



STATE OF IDAHO

DEPARTMENT OF ADMINISTRATION FOR THE DEPARTMENT
OF HEALTH AND WELFARE (IDHW)

REQUEST FOR PROPOSAL (RFP)
IPRO Sicomm.net RFP02482

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IDAHO BEHAVIORAL HEALTH PLAN

Issue Date 08-27-2012

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1. RFP Administrative Information

RFP Title:	Idaho Behavioral Health Plan
RFP Project Description:	Idaho's Statewide Behavioral Health Insurance Plan for Medicaid Members.
RFP Lead:	Mary Jepsen, Purchasing Officer Phone: 208-332-1607 Fax: 208-327-7320 Mary.jepsen@adm.idaho.gov
Deliver Sealed Package to:	Mary Jepsen, Purchasing Officer Division of Purchasing LBJ Building, Capitol Mall 650 W. State St. Lower Level, Room B-15 Boise, ID 83702
Pre-Proposal Conference:	Tuesday, 9/11/12, 1:00 p.m time Mountain Time
Pre-Proposal Conference Location:	450 W. State St., Boise, ID 83704 10th Floor Conference Room (Allow time to check in at the security desk.)
Deadline To Receive Questions (Round 1):	Friday, 9/21/12, 11:59:59 p.m. Mountain Time
Deadline to Receive Questions (Round 2):	Tuesday, 10/16/12, 11:59:59 p.m. Mountain Time
RFP Closing Date:	See IPRO Header Document
RFP Opening Date:	10:30 a.m. Mountain Time the following work day after closing.
Initial Term of Contract and Renewals:	Three (3) years. The IDHW shall have the option to renew this contract for two (2) additional two (2) year periods. The total contract term, including all extensions, may not exceed seven (7) years.

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- 1.1 **Purpose:** The objective of this RFP is to contract with an experienced and financially sound vendor who can implement, administer, and maintain the services of a Prepaid Ambulatory Health Plan (PAHP), as that term is defined in 42 CFR § 438.2 and as amended. The PAHP will be known as Idaho's Behavioral Health Plan for Medicaid Members (The Idaho Behavioral Health Plan). The vendor must provide behavioral health coverage for prevention, screening, diagnostic, treatment and support services and the coordination of such services for qualified Members enrolled in Idaho Medicaid through a statewide network of licensed and/or certified, qualified behavioral health providers.
- 1.2 A non-mandatory pre-proposal conference will be held at the location and time as indicated in **Section 1**, page 1 of this RFP. This will be your opportunity to ask questions, in person, with the Division of Purchasing and the Idaho Department of Health and Welfare (IDHW) staff. All interested parties are invited to participate either by attending the conference or by an established call in number. **Those choosing to participate by phone must pre-register via e-mail with the RFP lead to receive phone conferencing and meeting details. Offerors are asked to register by 9/7/12.** Any oral answers given by the State during the pre-proposal conference are unofficial, and will not be binding on the State. Conference attendance is at the participant's own expense and is limited to three (3) representatives from each vendor as space is limited.
- 1.3 Questions must be submitted, in writing, to the RFP Lead, by the date and time noted above, in order to be considered. Written questions must be submitted using **Attachment 1, Offeror Questions, and sent via e-mail to the RFP Lead.** Official answers to all written questions will be posted on the state's eProcurement System as an amendment to this RFP.

Any questions regarding the State of Idaho Standard Contract Terms and Conditions found at <http://adm.idaho.gov/purchasing/purchasingrules.html> and/or Special Terms and Conditions (See Appendix D) must ALSO be submitted in writing, using Attachment 1, Offeror Questions, by the deadline to receive questions. The State will not consider proposed modifications to these requirements after the date and time set for receiving questions.

Proposals which qualify the offer based upon the State accepting other terms and conditions **not found in the RFP or which take exception to the State's terms and conditions**, will be found non-responsive, and no further consideration of the proposal will be given.

1.4 **Background Information:**

Idaho Department of Health and Welfare: (Referred to as "IDHW")

The IDHW is the single state agency that operates the Idaho Medicaid program in accordance with the Public Assistance Law in Idaho Code (ID Code § 56-254) and Title XIX of the Social Security Act. The IDHW is led by a Director who is appointed by the Governor. The seven (7) member Board of Health and Welfare advises the Director on issues related to public health, licensure and certification standards. The mission of the IDHW is to actively promote and protect the health and safety of all Idahoans.

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The IDHW is an umbrella human services agency. Services are organized under eight (8) divisions. Each division provides services or partners with other agencies and groups to provide these services to Idaho communities throughout the seven (7) regions of the state listed in Table 1 in **Attachment 7- Idaho Department of Health and Welfare Regional Map**. The eight (8) divisions are:

1. Public Health
2. Information Technology
3. Welfare
4. Operational Services
5. Licensing and Certification
6. Family and Community Services
7. Behavioral Health
8. Medicaid

More information about the organization of the IDHW is available in “*Facts, Figures and Trends*” at www.healthandwelfare.idaho.gov

State Authority:

ID Code § 56-261 requires the Division of Medicaid to plan for managed care approaches to the administration of high cost services. The IDHW, as the single state agency responsible for the administration and supervision of the Idaho Medicaid program, has designated the Division of Medicaid to oversee the Idaho Behavioral Health Plan to assure compliance with federal financing requirements.

The contract resulting from this RFP will cover the management of behavioral health services known as the Idaho Behavioral Health Plan to serve Medicaid Members, also known as “enrollees” per 42 CFR § 438.10(a), hereafter referred to as “Members” who are:

1. Adults with Serious Mental Illness (SMI) or Serious and Persistent Mental Illness (SPMI);
2. Children with Serious Emotional Disturbance (SED);
3. Adults and children who manifest symptoms of mental illness;
4. Members with substance use disorders; or
5. Members with both substance use disorders and SMI, SPMI, or SED.

Refer to **Attachment 3**, Definitions, for detailed descriptions of these categories.

Federal Authority:

The IDHW has applied to the Centers for Medicare and Medicaid Services for a 1915(b) waiver in order to move from a fee-for-service reimbursement model to a managed care delivery system.

Administration of Benefits:

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In the Idaho State Medicaid Plan, Idaho Medicaid operates a standard plan and three (3) benchmark plans in order to better match healthcare services to Members' healthcare needs. The Standard Plan contains appropriate health benefits coverage for the applicable populations as determined by the Secretary of the U.S. Department of Health and Human Services pursuant to his authority under Title XIX of the Social Security Act. Following are the three (3) benchmark plans:

1. The **Basic Benchmark Plan** is for low-income children and adults with eligible dependent children. This plan provides health, prevention, and wellness benefits for children and adults who don't have special health needs. Most Idaho Medicaid Members select this benefit plan.
2. The **Enhanced Benchmark Plan** is for Members with disabilities or special health needs. This plan has all the benefits of the Basic Plan, plus additional benefits. Most Idaho Medicaid Members who use mental health services select this benefit plan.
3. The **Medicare-Medicaid Coordinated Plan (MMCP)** is for Members who are eligible for both Medicaid and Medicare. The IDHW has partnered with insurance companies to provide coordinated health coverage between Medicare Part A, Part B, Part D, and Medicaid through Medicare Advantage plans for those Members who select this plan. Currently the only behavioral health services Medicaid covers for Members in this plan is Rehabilitative Services. These Members are not included in the Idaho Behavioral Health Plan.

The Division of Medicaid reimburses a limited scope of behavioral health services that are intended to address the mental health care needs of children and adults as well as substance use disorder treatment needs of children and adults. Each benchmark plan offers different mental health benefits based on the plan. Substance use disorder benefits have been equally available in the Basic and Enhanced Plans.

CURRENT MEDICAID REIMBURSED MENTAL HEALTH PROVIDER NETWORK:

Idaho Medicaid currently enrolls mental health provider agencies on a temporary basis following their submission of a provider application through the Medicaid Credentialing Program which operates within the IDHW's Office of Mental Health and Substance Abuse (OMHSA).

After six (6) months of operation, Medicaid conducts an on-site credentialing survey of the agency to confirm the agency has all the necessary policies, procedures and operations in order to comply with Idaho statute and Medicaid rules.

Providers are credentialed for three (3) year periods after which they must apply for re-credentialing and earn their agency credential for another three (3) years. Alternatively, providers can obtain national accreditation in lieu of going through the Medicaid credentialing process. If a provider obtains national accreditation they must maintain a current accredited status per the requirements of the national accreditation they have chosen.

Primary Care Coordination:

Idaho Medicaid operates a primary care case management (PCCM) program, Healthy Connections, to help provide Members with a medical home. This coordinated quality healthcare approach helps manage Medicaid costs and promotes the appropriate utilization of services through a referral process.

Members may select or be assigned to a primary care provider (PCP) who is then identified as the Member's "medical home."

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In the current system, a Member's PCP must provide a referral to the behavioral health provider in order for the Member to access mental health or substance use disorder services.

In an attempt to rule out metabolic processes that mimic mental health symptoms, Medicaid also requires each Member seeking mental health services to receive a wellness exam (or similar service) within the twelve (12) months prior to obtaining these services.

Mental Health Service Delivery:

Division of Medicaid mental health benefits cover inpatient and outpatient psychiatric care:

1. Outpatient diagnostics, counseling/therapy, pharmacological management, and skill training and related supports in mental health clinics and mental health rehabilitation agencies.
2. Inpatient psychiatric hospitalization pursuant to 42 CFR § 440.140 and 160.

The agencies currently enrolled with the Division of Medicaid as mental health providers are able to operate independently such that:

1. Any willing provider is enrolled who meets the IDHW's minimum requirements that allow them to be conferred an initial credential;
2. Providers choose their service locations, administrative and staffing structure and scope of services.
3. Service type, duration and scope of treatment are determined by providers.
4. Utilization management activities by the IDHW include hard service limits for adults and targeted utilization reviews.
5. The IDHW conducts reviews of providers after initial credentialing based on complaints and critical incidents; requirement is for provider agencies to undergo re-credentialing every three (3) years.

CURRENT SUBSTANCE USE DISORDER SERVICES (SUDS):

1. In 2008, limited outpatient substance use disorder benefits were added to Idaho Medicaid's fee-for-service benefits.
2. The Division of Behavioral Health (DBH) currently administers Medicaid benefits for SUD treatment. However, the DBH contracts with an entity that maintains a fee-for-service provider network. The contractor entity's provider agreement contains requirements that a SUDs treatment provider adhere to all applicable Idaho statutes and Medicaid rules governing SUDs benefits.
3. The contracted entity receives referrals from the Idaho Department of Corrections, Idaho Department of Juvenile Corrections, the Courts, Idaho Department of Health and Welfare, counties, network providers and Member self-referrals.
4. The contracted entity screens Members for services, authorizes assessments and treatment, conducts utilization reviews for continued stays, authorizes the transfer of Members between providers, discharges Members from treatment, collects Member data, and submits Member data to the DBH.
5. The contracted entity pays the SUDS provider and then submits Medicaid claims for services via the Medicaid Management Information System (MMIS) and the payment goes directly to the DBH. The contracted entity then bills the DBH for the services and the DBH pays the contracted entity.
6. The contracted entity audits network providers, monitors corrective action plans, and handles appeals from providers.

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STATE FISCAL YEAR 2011 PARTICIPANT DATA

Idaho Medicaid has an average monthly enrollment of 223,505. Approximately 22,795 Members are dual-eligibles (Medicare & Medicaid), with three percent (3%) enrolled in the voluntary MMCP program.

Non-Duals:

The average number of ages 0 to 21 for state fiscal year (SFY) 2011 was 168,717 per month, and 31,993 Members ages 22 and over. Of these, 24,180 or 14% are children (ages 0-21) diagnosed with SED or SPMI. 5,716 or 18% of adults are diagnosed as SPMI. 1,164 or 1% of children used SUD services and 1,024 or 3% of adults used SUD services.

Duals:

The average number of Members ages 0 to 21 for state fiscal year (SFY) 2011 was 220 per month, and 21,955 Members ages 22 and over. Of these, 121 or 55% are children (ages 0-21) diagnosed with SED or SPMI. 4,950 or 23% of adults are diagnosed as SPMI. 7 or 3% of children used SUD services and 262 or 1% of adults used SUD services.

The average number of monthly unduplicated mental health claims is included in **Attachment 19 - Behavioral Health Claims Experience**. The average number of monthly unduplicated SUD claims is 4,143.

The utilization of mental health services for state fiscal year 2011, for children 0-21 and adults over age 21, are included in **Attachment 19 – Behavioral Health Claims Experience (SFY 11)**.

FUTURE CONSIDERATIONS:

The IDHW intends to change the Idaho Medicaid State Plan, Idaho statutes and pertinent administrative rules promulgated by the IDHW (IDAPA rules), based on this RFP and the resulting contract, in the 2014 legislative session.

The IDHW is currently working on a project to develop a managed care delivery system for Medicare-Medicaid eligible Members. The targeted implementation date is January 1, 2014. The dual-eligibles covered in this RFP will receive services under the new dual program.

Idaho Medicaid has obtained estimates that approximately 100,000 – 160,000 additional Idaho residents may be eligible for Medicaid in 2014 under the Affordable Care Act provisions for Medicaid expansion. Should Idaho move forward with this expansion, it would represent a significant increase in Members who will need services as well as a likely change in the overall demographic of Members served. The IDHW will be evaluating its options in providing benefits to this new population. The IDHW doesn't have additional information at this time regarding the utilization patterns of this population.

Capitation Rate Information:

Actuarially sound capitation rate ranges will be developed for each waiver period. The IDHW enlists an independent actuarial consulting firm to evaluate rates to ensure they are actuarially sound. "Actuarially sound capitation rate" is a federal term defined at 42 CFR § 438.6(c). The IDHW shall provide the actuarial certification of the capitation rates and payments under the contract. All payments under risk contracts and all risk sharing mechanisms in contracts shall be actuarially sound. Actuarially sound capitation rates are capitation rates that have been developed in accordance with generally accepted actuarial principles and practices; that are appropriate for the populations to be covered and the services to be furnished under the

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contract; and that have been certified as meeting the requirements of the regulation at 42 CFR § 438.6(c) by an actuary who meets the qualification standards established by the American Academy of Actuaries and follows the practice standards established by the Actuarial Standards Board.

Rate Setting Information:

The following is a layman’s description of the rate setting approach used to create the Idaho State managed care capitation rates for behavioral health service eligible Members for the contract period. Contracting health plans assume full risk for all covered behavioral health State Plan services for enrolled Members. Critical steps in the rate development process included the following:

1. The IDHW provided summaries of monthly eligibility and claim experience for each behavioral health service enrollee on a Per Member Per Month (PMPM) basis to facilitate the analysis for the actuarial rate certification. The summary was based on the most recent claims available. The detailed claims data was summarized by service category and Membership months for each of the counties and populations of mental health service eligible Members.
2. Expenses for services not covered by the health plans were removed from the base experience.
3. The cost projections included adjustments for trend, health care management, selection and health plan administrative costs.

Short, Intermediate and Long Term Goals of the RFP:

<i>Short Term Goals</i>	<i>Intermediate Goals</i>	<i>Long Term Goals</i>
Enrollment of sufficient number of competent professionals to deliver core services	Effective communications between the IDHW, Contractor and all other stakeholders	Positive outcomes for Members that result in Members’ recovery and/or resiliency.
Successful claims processing	Increase in number of Members who receive behavioral healthcare treatment that accurately matches their behavioral healthcare needs.	Decreased inappropriate use of higher cost services (hospital, emergency departments, crisis).
Improved identification of Members who meet program qualifications for behavioral health treatment	Implementation of utilization management and quality assurance processes that result in improved operations/services and improved payment approaches.	Administrative efficiencies realized that include greater reliance on technology, cost-effective management of the network and of services, and decrease in waste and fraud.
Successful transition process for both providers of services (agencies and individual practitioners) and Members	Improved coordination with all other treatment providers and programs that Members are involved with, specifically, the Healthy Connections program and the Health Home program.	Greater satisfaction with treatment and support services among Members and greater satisfaction for agencies and practitioners in the administration of the services

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2. INSTRUCTIONS FOR SUBMISSION OF PROPOSALS

- 2.1 The proposal must be submitted with a state supplied signature page, located on the IPRO solicitation page as an attachment, which must contain an **ORIGINAL HANDWRITTEN** signature executed in **INK** and be returned with the relevant Solicitation documents. **PHOTOCOPIED SIGNATURES** or **FACSIMILE SIGNATURES** are **NOT ACCEPTABLE (and will result in a finding that your proposal is non-responsive)**.
- 2.1.1 The proposals must be addressed to the RFP Lead and clearly marked “CONTRACT PROPOSAL – IPRO Sicomm.net **RFP02482** (Idaho Behavioral Health Plan).”
- 2.1.2 Each proposal must be submitted in one (1) original with six (6) copies of the Business and Scope of Work Proposal and one (1) original and one (1) copy of the Cost Proposal and Billing Procedures.
- 2.1.3 Offerors must also submit one (1) electronic copy of the proposal on CD or USB device. Word or Excel format is required (the only exception is for financials or brochures). The format and content must be the same as the manually submitted proposal. The electronic version must NOT be password protected or locked in any way. If your proposal contains trade secret information which you have identified, also submit a redacted copy (in electronic format, with the word “redacted” in the file name) of the Business and Scope of Work Proposal with all trade secret information removed or blacked out; as well as a separate document containing a complete list (per the instructions in **Section 3.5**, below) of all trade secret information which was removed/blacked out in the redacted copy.
- 2.1.4 The Business and Scope of Work Proposal must be sealed, identified “Business and Scope of Work Proposal – IPRO Sicomm.net **RFP02482** (Idaho Behavioral Health Plan) and include the required cover letter (See **Section 3.3**).
- 2.1.5 The Cost Proposal must be separately sealed, identified “Cost Proposal – IPRO Sicomm.net **RFP02482** (Idaho Behavioral Health Plan).”
- 2.2 Proposals should be submitted on the most favorable terms from both a price and technical standpoint which offerors can propose as negotiations, discussions and best and final offers cannot be guaranteed that they will occur.

