default. Such termination shall be accomplished by written notice of termination forwarded to the BHO by certified or registered mail and shall be effective as of the date specified in the notice. If it is determined, after notice of termination for default, that the BHO's failure was due to causes beyond the control of and without error or negligence of the BHO, the termination shall be deemed a termination for convenience under General Condition 4.3 in Appendix E.

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

61.320 Termination for Expiration or Modification of the Programs by CMS

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

61.330 Termination for Bankruptcy or Insolvency

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

In the event of insolvency of the BHO, the BHO shall cover continuation of services to members for the duration of period for which payment has been made, as well as for inpatient

admissions up until discharge. Members shall not be liable for the debts of the BHO. In addition, in the event of insolvency of the BHO, members may not be held liable for the covered services provided to the member, for which the State does not pay the BHO.

61.340 Procedure for Termination

In the event the State decides to terminate the contract, it shall provide the BHO with a pre-termination hearing. The State shall:

- Give the BHO written notice of its intent to terminate, the reason(s) for termination, and the time and place of the pre-termination hearing; and
- Give the BHO's members written notice of the intent to terminate the contract, notify members of the hearing, and allow them to disenroll immediately without cause.

Following the termination hearing, the State shall provide written notice to the BHO of the termination decision affirming or reversing the proposed termination. If the State decides to terminate the contract, the notice shall include the effective date of termination. In addition, if the contract is to be terminated, the State shall notify the BHO's members in writing of their options for receiving Medicaid services following the effective date of termination.

In the event of any termination, the BHO shall:

- Stop work under the contract on the date and to the extent specified in the notice of termination;
- Complete the performance of such part of the work as shall not have been terminated by the notice of the termination;
- Notify the members of the termination and arrange for the orderly transition to the new BHO(s), including timely provision of any and all records to the DHS that are necessary to transition the BHO's members to another BHO;
- Promptly supply all information necessary for the reimbursement of any outstanding Medicaid claims;
- Place no further orders or enter into subcontracts for materials, services, or facilities, except as may be necessary for completion of the work under the portion of the contract that is not terminated;

- Terminate all orders and subcontracts to the extent that they relate to the performance of work terminated by the notice of termination;
- Assign to the DHS in the manner and to the extent directed by the MQD Administrator of the right, title, and interest of the BHO under the orders or subcontracts so terminated, in which case the DHS shall have the right, in its discretion, to settle or pay any or all claims arising out of the termination of such orders and subcontracts;
- With the approval of the MQD Administrator, settle all outstanding liabilities and all claims arising out of such termination of orders and subcontracts, the cost of which would be reimbursable, in whole or in part, in accordance with the provisions of the contract.
- Take such action as may be necessary, or as the MQD administrator may direct, for the protection and preservation of any and all property or information related to the contract which is in the possession of the BHO and in which the DHS has or may acquire an interest; and
- Within thirty (30) business days from the effective date of the termination, deliver to the DHS copies of all current data files, program documentation, and other documentation and procedures used in the performance of the contract at no cost to the DHS. The BHO agrees that the DHS or its designee shall have a non-exclusive, royalty-free right to the use of any such documentation.

The BHO shall create written procedures for the orderly termination of services to any members receiving the required services under the contract, and for the transition to services supplied by another BHO upon termination of the contract, regardless of the circumstances of such termination. These procedures shall include, at the minimum, timely notice to the BHO's members of the termination of the contract, and appropriate counseling. The BHO shall submit these procedures to the DHS for approval upon their completion, but no later than one hundred eighty (180) days after the effective date of the contract.

61.350 Termination Claims

After receipt of a notice of termination, the BHO shall submit to the MQD Administrator any termination claim in the form and with the certification prescribed by the MQD Administrator. Such

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

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

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

In the event the BHO and the DHS fail to agree, in whole or in part, on the amount of costs to be paid to the BHO in connection with the total or partial termination of work pursuant to this section, the MQD Administrator shall determine, on the basis of information available to the DHS, the amount, if any, due to the BHO by reason of the termination and shall pay to the BHO the amount so determined.

The BHO shall have the right to appeal any such determination made by the MQD Administrator as stated in Section 61.600, Disputes.

61.400 Confidentiality of Information

In addition to the requirements of General Condition 8, the BHO understands that the use and disclosure of information concerning applicants, recipients or members is restricted to purposes directly connected with the administration of the Hawaii Medicaid program, and agrees to guard the confidentiality of an applicant's, recipient's or member's information as required by law. The BHO shall not disclose confidential information to any individual or entity except in compliance with the following:

- 42 CFR Part 431, Subpart F;

- The Administrative Simplification provisions of HIPAA and the regulations promulgated thereunder, including but not limited to the Security and Privacy requirements set forth in 45 CFR Parts 160, 162 and 164, (if applicable);
- Section 346-10, HRS; and
- All other applicable federal and State statutes and administrative rules, including but not limited to:
 - Section 325-101, HRS, relating to persons with HIV/AIDS;
 - Section 334-5, HRS, relating to persons receiving mental health services;
 - Chapter 577A, HRS relating to emergency and family planning services for minor females;
 - 42 CFR Part 2 relating to persons receiving substance abuse services;
 - Chapter 487J, HRS, relating to social security numbers
 - Chapter 487N, HRS, relating to personal information.

Access to member identifying information shall be limited by the BHO to persons or agencies that require the information in order to perform their duties in accordance with this contract, including the U.S. Department of Health and Human Services (DHHS), the DHS and other individuals or entities as may be required by the DHS. (See 42 CFR Section 431.300, et seq. and 45 CFR Parts 160 and 164.)

Any other party shall be granted access to confidential information only after complying with the requirements of state and federal laws, including but not limited to HIPAA, and regulations pertaining to such access. The BHO is responsible for knowing and understanding the confidentiality laws listed above as well as any other applicable laws. The BHO, if it reports services to its members, shall comply with all applicable confidentiality laws. Nothing herein shall prohibit the disclosure of information in summary, statistical or other form that does not identify particular individuals, provided that de-identification of protected health information is performed in compliance with the HIPAA Privacy Rule.

Federal and State Medicaid rules, and some other Federal and State statutes and rules, including but not limited to those listed above, are often more stringent than the HIPAA regulations. Moreover, for purposes of this contract, the BHO agrees that the confidentiality provisions contained in Chapter 17-1702, HAR, shall apply to the BHO to the same extent as they apply to MQD.

The BHO shall implement a secure electronic mail (email) encryption solution to ensure confidentiality, integrity, and authenticity of email communications that contain information relating to members.

All breaches of confidential information relating to Medicaid enrollees, as BHO members, shall be reported to the MQD. The BHO shall notify the MQD within two (2) business days following actual knowledge of a breach of confidentiality, including any use or disclosure of confidential information, any breach of Unsecured PHI, and any Security Incident (as defined in HIPAA regulations) of which the BHO becomes aware with respect to PHI in the custody of the BHO. In addition, the BHO shall provide the MQD with a written report of the investigation and mitigation efforts within thirty (30) business days of the discovery of the breach. The BHO shall work with MQD to ensure that the breach has been mitigated and reporting requirements, if any, or complied with. The actual requirements found in this section shall be detailed in all provider and subcontractor agreements.

61.500 BHO's Progress

61.510 BHO Reporting

On-site reviews may be conducted by DHS to verify the accuracy and appropriateness of information provided by offerors in their proposals. If awarded a contract, the BHO shall submit a plan for implementation of behavioral health services and shall provide progress/performance reports every two weeks beginning two weeks after the notification of contract award. The format to be used shall be approved by DHS. The purpose of the reports is to ensure that the BHO will be ready to enroll members as of commencement of services date found in Section 20.100, and that all required elements such as the QIP are in place.

61.520 Inspection of Work Performed

In addition to the ongoing monitoring described in Section 50.600, the DHS, the State Auditor of Hawaii, the U.S. Department of Health and Human Services (DHHS), the General Accounting Office (GAO), the Comptroller General of the United

States, the Office of the Inspector General (OIG), Medicaid Fraud Control Unit of the Department of the Attorney General, State of Hawaii, or their authorized representatives shall, during normal business hours, have the right to enter into the premises of the BHO, all subcontractors and providers, or such other places where duties under the contract are being performed, to inspect, monitor, or otherwise evaluate the work being performed. All inspections and evaluations shall be performed in such a manner to not unduly delay work. All records and files pertaining to the BHO shall be located in the State of Hawaii at the BHO's principal place of business or at a storage facility on Oahu that is accessible to the foregoing identified parties.

61.600 Disputes

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

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

61.700 Liquidated Damages, Sanctions and Financial Penalties

61.710 Liquidated Damages

In the event of any breach of the terms of the contract by the BHO, liquidated damages shall be assessed against the BHO in an amount equal to the costs of obtaining alternative medical

benefits for its members. The damages shall include, without limitation, the difference in the capitated rates paid to the BHO and the rates paid to a replacement BHO.

Notwithstanding the above, the BHO shall not be relieved of liability to the State for any damages sustained by the State due to the BHO's breach of the contract.

The DHS may withhold amounts for liquidated damages from payments to the BHO until such damages are paid in full.

61.720 Sanctions

The DHS may impose sanctions for non-performance or violations of contract requirements. Sanctions shall be determined by the State and may include:

- Imposing civil monetary penalties (as described below);
- Suspending enrollment of new members with the BHO;
- Suspending payment; or
- Terminating the contract (as described in Section 61.300).

The State shall give the BHO timely written notice that explains the basis and nature of the sanction as outlined in 42 CFR Part 438, Subpart I. The BHO may follow DHS appeal procedures to contest the penalties or sanctions. The DHS shall provide these appeal procedures to the BHO prior to the Date of Commencement of Services identified in Section 20.100.

The civil or administrative monetary penalties imposed by the DHS shall not exceed the maximum amount established by federal statutes and regulations on the BHO.