3. PROPOSAL FORMAT

- 3.1 These instructions describe the format to be used when submitting a proposal. The format is designed to ensure a complete submission of information necessary for an equitable analysis and evaluation of submitted proposals. There is no intent to limit the content of proposals.
- 3.2 Evaluation Codes:
- 3.2.1 **(M)** Mandatory Specification or Requirement - failure to comply with any mandatory specification or requirement will render offeror’s proposal non-responsive and no further evaluation will occur.

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3.2.2 **(ME)** Mandatory and Evaluated Specification - failure to comply will render offeror's proposal non-responsive and no further evaluation will occur. Offeror is required to respond to this specification with a statement outlining its understanding and how it will comply. Points will be awarded based on predetermined criteria. The State reserves the right to seek clarification on any M or ME requirement.

3.2.3 **(E)** Evaluated Specification - a response is desired. If not available, respond with "Not Available" or other response that identifies offeror's ability or inability to supply the item or service. Failure to respond will result in zero (0) points awarded for the specification.

3.3 **(M) Cover Letter:** The Business and Scope of Work Proposal must include a cover letter on official letterhead of the offeror; with the offeror's name, mailing address, telephone number, facsimile number, e-mail address, and name of offeror's authorized signer. The cover letter must identify the RFP Title and number, and must be signed, in ink, by an individual authorized to commit the offeror to the work proposed. In addition, the cover letter must include:

3.3.1 Identification of the offeror's corporate or other legal entity status. Offerors must include their tax identification number. The offeror must be a legal entity with the legal right to contract.

3.3.2 A statement indicating the offeror's acceptance of and willingness to comply with the requirements of the RFP and attachments, including but not limited to the State of Idaho Standard Contract Terms and Conditions http://purchasing.idaho.gov/pdf/terms/standard_terms_and_conditions.pdf and any Special Terms and Conditions included in Appendix D.

3.3.3. A statement of the offeror's compliance with affirmative action and equal employment regulations.

3.3.4 A statement that offeror has not employed any company or person other than a bona fide employee working solely for the offeror or a company regularly employed as its marketing agent, to solicit or secure this contract, and that it has not paid or agreed to pay any company or person, other than a bona fide employee working solely for the contractor or a company regularly employed by the contractor as its marketing agent, any fee, commission, percentage, brokerage fee, gifts or any other consideration contingent upon or resulting from the award of this contract. The offeror must affirm its understanding and agreement that for breach or violation of this term, the State has the right to annul the contract without liability or, in its discretion, to deduct from the contract price the amount of any such fee, commission, percentage, brokerage fee, gifts or contingencies.

3.3.5 A statement naming the firms and/or staff responsible for writing the proposal.

3.3.6 A statement that offeror is not currently suspended, debarred or otherwise excluded from federal or state procurement and nonprocurement programs. Vendor information is available on the Internet at: <http://www.sam.gov>.

3.3.7 A statement affirming the proposal will be firm and binding for one hundred eighty (180) days from the proposal opening date.

3.3.8 A statement, by submitting its proposal, that the offeror warrants that any contract resulting from this Solicitation is subject to Executive Order 2009-10

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[http://gov.idaho.gov/mediacenter/execorders/eo09/eo_2009_10.html]; it does not knowingly hire or engage any individuals who have entered the nation illegally or persons not legally authorized to work in the United States; it takes steps to verify that it does not hire or engage any individuals who have entered the nation illegally or persons not legally authorized to work in the United States; and that any misrepresentation in this regard or any employment of persons not authorized to work in the United States constitutes a material breach and will be cause for the imposition of monetary penalties up to five percent (5%) of the contract price, per violation, and/or termination of its contract.

3.3.9 (M/E) Submit proof of having achieved and maintained applicable national accreditation that covers the work described in this RFP with your proposal. Submit the accreditation report results with your proposal.

3.3.10 A statement acknowledging and agreeing to the requirements in Section 4.A.

3.4 **Acknowledgement of Amendments:** If the RFP is amended, the offeror must acknowledge each amendment with a signature on the acknowledgement form provided with each amendment. Failure to return a signed copy of each amendment acknowledgement form with the proposal may result in the proposal being found non-responsive. IDAPA 38.05.01.52

3.5 **Trade Secrets:** Paragraph 32 of the Solicitation Instructions to Vendors describes trade secrets to “*include a formula, pattern, compilation, program, computer program, device, method, technique or process that derives economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by other persons and is subject to the efforts that are reasonable under the circumstances to maintain its secrecy.*” In addition to marking each page of the document with a trade secret notation (as applicable; and as provided in Paragraph 32 of the Solicitation Instructions to Vendors), offerors must also:

3.5.1 Identify with particularity the precise text, illustration, or other information contained within each page marked “trade secret” (it is not sufficient to simply mark the entire page). The specific information you deem “trade secret” within each noted page must be highlighted, italicized, identified by asterisks, contained within a text border, or otherwise clearly delineated from other text/information and specifically identified as a “trade secret.”

3.5.2 Provide a separate document entitled “List of Redacted Trade Secret Information” which provides a succinct list of all trade secret information noted in your proposal; listed in the order it appears in your submittal documents, identified by Page#, Section#/Paragraph#, Title of Section/Paragraph, specific portions of text/illustrations; or in a manner otherwise sufficient to allow the state’s procurement personnel to determine the precise text/material subject to the notation.

3.6 **Table of Contents:** Include a table of contents in the Business and Scope of Work Proposal identifying the contents of each section, including page numbers of major subsections.

3.7 **Executive Summary:** Include an executive summary in the Business and Scope of Work Proposal providing a condensed overview of the contents of the Business and Scope of Work Proposal demonstrating an understanding of the services to be performed.

3.8 **Business Information:**

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3.8.1 (E) Experience: Submit, with your proposal, contact information for the following state entities for each state in which you have provided Medicaid behavioral health managed care services; 1) State Medicaid contact; 2) Public Behavioral Health contact; 3) NAMI contact; and 4) Mental Health Provider Organization contact. Describe in detail your knowledge and experience in providing services similar to those required in this RFP, including the following:

3.8.1.1. More than three (3) years of Medicaid behavioral health managed care experience and demonstrated success in your contracts for the provisions of Medicaid managed behavioral health care services with complex, publicly-funded behavioral health programs, including the following experience:

3.8.1.1.1 Management of Medicaid and other funding sources not part of the Medicaid program such as non-federal match State general funds and grant funds.

3.8.1.1.2. Management of statewide (or substantial portions of a state) Medicaid managed behavioral health care programs.

3.8.1.2. Proven track record in providing services to other governmental clients and populations similar to the Members covered under this contract as demonstrated by:

3.8.1.2.1. Experience managing care for children with SED and severe behavioral health challenges including, but not limited to, children who are, or have been, involved with the child welfare and juvenile justice systems, particularly those at risk of, or already in, restrictive settings outside their home;

3.8.1.2.2. Experience managing care for adults with SMI, SPMI and/or substance use disorders;

3.8.1.2.3. Success in establishing partnerships with governmental clients representing multiple child-serving agencies, and engaging community leaders, stakeholders and providers in the delivery of a coordinated system of care;

3.8.1.2.4. Success in implementing complex public sector managed care programs consistently within six (6) months of the execution date of a contract;

3.8.1.2.5. An integrated management structure that allows for timely decisions at the local level, within a corporate framework that processes access to industry-leading tools, technology, expertise, and oversight;

3.8.1.2.6. Experience managing within a single contract structure a variety of regional operations designed to reflect the unique characteristics and needs of each region in both urban and rural regional delivery systems;

3.8.1.2.7 Experience implementing a variety of provider reimbursement methodologies, improving consumer access, as well as provider and consumer satisfaction; and

3.8.1.2.8. Successful experience with a rural state's initial foray into behavioral health managed care.

3.8.2 **(E) References:** Provide at least three (3) completed Reference Questionnaires. Please see **Attachment 2**.

3.8.3 **(E) Financials:** Provide financial information as detailed on **Attachment 4**

3.9 **(E) Organization and Staffing:** Describe your qualifications to successfully complete the requirements of the RFP. To demonstrate your qualifications submit the following:

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- 3.9.1 **Organization Chart:** Provide a detailed organization chart showing all key positions that will be involved in the work of carrying out the ensuing contract. Show where this part of the organization, shown on the detailed organization chart, falls within the overall business structure.
- 3.9.2 **Qualifications of Personnel:** The IDHW reserves the right to approve or disapprove all initial and replacement key personnel prior to their assignment to the project. The IDHW shall have the right to require that the Contractor remove any individual (whether or not key personnel) from working on the contract.
- 3.9.3 **Subcontractors:** Describe the extent to which subcontractors will be used to comply with contract requirements. Include each position providing service, and provide a detailed description of how the subcontractors are anticipated to be involved under the contract. Include a description of how the Offeror will ensure that all subcontractors and their employees will meet all Business and Scope of Work requirements. Offerors must disclose the location of the subcontractor's business office and the location(s) of where the actual work will be performed. If the Offeror utilizes any entity other than the entity submitting the proposal to provide any of the services required by this RFP, the relationship between the two entities is considered that of a contractor-subcontractor for the purpose of this section, regardless of whether a relationship is based on an actual written contract between the two.

4. SCOPE OF WORK

Use this proposal outline as part of your response to the RFP, and identify it as **Appendix A – Scope of Work**.

A General Requirements: Offerors must include a statement acknowledging and agreeing to the requirements in Section A.

- 1 IDHW Responsibilities: The IDHW will:
 - a Provide an IDHW Contract Manager for ongoing contract administration and contract performance monitoring.
 - b Designate an IDHW Contract Manager who shall have overall responsibility for the management of all aspects of this contract and the IDHW Contract Manager shall be a member of the implementation team. This person shall oversee the Contractor's progress, facilitate issue resolution, coordinate the review of deliverables, and manage the delivery of IDHW resources to the project, consulting with the Contractor as needed. The IDHW Contract Manager may designate other IDHW staff to assume designated portions of the IDHW Contract Manager's responsibility. The IDHW Contract Manager shall be the central point of communications and any deliverables to the IDHW shall be delivered to the IDHW Contract Manager and any communication or approval from the IDHW shall be communicated to the Contractor through the IDHW Contract Manager. Should disagreements arise between Contractor staff and the IDHW's Project Team, those disagreements shall be escalated for resolution through each organization's respective reporting structure. Should those disputes remain unresolved after that process, the IDHW's Contract Manager has the authority to escalate through the Division of Medicaid's leadership to the IDHW's Director who retains ultimate authority to decide the outstanding issue or question.

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- c Review any required informational materials regarding the Idaho Behavioral Health Plan program prior to release, including, but not limited to brochures, provider and Member templates for correspondence. The IDHW will review draft documents, identify revisions, and return written comments to the Contractor within agreed upon timeframes.
 - d Prior to the provision of services under the contract, the IDHW's Division of Medicaid will notify all current eligible Members, and mental health and substance use disorder providers enrolled under the IDHW's current network of the following:
 - i Creation of the Idaho Behavioral Health Plan
 - ii An explanation of how the new managed care plan works; and
 - iii The Contractor's information: toll-free number, mailing address, and website.
 - e Enroll all Medicaid beneficiaries, except for excluded populations identified by the IDHW, into the Idaho Behavioral Health Plan upon eligibility determination. As used in this RFP, a Medicaid enrollee means a Medicaid Member who is enrolled in the Idaho Medicaid Management Information System (MMIS).
 - f Determine the on-going eligibility of a person for Medicaid funded services.
 - g Be responsible for all enrollment and disenrollment into the PAHP. The IDHW automatically enrolls Medicaid beneficiaries on a mandatory basis into the PAHP, for which it has requested a waiver of the requirement of choice of plans. There are no potential enrollees in this program because the IDHW automatically enrolls beneficiaries into the single PAHP. 42 CFR § 438.10(a)
- 2 Contractor's Responsibilities: The Contractor shall:**
- a Administer behavioral health coverage for all Medicaid eligible Members. The Contractor may not dis-enroll any Medicaid eligible Members.
 - b Notify all Members, at the time of enrollment, of the Member's rights to change providers.
 - c Provide all Members, at the time of enrollment, all information required per 42 CFR § 438.10(f)(6).
 - d Notify all Members, at least annually, of their rights provided under 42 CFR § 438.10(f)(6), 42 CFR § 438.10 (g) and 42 CFR § 438.10 (h) and written notice of any changes in the information specified in these provisions.
 - e Ensure services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished consistent with requirements at 42 CFR § 438.210(a)(3)(i) as amended.
 - f Not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the Member. 42 CFR § 438.210(a)(3)(ii).
 - g Comply with provisions of 42 CFR 438.210(a) (1)(2) and (4).
 - h Defend, indemnify and hold harmless Members, the IDHW or its agents, employees or contractors against any and all claims, costs, damages, or expenses (including attorney's fees) of any type or nature arising from the failure, inability, or refusal of the Contractor to pay the behavioral health provider for covered services or supplies.
 - i Designate a primary contact for the IDHW Contract Manager who will cooperate fully with respect to the direction and performance of the contract.
 - j Participate in a contract implementation meeting, either in person or by phone. The IDHW will facilitate the implementation meeting to review contract requirements and timelines. The Contractor shall attend this meeting and all meetings throughout the contract at its own expense.

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- k Comply with all provisions of state and federal laws, rules, regulations, policies, and guidelines as indicated, amended or modified that govern performance of the services. This includes, but is not limited to:
 - i 42 CFR § 438.8(b) – requirements that apply to PAHP contracts
 - ii 42 CFR § 438.224 – HIPAA Protected Health Information
 - iii The IDHW’s HIPAA Business Associated Agreement – **Appendix E**
 - iv Idaho statutes and administrative rules which can be accessed at http://www.idaho.gov/laws_rules/
- l Report to the IDHW’s Contract Manager any facts regarding irregular activities or practices that may conflict with federal or state rules and regulations discovered during the performance of activities under the contract. Such information may also need to be reported to the Medicaid Fraud Control Unit and the Medicaid Program Integrity Unit as appropriate.
- m Maintain oversight, and be responsible for any functions and responsibilities it delegates to any subcontracted provider.
- n Not subcontract with or employ individuals who have been excluded from the federal government or by the State’s Medicaid program for fraud or abuse. The Contractor is prohibited from subcontracting with providers who have been terminated by other states in accordance with 42 CFR § 455.416. The Contractor shall be responsible for checking the lists, on a monthly basis, of behavioral health providers currently excluded by the state and the federal government per the provisions of 42.CFR § 455.436. One of the federal lists is available at: <http://exclusions.oig.hhs.gov>. The state list is available at: <http://healthandwelfare.idaho.gov/portals/0/providers/medicaid/ProviderExclusionList.pdf>
- o Comply with the following: The Contractor is prohibited from (1) being an owner, in full or in part, of any organization participating as a behavioral health provider in the Medicaid program, or (2) having an equity interest in or being involved in the management of any behavioral health provider organization or entity. This also applies to family members of owners and managers, as well as to any administrative or management services subcontractors of the Contractor on this project.
- p Ensure that all behavioral health services provided under this contract are provided by, or under the supervision of, at least a licensed master behavioral health clinician in the practice of his or her profession.
- q Act as the State’s agent to collect Third Party Liability for all enrolled Medicaid recipients. The Contractor’s capitated payments have been computed based on claim experience that is net of these collections.
- r Ensure that any compensation, to individuals or entities that are subcontracted by the Contractor to conduct utilization management activities under this contract, is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any Member per 42 CFR § 438.210(e).
- s Not prohibit, or otherwise restrict a health care professional, acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient for the Member’s health status, medical care, or treatment options, including any alternative treatment that may be self-administered. 42 CFR § 438.102(a)(1)(i)
- t Not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient, for any information the enrollee needs in order to decide among all relevant treatment options. 42 CFR § 438.102(a)(1)(ii)

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- u Not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient, for the risks, benefits, and consequences of treatment or non-treatment. 42 CFR § 438.102(a)(1)(iii)
- v Not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient, for the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. 42 CFR § 438.102(a)(1)(iv)
- w Not provide, reimburse, or provide coverage for a counseling or referral service if Contractor objects to the service on moral or religious grounds. 42 CFR § 438.102(a)(2)
- x Notify the IDHW, in writing, when changes in key personnel of this contract occur, as well as other management and supervisory level staff. The Contractor shall provide the IDHW with resumes of the aforementioned individuals for review.
- y Notify the IDHW when there is a significant change in the Contractor's operations that would affect their ability to meet the required capacity and services. Operational changes may result in an amendment of the requirements, subcontracting to assure services are not disrupted for Members, or imposing the remedies identified in **Appendix D – Special Terms and Conditions**. A significant change includes, but is not limited to, changes in the Contractor's:
 - i Services
 - ii Benefits
 - iii Geographic service area
 - iv Payments
 - v Enrollment of a new population requiring services
- z Endorse and promote all therapeutic initiatives of the Idaho Medicaid Pharmacy and Therapeutics Committee and the Medicaid Pharmacy Program, including preferred drug list compliance, therapeutic guideline implementation and prior authorization criteria. The Contractor shall assist the IDHW with education to providers to drive implementation and compliance with pharmacy programs and shall not actively promote any programs or initiatives that conflict with those of the IDHW.
- aa If a network provider elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds per the provisions of 42 CFR § 438.102(a)(2), it shall furnish information about the services the provider does not cover, per the requirements at 42 CFR § 438.102(b)(1) as follows:
 - i To the IDHW;
 - ii With its application to be a network provider;
 - iii Whenever it adopts the policy during the term of the contract;
 - iv It shall be consistent with the provisions of 42 CFR § 438.10; and
 - v It shall be provided to Members within ninety (90) calendar days after adopting the policy with respect to any particular service.
- bb The Contractor shall coordinate with the IDHW's contracted transportation broker and support IDHW requirements for Medicaid reimbursed transportation services by providing sufficient information when it is needed to justify use of transportation. The IDHW's contracted transportation broker administers, coordinates, and manages all non-emergency medical transportation (NEMT). For information on Idaho's NEMT services, go to the following website:
<http://www.healthandwelfare.idaho.gov/Medical/Medicaid/MedicalCare/MedicalTransportation/tabid/704/Default.aspx>

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- cc Develop and maintain an updated Policies and Procedures Manual for the services identified in this RFP. The Policies and Procedures Manual shall be available in electronic and hard copy upon request to the IDHW at no additional cost.
- dd Participate in the IDHW's appeal and Fair Hearing processes when required by the IDHW.

Where indicated for each of the following, the proposal should include methodologies, pertinent timelines, personnel, activities, and other pertinent information in order to implement the Scope of Work (including **Attachment 6 – Technical Requirements**) successfully to achieve full compliance with all tasks and deliverables. Offerors must identify any information or resources needed from the IDHW in order to perform any of the work. Keep in mind, the evaluators will be scoring your proposal based on the methodologies proposed and the completeness of the response to each item listed below. The Offeror shall demonstrate a commitment to the recovery and resiliency model throughout its proposal by identifying specific programs, services, policies and procedures that embody the described principles. The Offeror shall demonstrate a commitment to proactive care rather than relying solely upon reactive models of care. The Offeror's proposal shall not include a separate section narrating their commitment to this requirement, but shall demonstrate its commitment to the recovery and resiliency model throughout the response made to this RFP, as these will also be evaluated.

- B (E) Administration and Operations:** The Contractor shall implement, administer and maintain the Idaho Behavioral Health Plan, an outpatient PAHP as defined in 42 CFR 438.2, and related services for all eligible Medicaid Members, an outpatient prepaid ambulatory health plan (PAHP), as defined in 42 CFR § 438.2., that provides behavioral health coverage for all Medicaid eligible children and adults. The following populations are excluded:
- a Those populations that are covered for premiums only;
 - b Undocumented aliens;
 - c Members who reside in State hospitals or institutions, except for discharge planning; and
 - d Members enrolled in the Medicare-Medicaid Coordinated Plan (MMCP).
- 1 Offeror shall:**
- a **Submit with your proposal**, a behavioral health benefit package for children and adults that is based on cost effective, evidence-based standards of practice within the behavioral health community. **Attachment 12 - Continuum of Care**, provides a detailed description of Medicaid-reimbursed services and services that statewide behavioral health stakeholders have identified as necessary components of a robust continuum of care. The package for children and adults must include community based behavioral health services as well as rehabilitative services.
- 2 Describe how you will:**
- a Develop a robust continuum of care based on State Plan services;
 - b Pay providers in compliance with the prompt pay standards as follows:
 - i Pay ninety percent (90%) of clean claims within thirty (30) days.
 - ii Pay ninety nine percent (99%) of clean claims within ninety (90) days.
 - c Develop and operate a complaint and grievance system which includes but is not limited to providing the IDHW with a Complaint and Grievance Resolution and Tracking Report;
 - d Educate Members and providers regarding all aspects of the Idaho Behavioral Health Plan;

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- e Hire, train, and maintain sufficient qualified staff to implement, administer, and manage the Idaho Behavioral Health Plan and all services related to the contract. Sufficiency shall be determined by comparison of baseline accessibility to changes in accessibility, Member complaints and quality assurance processes.

3 **Describe how you will:**

- a Ensure that written material is in an easily understood language and format. Written material shall be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. The Contractor shall also ensure Members are aware of this availability. 42 CFR § 438.10:
- b Ensure continuity of care between all providers of behavioral health services, PCPs, and other health care specialists and other services as needed (school/courts);
- c Ensure verification of program eligibility for Members and providers;
- d Process claims and prior authorize services when required;
- e Promote the well-being of the population served through preventive and population-based behavioral health interventions;
- f Provide general information and orientation regarding all aspects of the program and operations. The Contractor shall have in place a comprehensive program to provide all Members, not just those who access services, with appropriate information, such as information about behavioral health treatment services, available providers, and education related to recovery, resilience and best practices, as well as Member rights. In developing these materials, obtain input from consumers, secondary Member and/or family Members and other stakeholders who can contribute to both the content and presentation of the information so that the information is provided in a manner and format that may be easily understood per 42 CFR § 438.10(b)(1);
- g Identify any new service offeror proposes to develop under the capitated rate as cost-effective services per 42 CFR § 438.6(e) as determined by the IDHW, and identify any impacts the proposed service would have on the capitation rates;
- h Implement new special services and programs identified in the cost-benefit analysis as approved by the IDHW and CMS (as necessary); and
- i Provide day to day business operations for the state of Idaho to ensure ongoing communication and interaction with IDHW staff to implement and maintain the services outlined in the RFP. Response should include, but not be limited to, meeting with IDHW staff on an ongoing basis, providing ongoing support and interaction with network providers, and working with stakeholders. The IDHW will not provide work space for the Contractor's staff.

- C (E) Work Plan and Service Implementation:** The Contractor shall provide and utilize a Work Plan for service implementation of the Idaho Behavioral Health Plan. The Contractor shall immediately begin to collaborate with the IDHW after the contract is fully executed to work toward a timely implementation period. The implementation period shall be complete within six (6) months of the contract execution date. The preferred implementation date of services is July 1, 2013. The Contractor shall establish an implementation team that shall ensure the plan for implementation of services progresses according to the required timelines. The Contractor shall meet with the IDHW within the first five (5) business days of the contract execution date to establish the following deliverables and to establish priorities. The Contractor is responsible for any costs they may incur for all meetings during the implementation process. The Contract shall:

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- a Define the project management team, the communication paths and reporting standards between the IDHW and the Contractor staff;
 - b Establish a written comprehensive Work Plan, including the schedule for key activities and milestones which is a part of the Contractor's overall Work Plan;
 - c Define expectations for content and format of contract deliverables.
- 1 The Contractor shall develop and maintain a comprehensive written Work Plan which shall include timelines. This shall be initially submitted with the proposal. This plan will be used to monitor progress throughout the implementation period. The revised and updated Work Plan is due within ten (10) business days of the execution date of the contract and shall include time frames for critical milestones for implementation. The Work Plan shall clearly include all tasks necessary to meet the requirements of this RFP and shall include timeframes for critical milestones for implementation. It shall clearly specify the Contractor's understanding of information to be provided by the IDHW. The Work Plan shall include the following Contractor tasks and plans:
- a Schedules and timetables for implementation;
 - b A detailed description of the implementation methods;
 - c Communication Plan that includes a plan to communicate with Members, providers and stakeholders, including Member service and provider service call centers and Member and provider handbooks;
 - d Website Development Plan;
 - e Network Development Plan, including analysis and plans to effect a smooth transition;
 - f Service Transition Plan;
 - g A Staffing Plan identifying hiring expectations and staff associated with each task of the implementation period and the work of the contract itself; the Contractor should describe how they would make use of the following positions: Contract Manager, Chief Financial Officer, Chief Medical Officer, Outcomes or Quality Improvement Director, Member and Family Affairs Director, Account Manager, Project Manager, Business Analysis Lead, Systems Analysis Lead, Systems Manager, Data Conversion Manager, Testing Lead, Training Lead, Documentation Lead;
 - h Training Plan for Contractor staff, IDHW staff, Members, providers, and stakeholders;
 - i Facilities, Fiscal Requirements and Cost Avoidance Plans;
 - j Quality Management Plan;
 - k Utilization Management Plan, including outlier management and plans for care coordination;
 - l Complaints, Grievances and Appeals Plan;
 - m Customer Service System Plan;
 - n Overall Project Plan, including reports and interface plans, claims processing and information management integration, hardware and equipment acquisition and installation, operating system and software installation, systems testing, etc.;
 - o Business Continuity, Disaster Recovery, and Risk Management Plan;
 - p Contract Compliance Plan; and
 - q Operational Readiness Plan.
- 2 In addition to those items specifically enumerated above, the Contractor shall develop and execute plans that ensure completion of all necessary tasks, explicit or implicit, assigned to the Contractor by this RFP. Such plans shall be made available to the IDHW when completed and whenever updated.

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- 3 The Contractor shall utilize their Contract Manager, or a designee to be responsible for successful completion of Contractor's responsibilities and overseeing and monitoring the Contractor's staff on a day-to-day basis as they undertake project activities. The Contract Manager, or designee, shall also work closely with the IDHW Contract Manager and assist in coordinating IDHW resources. The Contractor's Contract Manager, or designee, shall maintain the Work Plan.
- 4 The Contractor's Contract Manager, or designee, and relevant contract staff shall meet with and provide project status to the IDHW Contract Manager and other IDHW staff weekly. The purpose of the status meetings is for the Contractor to communicate actual progress, identify problems, recommend courses of action, and obtain approval for making modifications to the Work Plan. In conjunction with the project status meetings, the Contractor shall provide written status reports to the IDHW's Contract Manager at least every two weeks during implementation. This status report shall include:
 - a Updated Work Plan and responsibility matrix.
 - b Tasks that are behind schedule.
 - c Dependent tasks for tasks behind schedule.
 - d Items requiring the IDHW Contract Manager's attention.
 - e Anticipated staffing changes.
 - f Risk assessment.
 - g Any issues that can affect schedules for project completion.
 - h Identification, time frames, critical path effects, resource requirements and materials.
- 5 The Contractor shall:
 - a Be responsible for documenting all meetings, including attendees, topics discussed, decisions recommended and/or made with follow-up details. Written minutes and summaries from all meetings are to be provided to the IDHW Contract Manager no later than three (3) business days after the date of each meeting;
 - b Provide a written project communication plan, the purpose of which is to keep contract management and staff informed about all information they need to complete assigned responsibilities, as well as to keep all system stakeholders proactively informed on the progress of the project.
 - c Prepare and submit, in its Work Plan, a comprehensive set of flow diagrams that clearly depict the proposed final work operations, including but not limited to, Member flow, Contractor workflow, expected IDHW workflow, data flow and authorization and provider payment process. These diagrams shall aid in the understanding of how the Contractor will perform work and support training. The level of detail in these diagrams shall be sufficient to communicate to the Members and providers their roles in the behavioral health managed care process. With a goal to maximize clarity, the Contractor shall use graphical software that matches what the IDHW currently uses as its platform.
 - d The Contractor shall demonstrate its readiness and ability to provide covered behavioral health services and to resolve any previously identified operational deficiencies. The Contractor shall undergo and must pass a two (2) phase readiness review process and be ready to assume responsibility for contracted behavioral health services within one-hundred eighty (180) calendar days of the effective date of the contract. See **Attachment 9 – Initial Deliverables** and **Attachment 10 - Readiness Review**, for a detailed description of expectations for the two (2) phase readiness review.

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- 6 **Offeror – submit the following with your proposal:**
 - a A draft comprehensive written Work Plan that includes, but is not limited to, the tasks and plans identified in this section C.1.a – q., and identifies timelines.
- 7 **Offeror – describe how you will:**
 - a Ensure the health and safety of Idahoans is not put at risk during the transition in administration from the fee-for-service reimbursement model to the managed care model of service delivery;
 - b Ensure major components of the current network delivery system are not adversely affected by transition to managed care;
 - c Honor existing Member-therapist relationships to the greatest extent possible;
 - d Effect transfers in care as seamlessly as possible to Members;
 - e Allow a transfer process with sufficient time for Members to receive notifications, make choices when choices are available, and ask questions of the Contractor regarding the transfer process and the Member's Idaho Behavioral Health Plan benefits;
 - f Ensure the provider network :
 - i Is sufficiently informed of the Contractor's administrative requirements for participation in the network and for delivery of benefits to Members provided under the Idaho Behavioral Health Plan;
 - ii Is able to deliver services according to the Contractor's standards and all state and federal requirements;
 - iii Is scheduled according to the Contractor's established timelines for "go live" activation.

D **(E) Behavioral Health Services:** The Contractor shall provide a recovery oriented system of care that is holistic and includes the following categories of mandatory State Plan services:

- a Community based outpatient
 - b Rehabilitation
 - c Substance use disorders
- 1 The Contractor shall ensure the more stringent requirements for SUDS treatments regarding confidentiality (42CFR Part 2) are incorporated into the Contractor's policies and procedures as well as the requirements for the network of providers.
 - 2 The Contractor may place appropriate limits on a service:
 - a On the basis of medical necessity criteria (Medical necessity is defined in IDAPA 16.03.09, The IDHW shall be the final authority regarding all disputed medical necessity decisions.); or
 - b For the purpose of utilization control, provided the services furnished can be reasonably expected to achieve their purpose. 42 CFR § 438.210(a)(3)(iii.)
 - 3 **Describe how you will:**
 - a Promote and assist in the recovery of adult Members with serious mental illnesses (SMI) and those with serious and persistent mental illness (SPMI) and resiliency of child Members with serious emotional disturbance (SED) and/or co-occurring substance use disorders through innovative services that empower Members, and families as appropriate, to determine and achieve their goals; this includes specific attention to behavioral health service needs of very young children as described in **Attachment 15 - Infant Toddler Mental Health.**

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- b Utilize and implement evidence-based practices in service delivery and describe how you will demonstrate fidelity to the tested model used for each evidence-based practice, when available, in order to assure the effectiveness of the service provided. Such fidelity should be applied except when adjustment is specifically described and justified for good cause, such as administering the practice in rural areas or to account for cultural differences. Information on sources for five (5) of the adult evidence-based practices, including fidelity checklists, and evidence-based practices applicable for children, is available on the SAMHSA website at <http://www.nrepp.samhsa.gov>.
 - c Provide culturally competent community-based services, including evidence-based, best practices, trauma-informed care and alternative services for Members of all ages. See **Attachment 18 - Trauma-informed Care** for more a detailed description of trauma-informed care.
 - d Provide Members with timely access to a comprehensive array of specialized behavioral health services delivered by culturally-competent, qualified service providers.
 - e Ensure that services reflective of continuous quality improvement are provided to Members, and families as appropriate.
 - f Provide all necessary services through a cost-effective system.
 - g Achieve a coordinated system of delivering medically necessary covered behavioral health services to Members.
 - h Maximize community resources in an effort to maintain the least restrictive level of care.
 - i Ensure provision for a second opinion from a qualified behavioral health care professional within the network, or arrange for a second opinion outside the network, at no cost to the Member per 42 CFR § 438.206(b)(3) and must occur within seven (7) calendar days from the date it is requested.
 - j Cover those services out-of-network for the Member for as long as the Contractor is unable to provide them by a network provider in the event that the network is unable to provide necessary services covered under the contract for a particular member, per 42 CFR § 438.206(b)(4).
 - k Coordinate with out-of-network with respect to payment and ensure that cost to the Member is no greater than it would be if the services were furnished within the network.
 - l Track and report Members' movement from one (1) level of care to another on a quarterly basis.
- 4 Describe how you will manage potential influences on the administration of behavioral health services under the PAHP, including the following:**
- a Each region features a different mix of professional expertise and community volunteerism, and the array of services might be achieved through different types of venues or may have a different configuration from one region to another;
 - b Services will be available in all areas of the state, but the prevalence of any service may vary among regions as appropriate to reflect the needs of a region's targeted population;
 - c Working with regional behavioral health advisory boards to develop local access standards using their own demographics, geography, and availability of services within pocketed areas of a particular region;
 - d The Contractor may need to establish arrangements across regions to help make a service available that is not available in a certain region;

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- e While initially it may only be possible that the Contractor provides services in areas where there are already services, the expectation is that the Contractor will engage in long term planning with regional behavioral health advisory boards to develop a full continuum of services across all areas of the state.

E (E) Member Enrollment/Disenrollment: The Contractor shall use the IDHW's Medicaid Management Information System (MMIS) eligibility to identify Medicaid eligible Members on a daily basis. The Contractor shall:

- 1 Accept Members in the order in which they are enrolled, without restriction;
- 2 Not discriminate against Members eligible to enroll on the basis of health status or need for health care services, race, color, or national origin per 42 CFR § 438.6(d)(3);
- 3 Not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin per 42 CFR § 438.6(d)(4);
- 4 Not request disenrollment of any Member for any reason, including requests because of a change in the Member's health status, or because of the Member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs. 42 CFR § 438.56(b)(2);
- 5 Not disenroll Members for any reason. The Contractor may propose a disenrollment to the IDHW, but the IDHW will make the final determination;
- 6 Eligible Members may not disenroll from the Idaho Behavioral Health Plan, but the IDHW may disenroll Members whose eligibility changes to a Medicaid coverage group excluded from the PAHP, or who otherwise lose Medicaid eligibility, consistent with the terms of this contract and the related waiver;
- 7 The Offeror must provide an assurance and description of its methods to the IDHW that it will not request disenrollment of Members for any reason and be consistent with the IDHW's policy that there will be no circumstances in which a qualified Member is disenrolled. 42 CFR § 438.56(b)(1) and (3.)

F (E) Coverage and Payment for Post-Stabilization Services: The Contractor shall provide post-stabilization services as defined in 42 CFR § 438.114(a) and (b), and ensure the services are covered and paid for in accordance with the following provisions:

- a Be financially responsible for medically necessary post-stabilization services that are pre-approved by an Idaho Behavioral Health Plan provider or other Idaho Behavioral Health Plan representative that the Contractor has authorized to make pre-approval decisions;
- b Be financially responsible for medically necessary post-stabilization services obtained within or outside the network that are not pre-approved, but administered to maintain the Member's stabilized condition within one (1) hour of a request to the Contractor for pre-approval of further post-stabilization covered services.

1 Describe how you will ensure the following:

- a Be financially responsible for medically necessary post-stabilization services obtained within or outside the network that are not pre-approved, but administered to maintain, improve or resolve the Member's stabilized condition if:
 - i The Contractor does not respond to a request for pre-approval within one (1) hour;
 - ii The Contractor cannot be contacted; or
 - iii The Contractor and the treating physician cannot reach an agreement concerning the Member's care and the Contractor's physician is not available for consultation. In this situation, the Contractor shall give the treating physician the opportunity to consult with the Contractor's physician and the treating physician may continue with care of the Member until the Contractor's physician is reached.