The civil monetary penalties that may be imposed on the BHO by the State are as follows:

Number	Activity	Penalty
1	Misrepresentation of actions or falsification of information furnished to the CMS or the State	A maximum of one hundred thousand dollars (\$100,000) for each determination
2	Acts to discriminate among members on the	A maximum of one hundred thousand

Number	Activity	Penalty
	basis of their health status or need for healthcare services	dollars (\$100,000) for each determination
3	Failure to implement requirements stated in the BHO's proposal, the RFP or the contract, or other material failures in the BHO's duties, including but not limited to failing to meet performance standards	A maximum of fifty thousand dollars (\$50,000) for each determination
4	Substantial failure to provide medically necessary services that are required under law or under contract, to an enrolled member	A maximum of twenty-five thousand dollars (\$25,000) for each determination
5	Imposition upon members premiums and charges that are in excess of the premiums or charges permitted under the program	A maximum of twenty-five thousand dollars (\$25,000) or double the amount of the excess charges (whichever is greater). The State shall deduct from the penalty the amount of overcharge and return it to the affected member(s)
6	Misrepresentation or false statements to members, potential members or providers	A maximum of twenty-five thousand dollars (\$25,000) for each determination
7	Violation of any of the other applicable requirements of Sections 1903(m), 1905(t)(3) or 1932 of	A maximum of twenty-five thousand dollars (\$25,000) for each determination

Number	Activity	Penalty
	the Social Security Act and any implementing regulations	
8	Failure to comply with the requirements for physician incentive plans, as set forth in 42 CFR Sections 422.208 and 422.210	A maximum of twenty-five thousand dollars (\$25,000) for each determination
9	Failure to resolve member appeals and grievances within the time frames specified in Section 40.500	A maximum of ten thousand dollars (\$10,000) for each determination of failure
10	Failure to provide accurate information, data, reports and medical records, including behavioral health and substance abuse records to the DHS by the specified deadlines provided in Section 50.700.	Two hundred dollars (\$200) per day until all required information, data, reports and medical records are received
11	Failure to report confidentiality breaches relating to Medicaid applicants and recipients to the DHS by the specific deadlines provided in Section 61.400	One hundred dollars (\$100) per day per applicant/recipient. A maximum of twenty-five thousand dollars (\$25,000) until the reports are received

Payments provided for under the contract shall be denied for new members when, and for so long as, payment for those members is denied by CMS in accordance with the requirements in 42 CFR section 438.730.

61.800 Acceptance

The BHO shall comply with all of the requirements of this RFP and DHS shall have no obligation to enroll any members in the BHO until such time as all of said requirements have been met. Any legal proceedings against the State of Hawaii regarding this RFP or any resultant contract shall be brought in a court of competent jurisdiction in the City and County of Honolulu, State of Hawaii.

61.900 Compliance with Laws

In addition to the requirements of General Condition 1.3, Compliance with Laws, the BHO shall comply with the following:

61.910 Wages, Hours and Working Conditions of Employees Providing Services

Pursuant to Section 103-55, HRS, services to be performed by the BHO and its subcontractors or providers shall be performed by employees paid at wages or salaries not less than the wages paid to public officers and employees for similar work. Additionally, the BHO shall comply with all applicable federal and state laws relative to workers compensation, unemployment compensation, payment of wages, prepaid healthcare, and safety standards. Failure to comply with these requirements during the contract period shall result in cancellation of the contract unless such noncompliance is corrected within a reasonable period as determined by the DHS. Final payment under the contract shall not be made unless the DHS has determined that the noncompliance has been corrected. The BHO shall complete and submit the Wage Certification provided in Appendix C.

61.920 Compliance with other Federal and State Laws

The BHO shall agree to conform with the following federal and state laws as affect the delivery of services under the Contract including, but not limited to:

- Titles VI, VII, XIX, and XXI of the Social Security Act; Title VI of the Civil Rights Act of 1964;
- the Age Discrimination Act of 1975;
- the Rehabilitation Act of 1973;
- the Americans with Disability Act;

- Chapter 489, HRS (Discrimination in Public Accommodations);
- Education Amendments of 1972 (regarding education programs and activities);
- Copeland Anti-Kickback Act;
- Davis-Bacon Act;
- Debarment and Suspension;
- all applicable standards, orders or regulations issued under section 306 of the Clean Air Act (42 USC 1857 (h)), section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR part 15) and the Federal Water Pollution Control Act, as amended (33 U.S.C. Section 1251, et seq.);
- the Byrd Anti-Lobbying Amendment (31 U.S.C. Section 1352); and
- E.O. 11246, "Equal Employment Opportunity," as amended by E.O. 11375 "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 C.F.R. part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor".

The BHO shall recognize mandatory standards and policies relating to energy efficiency that are contained in any State energy conservation plan developed by the State in accordance with the Energy Policy and Conservation Act (Pub. L. 94-163, Title III, Part A).

The BHO shall include notice of grantor agency requirements and regulations pertaining to reporting and patient rights under any contracts involving research, developmental, experimental or demonstration work with respect to any discovery or invention which arises or is developed in the course of or under such contract, and of grantor agency requirements and regulations pertaining to copyrights and rights in data.

62.100 Miscellaneous Special Conditions

62.110 Use of Funds

The BHO shall not use any public funds for purposes of entertainment or perquisites and shall comply with any and all conditions applicable to the public funds to be paid under the contract, including those provisions of appropriate acts of the

Hawaii State Legislature or by administrative rules adopted pursuant to law.

62.120 Prohibition of Gratuities

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

62.130 Publicity

General Condition 6.1 is amended to read as follows:
Acknowledgment of State Support. The BHO shall not use the State's or the DHS's name, logo or other identifying marks on any materials produced or issued without the prior written consent of the DHS. The BHO also agrees not to represent that it was supported by or affiliated with the State of Hawaii without the prior written consent of the DHS.

62.140 Force Majeure

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

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

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

62.150 Attorney's Fees

In addition to costs of litigation provided for under General Condition 5.2, in the event that the DHS shall prevail in any legal action arising out of the performance or non-performance of the contract, the BHO shall pay, in addition to any damages, all expenses of such action including reasonable attorney's fees and costs. The term 'legal action' shall be deemed to include administrative proceedings of all kinds, as well as all actions at law or in equity.

62.160 Time is of the Essence

Time is of the essence in the contract. As such, any reference to "days" shall be deemed calendar days unless otherwise specifically stated.

62.170 Authority

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

62.180 Health plan request for waiver of contract requirements

The BHO may request a waiver of operational contract requirements from DHS that are described in the RFP. The BHO plans may submit this request in a format provided by the DHS. DHS shall only approve the BHO's request for waiver of a contract requirement that does not adversely affect the outcome of services that its members receive. DHS reserves the right to revoke these waivers at any time upon written notice to the BHO. Whenever possible, DHS shall provide reasonable advance notice of any such revocation to allow the BHO to make any necessary operational changes.

SECTION 70 TECHNICAL PROPOSAL

70.100 Introduction

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

- Transmittal letter
- Proposal Narrative
- Company background and experience
 - Background of the company
 - Company experience
- Organization and staffing
 - Organization charts
 - Personnel resumes
- Provider Network
- Case Management
- Outreach and education programs
- Other Documentation (Appendix C)
 - A. The Proposal Application Identification form (Form SPO-H-200);
 - B. The State of Hawaii DHS Proposal Letter;
 - C. The Certification for Contracts, Grants, Loans and Cooperative Agreements form;
 - D. The Disclosure Statement (CMS required) form;
 - E. Disclosure Statement;
 - F. The Disclosure Statement (Ownership) form;
 - G. The Organization Structure and Financial Planning form;
 - H. The Financial Planning form;
 - I. The Controlling Interest form;
 - J. The Background Check Information form;
 - K. The Operational Certification Submission form;
 - L. The Grievance System form;
 - M. Insurance requirements certification form;
 - N. The Wage Certification form;
 - O. The Standards of Conduct Declaration form; and
 - P. The State and Federal Tax Clearance certificates from the prime offeror and, upon request from subcontractors, as

assurance that all federal and state tax liabilities have been paid and that there are no significant outstanding balances owed (a statement shall be included if certificates are not available at time of submission of proposal that the certificates will be submitted in compliance with Section 20.500.).

70.200 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 registered to do business in Hawaii and has obtained a State of Hawaii General Excise Tax License. Provide the Hawaii Excise tax number (if applicable).
- 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, creed, ancestry, age, marital status, arrest and court records, sex, including gender identity or expression, sexual orientation, religion, national origin or mental or physical handicap, except as provided by law.
- If the use of subcontractor(s) is proposed, a statement from each subcontractor must be appended to the transmittal letter signed by an individual authorized to legally bind the subcontractor and stating the general scope of work to be performed by the subcontractor(s).
- 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.
- If any page is marked "Confidential" or "Proprietary" in the Offeror's proposal, an explanation to DHS of how substantial competitive harm would occur if the information is released.

70.300 Proposal Narrative

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

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 required information is set forth in detail below.

70.410 Background of the Company

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

- Provide a general description of the primary business of your organization and its member base
- Provide a brief history and current company ownership including the ultimate parent organization and major shareholders/principals. Include date incorporated or formed and corporate domicile, and the date the company began operations. An out-of-state offeror must become duly qualified to do business in the State of Hawaii before a contract can be executed
- 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 offeror's point of contact for a contract resulting from this RFP
- The number of employees both in Hawaii 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 described for this RFP
- Existing volume of current non-Medicaid members receiving SMI services broken down by age and sex
- Existing volume of Medicaid recipients receiving SMI services broken down by age and sex

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, and demonstrate compliance with the requirements of section 40.600.

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 to include FTEs for each position as described in Section 40.600.

- 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, CM Supervisor and QA/UR Director. The offeror shall identify an individual within the organization who will be the key contact person for the BHO. 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 BHO.

The resumes of key personnel shall include, where applicable:

- Experience with the Medicaid or QUEST or QExA programs in Hawaii or Medicaid program in other States
- Experience in managed care systems
- Length of time with the BHO 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.

70.530 References (professional and member)

The offeror shall provide a list of no more than five (5) contacts of organizations that they are currently providing or have previously provided services and shall notify them that DHS may contact them. The following information shall be provided for each of these organizations:

- Name, title, address, telephone number, and e-mail address of the contract manager.
- For each organization listed above, the offeror shall provide the number of members that they have served, the number of years the contract has been in place, and the type of services provided (i.e., behavioral health, TANF, ABD, etc.).

The offeror shall provide a list of no more than five (5) members that they have served in one of their previous programs and shall notify them that DHS may contact them. The following information shall be provided for each of these members:

- Name, address, and current telephone number of the member.
- Release, signed by the member, allowing the DHS to contact them.

70.600 Provider Network

70.610 Provider Listing

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

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

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

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

Separate the providers by provider type noted below:

- Behavioral healthcare specialist services such as psychiatrist, psychologist, social workers, certified substance abuse counselors, and advance practice nurses trained in psychology
- Case management
- Inpatient behavioral health hospital services
- Outpatient behavioral health hospital services
- Mental health rehabilitation services
- Day treatment programs
- Psychosocial rehabilitation (PSR)/Clubhouse
- Residential treatment programs
- Pharmacies
- Laboratory Services

- Crisis services: mobile crisis response and crisis residential services
- Interpretation services
- Transitional housing
- Representative payee
- Supported employment
- Peer specialist

Each provider should be listed only once.