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- 2 The Contractor's financial responsibility for medically necessary post-stabilization covered services it has not pre-approved ends when:
 - a A network physician assumes responsibility for the Member's care through transfer; and
 - b The Contractor's representative and the treating physician reach an agreement concerning the enrollee's care.

G (E) Access to Care: The Contractor shall ensure services are provided through a well-organized service delivery system. The service delivery system shall include mechanisms for ensuring access to high quality, general and specialized care, from a comprehensive provider network. Mechanisms for access shall include opportunities for face-to-face inquiries, a twenty four (24) hour per day toll free telephone line, and electronic communication mediums. The Contractor shall ensure access to medically necessary covered behavioral health services for Members, and families as appropriate, including engaging Members with serious mental illness, serious and persistent mental illness and/or co-occurring substance use disorder who may not seek help on their own.

1 Describe how you will:

- a Ensure access to care for all Members in need of covered behavioral health services through the provision of the following:
 - i Varied geographic location of providers;
 - ii Providers located within thirty (30) miles or within thirty (30) minutes of travel within Ada, Canyon, Twin Falls, Nez Perce, Kootenai, Bannock and Bonneville counties and within forty five (45) miles or within forty five (45) minutes in all other counties. Where this standard is not achievable, the Contractor shall develop plans for moving toward achieving this standard; such planning is subject to IDHW oversight. Use of telehealth technology is encouraged;
 - iii Use of local providers whenever possible to minimize need for travel and promote local cultural competency;
 - iv Appropriate Member to provider ratio for all services in every region of the state, consistent with industry standards;
 - v Ensure sufficient numbers of prescribers/psychiatrists are available in the state;
 - vi Make use of licensed psychologists to extend network capacity.
- b Ensure services to Members are uninterrupted.
- c Adhere to professional standards for determining staffing patterns in all settings.
- d Ensure minimum hours of provider operation are sufficient in each time zone in Idaho to meet the needs of the population served in each location, which includes crisis coverage twenty-four (24) hours a day, seven (7) days a week, 365 days per year. Sufficiency shall be determined by comparison of baseline access to changes in access, Member complaints, and quality assurance processes.
- e Provide hours of operation and service coverage in every region at sufficient locations to meet the needs of the population in each region, which may include additional morning, evening or weekend hours, to accommodate Members who are unable to attend appointments during standard business hours.
- f Ensure network providers offer flexibility of appointment times to Members whenever possible.
- g Provide community-based access to increase accessibility and improve outcomes to ensure behavioral health services are provided in multiple community-based venues, based on a determination that the services:
 - i Are medically necessary;

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- ii Are appropriate to the Member's needs and are not duplicative of other services the Member is receiving; and
- iii Do not put the provider's safety at undue risk when provided in alternative treatment sites. Alternative treatment sites may include, but are not limited to,
 - (1) Schools;
 - (2) Federally Qualified Health Centers;
 - (3) Homeless shelters;
 - (4) Assisted living facilities; and
 - (5) Members' homes.

2 Describe how you will:

- a Provide evening and weekend support services for Members and families that include access to clinical staff, not just an answering service or referral service staff.
- b Provide access to a twenty four (24) hour, seven (7) days per week, 365 days per year, toll-free line dedicated to Members that meets the following minimum standards:
 - i The toll-free number shall be approved by the IDHW;
 - ii The Member line shall be answered by a live voice at all times;
 - iii All phone calls, voice mail and email shall be responded to on the same or next business day.
- c Identify Members who unexpectedly miss appointments or discontinue treatment. Appropriate and timely steps shall be taken to contact Members to determine if there is a problem that can be resolved and to promote continuation of services. The Contractor shall recognize that different strategies and levels of effort are appropriate for different populations (e.g. age groups, diagnosis, severity of illness, culture, language, etc.) and conduct outreach efforts that are appropriate for different populations, using numerous attempts and multiple methods that could include mail, telephone, e-mail, text messaging, home visits, or other efforts that are reasonably calculated to ensure verifiable contact.

3 Describe your criteria for discharge from treatment/services. The Contractor should establish clear and specific criteria for discharging Members from treatment and criteria should be included in Member materials and information. Ensure criteria for discharge, established with Member input, is agreed upon by Member and Provider and should be noted in the Member's health care record and modified, by agreement, as necessary.

4 Describe how you will meet industry standards for access in the following categories, including timeframes and types of professionals. Placing Members on waiting lists for initial routine service requests is not acceptable.

- a Capacity for crisis response and service authorization;
- b Life-threatening crisis intake and intervention services;
- c Non-life-threatening crisis intake and intervention services;
- d Urgent care, including urgent medication management;
- e Access to board certified physicians to provide clinical consultation for network providers, including a psychiatrist. Describe any special accommodation for children.
- f Access to board certified physicians to provide clinical consultation for PCPs, including a psychiatrist. Describe any special accommodations for children.
- g Routine appointments; and
- h Outpatient follow-up appointments after discharge from an inpatient psychiatric hospitalization or residential facility. Refer to Post-Stabilization Services for related requirements.

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5 Describe how you will:

- a Ensure the Member line is answered by a live voice at all times;
- b Assist and triage callers who may be in crisis by effectuating an immediate transfer to at least a licensed masters level care manager. The call shall be answered within thirty (30) seconds and only transferred via a warm line to at least a licensed masters level care manager;
- c Respond to Members with limited English proficiency through the use of bilingual/multicultural staff or language assistance services. Bilingual/multi-cultural staff, at a minimum, shall speak English and Spanish and any other language spoken by at least 5% of the eligible population. The Contractor shall notify Members that oral interpretation is available for any language and written information is available in English and Spanish, and inform the Members how to access such services 42 CFR § 438.10(c)(5);
- d Ensure every reasonable effort is made to overcome any barrier that Members may have to receiving services, including any language or other communication barrier;
- e Ensure network providers have staff available to communicate with the Member in his or her spoken language, and/or access to a phone-based translation service so that someone is readily available to communicate orally with the Member in his or her spoken language;
- f Have available, at all times, a Telecommunications Device for the Deaf (TDD) and/or relay systems;
- g Interact with callers in a courteous, respectful, polite, culturally responsive, and engaging manner;
- h Respect the caller's privacy during all communications and calls.

H **(E) Cultural Competency:** The Contractor shall provide culturally competent behavioral health services to its Members, consistent with standards described at 42 CFR § 438.206(c)(2).

1 **Submit, with your proposal,** your Cultural Competency Plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services with specific focus on Native Americans' and Hispanics' needs, and includes a positive statement that the Contractor shall have sufficient staff with cultural competency to implement and oversee compliance with the Cultural Competency Plan.

2 Describe how you will:

- a Identify Members whose cultural norms and practices may affect their access to health care and its plan to outreach these Members;
- b Recruit and retain qualified, diverse and culturally competent clinical staff within your provider network and include a positive statement that the Contractor will offer single case agreements to culturally competent staff outside of its network, if required to meet a Member's needs;
- c Work with Native American and Hispanic providers to promote the development of these culturally specialized networks of providers;
- d Monitor whether or not language services are being provided to all Members, upon request, and how it will address gaps or inadequacies found.

I **(E) Customer Service System:** The Contractor shall provide a customer service system that includes implementation of a Customer Service System Plan. The Customer Services System Plan must include services that meet the requirements at 42 CFR § 438.10(f)(6).

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- 1 **Submit, with your proposal**, a detailed Customer Service System Plan that includes a Call Center and Help Desk, policies on customer service, and identifies how staff will be trained to meet the customer service requirements.
- 2 **Describe how you will:**
 - a Ensure that a toll-free number, dedicated to customer service inquiries is established and publicized throughout Idaho and ensure multiple lines are available to accommodate Members, providers, IDHW staff and others that may be calling. The IDHW shall own the rights to the toll-free call center number at the conclusion of the contract;
 - b Maintain sufficient equipment and staff to meet the customer service requirements;
 - c Ensure no calls, e-mails or correspondence go unanswered (e-mails and other written correspondence shall be answered within two (2) business days);
 - d If an automated Interactive Voice Response (IVR) system is used, the system shall be programmed to answer all calls within three (3) telephone rings;
 - e The average daily hold time after initial automated response is two (2) minutes or less;
 - f Provide periodic live monitoring of service calls for quality management purposes;
 - g Ensure call tracking and record keeping is established and utilized for tracking and monitoring phone lines;
 - h Ensure customer service inquiries are reported monthly to the IDHW per the requirements of the contract. All customer service communications, written or verbal, shall be reflected in the report.
- 3 Should the Contractor choose to use an IVR the Contractor shall **describe how you will comply with the following requirements:**
 - a Provide an up-front message in the phone system to inform users when the system is down or experiencing difficulties, including an indication when the system is expected to be operational;
 - b Roll incoming calls to the Call Center staff during those instances when the system is unavailable during the hours the Call Center is staffed;
 - c For IVR users who are seeking data, verify that the person using IVR is an authorized user, and allow access to data by Member ID number, social security number, or Member name and date of birth;
 - d Assign and provide the user a unique verification number for each inquiry;
 - e Provide appropriate safeguards to protect the confidentiality of all information, in compliance with federal, State and IDHW confidentiality laws, including HIPAA;
 - f Provide toll-free telephone number(s);
 - g Integrate with the Call Center and Help Desk to provide IVR users with an option for customer service representative support when requested during the hours the Call Center is staffed;
 - h Provide sufficient in-bound access lines to ensure IVR users:
 - i Are connected with the IVR system within three (3) telephone rings at least ninety-nine percent (99%) of the time;
 - ii When transferred are connected with the IVR system within ten (10) seconds, ninety-nine percent (99%) of the time;
 - iii Receive a busy signal less than five percent (5%) of the time they call;
 - iv Are not dropped in excess of zero-point-five percent (0.5%) of the total daily call volume; and
 - v Are successfully transferred to live assistance at the Call Center in less than one-hundred-twenty (120) seconds of request to transfer;

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- vi Call abandonment rates should not exceed 7%;
- i Ensure that the IVR is available for information and service requests twenty (24) hours a day, seven (7) days a week, 365 days per year except for IDHW approved scheduled downtime;
- j Resolve all IVR system downtimes caused by the IVR hardware, software, or other components under the Contractor's control, within thirty (30) minutes of initial notification of system failure. If the system is not in service within that time frame, the Vendor shall provide a failover IVR system to ensure that system downtime is limited to a maximum of thirty (30) continuous minutes;
- k Maintain and retain for twenty-four (24) months, electronic records of all IVR inquiries made, information requested, and information conveyed;
- l Make updates to the IVR recorded responses within two (2) business days of receiving a request from the IDHW.

4 Describe how you will:

- a Manage the Call center and Help Desk function and ensure staff are trained to provide customer service response to inquiries;
- b Utilize a language line translation system for callers whose primary language is not English;
- c Have available, at all times, a Telecommunications Device for the Deaf (TDD) and/or relay systems;
- d Interact with callers in a courteous, respectful, polite, culturally responsive, and engaging manner;
- e Respect the caller's privacy during all communications and calls;
- f Assist callers with issues and concerns regarding service referrals, authorizations, payments, training, or other relevant inquiries, regarding service provision, eligibility or payment; a separate provider services line is also permitted to address provider issues;
- g Work with callers to provide referrals to obtain eligibility for other supportive services, such as, but not limited to, community organizations. For complex matters, callers should be referred to the Contractor's care management staff;
- h Facilitate access to information on available service requirements and benefits.

J (E) Provider Network Development and Management Plan: As part of the implementation process, the Contractor shall implement a Provider Network Development and Management Plan for transforming the current service delivery system into a comprehensive system.

- 1 **Submit your Network Development and Management Plan with your proposal.** The Network Development and Management Plan shall clearly identify your plan for transforming the current service delivery system into a comprehensive system that:
 - a Includes qualified service providers and community resources designed and contracted to deliver behavioral health care that is strength-based, family-focused as appropriate, community based, and culturally competent.
 - b Is of sufficient size and scope to offer Members a choice of providers for all covered behavioral health services.
 - c Ensures behavioral health services are uniformly available throughout the state incorporating recognized evidence-based practices, best practices, and culturally competent services that promote recovery and resiliency through nationally recognized integrated service models.
 - d Increases access to family and community-based services and reduces reliance on higher cost services.

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- e Includes the needs of all Members identified in the scope of the PAHP and includes the following:
 - i A fully operational network of psychiatric crisis response providers available twenty four (24) hours per day, seven (7) days per week, 365 days per year, prior to completion of the Readiness Review.
 - ii Within nine (9) months after the date of the implementation of services the Contractor shall conduct a statewide needs assessment to identify and quantify gaps in the array of State Plan services and in the network provider types, describe the challenges presented by such gaps, and then design an innovative solution for addressing the unmet service needs that is not limited to the agency/clinical model of service delivery. This solution shall be submitted by the Contractor to the IDHW within twelve (12) months after the implementation of services.
 - f Ensures there are a sufficient number of accessible qualified interpreters. Sufficiency shall be defined as baseline accessibility compared to changes in accessibility, Member complaints and quality assurance processes.
- 2 **Describe your plan for providing and maintaining a database** that contains real-time information identifying, according to ZIP code and by provider type, office hours, contracted capacity and out-of-region or out-of-network service alternatives. The IDHW shall have access to this database.
- 3 Describe your plan, including timelines, for soliciting input from the members of the provider network regarding their satisfaction with participating in the Contractor's network.
- K **(E) Provider Network:** The Contractor shall implement and maintain a network of providers to deliver behavioral health treatment, rehabilitation, and support services, while optimizing the use of natural and informal supports that meet the needs of Members. The Contractor's network of providers shall assure the health, safety, and appropriate treatment of Members.
- 1 The Contractor shall design the network to deliver culturally and linguistically (including the Member's prevalent language(s) and sign language) appropriate services in home and community-based settings and assist Members to achieve their recovery goals or treatment plans.
 - 2 The Contractor shall enter into written subcontracts with qualified service providers to deliver covered behavioral health services to Members. See **Attachment 5 – Network Provider Subcontracts** for minimum requirements for the subcontracts.
 - 3 The Contractor shall require providers to:
 - a Obtain a unique national provider identifier (NPI).
 - b Operate within their license and scope of practice.
 - c Obtain and maintain all applicable insurance coverage, in accordance with the Terms and Conditions of the contract.
 - 4 The Contractor is not obligated to contract with any provider agency or individual practitioner unable to meet contractual standards (see exceptions for FQHCs in section T and Tribal providers in section U). The Contractor shall provide written notice to any individual, facility or agency that applies to be part of the Contractor's network but is not enrolled. The notice shall include the reason(s) the applicant was not accepted into the network. The Contractor shall provide written notice to each network provider the Contractor chooses to end a contract with and shall state the reason for ending the

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contract. 42 CFR § 438.12(a)(1) and (b) (1).

- 5 The Contractor is not obligated to continue to contract with a provider agency or individual practitioner who does not provide services reflective of continuous quality improvement or who demonstrates utilization of services that are an outlier compared to providers with similarly acute populations and/or compared to the expectations of the Contractor and the IDHW.
- 6 The Contractor's provider agency and individual practitioner selection policies and procedures cannot discriminate against particular provider agencies or individual practitioners that serve high-risk populations or specialize in conditions that require costly treatment.
- 7 The Contractor may not discriminate for the participation, reimbursement, or indemnification of any provider agency or individual practitioner who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If the Contractor declines to include provider agencies or individual practitioners in its network, it shall give the affected provider agencies and individual practitioners written notice of the reason for its decision. 42 CFR § 438.12 (a)(1). This section may not be construed to:
 - a Require the Contractor to contract with provider agencies or individual practitioners beyond the number necessary to meet the needs of its enrollee.
 - b Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty.
 - c Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to Member. 42 CFR § 438.12(b)
- 8 The Contractor shall develop and implement written policies and procedures for the selection and retention of providers per 42 CFR § 438.214(a) and ensure 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 per 42 CFR § 438.207(b). The Contractor shall provide the policies and procedures to the IDHW when requested. The policies and procedures may be reviewed during the Readiness Review process. These policies and procedures shall include, at a minimum, the following:
 - a A documented process for receiving requests for initial services and continuing authorization of services per 42 CFR § 438.214(b)(1);
 - b A documented process for credentialing and re-credentialing of providers who have signed contracts or participation agreements with the Contractor per 42 CFR § 438.214(b)(2);
 - c The Contractor's provider selection policies and procedures, consistent with 42 CFR § 438.214(c), shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment;
 - d The Contractor may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act and per 42 CFR § 438.214(d);
 - e Requirement that criminal conviction information for anyone who has ownership or control interest in the provider, or is an agent or managing employee of the provider as per 42 CFR § 455.106 shall be disclosed; and
 - f Disclosure of owners, per 42 CFR § 455.104(b)(2), who own five percent (5%) or more in this provider entity (42 CFR § 455.104(a)(2)) shall be disclosed to the

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IDHW including the following:

- i All managing employees of the disclosing entity (provider) as defined in 42 CFR § 455.101;
- ii Subcontractor in which a practitioner has direct or indirect ownership of five percent (5%) or more per 42 CFR § 455.104(b)(2);
- iii List ownership of any subcontractor with whom this provider has had business transactions totaling more than \$25,000 during the previous twelve (12) month period per 42 CFR § 455.105;
- iv List persons that are related to each other (spouses, parents, children, or siblings); and
- v Identification of persons with criminal offenses for criminal offenses related to the person's involvement in any program under Medicare, Medicaid, or Title XX. 42 CFR §455.100; 42 CFR §455.106.

- 9 The Contractor shall not restrict or inhibit providers in any way from freely communicating with or advocating for a Member regarding behavioral health, medical needs, and treatment options, even if the Member needs services that are not covered or if an alternate treatment is self-administered. The Contractor may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an Member who is his or her patient:
 - a For the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
 - b For any information the Member needs in order to decide among all relevant treatment options.
 - c For the risks, benefits, and consequences of treatment or non-treatment.
 - d For the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- 10 The Contractor shall require providers to communicate information to assist a Member to select among relevant treatment options, including the risks, benefits, and consequences of treatment or non-treatment; the right to participate in decisions regarding his or her behavioral health care; and the right to refuse treatment and to express preferences about future treatment decisions.
- 11 **Submit a sample of your proposed network provider agreement/contract with your proposal.**
- 12 **Describe how you will:**
 - a Ensure the provider network is sufficient in size and composition to meet the needs of Members, per 42 CFR 438.206(b)(1), based on the following factors:
 - i Growth trends in eligibility and enrollment.
 - ii Best practice approaches.
 - iii Accessibility of services including:
 - (1) The number of current qualified service providers in the network who are not accepting new referrals.
 - (2) The geographic location of providers and Members considering distance, travel time, and available means of transportation.
 - (3) Availability of services with physical access for persons with disabilities.
 - (4) Cultural and linguistic needs, including the Member's prevalent language(s) and sign language.

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- b Maintain a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract per 42 CFR § 438.206(b)(1). In establishing and maintaining the network, the entity shall consider the following:
 - i The anticipated Medicaid enrollment.
 - ii The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the particular contract.
 - iii The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services.
 - iv The numbers of network providers who are not accepting new Members.
 - v 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.
- c Ensure at least as much access to services as exists within Medicaid's fee-for-service program.
- d Establish the initial managed care provider network by drawing from the pool of the existing enrolled Medicaid behavioral health agencies that have either successfully achieved Medicaid credentialing or national accreditation in addition to any other qualified practitioners that may or may not have ever delivered services to Members. Network providers shall meet the standards set by the Contractor and IDAPA and be in compliance with all federal and state requirements, including not being on the federal and state exclusion lists.
- e Perform credentialing and re-credentialing of qualified service providers in order to ensure they meet the accreditation requirements set by the Contractor and compliance to IDAPA, state and federal statutes.
- f Implement and maintain written credentialing and re-credentialing policies consistent with federal and state regulations for selection and retention of providers, credentialing and re-credentialing, and nondiscrimination. 42 CFR § 438.214;
- g The Contractor is required to contract with providers of behavioral health services who are appropriately licensed and/or certified and meet the Contractor's criteria for network enrollment including completion of a Network Provider Subcontracts. See **Attachment 5 – Network Provider Subcontracts**.
- h Evaluate every prospective individual practitioner's ability to deliver behavioral health services in the continuum of care prior to contracting with any provider agency that employs such practitioners.
- i Identify the gaps in services and access, and implement solutions to resolve the issues.
- j Develop and recruit culturally informed Native American and Hispanic practitioners into the provider network to provide services.
- k Whenever possible, ensure Members have a choice of providers, to the extent possible, which offer the appropriate level of care. (42 CFR § 438.6(m)) Exceptions would involve highly specialized services which are usually available through only one (1) agency or provider in the geographic area. Members may change providers.
- l Honor existing Member/provider relationships as much as possible in the newly established network. If a change is necessary, the Contractor shall ensure a seamless transition of services or providers.
- m Pursuant to Early Periodic Screening, Diagnosis and Treatment (EPSDT) requirements, if a child under the age of twenty one (21) needs a specialized

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medically necessary service that is not available through the network, the Contractor shall arrange for the service to be provided outside the network by a qualified provider.

- n Maintain a list of current network providers that is available to Members, the Member's family/ caregiver and referring providers in hard copy and electronically. The list shall specify providers who are able to deliver services in languages other than English.
- o Conduct an Annual Network Inventory and provide a written report to the IDHW by a date determined by the IDHW. The first inventory due date will be relative to the implementation of services date of the Idaho Behavior Health Plan. The Contractor shall prepare the network inventory to quantify the number of qualified service providers, including the crisis response providers, available within the network as follows:
 - i Each category of covered behavioral health services as identified by the IDHW.
 - ii Specialty behavioral health service providers, including providers with expertise to deliver services to persons with developmental disabilities, non-English speaking persons, and other specialties as identified by the IDHW.

L (E) Notification Requirements for Changes to the Network: Describe how you will:

- 1 Notify and obtain written approval from the IDHW before making any material changes in the size, scope, or configuration of its network, as described in the Contractor's Network Development and Management Plan. A material change includes any event that affects service delivery and includes a reduction in workforce at a qualified service provider level; any plan to not fill, or delay filling, staff vacancies; or termination of a subcontract, the crisis provider and other qualified providers. The Contractor shall notify the IDHW, in writing within one (1) business day of the Contractor's knowledge of an expected, unexpected, or anticipated material change to the network or a network deficiency that could affect service delivery, availability, or capacity within the provider network. The notice shall include:
 - a Information describing how the change will affect service delivery, availability, or capacity of covered behavioral health services.
 - b A plan to minimize disruption to the behavioral health Member's care and service delivery.
 - c A plan for clinical team meetings with the behavioral health Member and his or her family/caregiver as appropriate to discuss available options and revise the treatment plan to address any changes in services or service providers.
 - d A plan to correct any network deficiency.
- 2 Should the Contractor terminate a provider from the network for cause, ensure this information is reported to the Medicaid Program Integrity Unit as well as the IDHW Contract Manager.
- 3 Utilize performance and quality assurance data when determining to retain providers. Describe the criteria to be used for making the determination to terminate a network provider.
- 4 Notify a network provider in writing when a determination is made to terminate a provider from the network and ensure prior written notice includes details pertaining to the decision to terminate. Submit a sample of a termination notice with your proposal.
- 5 Ensure the IDHW is notified within two (2) business days if a provider fails to meet

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licensing criteria, or if the Contractor decides to terminate, suspend, limit, or materially change qualified service providers or subcontractors. The notice to the IDHW shall include:

- a The number of Members affected by the termination, limitation, suspension, or material change decision.
- b A plan to ensure that there is minimal disruption to the behavioral health Member's care and service delivery.
- c The Contractor shall require the behavioral health Member's original provider to be responsible for transitioning his or her Members until the behavioral health Member has attended the first appointment with the new provider.
- d A plan for clinical team meetings with the behavioral health Member and his or her family/caregiver as appropriate to discuss available options and to revise the treatment plan to address any changes in services or service providers.
- e A plan to communicate changes to affected Members, including provision of required notices per 42 CFR § 438.10(f)(4) and (5).
- f A written transition plan for Members affected by these network changes.

- 6 Track all Members transitioned due to a subcontract's suspension, limitation, termination, or material change to ensure service continuity. At a minimum, the Contractor shall track the following elements: name, date of birth, population type, current services the Member is receiving, services that the Member will be receiving, name of new provider, date of first appointment, and activities to re-engage persons who miss their first appointment with the new provider. The IDHW may require the Contractor to add other elements based on the particular circumstances.
- 7 Ensure the Contractor and its providers, where applicable, use common data elements to match existing required data fields specified by the IDHW.

M **(E) Provider Training and Technical Assistance:** The Contractor shall develop and implement comprehensive provider training and support a training program for providers to gain and maintain appropriate knowledge, skills, and expertise and receive technical assistance to comply with the requirements resulting from this RFP. The trainings should be reported in the annual Provider Training Report. The Contractor shall incur all costs required to perform the training tasks, including facility, staffing, hardware and software cost, printing and distribution of all reports, forms, training materials, and correspondence.

1 Describe how you will:

- a Stimulate the development of providers' capacity to treat co-occurring disorders, dual diagnoses, very young children, Native American Members, and Hispanic Members;
- b Develop and implement training opportunities for qualified providers to occur, at minimum, once per quarter;
- c Provide technical assistance to network providers;
- d Include a cultural competency component in each training topic;
- e Educate and require providers to use evidence-based practices, promising practices, and emerging best practices;
- f Educate providers on billing and documentation requirements;
- g Provide required orientation and training for all providers new to the Contractor's network.
- h Develop and implement an annual training plan that addresses all training requirements;

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- i Involvement of Members and family members in the development and delivery of trainings.
 - 2 **Submit** a draft provider training and technical assistance plan with your proposal.
- N** **(E) Electronic Health Records (EHR):**
- 1 **Describe how you will** work with network providers to develop and implement EHR systems that will meet provider needs for real time data access and evaluation in medical care. See **Attachment 13 – Electronic Health Records**.
 - 2 **Describe how and when you will be able to** ensure that behavioral health providers participating in the managed care program adopt and use electronic health record technology. Please refer to **Attachment 3 - Definitions** for a definition of electronic health record and **Attachment 13 - Electronic Health Records** for more details regarding these requirements.
- O** **(E) Management of Care: Describe how you will:**
- 1 Provide care management and case management functions to promote achievement of the goals of this RFP including, but not limited to:
 - a Ensuring a person-centered process of care management and case management;
 - b Providing a multidisciplinary team approach that ensures working with all parties involved in the children’s and adults’ systems of care to establish service eligibility;
 - c Arranging for services in network including movement to higher or less restrictive levels of care;
 - d Linking to services out-of-network as appropriate;
 - e Coordinating the delivery of services including primary care services that function to rule out metabolic processes that may mimic behavioral health symptoms;
 - f Monitoring and evaluating the Member’s response to the behavioral health services as well as tracking such Members with complex medical needs use of medical services;
 - g Advocating for Members who need multiple services to meet complex needs;
 - h Promoting activities and referrals to services that facilitate a Member’s independence;
 - i Operating a screening process for Member’s seeking inpatient behavioral health services in order to activate a hospital diversion mechanism;
 - j Participating in hospital discharge planning processes in an effort to impact lengths of stay and to facilitate timely admissions to step-down services;
 - k Coordinating the provision of behavioral healthcare services with Medicaid’s Primary Care Case Management program and with Medicaid’s Health Home program to ensure the best possible outcomes for coordinated physical and behavioral health services;
 - l Ensure that in the coordination of care that occurs through the Primary Care Case Management and Health Homes program confidentiality, requirements in 45 CFR parts 160 and 164 are observed; and
 - m Coordinating with other providers and programs that deliver behavioral health services outside of the Contractor’s delivery system.

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- P (E) Intake and Assessment:** The Contractor shall design and manage an intake process distinctive from the assessment process and that makes use of standardized tools. Currently the IDHW doesn't require a standardized tool to be used for determining Members' mental health program eligibility. The IDHW currently requires providers of substance use disorder services to use the Global Appraisal of Individual Needs (GAIN1) instruments for assessing Members seeking substance use disorders. For information on GAIN go to <http://www.chestnut.org/LI/gain/index.html>. The IDHW currently relies on a standardized tool for helping determine whether or not a child Member is experiencing a Serious Emotional Disturbance—the Child and Adolescent Functional Assessment System/Pre-school and Early Childhood Functional Assessment Scale® (CAFAS/PECFAS). For information on the CAFAS/PECFAS go to <http://www.fasoutcomes.com/>.
- 1 **Submit, with your proposal,** your intake process that includes a triage process which will identify and distinguish crises, urgent services and routine treatment needs.
 - 2 **Describe how you will:**
 - a Ensure the intake process allows the Member to receive needed services immediately, when indicated by the presenting problem, without the delay that would be caused by the assessment process.
 - b Implement a process that results in an independent, standardized assessment of the Member's behavioral health care needs.
 - c Ensure the assessment process meets the intent of Idaho Code § 56-263.
 - d Identify and monitor episodic behavioral health needs and support intervention in a coordinated and minimally disruptive manner. Contractor's response should include screening strategies for common episodic behavioral health conditions such as affective disorders, eating disorders, adjustment disorders and coping disorders.
 - e Identify and monitor persistent behavioral health needs and support intervention in a coordinated and minimally disruptive manner. Contractor's response should include screening strategies for proactively identifying and locating persons with persistent behavioral health conditions.
- Q (E) Treatment Planning/Self Determination and Choice:** The Contractor shall implement a person-centered treatment planning process that results in improved Member and family experiences of care, promotes effectiveness and enhances outcomes. See **Attachment 3–Definitions.**
- 1 Describe how you will:
 - a Ensure the development of a plan of care for each Member receiving behavioral health services;
 - b Ensure the plan of care is developed according to the Member's choices regarding his or her recovery (and in the case of dependent minors, the choices of the minor's guardian are also considered);
 - c Ensure the plan is derived from all available diagnostic information and all available historical and current treatment information;
 - d Ensure development of plans of care provides opportunities for the following to participate in the process:
 - i All service providers affiliated with the Member;
 - ii The Member; and
 - iii All support persons the Member chooses (and in the case of dependent minors, the choices of the minor's guardian).
 - e Ensure the plan of care includes all the components recognized as industry standards for behavioral health treatment planning;
 - f Ensure an appropriate intermittent review and oversight process is utilized that is

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consistent with industry standards.

- R** **(E) Primary Care Interface: Primary Care Case Management Program (PCCM) and Health Homes:** The Contractor shall coordinate services with the IDHW's two (2) programs for coordination of Members' physical health needs PCCM program: Healthy [Connections](#) and a program recently developed at Medicaid: Health Homes. More information about the Healthy Connections program can be read at the following link: <http://www.healthandwelfare.idaho.gov/Medical/Medicaid/HealthyConnections/tabid/216/Default.aspx>). Please see **Attachment 20 –State Medicaid Director Letters** for more information about the Health Home program.
- 1 Describe how you will:
 - a Ensure a Member's primary care provider (PCP) has the opportunity to participate in the process used to diagnose and plan treatment for the Member;
 - b Ensure ongoing communication and collaboration with a Member's PCP throughout the time period that the Member receives services through the Idaho Behavioral Health Plan, including the sharing of all screenings, assessments and treatment plans;
 - c Ensure coordination of use of medications;
 - d Operate a PCP hotline, or equivalent service, for PCPs' real-time telephonic consultation with a licensed behavioral health professional at the master's level or higher for either of the following two (2) purposes:
 - i Information to support the PCP in the provision of behavioral health interventions/services that the PCP and Member choose;
 - ii Information for the PCP to use for referring the Member to the Contractor's services.
 - e Provide on-line access to standardized screening tools for PCPs to use for identifying behavioral health issues.
- S** **Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC):** FQHC services are defined in IDAPA 16.03.09.832. RHC services are defined in IDAPA 16.03.09.820.
- 1 The Contractor shall recognize FQHC's that provide behavioral health services as behavioral health providers and enroll them in the Contractor's network.
 - 2 The Contractor shall describe how they will interface with FQHC patient-centered processes to help ensure services are delivered in the most effective manner to the Members.
 - 3 Reimbursement to FQHCs and RHCs for behavioral health services done in the FQHC facility or RHC facility will be made using Medicaid's reimbursement methodology, which is payment at an encounter rate, in an amount unique to each FQHC and RHC, as determined by the IDHW.
 - 4 One (1) behavioral health encounter rate will be paid for all covered behavioral health services provided on the same visit to an FQHC or an RHC. Medicaid encounter rates for FQHC and RHC behavioral health providers are listed in **Attachment 11 - FQHC and RHC Encounters**.
 - 5 Because it is not possible to accurately project what the annual FQHC or RHC encounter rate increases may be, the IDHW will reimburse the Contractor for the difference between the encounter rates effective at the Idaho Behavioral Health Plan implementation and the FQHC or RHC rate increases over and above the annual inflation rate that may occur after the plan implementation.

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- 6 If there are no FQHCs in the Contractor's network to choose from, then the Contractor shall pay for the access out-of-network.

T Indian Health Services (IHS) and other Tribal Facilities: The Contractor shall:

- 1 Recognize IHS and other Tribal facilities that provide behavioral health services as behavioral health providers and enroll them in the Contractor's network.
- 2 Provide reimbursement for Native Americans accessing behavioral health services at IHS or other Tribal facilities. Reimbursement shall be made at the federally set encounter rate.
- 3 Report the number of encounters and the difference between the Contractor's standard reimbursement for the service and the encounter rate to the IDHW on a monthly basis.

U (E) Member Service Transitions: The Contractor shall implement and monitor written policies and procedures regarding service transitions for all members.

- 1 **The Contractor shall demonstrate** its awareness of the unique set of challenges faced by children between the ages of fourteen (14) and twenty one (21), referred to in this RFP as youth, and families when the youth transitions from the child to the adult behavioral health system. Such challenges may include application for adult Medicaid benefits, service and provider changes, lack of coordination even within a provider organization, and failure of providers to recognize the additional time, training and support necessary for youth with behavioral health disorders to achieve customary developmental milestones. Youth with serious behavioral health challenges are delayed in almost every area of psychosocial development. There may also be significant resistance to accepting the label of mental illness or a substance use disorder among youth as they approach adulthood, and accompanying resistance to engaging in treatment.
- 2 **Submit, with your proposal,** a Member Service Transition Plan that identifies how you will ensure effective and timely transitions for all Members. The Member Service Transition Plan shall include:
 - a How you will identify Members who need assistance and how the Members will be evaluated;
 - b At a minimum, how you will address the specialized needs of adult and youth members as noted below:
 - i **Adults:**
 - (1) Behavioral health Member transitions to/from another behavioral health practitioner or agency;
 - (2) Behavioral health Members whose behavioral health service provider becomes unable to continue service delivery for any reason;
 - (3) Behavioral health Member transitions to/from an assisted care facility or long term care placement for Members who continue to require behavioral health services;
 - (4) Behavioral health Member transitions from the correctional or community corrections system back to the community;
 - (5) Behavioral health Member discharges from an inpatient, sub-acute, psychiatric residential treatment facility, or mental health institute.
 - ii **Youth:**

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- (1) Assistance with application for adult Medicaid benefits, including submitting applications in advance so that reapplication may be made, if necessary, without losing benefits, and assisting families, as needed, to transfer diagnoses used in the child behavioral health system to the appropriate adult diagnoses;
- (2) Provide person-centered, strengths-based programming for youth from ages fourteen (14) to twenty one (21), focusing on education, employment, social and problem-solving skills, symptom management, reaction to stigma, sexual and gender identity, living situation/housing, personal health care, transportation resources, substance use disorder prevention or relapse prevention, and cultural and spiritual resources;
- (3) Provide programming to facilitate Member transitions from the juvenile correctional or community corrections system or inpatient/residential treatment back to the community;
- (4) Assist the youth and family to create a personal Safety Net of community supports, including a reliable family-like or healthy peer connection;
- (5) Assess internal business practices, communication channels, and administrative support necessary to ensure a smooth transition for youth Members to the adult behavioral health system; and
- (6) Provide training and a curriculum to educate staff about the unique needs of this population.