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

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

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

70.620 Map of Behavioral Health Providers and Hospitals

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

70.700 Case Management

The offeror shall explain how its case management system complies with section 40.200, including but not limited to:

- How persons (members, family members, community providers and providers) may access the case management system;
- How the BHO intends to perform assessments and develop individual treatment plans (ITP) for their members
- A description and inclusion of the health plan's assessment that was used to gather information on the member, when referred by a health plan, provider, DOH-CAMHD or others;
- How the BHO will interface with the member's PCP in the BHO and other service providers;
- How the BHO will coordinate with the health plans;
- How the BHO will perform concurrent review during acute psychiatric hospitalization and perform safe and appropriate discharge planning;
- How the BHO will prioritize cases for case management (i.e., how it will address the various levels of complexity and intensity of members' behavioral health care needs);
- How the BHO intends to implement the different levels of CM services described in Section 40.220;
- How the BHO intends to assure that case load ratios described in Section 40.220 are met;
- A description of how the BHO will review cases suspected of not meeting SMI criteria;
- A description of the components of a ITP;
- A description of how the BHO will monitor CM services to report encounters, discharge planning and outcomes;
- A description of the case management staffing including a job description of the case manager and the type of initial and/or on-going training and education that it will provide to its case managers;
- A description of how the BHO will monitor member's progress and continued need for enrollment in the BHO; and
- A description of how the BHO will coordinate enrollment and disenrollment with DHS description of the offeror's policies and procedures for the ITP process that includes the forms to be used to document the ITP.

70.800 Outreach and Education Programs

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

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

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

SECTION 80 CAPITATION RATES

80.100 Introduction

This section describes the rate structure and the guidelines for future rate setting.

80.200 Overview of the Rate Structure

For any given behavioral health member, the DHS will pay a capitation rate as one of two base rates. Rates shall be pro-rated for partial month enrollments. Rates shall be based on age as described below.

- Adults 19 to 39
- Adults 40 and older

All behavioral health services listed in Section 40.800 shall be provided as part of the capitation rate except for those listed below:

- Transitional housing;
- Representative payee;
- Supported employment; and
- Peer specialist.

These services shall be reimbursed by the BHO and submitted to the DHS for reimbursement monthly via an invoice. DHS shall reimburse the BHO for direct services provided. No additional charges may be submitted for reimbursement.

The capitation rates shall assume a case management /administrative per member per month amount of \$382.50 in the initial year of the contract. This amount is inclusive of case management, administrative expenses and risk margin but excludes any general excise and insurance premium tax, if applicable.

80.300 Risk Share Program

The DHS shall implement and manage a risk share arrangement and shall share in any significant savings or losses. Additional information about the risk share program is available in Appendix H.

80.400 Rate Development

The DHS shall provide all offerors with capitation rates with supporting documentation. The offeror shall submit any questions regarding capitation rates by the date identified in Section 20.100.

80.500 Future Rate Setting

Subject to limitations imposed by CMS, legislative direction or other outside influence for which the DHS must comply, it is the intent of the DHS to publish revised rates each state fiscal year.

The DHS may consider adverse selection or risk adjustment in the future years. In the event that any adjustments are made, the DHS will utilize audited data tied to financial records to make such adjustments.

SECTION 90 EVALUATION AND SELECTION

90.100 Introduction

The evaluation of proposals received in response to the RFP will be conducted comprehensively, fairly and impartially. Structural, quantitative scoring techniques will be utilized to maximize the objectivity of the evaluation.

90.200 Evaluation Process

The DHS shall establish an evaluation committee that shall evaluate designated sections of the proposal. The committee shall consist of members who are familiar with the programs and the minimum standards or criteria for the particular area. Additionally, the DHS may, at its discretion, designate additional representatives to assist in the evaluation process. The committee shall evaluate the proposal and document their comments, concerns and questions.

90.300 Mandatory Proposal Evaluation

Each proposal shall be evaluated to determine whether the requirements as specified in this RFP have been met. The proposal shall first be evaluated against the following criteria:

- Proposal was submitted within the closing date and time for proposals as required in Section 21.200;
- The proper number of separately bound copies are in sealed envelopes as required in Section 21.200;
- All information required in Section 70.100 and 70.200 has been submitted; and
- Proposal contains the necessary information in the proper order.

A proposal must meet all mandatory requirements prior to the technical evaluation. Any proposal that does not meet all mandatory requirements shall be rejected.

90.400 Proposal Evaluation

The proposals that have met the minimum mandatory requirements shall be evaluated in order to identify those

offerors that meet the minimum technical requirements detailed in this section.

<u>Evaluation Categories</u>	Available Points
Transmittal Letter	0 points
Proposal Application	
Proposal Narrative	10 points
Company Background and Experience	15 points
Organization and Staffing	15 points
Provider Network	20 points
Case Management	25 points
Outreach and Education Programs	15 points
 TOTAL POSSIBLE POINTS	 100 points

90.500 Evaluation Criteria

Each evaluated category shall be given a rating score using the following rating system:

<u>Rating Score</u>	<u>Description</u>
5	The response has no deficiencies and provides a detailed and comprehensive description that demonstrates the ability to more than minimally meet the contractual requirements.
4	The response has no deficiencies and describes how the requirements will be minimally met.
3	The response has no major deficiencies and only minor deficiencies that are easily correctable.
2	The response has one major deficiency and/or multiple minor deficiencies that do not appear to be easily correctable.
1	The response has multiple major deficiencies that do not appear to be correctable.
0	No response provided.

The offeror must receive a rating score of 3 for each Evaluation Category or the proposal will not be considered technically acceptable and shall be rejected. Those proposals that do not

meet the minimum points to pass each of the required criteria shall be returned to the offeror with a letter of explanation.

The rating score (0-5) shall represent the corresponding conversion factor used to calculate the points awarded for each Evaluation Category listed in section 90.400, as follows:

<u>Rating Score</u>	<u>Conversion Factor</u>
0	0
1	25%
2	50%
3	75%
4	88%
5	100%

The total maximum number of points available for each Evaluation Category will be multiplied by the applicable conversion factor, based on the rating score given, to determine the number of points awarded for the Evaluation Category. The points awarded for each Evaluation Category shall be totaled to yield a final score. The offeror with the highest final score shall be awarded the contract.

Scoring will be based on the entire content of the proposal and the information as communicated to the evaluators. The information contained in any part of the proposal may be evaluated by the DHS with respect to any other scored section of the proposal. Lack of clarity and inconsistency in the proposal will impede effective communication of the content and may result in a lower score.

The broad criteria for each Evaluation Category are listed below and includes consideration of the specific elements identified in Section 70. MQD reserves the right to add, delete or modify any criteria in accordance with applicable procurement rules.

90.510 Transmittal Letter (0 points possible)

- On an official letterhead and signed by an individual authorized to legally bind the offeror
- Includes all statements as specified in Section 70.200.

If the transmittal letter is incomplete, the proposal will be rejected and not be scored and will be returned to the offeror since this is part of the mandatory requirements established in Section 90.300.

90.520 Proposal Narrative (10 points possible)

- Provides a broad understanding of the proposal
- Clearly and concisely condenses the proposal
- Highlights the contents of the proposal
- Identifies how the offeror will implement the CCS program consistent with the RFP requirements if a contract is awarded to them.

90.530 Company Background and Experience (15 points possible)

- Answers all of the questions posed in Section 70.400 for both themselves and each subcontractor
- Company background and experience including experience implementing a program of the nature/size required by this contract
- Each subcontractor's background and experience
- Extent to which the scope of services under this RFP can be completed by the offeror
- Quality with which scope of services under this RFP can be completed by the offeror
- Offeror's ability to meet the contract requirements
- Other factors identified in section 70.400

90.540 Organization and Staffing (15 points possible)

- Basis of relevant experience and member references. Note: For offerors currently providing services to Medicaid members, MQD reserves the right to contact previous and current members beyond those provided in Section 70.530
- Past and current management experience for similar services of like projects in scope
- Ability to provide high-quality behavioral health services
- Relevant program experience and success in performing projects of similar scope to that described herein
- Provider network and QIP
- Competence of proposed key professionals and other employees

- Qualifications of personnel including education, experience with behavioral health populations, length of time with the organization, and Hawaii Medicaid experience. (Resumes of all key personnel must be provided.)
- Capability of organizational and administrative systems in Hawaii to implement contractual obligations for this RFP
- Other factors identified in Section 70.500

90.550 Provider Network (20 points possible)

- Provision of the data required in Section 70.600
- Capability of offeror's provider network of providing the services set forth in the RFP in all areas statewide
- Sufficiency of provider network to meet the behavioral health needs of its members
- Comprehensiveness of the provider network to provide access to all required services as set forth in the RFP
- Provider availability and geographic access, especially on the islands other than Oahu
- Other factors identified in Section 70.600

90.560 Case Management (25 points possible)

- Process for providing case management
- Staff functions, interactions, and internal coordination
- Staff level and case load ratios
- Plan for monitoring and coordinating needed clinical and other services to support the member in the community
- Relationship of BHO with case management agencies in the community
- Answer all of the questions from Section 70.700
- Other factors identified in Section 70.700

90.570 Outreach and Education Programs (15 points possible)

- Plan for serving persons who are homebound and/or physically disabled
- Plan to serve difficult to find members (to include those that do not have a home)
- Ability to provide services to members whose primary language is not English
- Plan to support members in maintaining their Medicaid eligibility

- Plan for transition of care for new members into the BHO to include but not limited to health plans or CAMHD
- Other factors identified in Section 70.800

APPENDIX A – WRITTEN QUESTIONS FORMAT

Appendix A

**Written Questions Format
Community Care Services (CCS) Program RFP**

Offeror Name	Date Submitted	Question #	RFP Section #	RFP Page #	Paragraph #	Question

APPENDIX B – NOTICE OF INTENT TO PROPOSE FORMAT

Notification to State Agency of Interest in Responding to an RFP

RFP Number and Title: _____

Organization or Individual: _____

Contact Person Information

First Name: _____ Last Name: _____

E-mail Address: _____

Telephone: _____

Fax Number: _____

Mailing Address

Street Address or PO Box _____

City _____ State _____ Zip Code _____

Please provide to the agency contact person listed in the Request for Proposals (RFP).