V **(E) Early Periodic Screening, Diagnosis and Treatment (EPSDT):** The Contractor shall provide EPSDT benefits for Members up to the last day of the month in which they reach twenty-one (21) years of age.

- 1 ***Describe*** your specific policies and procedures identifying operations and processes associated with adherence to the EPSDT requirements.
- 2 ***Describe how you will:***
 - a Ensure Members and the network of behavioral health providers are sufficiently informed of EPSDT requirements;
 - b Ensure accurate quarterly reporting of EPSDT requests, EPSDT benefits provided, EPSDT benefits denied, and the outcomes of such authorization decisions.

W **(E) Complaint Resolution and Tracking System:** The Contractor shall implement and maintain a Complaint Resolution and Tracking System for all complaints received. The Contractor shall have a system in place allowing providers, Members and authorized representatives of Members, the opportunity to express dissatisfaction with the general administration of the plan and services received. The Contractor shall have policies and procedures for resolving and tracking General Complaints.

- 1 **General Complaint Process.** The following must be included in the Contractor's General Complaint procedures:
 - a Complaints may be lodged by a Member,
 - i Member's authorized representative or a provider either orally or in writing.
 - ii The Contractor will designate a person to conduct a reasonable investigation or inquiry into the allegations made by or on behalf of the participant or provider and shall give due consideration and deliberation to all information and arguments submitted by or on behalf of the participant or provider.
 - iii The Contractor's designee shall respond in writing to each General Complaint, stating at a minimum:
 - (1) A summary of the General Complaint, including a statement of the issues raised and pertinent facts determined by the investigation;

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- (2) A statement of the specific coverage or policy or procedure provisions that apply; and
 - (3) A decision or resolution of the General Complaint including a reasoned statement explaining the basis for the decision or resolution.
 - 2 The Complaint Resolution and Tracking System shall include components that allow the Contractor to analyze the complaint and provide reports as requested by the IDHW.
 - 3 **Describe your complaint resolution and tracking system and submit, with your proposal,** a sample of your proposed electronic complaint resolution and tracking log.
 - 4 **Provide a detailed description of the following:**
 - a Methodology for reviewing and resolving complaints received, including timelines for the process.
 - b How they will ensure complaints are resolved within ten (10) business days.
 - c How they will ensure complainants are sent written notifications of complaint resolutions that have all of the required information.
 - d How they will address complaints that may need resolution at the IDHW level.
 - e Internal controls to monitor the operation of the complaint resolution and tracking system.
 - f How they will track all complaints received, whether they are resolved or in the process of resolution, and report the information to the IDHW.
 - g Analyze the complaints and utilize the information to improve business practices.
 - 5 **Provide a detailed description** of how all documents pertaining to General Complaints, investigations and resolutions will be preserved in an orderly and accessible manner.
- X **(E) Member Grievances and Tracking System:** The Contractor shall have a system in place for Members and a Member's authorized representative to file a Grievance challenging the Contractor's actions related to services. The Contractor shall have policies and procedures for addressing and tracking Grievances.
- 1 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 by a licensed clinician or physician who has appropriate clinical expertise in the treatment requested for the Member.
 - 2 Definitions: The Contractor's policies and procedures shall define the following terms with the following indicated meanings:
 - a Action means the denial or limited authorization of a requested service; termination, suspension, or reduction of a previously authorized service, the denial, in whole or in part, of a payment for service; or the failure to act upon a request for services in a timely manner.
 - b Appeal means a clear expression by the Member, or the Member's authorized representative, following a decision by the Contractor, that the Member wants the opportunity to present their case to the IDHW.
 - c Grievance means an expression of dissatisfaction challenging the Contractor's action.
 - d Notice means a written statement of the action the Contractor has taken or intends to take, the reasons for the action, the Member's right to file a Grievance and request a fair hearing with the IDHW, and the procedures for exercising that right.

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- 3 Notice of Action. The Contractor's policies and procedures shall include the following requirements for notifying Members of actions the Contractor has taken or intends to take:
 - a The notice must be in writing and comply with the language and format requirements of 42 CFR §438.10(c) & (d), with Spanish as the prevalent non-English language.
 - b The notice must be given to the requesting provider and to the Member.
 - c The notice must explain the following:
 - i The action the Contractor has taken or intends to take;
 - ii The reasons for the action;
 - iii The procedures for filing a Grievance with the Contractor;
 - iv The Member's right to represent themselves or be represented by a person of their choosing; and
 - v The future right to request a fair hearing with the IDHW if they are not satisfied with the Contractor's resolution of the Grievance.

- 4 Timing of Notice. The Contractor must mail the notice within the following timeframes:
 - a For standard service authorization decisions that deny or limit services, within the timeframe specified in 42 CFR § 438.210(d)(1);
 - b For cases in which a provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the participant's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the participant's health condition requires and no later than three (3) business days after receipt of the request for service. The Member or provider may file an expedited appeal either orally or writing. No additional Member follow-up is required.
 - c If the Contractor extends the timeframe for decision in accordance with 42 CFR § 438.210(d)(1), it must:
 - i Give the Member written notice of the reason for the extension of time and inform the participant of the right to file a Grievance if they disagree; and
 - ii Issue and carry out its decision no later than the date the extension expires.
 - d For termination, suspension, or reduction of previously authorized covered services, within the timeframes specified in 42 CFR §§ 431.211, 431.213, and 431.214.
 - e For service authorizations decisions not reached within the timeframes specified in 42 CFR § 438.210(d) (which constitutes a denial), on the date the timeframes expire.

- 5 Grievance Process. The Contractor's policies and procedures for handling Grievances shall include the following requirements:
 - a A Member or Member's authorized representative may file a Grievance.
 - b A Grievance may be filed either orally or in writing with the Contractor. If mistakenly filed with the IDHW, it will be immediately forwarded to the Contractor.
 - c The Contractor must allow a reasonable time period following its action for the Member or authorized representative to file a Grievance. The time period shall be no less than twenty (20) days and no more than (28) days from the date of the Contractor's action.
 - d The Contractor shall give Members any reasonable assistance in completing forms and taking other procedural steps including, but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
 - e The Contractor shall acknowledge receipt of each Grievance.
 - f The Contractor shall ensure that individuals who make decisions on Grievances are individuals who:
 - i Were not involved in any previous review or decision of the action; and

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- ii If deciding a Grievance of a denial based on medical necessity or involving clinical issues, are health care professionals who have the appropriate clinical expertise, as determined by the IDHW, in treating the Member's condition.
 - 6 Grievance Decision and Notification. The Contractor shall make a decision on each Grievance and provide notice of its decision within thirty (30) days from the date the Contractor received the Grievance.
 - a Notice of Grievance decisions shall be provided to the affected parties, in writing, stating at a minimum:
 - i A statement of the Grievance issue(s);
 - ii A summary of the facts asserted by each party;
 - iii The Contractor's decision supported by a well-reasoned statement that explains how the decision was reached;
 - iv The date of the decision; and
 - v For Grievances not resolved wholly in favor of the Member, the Contractor's decision notice shall also include the Member's right to request a State fair hearing, the timeframe and procedure to do so by stating the following:
 - (1) You, or your representative have the right to request a fair hearing with the Idaho Department of Health and Welfare if you are not satisfied with the resolution of your Grievance. You have twenty-eight (28) days from the date of this decision to file your appeal. You must explain why you disagree with this decision and include any other information you want the IDHW to know. Your appeal must be received by the IDHW or postmarked within twenty-eight (28) days.
 - (2) To appeal, notify the IDHW in writing or complete a "Fair hearing Request" form. "Fair Hearing Request" forms are available at any Health and Welfare local office or via e-mail at: MyBenefits@dhw.idaho.gov. Include a copy of this notice with your appeal. You can bring your appeal to any local Health and Welfare office, fax or mail it to:
Administrative Procedures Section
Idaho Department of Health and Welfare
450 W. State St., 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Fax: (208) 334-6558
- 7 Miscellaneous Requirements.
 - a Information about Grievance System. The Contractor shall provide the information specified in this section about the Grievance system to all providers and subcontractors at the time they enter into a contract.
 - b Recordkeeping and Reporting Requirements. The Contractor shall maintain records of Grievances and must review the information as part of the State quality assurance.
 - c Effect of Reversed Grievance Decisions.
 - i If the Contractor or the State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the Grievance or appeal was pending, the Contractor shall authorize or provide the disputed services promptly.
 - ii If the Contractor or the State Fair Hearing officer reverses a decision to deny authorization of services, and the participant received the disputed services while the Grievance or appeal was pending, the Contractor must pay for those services, in accordance with State policy and regulations.

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- 8 **Provide a detailed description of your Member Grievance Tracking System** and submit a sample of your electronic Member Grievance tracking log with your proposal.
 - 9 **Provide a detailed description of the following:**
 - a Methodology for reviewing and resolving Member Grievances, including timelines for the process.
 - b Internal controls to monitor the operation of a Member Grievance Tracking System.
 - c How you will track all Member Grievances received, whether they are resolved or in the process of resolution, and report the information to the IDHW.
 - d Analyze the Member Grievances and utilize the information to improve business requirements.
 - 10 **Describe how you will** meet each of the Member Grievance Requirements and ensure the timeframes required in the CFR are met.
 - 11 **Describe how** all documents pertaining to Member Grievances, investigations and resolutions will be preserved in an orderly and accessible manner.
 - 12 **Submit, with your proposal,** a copy of your notice of decision letter.
 - 13 **Submit, with your proposal,** a copy of your notice of grievance decision letter.
- Y** **(E) Electronic System and Data Security:** The Contractor shall implement and maintain an electronic system and data security plan.
- 1 **Submit, with your proposal,** an Electronic System and Data Security Plan that includes, but is not limited to all of the requirements outlined in **Attachment 6 - Technical Requirements: Electronic Systems, Data Security and Website Requirements**. In addition to submitting the Electronic System and Data Security Plan with the proposal, the Contractor may be required to submit a revised Electronic System and Data Security Plan for review as outlined in **Attachment 10 – Readiness Review**.
 - 2 **Provide a detailed description** of your current electronic system and explain how it will be maintained to meet the requirements of the RFP.
 - 3 **Provide a written statement** confirming you have reviewed and agree to the requirements in **Attachment 6 - Technical Requirements: Electronic Systems, Data Security and Website Requirements** and describe how you will comply with each of the requirements.
- Z** **Website:** The Contractor shall provide and maintain an internet website for Idaho's Medicaid Members and the network providers to access information pertaining to the Idaho Behavioral Health Plan. The Contractor shall submit any website content regarding the Idaho Behavioral Health Plan to the IDHW for review and approval prior to posting the information on the website. See **Attachment 6 - Technical Requirements: Electronic Systems, Data Security and Website Requirements**.
- 1 **Submit an outline of your proposed website** with your proposal and **describe how you will:**
 - a Communicate policies, procedures and relevant information to providers through secure or public Web pages.
 - b Provide, in accordance with national standards, claims inquiry information to qualified service providers and subcontracts via the Contractor's Website.

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- 2 **Provide a written statement** confirming you have reviewed and agree to the requirements in **Attachment 6 - Technical Requirements: Electronic Systems, Data Security Plan and Website Requirements** and **describe how you will comply** with each of the requirements.

AA (E) Member Information and Member Handbook: The Contractor shall provide all Members, not just those who access services, with appropriate information about behavioral treatment services, available providers, and education related to recovery, resilience and best practices. The Contractor shall develop and maintain a Member Handbook for behavioral health coverage and benefits. Member Information and the Member Handbook shall be available in hard copy and through web site access at least twenty (20) calendar days prior to the start of services. The Member Handbook shall include, but not be limited to:

- a Behavioral Health program eligibility process and guidelines;
- b Benefit descriptions and limitations;
- c Resource information including, but not limited to:
 - i Provider directory by city;
 - ii Hospital information and resources;
 - iii Behavioral health information and resources; and
 - iv Crisis information and resources.
- d Member's Rights, including the following:
 - i Each Member is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.
 - ii Each Member is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.
 - iii Each Member is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment.
 - iv Each Member is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
 - v Each Member is guaranteed the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR 164.
 - vi Each Member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the Contractor and its providers or the IDHW treats the Member. 42 CFR § 438.100(c).
 - vii The Contractor shall comply with any other applicable federal and state laws (such as Title VI of the Civil Rights Act of 1964, etc.) and any other federal and state laws that pertain to Members' rights, i.e., "Members Bill of Rights", and other laws regarding privacy and confidentiality. 42 CFR § 438.100(a)(2) and (d); 42 CFR § 438.6(f)(1)

- 1 **Describe how you will**, as you develop Member Information, obtain input from consumers, secondary Member and/or family Members and other stakeholders who can inform both the content and presentation of the information so that the information is provided in a manner and format that may be easily understood per 42 CFR § 438.10(b)(1).
- 2 **Submit a sample** Member Handbook with your proposal.
- 3 **Describe how you will:**

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- a Ensure that written material is in an easily understood language and format, and be provided in English and Spanish. Written material shall be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. The Contractor shall also ensure Members are aware of this availability. 42 CFR § 438.10(d)(1)(i) and (ii) and (2);
- b Ensure written policies regarding the Member rights specified in this section;
- c Comply with any applicable federal and state laws that pertain to Member rights and ensure that its staff and affiliated providers take those rights into account when furnishing services to Members;
- d Ensure limitations are not imposed on Members' freedom to change between mental health or Substance Use Disorder providers;
- e Ensure the requirements in **Attachment 8 – Member Rights** are incorporated in your business operations.

BB **(E) Member Protections/Liability for Payment:** The Contractor shall implement policies to ensure no participating or non-participating provider bills a Member for all or any part of the cost of a covered, required, or optional service. The Contractor shall cover continuation of services to enrollees for the duration of the period for which payment has been made. (State Medicaid Manual 2086.6.B)

1 Describe how you will ensure Members are not held liable for:

- a Payments, including the Contractor's debts, in the event of the Contractor's insolvency per 42 CFR § 438.106(a) and 42 CFR § 438.116(a);
- b Payments in the event the state agency does not pay the Contractor, or the State or the Contractor does not pay the Member or health care provider, 42 CFR § 438.106(b);
- c The covered services provided to the Member for which the Contractor does not pay the agency or individual practitioner; 42 CFR § 438.106(b); and
- d Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount the Member would owe if the Contractor provided the service directly (i.e., no balance billing by providers). 42 CFR § 438.106(c)

CC **(E) Provider Manual:** The Contractor shall develop and maintain a Provider Manual for use by the Contractor's network of providers. The Contractor shall ensure providers have access to the Provider Manual and any updates either through the Contractor's website, or by providing paper copies to providers who do not have Internet access. The manual shall be updated as information changes and shall include, but not be limited to:

1 General Information:

- a Overview of Program
- b Directory
- c Remittance Advice Analysis

2 References

- a Glossary
- b Billing Instructions
- c Resources

3 Claims Instructions

- a Provider Guidelines
- b Service Definitions

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- c Provider Qualifications
- d Provider Responsibilities
- e Authorization Process
- f Payment

4 Contractor shall give all qualified service providers and subcontractors access to the Medicaid Provider handbook and the Contractor's Provider Manual.

5 **Submit a sample Provider Manual with your proposal.**

DD (E) Community Partnerships: Describe how you will:

- 1 Operate in cooperation with the IDHW functions of being the designated agency to serve as the state's Behavioral Health Authority and the designated "safety net" agency for the state.
- 2 Facilitate the delivery of medically necessary services in fulfillment of court ordered treatment for Members stemming from Idaho's problem-solving courts (mental health court, drug court, veterans' court).
- 3 Collaborate with and support the efforts of local advocacy organizations and state agencies including, but not limited to, current efforts underway to establish a sustainable community-based twenty four (24) hour suicide response system.
- 4 Offer processes and services in support of the challenges faced by foster parents of children with SED, refugee relocation agencies, and various IDHW home visiting programs.
- 5 Lead an ongoing collaboration with the practitioners and agencies that the Contractor enrolls in the provider network to deliver services under the Idaho Behavioral Health Plan and demonstrate how input from this group shall be incorporated into the Contractor's policies and procedures.
- 6 Support the development of a consumers' organization that will serve in an advisory capacity to the Contractor that would represent the voice of Members and their families who use the services provided under the Idaho Behavioral Health Plan and demonstrate how input from this group shall be incorporated into the Contractor's policies and procedures.
- 7 Collaborate with Idaho's Regional Mental Health Boards (ID Code § 39-3130, www.healthandwelfare.idaho.gov/Medical/MentalHealth/RegionalMentalHealthBoards/tabid/332/Default.aspx).
- 8 Collaborate with the Substance Use Disorders Regional Advisory Committees (ID Code §39-303A) www.healthandwelfare.idaho.gov/Medical/SubstanceUseDisorders/RegionalAdvisoryCommittees/RACRegion4/tabid/198/Default.aspx. The Boards and Councils are scheduled for reorganization through statutory changes in the 2013 legislative session which is expected to combine the two (2) types in readiness for mental health services and substance use disorder services to become integrated into "behavioral health services."
- 9 Interact and support the efforts of behavioral health advocacy groups in Idaho including but not limited to the Idaho State Planning Council on Mental Health, the Idaho chapter of National Association of Mental Illness (NAMI Idaho), and the Office of Consumer and Family Affairs.

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- 10 Interact and collaborate with the various Idaho chapters of national associations for behavioral health professionals, including but not limited to the National Association of Social Workers, American Psychological Association, American Psychiatric Association, American Counseling Association, American Association for Marriage and Family Therapists, United States Psychosocial Rehabilitation Association, the Idaho Association of Infant Mental Health, as well as the regulatory agencies, e.g., Idaho Bureau of Occupational Licensing, the Idaho Board of Nursing, the Idaho Board of Medicine, and the Idaho Board of Alcohol/Drug Counselor Certification.

EE (E) Community Reinvestment Services: Describe the following:

- 1 Experience you have participating in Community Reinvestment activities in other states.
- 2 Services you would develop through reinvestment and how you would incorporate stakeholder input into this process.
- 3 The threshold in terms of Medical Loss Ratio (or other trigger mechanisms) where you would begin reinvesting in community services. Include in your description the amount(s) to be reinvested. Indicate whether or not you will commit to reinvesting in community services in Idaho.

FF (E) Outcomes, Quality Assessment, and Performance Improvement Program: For all covered services, the Contractor shall maintain a comprehensive outcomes, quality assessment, quality management, quality assurance, and performance improvement program and includes evaluation of the Contractor's operations. **Describe how you will meet the requirements in each of the following sections. Include detailed methodologies for developing and implementing each task, as well as descriptions of how these requirements will be met throughout the life of the contract. Include drafts of supporting proposed documents for each section including, but not limited to, proposed plans, programs, guidelines, projects, processes, policies and procedures, systems, activities, and surveys.**

1 Quality Improvement Plan:

- a The Contractor shall have, in effect, a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program.
- b The Contractor's quality assurance plan shall be approved by the IDHW.
- c The Contractor shall maintain a sufficient number of qualified quality assurance personnel to comply with and implement all of the requirements of this contract in a timely manner, including:
 - i Reviewing performance standards;
 - ii Measuring treatment outcomes;
 - iii Assuring timely access to care; and
 - iv Participating in an independent assessor's quality review activities.
- d The Contractor shall provide a mechanism for the input and participation of Members, families, caretakers, and other stakeholders in the monitoring of service quality and determining strategies to improve outcomes.
- e The scope of the Contractor's outcomes, quality assessment and performance improvement program shall include all requirements in this section but is not limited to these requirements. These requirements include:
 - i Processes to assess, measure, and improve the quality of care provided to Members in accordance with:
 - (1) All quality assurance requirements identified in this contract;

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- (2) The IDHW's Division of Medicaid;
 - (3) All IDHW and federal regulatory requirements; and
 - (4) All other applicable documents incorporated by reference.
- f Identify and resolve systems issues consistent with a continuous quality improvement approach. The Contractor shall include a Corrective Action Plan (CAP) that defines the corrective action response needed to arrive at a common solution to operations.
 - g Disseminate relevant information to the IDHW, Members, providers, and key stakeholders, including families and caregivers.
 - h Solicit feedback and recommendations from key stakeholders, subcontractors, Members, families, and caregivers, and use the feedback and recommendations to improve the quality of care and system performance.
 - i Measure and enforce adherence with the goals and principles of the IDHW through the following strategies, at a minimum:
 - i Methods and processes that include in-depth chart reviews and interviews with key persons in the Member's life.
 - ii Use of findings to improve practices at the subcontractor and Contractor levels.
 - iii Timely reporting of findings and improvement actions taken and their effectiveness.
 - iv Dissemination of findings and improvement actions taken and their effectiveness to key stakeholders, committees, Members, families, and caregivers, and posting on the Contractor's Website.

2 Practice Guidelines:

- a The Contractor shall adopt and implement practice guidelines per 42 CFR §438.236(b) that, at a minimum meet the following requirements:
 - i Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.
 - ii Consider the needs of the Members.
 - iii Are adopted in consultation with contracting health care professionals.
 - iv Are reviewed and updated periodically as appropriate.
 - v Are approved by the IDHW.
- b The Contractor shall meet the requirements of the federal managed care regulations, and the 42 CFR Part 2 confidentiality regulations when adopting practice guidelines.
- c Decisions for Member education, coverage of services, utilization management and other areas to which the practice guidelines apply shall be consistent with the practice guidelines per 42 CFR § 438.236(d).
- d The Contractor shall disseminate the practice guidelines to all affected providers, and upon request, to Members per 42 CFR § 438.236(c).

3 Performance Improvement Projects:

- a The Contractor shall have in progress a minimum of one (1) performance improvement project (PIP) and one (1) focused study with intervention or two (2) PIPs annually.
- b At least one (1) PIP or the focused study shall be outcome-focused.
- c The PIPs shall be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction.
- d Each PIP shall be completed in a reasonable time period, so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.
- e The PIPs shall involve the following:
 - i Measurement of performance using objective quality indicators.

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- ii Implementation of system interventions to achieve improvement in quality.
 - iii Evaluation of the effectiveness of the interventions.
 - iv Planning and initiation of activities for increasing or sustaining improvement.
- f The Contractor shall summarize the status and results of each PIP in the annual quality report and when requested by the IDHW.
- g The status and results of each PIP shall be submitted on the agreed upon schedule in sufficient detail to allow the IDHW and/or its designee to validate the projects.
- h PIPs will be validated by the IDHW's independent assessor. The primary objective of the PIP validation is to determine compliance with the following requirements:
 - i Measurement of performance using objective valid and reliable quality indicators.
 - ii Implementation of system interventions to achieve improvement in quality.
 - iii Empirical evaluation of the effectiveness of the interventions.
 - iv Planning and initiation of activities for increasing or sustaining improvement.
- i During the life of the contract, the Contractor shall participate in the annual measurement and reporting of the performance measures required by the IDHW, with the expectation that this information will be placed in the public domain.
- j The Contractor shall calculate additional performance measures when they are developed and required by CMS or the IDHW.
- k The quality assurance program shall include a system of performance indicators and Member and family outcome measures that address different audiences and purposes.

4 Outcomes Assessment Process:

- a The Contractor shall implement and maintain a formal outcomes assessment process that is standardized, reliable, and valid in accordance with industry standards.
- b The Contractor shall work with the IDHW to develop agreed-upon measurement criteria, reporting frequency and other components of this requirement.
- c The Contractor shall participate in developing, implementing, and reporting on performance measures and topics for PIPs required by the IDHW or other federal agencies, including performance improvement protocols or other measures, as directed by the IDHW and shall report the outcomes of such PIPs.
- d Performance indicators shall be measured for the provider network, as a whole, and for each provider individually.
- e The Contractor shall have policies and procedures in place that detail how the Contractor will assess the quality and appropriateness of care and services furnished to all Members enrolled under the contract.
- f The Contractor shall have policies and procedures in place that explain how the Contractor will ensure that providers are assessing Members outcomes in accordance with the requirements identified this contract.

5 Record System:

- a The Contractor shall establish, maintain, and use a Member record system that meets requirements at 42 CFR § 456.111 and 211 and IDAPA 16.03.09. The Member record system shall facilitate the documentation and retrieval of statistically-meaningful clinical information, as follows:
 - i Clinical records shall be maintained in a manner that is current, detailed, and organized and that permits effective Member care and quality review;
 - ii The Contractor shall require providers to maintain records in the same manner;
 - iii Records may be written or electronic;
 - iv The Contractor shall have written policies and procedures regarding clinical records that include, at a minimum:

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- (1) Content, confidentiality protections, retention, and access by Members to their individual records, which shall include the Member's right to see their individual medical records upon request during regular business hours and to copy those records for a reasonable fee, which will not exceed the actual cost of making the copies.
 - (2) The processing and storage of records, disposal procedures, and retrieval and distribution.
 - (3) A system to access and audit the content of clinical records to ensure that they are legible, organized, complete, and conform to its standards and that clinical records shall be made available to the IDHW immediately upon request by the IDHW.
 - (4) A copy of the Contractor's policies and procedures shall be made available to the IDHW and to network providers upon request, and copies of the amendments or modifications to the policy will be promptly filed.
 - (5) The Contractor and its providers shall have the ability to record and report data at the level of clinical transactions.
- v The Contractor shall support Medicaid's efforts currently underway to implement the use of electronic health records as described in **Attachment 13 - Electronic Health Records**, including effectively interfacing with primary care practices in the Medicaid Health Home Project that are required to use electronic health records.

6 Health Information System (HIS) in Quality Assurance Activities:

- a The Contractor shall maintain a health information system that collects, analyzes, integrates and reports data. Requirements for the development of a Health Information System for the provider network users are described in detail in this RFP.
- b The system shall provide information on areas including, but not limited to, grievances and appeals, third party liability, for other than loss of Medicaid eligibility.
- c The system shall also collect data on Member and provider characteristics as specified by the IDHW and on services furnished to Members through an encounter data system.
- d The Contractor shall make all collected data available to the IDHW and/or designee and upon request by CMS.
- e The Contractor shall collect data and conduct data analysis with the goal of improving quality of care.
- f The Contractor's information system shall support the quality assurance and program improvement process by collecting, analyzing, integrating, and reporting necessary data.
- g The system shall ensure that data received from providers is accurate and complete by:
 - i Verifying the accuracy and timeliness of reported data.
 - ii Screening the data for completeness, logic, and consistency.
 - iii Collecting service information in standardized formats to the extent feasible and appropriate.

7 Member Satisfaction:

- a The Contractor shall monitor Member perceptions of well-being and functional status, as well as accessibility and adequacy of services provided by the Contractor.
- b The Contractor shall support the IDHW's efforts to collect Member satisfaction data.
- c The Contractor shall conduct an annual Member satisfaction survey as directed and prior approved by the IDHW. The results of the survey shall be disclosed to Members upon request.

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- d The Contractor shall describe in the proposal how they intend to use the information from the Member satisfaction survey to improve services.
- 8 Quality of Care Concerns:**
- a The Contractor shall have a system for identifying and addressing all alleged quality of care concerns, including those involving physician providers.
 - b The Contractor shall take action as necessary to address all confirmed quality of care concerns.
 - c The Contractor shall not be required to disclose to the public any information that is confidential by law.
- 9 Quality Assurance and Program Improvement Committee:**
- a The Contractor shall form a quality assurance and program improvement Committee. The Contractor's Medical Director shall provide oversight of the Committee.
 - b The Contractor shall include practitioners and agencies that are enrolled in the Contractor's provider network in designing the work of the quality assurance processes.
- 10 Independent Assessment:**
- a The Contractor shall participate in annual independent reviews performed by a IDHW approved independent assessor of quality outcomes, timeliness of, and access to, services in order to validate performance improvement projects and performance measures and to review compliance with the IDHW standards and contract requirements.
 - b The Contractor shall provide any information required by the independent assessor to complete the review
- 11 Performance Measures:**
- a On an annual basis, the Contractor shall ensure and report to the IDHW its performance, using standard measures required by the IDHW. In addition, CMS, in consultation with the IDHW's and other stakeholders, may specify performance measures and topics for performance improvement projects to be required by the IDHW in the contract with the Contractor.
- 12 Methods of Data Analysis:**
- a The Contractor shall use an industry recognized methodology, such as SIX SIGMA or another method(s) for analyzing data.
 - b The Contractor shall demonstrate inter-rater reliability testing of evaluation and assessment decisions.
 - c The Contractor shall measure the effectiveness of service delivery through the use of standardized, outcome-based instruments.
- 13 Outcomes Management and Quality Improvement Plan:**
- a The Contractor shall develop and implement an Outcomes Management and Quality Improvement Plan. The Contractor shall participate in the review of the quality improvement findings and shall take action as directed by the IDHW.
 - b The plan shall delineate future quality assessment and performance improvement activities based on the results of those activities in the annual report.

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- c The plan shall integrate findings and opportunities for improvement identified in studies, performance outcome measurements, Member satisfaction surveys, provider satisfaction surveys, and other monitoring and quality activities.
- d The plan is subject to the IDHW and/or designee's approval.
- e The Plan shall include, but is not limited to, the following:
 - i Call center performance in answering calls.
 - ii Child, youth, young adult and families/caregivers satisfaction with providers.
 - iii Reliability and timeliness of service.
 - iv Decision-making processes.
 - v Network adequacy.
 - vi Attainment of positive outcomes by service line and system wide, including clinical and functional outcomes and system-wide outcomes.

14 Provider Quality Improvement Activities:

- a The Contractor shall monitor subcontracted provider quality improvement activities to ensure compliance with federal and state laws, regulations, IDHW requirements, this Contract, and all other Quality Management (QM) requirements.
- b The Contractor shall make records and other documentation available to the IDHW, and ensure subcontractors' participation in, and cooperation with, any QM reviews. This may include participation in staff interviews and facilitation of Member/family/caregiver and subcontractor interviews.
- c The Contractor shall use quality management review findings to improve quality of care.
- d The Contractor shall take action to address identified issues, as directed by the IDHW.

15 Provider Monitoring:

- a The Contractor shall monitor and evaluate qualified service providers in order to promote improvement in the quality of care provided to Members.
- b The Contractor shall monitor all provider agencies and individual practitioners' performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the IDHW, consistent with industry standards, federal and state laws and regulations.
- c The Contractor shall update a provider monitoring plan in the required annual Quality Management Plan.
- d In accordance with federal requirements 42 CFR § 438.206, the provider monitoring plan shall address, at a minimum, the following requirements:
 - i Maintaining and monitoring a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract.
 - ii Identifying deficiencies or areas for improvement and ensuring and the provider agencies and individual practitioners shall take corrective action in the following areas:
 - (1) Monitoring and reporting network turnover.
 - (2) Monitoring and reporting requests for a change in provider.
 - (3) Continually monitoring access to network services and provider capacity to maintain a sufficient number of qualified service providers, to deliver covered behavioral health services for Members, including provision of culturally informed services to persons with limited proficiency in English and those with cross-cultural treatment requirements and adapted service delivery for blind or deaf Members.

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- (4) Complying with service provider monitoring and reporting requirements in accordance with this Contract, including but not limited to a Member Access Rates Report.
- iii Demonstrating that its providers are credentialed as required by 42 CFR § 438.206(b)(6) and 42 CFR § 438.214.
- iv Ensure timely access to services:
 - (1) Meeting and requiring its providers to meet IDHW standards for timely access to care and services, taking into account the urgency of the need for services per 42 CFR § 438.206(c)(1)(i);
 - (2) Ensuring that the network providers offer hours of operation that are no less than the hours of operation offered to non-Medicaid clients or comparable to Medicaid fee-for-service, if the provider serves only Medicaid Members. 42 CFR § 438.206(c)(1)(ii);
 - (3) Making services included in the Contract available twenty-four (24) hours a day, seven (7) days a week, when medically necessary. 42 CFR § 438.206(c)(1)(iii);
 - (4) Establishing mechanisms to ensure compliance by providers. 42 CFR § 438.206(c)(1)(iv);
 - (5) Monitoring providers regularly to determine compliance. 42 CFR § 438.206(c)(1)(v); and
 - (6) Taking corrective action if there is a failure to comply. 42 CFR § 438.206(c)(1)(vi.)

16 Policies and Procedures for Managing Network:

- a The Contractor shall uniquely identify each practitioner, allowing for the association of multiple standardized and user defined identifiers and qualifiers, including Master Provider Index (MPI), Drug Enforcement Administration (DEA), and National Association of Boards of Pharmacy (NABP) identifiers.
- b The Contractor shall provide online access to the IDHW for all historical provider related information to include:
 - i Claims;
 - ii Prior authorizations and referrals; and
 - iii Correspondence.
- c The Contractor shall perform data exchanges to obtain provider data from licensing boards, CMS, DEA, the MPI enumeration contractor, and other IDHW specified sources.
- d The Contractor shall maintain provider Clinical Laboratory Improvement Amendments (CLIA) data with full audit capabilities for those providers who have CLIA certification.
- e The Contractor shall provide online inquiry or lookup for the IDHW for a minimum of sixty (60) months of historical provider information, searchable by entering complete or partial identifying information:
 - i Medicaid provider identification;
 - ii Provider name;
 - iii NPI;
 - iv Medicare number;
 - v Social security number;
 - vi Phone number;
 - vii EIN/TIN;
 - viii DEA;
 - ix Type/specialty/taxonomy;
 - x Previous identifier(s); and
 - xi Other identifiers used by the IDHW.