APPENDIX C – PROPOSAL DOCUMENTS

APPENDIX C

STATE OF HAWAII
STATE PROCUREMENT OFFICE
PROPOSAL APPLICATION IDENTIFICATION FORM

STATE AGENCY ISSUING RFP: _____

RFP NUMBER: _____

RFP TITLE: _____

Check one:

Initial Proposal Application

Final Revised Proposal (Completed Items _____ - _____ only)

1. APPLICANT INFORMATION

Legal Name:

Doing Business As:

Street Address:

Mailing Address:

Contact person for matters involving this application:
Name:

Title:

Phone Number:

Fax Number:

e-mail:

2. BUSINESS INFORMATION

Type of Business Entity (*check one*):

Non-Profit Corporation

Limited Liability Company

Sole Proprietorship

For-Profit Corporation

Partnership

If applicable, state of incorporation and date incorporated:

State:

Date:

3. PROPOSAL INFORMATION

Geographic area(s):

Target group(s):

4. FUNDING REQUEST

FY _____

FY _____

FY _____

FY _____

FY _____

FY _____

Grand Total _____

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

Authorized Representative Signature

Date Signed

Name and Title

STATE OF HAWAII

Department of Human Services

PROPOSAL LETTER

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

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

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

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

Authorized Offeror's Signature/Corporate Seal

Date

**CERTIFICATION FOR CONTRACTS, GRANTS, LOANS AND
COOPERATIVE AGREEMENTS**

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

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

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

Offeror: _____
Signature: _____
Title: _____
Date: _____

DISCLOSURE STATEMENT (CMS REQUIRED)

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

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

455.104 Information on Ownership & Control

- (1) The name and address of each person with an ownership or controlling interest in the disclosing entity.
- (2) The name and address of each person with an ownership or controlling interest in any subcontractor in which the disclosing entity has direct or indirect ownership of five (5) percent or more.
- (3) Names of persons named in (a) and (b) above who are related to another as spouse, parent, child or sibling of those individuals or organizations with an ownership or controlling interest.
- (4) The names of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity also has an ownership or controlling interest.

455.105 Information Related to Business Transactions

- (5) The ownership of any subcontractor with whom the offeror has had business transactions totaling more than \$25,000 during the past 12-month period.
- (6) Any significant business transactions between the offeror and any wholly owned supplier or between the offeror and any subcontractor during the past five-year period.

455.106 Information on Persons Convicted of Crimes

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

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

- (1) Names and addresses of the Board of Directors of the disclosing entity.
- (2) Name, title and amount of compensation paid annually (including bonuses and stock participation) to the ten (10) highest management personnel.
- (3) Names and addresses of creditors whose loans or mortgages are secured by a five (5) percent or more interest in the assets of the disclosing entity.

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

- (1) Describe transactions between the disclosing entity and any related party in which a transaction or series of transactions during any one (1) fiscal year exceeds the lesser of \$10,000 or two (2) percent of the total operating expenses of the disclosing entity. List property, goods, services, and facilities involved in detail. Note the dollar amounts or other consideration for each item and the date of the transaction(s). Also include justification of the transaction(s) as to the reasonableness, potential adverse impact on the fiscal soundness of the disclosing entity, and the nature and extent of any conflict of interest. This requirement includes, but is not limited to, the sale or exchange, or leasing of any property; and the furnishing for consideration of goods, services or facilities.
- (2) Describe all transactions between the disclosing entity and any related party which includes the lending of money, extensions of credit or any investments in a related party. This type of transaction requires advance administrative review by the Director before being made.
- (3) As used in this section, "related party" means one that has the power to control or significantly influence the offeror, or one that is controlled or significantly influenced by the offeror. "Related parties" include, but are not limited to, agents, managing employees, persons with an ownership or controlling interest in the disclosing entity, and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any of such entities or persons.

42 CFR 456.101 DEFINITIONS

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

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

- c) "Disclosing entity" means a BHO.
- d) "Other disclosing entity" means any other disclosing entity but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Social Security Act.
- This includes:
- (1) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII);
 - (2) Any Medicare intermediary or carrier; and
 - (3) Any entity that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XIX of the Social Security Act.
- e) "Fiscal agent" means a contractor that processes or pays vendor claims on behalf of DHS.
- f) "Group of practitioners" means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).
- g) "Indirect ownership interest" means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.
- h) "Managing employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.
- i) "Ownership interest" means the possession of equity in the capital, the stock, or the profits of the disclosing entity.
- j) "Person with an ownership or controlling interest" means a person or corporation that:
- (1) Has an ownership interest totaling five (5) percent or more in a disclosing entity;
 - (2) Has an indirect ownership interest equal to five (5) percent or more in a disclosing entity;
 - (3) Has a combination of direct and indirect ownership interests equal to five (5) percent or more in a disclosing entity;

- (4) Owns an interest of five (5) percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five (5) percent of the value of the property or assets of the disclosing entity;
 - (5) Is an officer or director of a disclosing entity that is organized as a corporation; or
 - (6) Is a partner in a disclosing entity that is organized as a partnership.
- k) "Significant business transaction" means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of \$25,000 and five (5) percent of an offeror's total operating expenses.
- l) "Subcontractor" means:
- (1) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
 - (2) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the DHS agreement.
- m) "Supplier" means an individual, agency, or organization from which a Provider purchases goods and services used in carrying out its responsibilities under its NHS contract (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).
- n) "Wholly owned subsidiary supplier" means a subsidiary or supplier whose total ownership interest is held by an offeror or by a person, persons, or other entity with an ownership or controlling interest in an offeror.

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

Description of Transaction(s)

Name of Related Party and
Relationship

Dollar Amount for Reporting
Period

Justification

DISCLOSURE STATEMENT

BHO NAME/NO. _____

DISCLOSURE STATEMENT FOR THE YEAR ENDED _____

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

Date Signed

Chief Executive Officer (Name and Title
Typewritten)

Notarized

Signature

DISCLOSURE STATEMENT OWNERSHIP

BHO Name, BHO No.: _____
Address (City, State, Zip): _____
Telephone: _____

For the period beginning: _____ and ending _____ Type

of BHO:

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

Type of Entity:

- Sole Proprietorship
- Partnership
- Corporation
- Governmental

- For-Profit
- Not-For-Profit
- Other (specify) _____

455.104 Information on Ownership and Control

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

Name	Address	Percent of Ownership Control

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

Name	Address	Percent of Ownership Control

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

Name	Address	Percent of Ownership Control

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

Name	Address	Percent of Ownership Control

455.105 Information Related to Business Transactions

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

Describe Ownership of Subcontractors	Type of Business Transaction with Provider	Dollar Amount of Transaction

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

Describe Ownership of Subcontractors	Type of Business Transaction with Provider	Dollar Amount of Transaction

455.106 Information on Persons Convicted of Crime

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

Name	Address	Title

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

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

Name/Title	Address

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

Name/Title	Address

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

Name	Address	Amount of Debt	Description of Security

Financial Reporting Guide Forms
Organization Structure and Financial Planning Form

- 1) If other than a government agency:
- a. When was your organization formed?
 - b. If your organization is a corporation, attach a list of the names and addresses of the Board of Directors.

2) License/Certification

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

<u>Service Component</u>	<u>License/Requirement</u>	<u>Renewal Date</u>
--------------------------	----------------------------	---------------------

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

Yes _____ No _____ If yes, please explain:

3) Civil Rights Compliance Data

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

Yes _____ No _____ If yes, please explain:

4) Handicapped Assurance

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

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

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

5) Prior Convictions

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

6) Federal Government Suspension/Exclusion

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

Yes _____

No _____ If yes, please explain:

Financial Planning Form

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

- a. Cash []
- b. Accrual []
- c. Modified [] Give brief explanation

2) Does the offeror prepare an annual financial statement?

Yes _____ No _____ If yes, please explain:

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

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

b. If yes, are footnotes and supplementary schedules an integral part of the statements?

Yes _____ No _____

c. If yes, are actuals analyzed and compared to budgeted amounts?

Yes _____ No _____

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

4) Is the offeror audited by an independent accounting firm/accountant?

Yes _____ No _____

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

b. By whom are they conducted? _____

c. Did this auditor perform that offeror's last audit?

Yes _____ No _____

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

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

Yes _____ No _____

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

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

e. Do you have any uncorrected audit exceptions?

Yes _____ No _____

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

5) Does the offeror have an accounting manual?

Yes _____ No _____

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

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

Yes _____ No _____

Explain principal allocation techniques used or to be used. Note the allocation base used for each type of cost allocated.

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

a. With what company(s)? _____

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

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

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

Yes _____ No _____

Briefly describe each item and indicate probable amount.

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

Yes _____ No _____

If yes, when? _____

11) Do(es) the offeror's owner(s) intend to provide all necessary funds to make full and timely payments for liabilities (reported or not recognized)?

Yes _____ No _____

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

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

12) Does the offeror have a performance bonding mechanism in accordance with DHS rules?

Yes _____ No _____

If yes, provide the following information:

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

If no, describe how the offeror intends to provide a bond and/or security to meet established DHS rules.

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

Yes _____ No _____

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

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

b. How often are IBNRs projected? _____

c. Identify all major data sources most often used.

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

Yes _____ No _____ If so, how?

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

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

Yes _____ No _____

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

Yes _____ No _____

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

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

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

Yes _____ No _____ If yes, enter name: _____

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

a. Medicare reimbursement Yes _____ No _____

b. Other third-party recoveries Yes _____ No _____

If no, explain why.

Controlling Interest Form

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

Name	Address	Owner or Controller	Has Controlling Interest?	
			Yes	No

Background Check Information Form

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

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

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

** For each person listed:

- a. Give addresses for the last ten years
- b. Ever suspended from any Federal program for any reason?

Yes _____

No _____

If yes, please explain.

Operational Certification Submission Form

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

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

Signature

Date

Grievance System Form

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

I hereby certify that

_____ **Offeror Name**

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

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

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

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

Authorized Signature

Date

Printed Name

Title

INSURANCE REQUIREMENTS CERTIFICATION

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

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

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

(Check and complete one)

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

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

Name of Offeror

Authorized Representative Signature

Date

Print Name and Title

CERTIFICATE OF LIABILITY INSURANCE (COLI)
CHECKLIST & SAMPLE FORM (ACORD 25 Form (2009/09)¹)

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

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

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

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

NO.

CERTIFICATE OF INSURANCE LIABILITY REQUIRED ELEMENTS

✓

D. PROFESSIONAL LIABILITY

**\$1 MILLION PER CLAIM, AND
\$2 MILLION ANNUAL AGGREGATE**

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

DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES BOX: THIS SECTION SHOULD CONTAIN THE FOLLOWING LANGUAGE:

**THE STATE OF HAWAII IS AN ADDITIONAL INSURED WITH RESPECT TO OPERATIONS PERFORMED FOR THE STATE OF HAWAII.
ANY INSURANCE MAINTAINED BY THE STATE OF HAWAII SHALL APPLY IN EXCESS OF, AND NOT CONTRIBUTE WITH, INSURANCE PROVIDED BY THIS POLICY.**



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
(1)

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

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

PRODUCER	CONTACT NAME:	
	PHONE (A.C. No. Ext):	FAX (A.C. No.):
INSURED (2)	INSURER(S) AFFORDING COVERAGE	
	INSURER A:	NAIC #
	INSURER B:	(3)
	INSURER C:	
	INSURER D:	
	INSURER E:	
	INSURER F:	

COVERAGES

CERTIFICATE NUMBER:

REVISION NUMBER:

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

INSR LTR	TYPE OF INSURANCE	ADDL SUBR INSR W/O/D	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS (8)	
	GENERAL LIABILITY <input type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR (4) GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC	13	(5)	(6)	(7)	EACH OCCURRENCE	\$
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO (9) <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS	13				COMBINED SINGLE LIMIT (Ea accident)	\$
	<input type="checkbox"/> UMBRELLA LIAB <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS-MADE (13) DEDUCTIBLE RETENTION \$	13				EACH OCCURRENCE	\$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? <input type="checkbox"/> Y/N N/A <small>(Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below</small>					WC STATUTORY LIMITS	OTHER
	(12)					E.L. EACH ACCIDENT	\$ (10)
						E.L. DISEASE - EA EMPLOYEE	\$ (11)
						E.L. DISEASE - POLICY LIMIT	\$

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

CERTIFICATE HOLDER**CANCELLATION**

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

Wage Certification

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

1. The services to be rendered shall be performed by employees paid as wages or salaries not less than wages paid to the public officers and employees for similar work, if similar positions are listed in the classification plan of the public sector.
2. All applicable laws of the Federal and State governments relating to worker's compensation, unemployment insurance, payment of wages, and safety will be fully complied with.

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

Offeror: _____
Signature: _____
Title: _____
Date: _____

**PROVIDER'S
STANDARDS OF CONDUCT DECLARATION**

For the purposes of this declaration:

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

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

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

On behalf of:

(Name of PROVIDER)

PROVIDER, the undersigned does declare as follows:

1. PROVIDER is* is not a legislator or an employee or a business in which a legislator or an employee has a controlling interest. (Section 84-15(a), HRS).
2. PROVIDER has not been represented or assisted personally in the matter by an individual who has been an employee of the agency awarding this Contract within the preceding two years and who participated while so employed in the matter with which the Contract is directly concerned. (Section 84-15(b), HRS).
3. PROVIDER has not been assisted or represented by a legislator or employee for a fee or other compensation to obtain this Contract and will not be assisted or represented by a legislator or employee for a fee or other compensation in the performance of this Contract, if the legislator or employee had been involved in the development or award of the Contract. (Section 84-14 (d), HRS).
4. PROVIDER has not been represented on matters related to this Contract, for a fee or other consideration by an individual who, within the past twelve (12) months, has been an agency employee, or in the case of the Legislature, a legislator, and participated while an employee or legislator on matters related to this Contract. (Sections 84-18(b) and (c), HRS).

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

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

CONTRACT NO. _____

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

PROVIDER

By _____
(Signature)

Print Name _____

Print Title _____

Date _____

APPENDIX D – CCS REFERRAL PROCESS

REFERRAL FOR SERIOUS MENTAL ILLNESS (SMI) COMMUNITY CARE SERVICES (CCS) PROGRAM

NAME _____, _____, _____ MALE FEMALE
Last First M.I.

HOME ADDRESS _____ PHONE NO. _____
 _____ CASE NO. _____

MAILING ADDRESS _____ CLIENT ID NO. _____
 _____ SOCIAL SECURITY NUMBER _____

DATE OF BIRTH _____ AGE _____ COUNTY OAHU HAWAII MAUI KAUAI

HEALTH PLAN: EVERCARE OHANA OTHER: _____

PRIMARY DIAGNOSIS _____ DSMIV CODE _____

SECONDARY DIAGNOSIS _____ DSMIV CODE _____

CURRENT MEDICAL CONDITIONS (Indicate, if none) _____

DATE OF REFERRAL: _____ NAME OF PCP: _____ PCP NOTIFIED: Y / N

HOSPITALIZATIONS	CURRENTLY AT: <input type="checkbox"/> Castle <input type="checkbox"/> Queen's <input type="checkbox"/> Other: _____ (list) Admitted on ____/____/____			
Past Hospitalizations- Facility	Location	Date Admitted	Date Discharged	Diagnosis
MEDICATIONS	Strength	Dosage	Start Date	End Date
OUTPATIENT THERAPISTS	Diagnosis	Start Date	End Date	

Section below to be completed by MQD/CSO Evaluation Panel

Date of Evaluation _____ Date of Enrollment/Disenrollment of CCS Services _____

Approved for CCS Referral: Yes No Additional Information Needed
 Re-Evaluation Required: Yes No If Yes, date to be re-evaluated: ____/____/____

Reason for denial/comments _____

Client Name: _____

Client I.D. No.: _____

I. MENTAL STATES

A. GENERAL

1. Appearance: Within normal limits Other _____
2. Dress: Appropriate Bizarre Clean Dirty
3. Grooming: Neat Disheveled Needs improvement

B. BEHAVIOR

1. Eye Contact: Good Fair Poor
2. Posture: Good Slumped Rigid Other _____
3. Body Movements: None Involuntary Akathisia Other _____

- C. SPEECH:** Clear Mumbled Rapid Whispers Monotone
Slurred Slow Loud Constant Mute
Other _____

- D. MOOD:** Anxious Fearful Friendly Euphoric Calm
Aggressive Hostile Depressed
Other _____

- E. AFFECT:** Full range Flat Constricted Inappropriate
Other _____

F. THOUGHT

1. Process or Form: Loose associations Poverty of content Flight of ideas
Neologism Perseveration Blocking
2. Content: Delusions Thought broadcasting
Thought insertion Thought withdrawal Other _____

G. PERCEPTION – HALLUCINATIONS:

- Auditory Tactile Somatic Other _____

H. REALITY ORIENTATION:

1. Mark all areas which the recipient can name:
Time: Day Month Year
Place: (can describe location) Yes No
Person: Self Family or friend
2. Memory: Recent intact? Yes Remote intact: Yes
No No

- I. INSIGHT:** Aware of illness Denies illness Other _____

- J. JUDGMENT:** Good Fair Poor

Client Name: _____ Client I.D. No.: _____

II. FUNCTIONAL SCALES: *(check and specify any problem(s) in the following areas)*

Medical/Physical

Family/Living

Interpersonal Relations

Role Performance

Socio-Legal

Self-Care/Basic Needs

III. ADDITIONAL COMMENTS: Please supply any additional information which would be of assistance in reaching a decision with regard to this patient's evaluation.

Signed: _____ Date: _____

Reporting Psychiatrist/Psychologist (*Print Name*): _____

Reporting Psychiatrist/Psychologist Phone No.: _____

Signed: _____ Date: _____

Medical Director or Attending Physician for in-patients (*Print Name*): _____

APPENDIX E - CONTRACT FORMS & GENERAL CONDITIONS

APPENDIX E

CONTRACT NO. _____



**STATE OF HAWAII
CONTRACT FOR HEALTH AND HUMAN SERVICES:
COMPETITIVE PURCHASE OF SERVICES**

This Contract, executed on the respective dates indicated below, is effective as of

_____ , 20 _____ between the _____

(Name of the state department, agency board or commission)

State of Hawai'i ("STATE"), by its _____
(Title of person signing for the STATE)

whose address is: _____

and _____
(Name of PROVIDER)

("PROVIDER"), a _____
(Legal form of PROVIDER i.e., Corporation, Limited Liability Company, etc.)

under the laws of the State of _____ whose business street address and taxpayer
identification numbers are as follows:

Business street address:

Mailing address if different than business street address:

Federal employer identification number: _____

Hawai'i general excise tax number: _____

RECITALS

A. This Contract is for a competitive purchase of services (a "Competitive POS"), as defined in section 103F-402, Hawaii Revised Statutes ("HRS"), and chapter 3-143, Hawai'i Administrative Rules.

B. The STATE needs the health and human services described in this Contract and its attachments ("Required Services") and the PROVIDER agrees to provide the Required Services.

C. Money is available to fund this Contract pursuant to:

(1) _____,
(Identify state sources)

in the amount of _____, or
(state funding)

(2) _____,
(Identify federal sources)

in the amount of _____, or both.
(federal funding)

D. The STATE is authorized to enter into this Contract pursuant to:

(Legal authority for Contracts)

E. The undersigned representative of the PROVIDER represents, and the STATE relies upon such representation, that he or she has authority to sign this Contract by virtue of (check any or all that apply):

- corporate resolutions of the PROVIDER or other authorizing documents such as partnership resolutions;
- corporate by-laws of the PROVIDER, or other similar operating documents of the PROVIDER, such as a partnership contract or limited liability company operating contract;
- the PROVIDER is a sole proprietor and as such does not require any authorizing documents to sign this Contract;
- other evidence of authority to sign:

F. The PROVIDER has provided a "Certificate of Insurance" to the STATE that shows to the satisfaction of the STATE that the PROVIDER has obtained liability insurance

which complies with paragraph 1.4 of the General Conditions of this Contract and with any relevant special condition of this Contract.

G. The PROVIDER produced, and the STATE inspected, a tax clearance certificate as required by section 103-53, HRS.

NOW, THEREFORE, in consideration of the promises contained in this Contract, the STATE and the PROVIDER agree as follows:

1. Scope of Services. The PROVIDER shall, in a proper and satisfactory manner as determined by the STATE, provide the Required Services set forth in Attachment "1" to this Contract, which is hereby made a part of this Contract, and the Request for Proposals ("RFP"), and the PROVIDER's Proposal, which are incorporated in this Contract by reference. In the event that there is a conflict among the terms of this Contract, and either the Proposal or the RFP, or both, then the terms of this Contract shall control.

2. Time of Performance. The PROVIDER shall provide the Required Services from _____, 20 _____, to _____, 20 _____, as set forth in Attachment "2" to this Contract, which is hereby made a part of this Contract.

3. Certificate of Exemption from Civil Service. The Certificate of Exemption from Civil Service is attached and made a part of this Contract.

4. Standards of Conduct Declaration. The Standards of Conduct Declaration of the PROVIDER is attached and made a part of this Contract.

5. General and Special Conditions. The General Conditions for Health and Human Services Contracts ("General Conditions") and any Special Conditions are attached hereto and made a part of this Contract. In the event of a conflict between the General Conditions and the Special Conditions, the Special Conditions shall control.

6. Notices. Any written notice required to be given by any party under this Contract shall be (a) delivered personally, or (b) sent by United States first class mail, postage prepaid.

Notice required to be given to the STATE shall be sent to:

Notice to the PROVIDER shall be sent to the mailing address as indicated on page 1. A notice shall be deemed to have been received three (3) days after mailing or at the time of actual receipt, whichever is earlier. The PROVIDER is responsible for notifying the STATE in writing of any change of address.

IN VIEW OF THE ABOVE, the parties execute this Contract by their signatures below.

STATE

By _____
(Signature)

Print Name _____

Print Title _____

Date _____

FUNDING AGENCY (to be signed by head of funding agency if other than the Contracting Agency)

By _____
(Signature)

Print Name _____

Print Title _____

Date _____

CONTRACT NO. _____

CORPORATE SEAL
(if available)

PROVIDER

By _____
(Signature)

Print Name _____

Print Title _____

Date _____

APPROVED AS TO FORM:

Deputy Attorney General

GENERAL CONDITIONS FOR HEALTH & HUMAN SERVICES CONTRACTS
TABLE OF CONTENTS

	<u>Page(s)</u>
1. Representations and Conditions Precedent.....	1
1.1 Contract Subject to the Availability of State and Federal Funds.....	1
1.1.1 State Funds.....	1
1.1.2 Federal Funds.....	1
1.2 Representations of the PROVIDER.....	1
1.2.1 Compliance with Laws	1
1.2.2 Licensing and Accreditation	1
1.3 Compliance with Laws	1
1.3.1 Smoking Policy.....	1
1.3.2 Drug Free Workplace.....	1
1.3.3 Persons with Disabilities.....	2
1.3.4 Nondiscrimination.....	2
1.4 Insurance Requirements.....	2
1.5 Notice to Clients	2
1.6 Reporting Requirements	3
1.7 Conflicts of Interest.....	3
Documents and Files.....	3
Confidentiality of Material	3
Proprietary or Confidential Information	3
Uniform Information Practices Act	3
2.2 Ownership Rights and Copyright.....	3
2.3 Records Retention.....	3
3. Relationship between Parties.....	4
3.1 Coordination of Services by the STATE.....	4
3.2 Subcontracts and Assignments	4
3.3 Change of Name	4
Independent Contractor Status and Responsibilities, Including Tax Responsibilities	4
Independent Contractor.....	4

Contracts with other individuals and entities..... 4

PROVIDER’s employees and agents..... 5

PROVIDER’s Responsibilites 5

Personnel Requirements..... 6

 Personnel..... 6

 Requirements 6

4. Modification and Termination of Contract..... 6

 4.1 Modifications of Contract..... 6

 4.1.1 In writing..... 6

 4.1.2 No oral modification 6

 4.1.3 Tax clearance 6

 4.2 Termination in General 6

 4.3 Termination for Necessity or Convenience 7

 4.4 Termination by PROVIDER..... 7

 4.5 STATE’s Right of Offset..... 7

Indemnification 7

 5.1 Indemnification and Defense 7

 5.2 Cost of Litigation 7

6. Publicity 8

 6.1 Acknowledgment of State Support 8

 6.2 PROVIDER’s publicity not related to contract 8

7. Miscellaneous Provisions..... 8

 7.1 Nondiscrimination..... 8

 7.2 Paragraph Headings 8

 7.3 Antitrust Claims 8

 7.4 Governing Law 8

 7.5 Conflict between General Conditions and Procurement Rules..... 8

 7.6 Entire Contract..... 8

 7.7 Severability 9

 7.8 Waiver..... 9

7.9 Execution in Counterparts..... 9

8. Confidentiality of Personal Information..... 9

8.1 Definitions..... 9

8.1.1 Personal Information..... 9

8.1.2 Technological Safeguards 9

8.2 Confidentiality of Material 10

8.2.1 Safeguarding of Material 10

8.2.2 Retention, Use, or Disclosure 10

8.2.3 Implementation of Technological Safeguards 10

8.2.4 Reporting of Security Breaches 10

8.2.5 Mitigation of Harmful Effect 10

8.2.6 Log of Disclosures 10

8.3 Security Awareness Training and Confidentiality Agreements..... 10

8.3.1 Certification of Completed Training..... 10

8.3.2 Certification of Confidentiality Agreements 10

8.4 Termination for Cause 11

8.5 Records Retention 11

8.5.1 Destruction of Personal Information..... 11

8.5.2 Maintenance of Files, Books, Records 11

APPENDIX E

GENERAL CONDITIONS FOR HEALTH & HUMAN SERVICES CONTRACTS

1. Representations and Conditions Precedent

1.1 Contract Subject to the Availability of State and Federal Funds.

1.1.1 State Funds. This Contract is, at all times, subject to the appropriation and allotment of state funds, and may be terminated without liability to either the PROVIDER or the STATE in the event that state funds are not appropriated or available.

1.1.2 Federal Funds. To the extent that this Contract is funded partly or wholly by federal funds, this Contract is subject to the availability of such federal funds. The portion of this Contract that is to be funded federally shall be deemed severable, and such federally funded portion may be terminated without liability to either the PROVIDER or the STATE in the event that federal funds are not available. In any case, this Contract shall not be construed to obligate the STATE to expend state funds to cover any shortfall created by the unavailability of anticipated federal funds.

1.2 Representations of the PROVIDER. As a necessary condition to the formation of this Contract, the PROVIDER makes the representations contained in this paragraph, and the STATE relies upon such representations as a material inducement to entering into this Contract.

1.2.1 Compliance with Laws. As of the date of this Contract, the PROVIDER complies with all federal, state, and county laws, ordinances, codes, rules, and regulations, as the same may be amended from time to time, that in any way affect the PROVIDER's performance of this Contract.

1.2.2 Licensing and Accreditation. As of the date of this Contract, the PROVIDER holds all licenses and accreditations required under applicable federal, state, and county laws, ordinances, codes, rules, and regulations to provide the Required Services under this Contract.

1.3 Compliance with Laws. The PROVIDER shall comply with all federal, state, and county laws, ordinances, codes, rules, and regulations, as the same may be amended from time to time, that in any way affect the PROVIDER's performance of this Contract, including but not limited to the laws specifically enumerated in this paragraph:

1.3.1 Smoking Policy. The PROVIDER shall implement and maintain a written smoking policy as required by Chapter 328K, Hawaii Revised Statutes (HRS), or its successor provision.

1.3.2 Drug Free Workplace. The PROVIDER shall implement and maintain a drug free workplace as required by the Drug Free Workplace Act of 1988.

1.3.3 Persons with Disabilities. The PROVIDER shall implement and maintain all practices, policies, and procedures required by federal, state, or county law, including but not limited to the Americans with Disabilities Act (42 U.S.C. §12101, et seq.), and the Rehabilitation Act (29 U.S.C. §701, et seq.).

1.3.4 Nondiscrimination. No person performing work under this Contract, including any subcontractor, employee, or agent of the PROVIDER, shall engage in any discrimination that is prohibited by any applicable federal, state, or county law.

1.4 Insurance Requirements. The PROVIDER shall obtain from a company authorized by law to issue such insurance in the State of Hawai'i commercial general liability insurance ("liability insurance") in an amount of at least TWO MILLION AND NO/100 DOLLARS (\$2,000,000.00) coverage for bodily injury and property damage resulting from the PROVIDER's performance under this Contract. The PROVIDER shall maintain in effect this liability insurance until the STATE certifies that the PROVIDER's work under the Contract has been completed satisfactorily.

The liability insurance shall be primary and shall cover the insured for all work to be performed under the Contract, including changes, and all work performed incidental thereto or directly or indirectly connected therewith.

A certificate of the liability insurance shall be given to the STATE by the PROVIDER. The certificate shall provide that the STATE and its officers and employees are Additional Insureds. The certificate shall provide that the coverages being certified will not be cancelled or materially changed without giving the STATE at least 30 days prior written notice by registered mail.

Should the "liability insurance" coverages be cancelled before the PROVIDER's work under the Contract is certified by the STATE to have been completed satisfactorily, the PROVIDER shall immediately procure replacement insurance that complies in all respects with the requirements of this section.

Nothing in the insurance requirements of this Contract shall be construed as limiting the extent of PROVIDER's responsibility for payment of damages resulting from its operations under this Contract, including the PROVIDER's separate and independent duty to defend, indemnify, and hold the STATE and its officers and employees harmless pursuant to other provisions of this Contract.

1.5 Notice to Clients. Provided that the term of this Contract is at least one year in duration, within 180 days after the effective date of this Contract, the PROVIDER shall create written procedures for the orderly termination of services to any clients receiving the Required Services under this Contract, and for the transition to services supplied by another provider upon termination of this Contract, regardless of the circumstances of such termination. These procedures shall include, at

the minimum, timely notice to such clients of the termination of this Contract, and appropriate counseling.

- 1.6 Reporting Requirements. The PROVIDER shall submit a Final Project Report to the STATE containing the information specified in this Contract if applicable, or otherwise satisfactory to the STATE, documenting the PROVIDER’s overall efforts toward meeting the requirements of this Contract, and listing expenditures actually incurred in the performance of this Contract. The PROVIDER shall return any unexpended funds to the STATE.
- 1.7 Conflicts of Interest. In addition to the Certification provided in the Standards of Conduct Declaration to this Contract, the PROVIDER represents that neither the PROVIDER nor any employee or agent of the PROVIDER, presently has any interest, and promises that no such interest, direct or indirect, shall be acquired, that would or might conflict in any manner or degree with the PROVIDER’s performance under this Contract.

2. Documents and Files

2.1 Confidentiality of Material.

- 2.1.1 Proprietary or Confidential Information. All material given to or made available to the PROVIDER by virtue of this Contract that is identified as proprietary or confidential information shall be safeguarded by the PROVIDER and shall not be disclosed to any individual or organization without the prior written approval of the STATE.
- 2.1.2 Uniform Information Practices Act. All information, data, or other material provided by the PROVIDER to the STATE shall be subject to the Uniform Information Practices Act, chapter 92F, HRS, and any other applicable law concerning information practices or confidentiality.

2.2 Ownership Rights and Copyright. The STATE shall have complete ownership of all material, both finished and unfinished that is developed, prepared, assembled, or conceived by the PROVIDER pursuant to this Contract, and all such material shall be considered “works made for hire.” All such material shall be delivered to the STATE upon expiration or termination of this Contract. The STATE, in its sole discretion, shall have the exclusive right to copyright any product, concept, or material developed, prepared, assembled, or conceived by the PROVIDER pursuant to this Contract.

2.3 Records Retention. The PROVIDER and any subcontractors shall maintain the books and records that relate to the Contract, and any cost or pricing data for three (3) years from the date of final payment under the Contract. In the event that any litigation, claim, investigation, audit, or other action involving the records retained under this provision arises, then such records shall be retained for three (3) years from the date of final payment, or the date of the resolution of the action, whichever occurs later. During the period that records are retained under this section, the

PROVIDER and any subcontractors shall allow the STATE free and unrestricted access to such records.

3. Relationship between Parties

- 3.1 Coordination of Services by the STATE. The STATE shall coordinate the services to be provided by the PROVIDER in order to complete the performance required in the Contract. The PROVIDER shall maintain communications with the STATE at all stages of the PROVIDER's work, and submit to the STATE for resolution any questions which may arise as to the performance of this Contract.
- 3.2 Subcontracts and Assignments. The PROVIDER may assign or subcontract any of the PROVIDER's duties, obligations, or interests under this Contract, but only if (i) the PROVIDER obtains the prior written consent of the STATE and (ii) the PROVIDER's assignee or subcontractor submits to the STATE a tax clearance certificate from the Director of Taxation, State of Hawai'i, and the Internal Revenue Service showing that all delinquent taxes, if any, levied or accrued under state law against the PROVIDER's assignee or subcontractor have been paid. Additionally, no assignment by the PROVIDER of the PROVIDER's right to compensation under this Contract shall be effective unless and until the assignment is approved by the Comptroller of the State of Hawai'i, as provided in section 40-58, HRS.
- 3.3 Change of Name. When the PROVIDER asks to change the name in which it holds this Contract, the STATE, shall, upon receipt of a document acceptable or satisfactory to the STATE indicating such change of name such as an amendment to the PROVIDER's articles of incorporation, enter into an amendment to this Contract with the PROVIDER to effect the change of name. Such amendment to this Contract changing the PROVIDER's name shall specifically indicate that no other terms and conditions of this Contract are thereby changed, unless the change of name amendment is incorporated with a modification or amendment to the Contract under paragraph 4.1 of these General Conditions.
- 3.4 Independent Contractor Status and Responsibilities, Including Tax Responsibilities.
- 3.4.1 Independent Contractor. In the performance of services required under this Contract, the PROVIDER is an "independent contractor," with the authority and responsibility to control and direct the performance and details of the work and services required under this Contract; however, the STATE shall have a general right to inspect work in progress to determine whether, in the STATE's opinion, the services are being performed by the PROVIDER in compliance with this Contract.
- 3.4.2 Contracts with Other Individuals and Entities. Unless otherwise provided by special condition, the STATE shall be free to contract with other individuals and entities to provide services similar to those performed by the Provider under this Contract, and the

PROVIDER shall be free to contract to provide services to other individuals or entities while under contract with the STATE.

- 3.4.3 PROVIDER's Employees and Agents. The PROVIDER and the PROVIDER's employees and agents are not by reason of this Contract, agents or employees of the State for any purpose. The PROVIDER and the PROVIDER's employees and agents shall not be entitled to claim or receive from the STATE any vacation, sick leave, retirement, workers' compensation, unemployment insurance, or other benefits provided to state employees. Unless specifically authorized in writing by the STATE, the PROVIDER and the PROVIDER's employees and agents are not authorized to speak on behalf and no statement or admission made by the PROVIDER or the PROVIDER's employees or agents shall be attributed to the STATE, unless specifically adopted by the STATE in writing.
- 3.4.4 PROVIDER's Responsibilities. The PROVIDER shall be responsible for the accuracy, completeness, and adequacy of the PROVIDER's performance under this Contract.

Furthermore, the PROVIDER intentionally, voluntarily, and knowingly assumes the sole and entire liability to the PROVIDER's employees and agents, and to any individual not a party to this Contract, for all loss, damage, or injury caused by the PROVIDER, or the PROVIDER's employees or agents in the course of their employment.

The PROVIDER shall be responsible for payment of all applicable federal, state, and county taxes and fees which may become due and owing by the PROVIDER by reason of this Contract, including but not limited to (i) income taxes, (ii) employment related fees, assessments, and taxes, and (iii) general excise taxes. The PROVIDER also is responsible for obtaining all licenses, permits, and certificates that may be required in order to perform this Contract.

The PROVIDER shall obtain a general excise tax license from the Department of Taxation, State of Hawai'i, in accordance with section 237-9, HRS, and shall comply with all requirements thereof. The PROVIDER shall obtain a tax clearance certificate from the Director of Taxation, State of Hawai'i, and the Internal Revenue Service showing that all delinquent taxes, if any, levied or accrued under state law against the PROVIDER have been paid and submit the same to the STATE prior to commencing any performance under this Contract. The PROVIDER shall also be solely responsible for meeting all requirements necessary to obtain the tax clearance certificate required for final payment under section 103-53, HRS, and these General Conditions.

The PROVIDER is responsible for securing all employee-related insurance coverage for the PROVIDER and the PROVIDER's employees and agents that is or may be required by law, and for payment of all premiums, costs, and other liabilities associated with securing the insurance coverage.

3.5 Personnel Requirements.

3.5.1 Personnel. The PROVIDER shall secure, at the PROVIDER's own expense, all personnel required to perform this Contract, unless otherwise provided in this Contract.

3.5.2 Requirements. The PROVIDER shall ensure that the PROVIDER's employees or agents are experienced and fully qualified to engage in the activities and perform the services required under this Contract, and that all applicable licensing and operating requirements imposed or required under federal, state, or county law, and all applicable accreditation and other standards of quality generally accepted in the field of the activities of such employees and agents are complied with and satisfied.

4. Modification and Termination of Contract

4.1 Modification of Contract.

4.1.1 In Writing. Any modification, alteration, amendment, change, or extension of any term, provision, or condition of this Contract permitted by this Contract shall be made by written amendment to this Contract, signed by the PROVIDER and the STATE.

4.1.2 No Oral Modification. No oral modification, alteration, amendment, change, or extension of any term, provision or condition of this Contract shall be permitted.

4.1.3 Tax Clearance. The STATE may, at its discretion, require the PROVIDER 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 this Contract, a tax clearance from the Director of Taxation, State of Hawai'i, and the Internal Revenue Service showing that all delinquent taxes, if any, levied or accrued under state and federal law against the PROVIDER have been paid.

4.2 Termination in General. This Contract may be terminated in whole or in part because of a reduction of funds available to pay the PROVIDER, or when, in its sole discretion, the STATE determines (i) that there has been a change in the conditions upon which the need for the Required Services was based, or (ii) that the PROVIDER has failed to provide the Required Services adequately or satisfactorily, or (iii) that other good cause for the whole or partial termination of this Contract exists. Termination under this section shall be made by a written notice sent to the PROVIDER ten (10) working days prior to the termination date that includes a brief statement of the reason for the termination. If the Contract is terminated under this paragraph, the PROVIDER shall cooperate with the STATE to effect an orderly transition of services to clients.

- 4.3 Termination for Necessity or Convenience. If the STATE determines, in its sole discretion, that it is necessary or convenient, this Contract may be terminated in whole or in part at the option of the STATE upon ten (10) working days' written notice to the PROVIDER. If the STATE elects to terminate under this paragraph, the PROVIDER shall be entitled to reasonable payment as determined by the STATE for satisfactory services rendered under this Contract up to the time of termination. If the STATE elects to terminate under this section, the PROVIDER shall cooperate with the STATE to effect an orderly transition of services to clients.
- 4.4 Termination by PROVIDER. The PROVIDER may withdraw from this Contract after obtaining the written consent of the STATE. The STATE, upon the PROVIDER's withdrawal, shall determine whether payment is due to the PROVIDER, and the amount that is due. If the STATE consents to a termination under this paragraph, the PROVIDER shall cooperate with the STATE to effect an orderly transition of services to clients.
- 4.5 STATE's Right of Offset. The STATE may offset against any monies or other obligations that STATE owes to the PROVIDER under this Contract, any amounts owed to the State of Hawai'i by the PROVIDER under this Contract, or any other contract, or pursuant to any law or other obligation owed to the State of Hawai'i by the PROVIDER, including but not limited to the payment of any taxes or levies of any kind or nature. The STATE shall notify the PROVIDER in writing of any exercise of its right of offset and the nature and amount of such offset. For purposes of this paragraph, amounts owed to the State of Hawai'i shall not include debts or obligations which have been liquidated by contract with the PROVIDER, and that are covered by an installment payment or other settlement plan approved by the State of Hawai'i, provided, however, that the PROVIDER shall be entitled to such exclusion only to the extent that the PROVIDER is current, and in compliance with, and not delinquent on, any payments, obligations, or duties owed to the State of Hawai'i under such payment or other settlement plan.

5. Indemnification

- 5.1 Indemnification and Defense. The PROVIDER shall defend, indemnify, and hold harmless the State of Hawai'i, the contracting agency, and their officers, employees, and agents from and against any and all liability, loss, damage, cost, expense, including all attorneys' fees, claims, suits, and demands arising out of or in connection with the acts or omissions of the PROVIDER or the PROVIDER's employees, officers, agents, or subcontractors under this Contract. The provisions of this paragraph shall remain in full force and effect notwithstanding the expiration or early termination of this Contract.
- 5.2 Cost of Litigation. In case the STATE shall, without any fault on its part, be made a party to any litigation commenced by or against the PROVIDER in connection with this Contract, the PROVIDER shall pay any cost and expense incurred by or imposed on the STATE, including attorneys' fees.

6. Publicity

- 6.1 Acknowledgment of State Support. The PROVIDER shall, in all news releases, public statements, announcements, broadcasts, posters, programs, computer postings, and other printed, published, or electronically disseminated materials relating to the PROVIDER's performance under this Contract, acknowledge the support by the State of Hawai'i and the purchasing agency.
- 6.2 PROVIDER's Publicity Not Related to Contract. The PROVIDER shall not refer to the STATE, or any office, agency, or officer thereof, or any state employee, or to the services or goods, or both provided under this Contract, in any of the PROVIDER's publicity not related to the PROVIDER's performance under this Contract, including but not limited to commercial advertisements, recruiting materials, and solicitations for charitable donations.

7. Miscellaneous Provisions

- 7.1 Nondiscrimination. No person performing work under this Contract, including any subcontractor, employee, or agent of the PROVIDER, shall engage in any discrimination that is prohibited by any applicable federal, state, or county law.
- 7.2 Paragraph Headings. The paragraph headings appearing in this Contract have been inserted for the purpose of convenience and ready reference. They shall not be used to define, limit, or extend the scope or intent of the sections to which they pertain.
- 7.3 Antitrust Claims. The STATE and the PROVIDER recognize that in actual economic practice, overcharges resulting from antitrust violations are in fact usually borne by the purchaser. Therefore, the PROVIDER hereby assigns to the STATE any and all claims for overcharges as to goods and materials purchased in connection with this Contract, except as to overcharges which result from violations commencing after the price is established under this Contract and which are not passed on to the STATE under an escalation clause.
- 7.4 Governing Law. The validity of this Contract and any of its terms or provisions, as well as the rights and duties of the parties to this Contract, shall be governed by the laws of the State of Hawai'i. Any action at law or in equity to enforce or interpret the provisions of this Contract shall be brought in a state court of competent jurisdiction in Honolulu, Hawai'i.
- 7.5 Conflict between General Conditions and Procurement Rules. In the event of a conflict between the General Conditions and the Procurement Rules or a Procurement Directive, the Procurement Rules or any Procurement Directive in effect on the date this Contract became effective shall control and are hereby incorporated by reference.
- 7.6 Entire Contract. This Contract sets forth all of the contracts, conditions, understandings, promises, warranties, and representations between the STATE and the PROVIDER relative to this Contract. This Contract supersedes all prior agreements, conditions, understandings,

promises, warranties, and representations, which shall have no further force or effect. There are no contracts, conditions, understandings, promises, warranties, or representations, oral or written, express or implied, between the STATE and the PROVIDER other than as set forth or as referred to herein.

- 7.7 Severability. In the event that any provision of this Contract is declared invalid or unenforceable by a court, such invalidity or unenforceability shall not affect the validity or enforceability of the remaining terms of this Contract.
- 7.8 Waiver. The failure of the STATE to insist upon the strict compliance with any term, provision, or condition of this Contract shall not constitute or be deemed to constitute a waiver or relinquishment of the STATE's right to enforce the same in accordance with this Contract. The fact that the STATE specifically refers to one provision of the Procurement Rules or one section of the Hawai'i Revised Statutes, and does not include other provisions or statutory sections in this Contract shall not constitute a waiver or relinquishment of the STATE's rights or the PROVIDER's obligations under the Procurement Rules or statutes.
- 7.9 Execution in Counterparts. This Contract may be executed in several counterparts, each of which shall be regarded as an original and all of which shall constitute one instrument.

8. Confidentiality of Personal Information

8.1 Definitions.

8.1.1 Personal Information. "Personal Information" means an individual's first name or first initial and last name in combination with any one or more of the following data elements, when either name or data elements are not encrypted:

- 1) Social Security number;
- 2) Driver's license number or Hawaii identification card number; or
- 3) Account number, credit or debit card number, access code, or password that would permit access to an individual's financial information.

Personal information does not include publicly available information that is lawfully made available to the general public from federal, state, or local government records.

8.1.2 Technological Safeguards. "Technological safeguards" means the technology and the policy and procedures for use of the technology to protect and control access to personal information.

8.2 Confidentiality of Material.

8.2.1 Safeguarding of Material. All material given to or made available to the PROVIDER by the STATE by virtue of this Contract which is identified as personal information, shall be safeguarded by the PROVIDER and shall not be disclosed without the prior written approval of the STATE.

8.2.2 Retention, Use, or Disclosure. PROVIDER agrees not to retain, use, or disclose personal information for any purpose other than as permitted or required by this Contract.

8.2.3 Implementation of Technological Safeguards. PROVIDER agrees to implement appropriate “technological safeguards” that are acceptable to the STATE to reduce the risk of unauthorized access to personal information.

8.2.4 Reporting of Security Breaches. PROVIDER shall report to the STATE in a prompt and complete manner any security breaches involving personal information.

8.2.5 Mitigation of Harmful Effect. PROVIDER agrees to mitigate, to the extent practicable, any harmful effect that is known to PROVIDER because of a use or disclosure of personal information by PROVIDER in violation of the requirements of this paragraph.

8.2.6 Log of Disclosures. PROVIDER shall complete and retain a log of all disclosures made of personal information received from the STATE, or personal information created or received by PROVIDER on behalf of the STATE.

8.3 Security Awareness Training and Confidentiality Agreements.

8.3.1 Certification of Completed Training. PROVIDER certifies that all of its employees who will have access to the personal information have completed training on security awareness topics related to protecting personal information.

8.3.2 Certification of Confidentiality Agreements. PROVIDER certifies that confidentiality agreements have been signed by all of its employees who will have access to the personal information acknowledging that:

- 1) The personal information collected, used, or maintained by the PROVIDER will be treated as confidential;
- 2) Access to the personal information will be allowed only as necessary to perform the Contract; and
- 3) Use of the personal information will be restricted to uses consistent with the services subject to this Contract.

8.4 Termination for Cause. In addition to any other remedies provided for by this Contract, if the STATE learns of a material breach by PROVIDER of this paragraph by PROVIDER, the STATE may at its sole discretion:

- 1) Provide an opportunity for the PROVIDER to cure the breach or end the violation; or
- 2) Immediately terminate this Contract.

In either instance, the PROVIDER and the STATE shall follow chapter 487N, HRS, with respect to notification of a security breach of personal information.

8.5 Records Retention.

8.5.1 Destruction of Personal Information. Upon any termination of this Contract, PROVIDER shall, pursuant to chapter 487R, HRS, destroy all copies (paper or electronic form) of personal information received from the STATE.

8.5.2 Maintenance of Files, Books, Records. The PROVIDER and any subcontractors shall maintain the files, books, and records, that relate to the Contract, including any personal information created or received by the PROVIDER on behalf of the STATE, and any cost or pricing data, for three (3) years after the date of final payment under the Contract. The personal information shall continue to be confidential and shall not be disclosed without the prior written approval of the STATE. After the three (3) year retention period has ended, the files, books, and records that contain personal information shall be destroyed pursuant to chapter 487R, HRS.

APPENDIX F – PROVIDER LETTER OF INTENT

**ADDITIONAL PROVIDER AND SERVICES INFORMATION FOR LOI
BETWEEN PROVIDERS AND OFFERORS
FOR PROVISION OF SERVICES TO CCS MEMBERS**

1. MQD PROVIDER IDENTIFICATION NUMBER, if any

2. PROVIDER'S PRINTED NAME

3. ADDRESS (where services will be provided)

If services will be provided in more than one location,
attach separate sheet with addresses.

4. ZIP CODE

5. COUNTY

6. TELEPHONE

7. FAX

Check here if additional service site information is
attached.

8. PROVIDER TYPE (e.g., behavioral health provider,
case management agency, inpatient behavioral health
hospital, outpatient behavioral health hospital, mental
health rehabilitation, psychosocial rehabilitation,
pharmacy, laboratory, crisis service, etc.)

9. SERVICE(S) TO BE PROVIDED TO CCS MEMBERS

10. AREAS OF PROVIDER SPECIALTY, IF ANY

11. LANGUAGES SPOKEN BY THE PROVIDER (OTHER
THAN ENGLISH)

12. NAME OF HOSPITAL(S) WHERE PHYSICIAN HAS
ADMITTING PRIVILEGES

APPENDIX G – PROVIDER LISTING

Appendix G

Format for Provider Listing for Section 70.610

Provider Type (examples listed below)	Island/County (for Oahu include the city)	Provider Name (Last name, First name, Middle Initial)	Address	City	Zip Code	Accepting new members (Y/N)?	Any limit on CCS members (Y/N)?
Behavioral Health Specialist	Honolulu, Oahu	Last Name, First Name, MI					
Case Management	Kapolei, Oahu	Last Name, First Name, MI					
Inpatient behavioral health hospital	Maui County	Last Name, First Name, MI					
Hospital	Kauai	Hospital Name					
Crisis Services: mobile crisis response	Hawaii- East	Agency Name					

APPENDIX H – RISK SHARE PROGRAM

RISK SHARE PROGRAM

Objective of the Program: The State acknowledges that due to circumstances beyond the control of the BHO and the State, the established capitation rates may not be appropriate for the services to be provided. Even with utilization data and experience serving the behavioral health population, it is difficult for the BHO and the State to accurately predict the actual performance or utilization of services by the enrolled population. It is possible that individuals will utilize more services than estimated. Conversely, it is also possible that individuals will utilize substantially less services than estimated.

To address the unknown risk to the BHO and the State, the DHS will implement a risk share program. The risk share program will be applied when there is an overall impact on the program such that there is a significant differential between the Total Revenue (as defined below) received by the BHO for behavioral health services, and the expenses of the BHO.

Definitions:

Total Revenue is the sum of all capitation payments made to the BHO during the calendar year ended December 31. The behavioral health services portion is equal to Total Revenue net of the case management/administration component as well as excluding general excise and insurance premium tax, if applicable. The case management/administration component has been set for calendar year 2013 at \$382.50 per member per month.

The behavioral health services expenses shall be taken from the financial reports provided by the health plans for the year ended December 31. These expenses do not include costs for case management and administration for purposes of this calculation. DHS recognizes that the financial reports are due within 45 days from the end of the reporting period and that some data may not be available at the time the reports are submitted. Therefore, prior to compiling the statement for the gain share program, the plans shall be requested to update their prior year's report for any adjustments. The report shall be due to the DHS by July 15. DHS would like case management and administration costs separated in the financial statements. DHS also requests that the BHO be prepared to provide the underlying claim data supporting the financials upon request.

Conceptual Framework: Under the risk share program, the DHS will share in a significant difference between the Total Revenue and the actual costs experienced by the BHO. Six (6) months following the end of the calendar year using the financial reports provided by the BHO, a simple profit and loss statement will be developed for the behavioral health services portion of the CCS program. The behavioral health services portion of the Total Revenue is assumed to be Total Revenue net of the case management/administration component multiplied by the number of member months during the calendar year. Actual administrative expenses will not be included in the computation since the intent of the program is to adjust for unknown risk associated with providing the health services to the enrolled population.

Following the computation of the aggregate profit and loss statement, a net loss or gain percentage will be computed based upon the Total Revenue paid to the BHO for provision of behavioral health services. If the loss percentage is within a 5% risk corridor, there will be no loss sharing between the DHS and the BHO and the BHO will absorb all of the loss. If the aggregate loss is outside of this risk corridor, the DHS will share equally in the loss exceeding the risk corridor with a maximum amount DHS will pay of \$1,250,000.

If there is a gain exceeding 3%, the DHS will share equally in the gain between 3% and 5%. The DHS will recover all gains exceeding 5%.

The individual amounts to be remitted to the BHO or to the State will be distributed based on eligible months. The following formula will be used to determine the gain/loss:

Σ Behavioral health services portion of Total Revenue

Less: Σ Net behavioral health expenses (based on the actual incurred expenses for behavioral health services)

Equals: Net profit/loss (for the behavioral health services provided to the CCS population)

The net profit/loss divided by the Behavioral Health Services portion of Total Revenue will provide the percentage of the profit/loss which will be compared to the risk corridor established by the DHS.

APPENDIX H

Examples: The following examples illustrate how the Risk Share Program would be applied. A negative settlement represents additional payment from DHS to the BHO. Note the examples below assume no general excise or insurance premium tax.

Risk Share Program Settlement Examples

	Total Revenue	Member Months	Net		Profit/Loss		Settlement
			Behavioral Health Revenue	Behavioral Health Expenses	Percentage	Amount	
Example 1	\$8,924,829	9,820	\$5,168,649	\$5,013,590	3%	\$155,059	\$0
Example 2	\$8,924,829	9,820	\$5,168,649	\$4,910,217	5%	\$258,432	\$51,686
Example 3	\$8,924,829	9,820	\$5,168,649	\$4,806,844	7%	\$361,805	\$155,059
Example 4	\$8,924,829	9,820	\$5,168,649	\$5,427,082	-5%	(\$258,432)	\$0.00
Example 5	\$8,924,829	9,820	\$5,168,649	\$5,685,514	-10%	(\$516,865)	(\$129,216)
Example 6	\$8,924,829	9,820	\$5,168,649	\$7,752,974	-50%	(\$2,584,325)	(\$1,162,946)
Example 7	\$8,924,829	9,820	\$5,168,649	\$9,045,136	-75%	(\$3,359,622)	(\$1,250,000)