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- f The Contractor shall display claims summary information, by provider, to include: month-to-date, quarter-to-date, and year to date levels that will indicate the total number of claims submitted, pending, denied, paid and the total dollar amounts of each category.
- g The Contractor shall display prior authorization by provider to include: month-to-date, quarter-to-date, and year-to-date levels that will indicate the total number of prior authorization's requested, approved, pending, denied, and the total dollar amount of each category.
- h The Contractor shall include provider data repository definition of provider entities to include:
 - i Pay-to or tax entities;
 - ii Service entities including:
 - iii Licensed or certified entities providing services including physicians and all behavioral health practitioners;
 - iv Medical groups and FQHCs; and
 - v Non-traditional providers including transportation Providers.
- i The Contractor shall define provider's periods of eligibility using, at a minimum, eligibility begin and end dates and status indicator(s).
- j The Contractor shall display provider eligibility information in reverse chronological order (i.e., most current information is displayed first).
- k The Contractor shall affiliate one or more service provider(s) to one or more 'pay to' entities.
- l The Contractor shall have the ability to capture, at a minimum, provider:
 - i Address information;
 - ii Office contact person;
 - iii Phone number;
 - iv Fax number;
 - v Personal contact numbers (home phone, cell phone); and
 - vi Office or facility profile (content will vary based on entity type).
- m The Contractor shall accommodate Idaho Bureau of Occupational Licensing (IBOL) certification information which includes:
 - i Type, specialty, and sub specialty;
 - ii Taxonomy;
 - iii Certification begin and end dates;
 - iv Certification type code;
 - v Certifying agency;
 - vi Certifying state;
 - vii Verification date; and
 - viii Verification due date.
- n The Contractor shall accommodate licensing, credentialing, sanction and certification information that includes:
 - i License identification;
 - ii Certification type;
 - iii Certifying agency;
 - iv Certifying state;
 - v Certification begin and end dates;
 - vi Verification date;
 - vii Verification due date;
 - viii Verification type;
 - ix Sanctioning agency;
 - x Sanctioning state; and

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- xi Sanction beginning and end dates.
- o The Contractor shall identify and create alerts and reports of providers due for re-certification or license verification, sixty (60) days prior to the end date of the current license, certification, or provider agreement.
- p The Contractor shall define the relationship between a provider and an Electronic Data Interchange (EDI) submitter.
- q The Contractor shall define surveillance status and pend or deny for CMS-1500 claims by date parameters and other qualifiers which may include:
 - i Media type;
 - ii Healthcare Common Procedure Coding System (HCPCS) code begin and end range;
 - iii International Classification of Diseases (ICD) diagnosis code begin and end range; and
 - iv ICD procedure code beginning and end range.
- r The Contractor shall identify the affiliation a physician in the provider network may have with a hospital or multiple hospitals and indicate what types of privileges they have.
- s The Contractor shall identify the providers PCP panel information including:
 - i Accepting new patient indicator;
 - ii Age range;
 - iii Gender;
 - iv Authorized enrollment; and
 - v Current enrollment.
- t The Contractor shall associate multiple service locations to the same provider base identifier.
- u The Contractor shall identify provider 'on call' information to capture 'covering for' and 'covered by' providers.
- v The Contractor shall indicate a Provider's financial information, at a minimum, EIN, SSN, W9, EFT bank account, 1099 information, hold payment indicators, and federal match rate.
- w The Contractor shall identify the individual practitioner's insurance coverage information which includes carrier, effective and end dates, dollar limits, verification date, and verification due date for the following types of coverage:
 - i Malpractice;
 - ii Workers compensation; and
 - iii General liability.
- x The Contractor shall produce reports showing which practitioners or provider agencies a Member is using and each individual agency's caseload.
- y The Contractor shall provide an unlimited free-form text narrative at the base Provider level that:
 - i Identifies the user, date, and time entered; and
 - ii Provides the capability to display free form narrative in chronological or reverse chronological sequence.

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GG (E) Compliance and Monitoring (Utilization Management): Utilization management (UM) is the key process to support appropriate compliance and monitoring requirement. UM efforts are designed to ensure the appropriate utilization of covered services. The Contractor shall have a system for conducting utilization management, program integrity and compliance reporting activities. All aspects of the system shall be focused on providing high quality, medically necessary services in accordance with contract requirements. ***Describe how you will meet the requirements in each of the following sections. Include detailed methodologies for developing and implementing each task, as well as descriptions of how these requirements will be met throughout the life of the contract. Include drafts of supporting proposed documents for each section including, but not limited to, proposed plans, programs, guidelines, projects, processes, policies and procedures, agreements, systems, activities, documentation, surveillance reports.***

1 Program:

- a The Contractor shall develop, implement and maintain a utilization management program to monitor the appropriate utilization of covered services.
- b The program shall comply with CMS requirements described in 42 CFR §456.
- c The program shall be under the direction of an appropriately qualified clinician; appropriateness of the qualifications of the assigned clinician shall be determined by matching the clinician's scope of expertise with the material under review.
- d Utilization determinations shall be based on written criteria and guidelines developed or adopted with involvement from practicing providers and nationally recognized standards.
- e The utilization management process shall in no way impede timely access to services.

2 Policies and Procedures (P&P) – Utilization Management:

- a The Contractor shall have P&Ps regarding the management of service utilization. UM P&Ps shall include, but are not limited to, the following:
 - i Annual Review and Evaluation of UM Program: P&P stating how the Contractor will evaluate the effectiveness of the UM program and subsequently revise the program as necessary. This information shall be made available to the IDHW.
 - ii Criteria:
 - (1) P&P regarding the development, review and modification of utilization review criteria to include the practitioners involved and documentation of the involvement.
 - (2) Criteria shall be developed for all routinely provided care and services.
 - (3) P&P shall reflect that available criteria shall be applied to all utilization review (UR) decisions and that criteria are clearly written, are objective and evidence based whenever possible, appropriate and available to providers and Members upon request.
 - (4) There shall be a statement regarding the congruence between adopted clinical guidelines and UR criteria.
 - (5) P&P for applying the criteria based on individual needs and taking into account the local delivery system.
 - (6) P&P for processing requests for initial and continuing authorizations of services per 42 CFR § 438.210(b)(1.)
 - iii The Contractor shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and consult with the requesting provider when appropriate per 42 CFR § 438.210.

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- iv The Contractor 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, be made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease per 42 CFR § 438.210(b)(3).
- v Monitoring Over- and Under-Utilization:
 - (1) P&P stating that prior authorization shall be conducted for identified levels of care.
 - (2) P&P outlining the activities undertaken to specifically identify and address under-utilization as well as over-utilization.
 - (3) At a minimum, the P&P shall include routine trending and analysis of data on levels of care (including care not prior authorized) and by provider.
 - (4) P&P providing for peer review of quality of care concerns.
- vi Utilization Review (UR) Decisions:
 - (1) Evidence, available to the IDHW upon request, of formal staff training designed to improve the quality of UR decisions.
 - (2) P&P to evaluate and improve the consistency with which UR staff apply criteria (inter-rater reliability) across multiple levels of care.
 - (3) P&Ps and job descriptions to specify the qualifications of personnel responsible for each level of UR decision making (e.g., review, potential denial).
 - (4) P&P to ensure that a practitioner with appropriate clinical experience in treating the Member's condition reviews any potential denial based on medical necessity.
- vii Timeframes:
 - (1) P&Ps to address the timeliness of UR decisions made on the basis of medical necessity.
 - (2) P&Ps to address the timeframes for which prior authorization, concurrent and retrospective reviews decisions are made.
 - (3) P&Ps to address the timeliness of expedited reviews.
 - (4) P&Ps to assess the adherence to the timeframes in items i-iii.
- viii Data and Communication:
 - (1) P&P that specifies how Members and practitioners can access UM staff to discuss UM issues and decisions. This information shall be made available to Members and providers.
 - (2) P&P that describes how the organization will notify the providers and Members of UM decisions.
- ix Obtaining Clinical Information:
 - (1) P&P to obtain relevant clinical information and the circumstances under which the Contractor will consult with the treating providers when making a determination of medical necessity.
 - (2) P&P describing the decision-making process that identifies information needed to support UR decision making.
 - (3) P&P describing the process for obtaining any missing clinical information.
- x Other:
 - (1) P&P to evaluate new technology and new applications of existing technology, to include behavioral health procedures.
 - (2) P&P to ensure any Contractor centralized triage and referral functions for behavioral health services are appropriately implemented, monitored, and professionally managed.
 - (3) P&P describing how practitioners are given information on the process to obtain the UR criteria.

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3 Documentation:

- a The Contractor shall maintain documentation that supports the activities described in the UM program and UM policies and procedures. The Contractor shall report service utilization by type of service to the IDHW on a monthly basis.
- b Supporting documentation shall include, but is not limited to, committee meeting minutes, job descriptions, signatures on related materials and utilization review notes.
- c The UM program description shall be written so that staff members and others can understand the program. The program description shall include, but not be limited to:
 - i Program goals;
 - ii Program structure, scope, processes and information sources, including the identification of all intensive levels of care;
 - iii Roles and responsibilities;
 - iv Evidence of Medical Director leadership in key aspects of the UM program to include denial decisions and criteria development;
 - v A description of how oversight of any delegated UM function will occur;
 - vi A description of how staff making Utilization Review (UR) decisions will be supervised;
 - vii A statement regarding staff availability at least eight (8) hours a day during normal business hours for inbound calls regarding UM issues;
 - viii The mechanisms that will be used to ensure that Members receive equitable access to care and service across the provider network; and
 - ix The mechanisms that will be used to ensure that the services authorized are sufficient in amount, duration, or scope and can reasonably be expected to achieve the purposes for which the services are furnished.

4 Accountability:

- a The Contractor shall remain accountable for and have appropriate structures and mechanisms in place to oversee activities that are delegated to a subcontractor per 42 CFR § 438.230(a) and (b)(1), (2), (3), including a way to verify services were actually provided as required by 42 CFR§ 455.1(a)(2). This will include a written delegation agreement. The following items apply to sub-contracted activities and do not reflect the total requirements for any delegated subcontract or agreement. The Contractor shall have the following in place:
 - i A written Delegation Agreement that includes:
 - (1) A description of the responsibilities of the Contractor and the delegated entity as it relates to delegated activities;
 - (2) A description of the delegated activities;
 - (3) A description of reporting responsibilities;
 - (4) A statement that the subcontractor will comply with the standards specified in the contract between the Contractor and the IDHW for any responsibilities delegated to the subcontractor;
 - (5) A description of the processes for ongoing monitoring (i.e., continuous quarterly reporting) and at least an annual formal review; and
 - (6) A description of the remedies available to the Contractor if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement and corrective action.
 - ii Oversight P&Ps:
 - (1) A P&P describing the oversight (ongoing monitoring) activities that will be done (e.g., required reporting and report frequency, activities conducted by the Contractor in reviewing the required reports, actions that will be taken depending on the review).

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- (a) The procedure shall include who reviews the reports, whether or not a committee approval is required, etc.
- (a) The scope of oversight activities shall include all delegated UR/UM functions.
- (a) P&P describing the formal review, which shall occur no less than annually, and at a minimum include a visit to the organization, and a document or record review.
- iii P&P describing how the quality (application of criteria, denial decisions, inter-rater reliability, etc.) of contracted services will be monitored and assessed.

5 Guidelines:

- a The Contractor shall develop or adopt Utilization Management Guidelines to interpret the medical necessity of behavioral health services provided to Members. Medical necessity is defined in IDAPA 16.03.09. The IDHW shall be the final authority regarding all disputed medical necessity decisions.
- b The guidelines for interpreting medical necessity shall:
 - i Be based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
 - ii Consider the needs of the Members;
 - iii Be adopted in consultation with contracting health care professionals, and
 - iv Be reviewed and updated periodically as appropriate.
- c The Contractor shall disseminate the guidelines to all providers and, upon request, to Members.
- d In the development and implementation of Utilization Management Guidelines, the Contractor shall include policies and procedures which recognize the need for long-term services for some Members and the need for some Members to access several services concurrently. These needs shall be recognized for both children and adults.
- e All guidelines developed by the Contractor and any modifications made to the guidelines shall be approved by the IDHW and shared with providers at least thirty (30) calendar days prior to implementation of the guidelines.
- f The Contractor shall ensure that contracted providers use the required criteria for determination of level of service, even when authorization from Contractor is not required.
- g The Contractor shall ensure that decisions for utilization management, Member education, coverage of services, and other areas to which the guidelines apply shall be consistent with the guidelines.
- h The Contractor may limit payment to only those services that the Contractor has authorized under the guidelines which the Contractor has developed and the IDHW has approved. Any denial of payment for services funded through the Medicaid capitation payment is subject to appeal to the IDHW pursuant to standards in both state administrative rules and the State Plan or waiver.
- i The Contractor shall provide a forum to receive practitioner suggestions for UM Guideline revisions at least annually, and shall document all changes made subsequent to practitioner input.

6 Health Information System (HIS) in Utilization Management:

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- a Currently the IDHW's Division of Medicaid does not require mental health providers to operate any uniform HIS. The IDHW's Division of Behavioral Health operates the WITS system which is described in greater detail in **Attachment 16 - Web Infrastructures for Treatment Services (WITS)**. The network of substance use disorder providers currently uses this system. The Contractor shall maintain a health information system that:
 - i Supports WITS or at the very least, uses a system that shall interface with WITS.
 - ii Supports the utilization management process by collecting, analyzing, integrating, and reporting necessary data.
 - iii Provides information on the utilization of services.
 - iv Collects data on Member and provider characteristics as specified by the IDHW and on services furnished to Members through an encounter data system.
 - v Makes all collected data available to the IDHW and/or designee and upon request by CMS.
 - vi Ensures that data received from providers is accurate and complete by:
 - (1) Verifying the accuracy and timeliness of reported data.
 - (2) Screening the data for completeness, logic, and consistency.
 - (3) Collecting service information in standardized formats to the extent feasible and appropriate.
 - vii The Contractor shall use a system, such as Health and Effectiveness Data and Information Set (HEDIS), to conduct comparative analysis.

7 Compliance and Management:

- a The Contractor shall have a mandatory compliance plan and administrative and management arrangements or procedures designed to prevent and detect fraud, abuse and misuse of Medicaid funds and resources.
- b The Contractor shall diligently safeguard against the potential for, and promptly investigate reports of, suspected fraud and abuse by employees, subcontractors, providers, and others with whom the Contractor does business by having controls in place to detect fraud and abuse, including technology to identify aberrant billing patterns, claims edits, post processing review of claims and records reviews.
- c The Contractor shall have documentation to support that safeguards at least equal to federal safeguards at 41 USC 423, section 22101-21077 are in place.
- d The Contractor shall provide the IDHW with the Contractor's policies and procedures on handling fraud and abuse including responding to IDHW requests for records and documentation of any sort such as provider agreements and all written and telephonic communications with a provider per the terms of the contract.
- e The Contractor shall report possible instances of Medicaid fraud to the IDHW within contractual timeframes. This information shall be reported in the quarterly Surveillance Activities Report.
- f The Contractor shall describe how frequently, and by what method, it shall assure that providers' CPT billing accurately reflects the level of services provided to Members so that there is no intentional or unintentional up-coding or miscoding of services.
- g The Contractor shall have in place a method to verify whether services reimbursed by the Contractor were actually furnished to eligible Members as billed by providers.
- h The Contractor shall provide the IDHW with a quarterly update of surveillance activity, including corrective actions taken. This information should be reported in the Surveillance Report.
- i The Contractor shall have administrative and management arrangements or procedures, and a mandatory compliance plan that are designed to guard against fraud and abuse and include the following:

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- i Written policies, procedures, and standards of conduct consistent with all applicable federal and state laws pertaining to fraud and abuse;
- ii The designation of a compliance officer and a compliance committee that are accountable to senior management;
- iii Effective training and education for the compliance officer and the staff;
- iv Effective lines of communication between the compliance officer and staff;
- v Enforcement of standards through well-publicized disciplinary guidelines;
- vi Provision for internal monitoring and auditing, including inspection and audit of financial records per 42 CFR § 438.6(g);
- vii Provisions for prompt response to detected offenses, and for development of corrective action initiatives relating to the contract services;
- viii Written procedures in place to suspend payment in accordance with Affordable Care Act provisions, Section 6402(h)(2), as well as IDAPA 16.05.07, The Investigation and Enforcement of Fraud, Abuse, and Misconduct;
- ix Responsibility to check the Medicaid Program Integrity Unit's Termination and Outstanding Debt List and not enter into agreements with providers who have been terminated or have outstanding debts. The list can be found at: <http://www.healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/ProviderExclusionList.pdf>;
- x Provision of a comprehensive written Work Plan which shall include timelines for formal communications and trainings to the provider network, no less than annually, on topics of fraud and abuse, including the Medicaid Program Integrity Unit's contact information. The trainings need to be reported in the annual Provider Training Report; and
- xi Reporting receipt of any complaints of fraud or abuse from any sources to the Medicaid Program Integrity Unit. Additionally, any information obtained regarding the abuse or exploitation of adults shall be reported to the Medicaid Program Integrity Unit.

8 Report of Fraud, Waste, Abuse:

- a The Contractor shall submit, quarterly, a Surveillance Report to the IDHW detailing all incidents of fraud, waste and abuse detected, reported to, reviewed or investigated by the Contractor. The report shall, at a minimum, provide:
 - i The current status and resolution of all fraud, waste, and abuse incidents detected or referred to the Contractor including the name and identification number, sources of complaint, type of provider, nature of complaint, approximate dollars involved and legal and administrative disposition of the case;
 - ii The number of provider reviews opened, pending, and completed for the current quarter, year to date, and averages per quarter;
 - iii Fraud and/or abuse issues identified;
 - iv Overpayment amounts identified in the quarter, contract to date, and average amount per quarter;
 - v Means by which overpayments were identified;
 - vi Actions taken;
 - vii Recoupment amount collected in the previous quarter, contract to date, and average amount per quarter;
 - viii Any provider education that the Contractor delivered;
 - ix Number of cases before the IDHW awaiting approval;
 - x Number of cases recommended for referral to Bureau of Audits and Investigations and the Medicaid Fraud Control Unit (MFCU);
 - xi Number of provider appeals filed;
 - xii Case status of appeals; and

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- xiii Discussion that may include, but is not limited to, problems encountered, provider specific or statewide trends noted, and regulation revisions needed.
- xiv In partnering with the Medicaid Program Integrity Unit the Contractor shall make available to the IDHW within five (5) business days upon request:
 - (1) Copies of individual provider contracts
 - (2) Copies of prior authorizations
 - (3) All written communication between the Contractor and a specified provider.
- b The Contractor shall furnish the IDHW, the Secretary of the U.S. Department of Health and Human Services (DHHS), or the IDHW's Idaho Medicaid Fraud Control Unit (MFCU) with such information as it may request regarding payments claimed for services provided.
- c The Contractor shall grant the IDHW, DHHS and/or MFCU access during the Contractor's or subcontractors' regular business hours to examine health service and financial records related to a health service billed to a program. The IDHW will:
 - i Notify the Contractor or subcontractor before obtaining access to a health service or financial record, unless the Contractor or subcontractor waives notice.
 - ii Access records in accordance with 45 CFR 160-164.
 - iii Send a monthly Excel file to the Contractor of any providers that have had payment suspended or have been terminated by CMS.

9 Compliance Program Plan:

- a The Contractor shall submit, annually for approval, its Compliance Program Plan.
- b The Contractor shall submit, within forty five (45) calendar days of the effective date of this contract, a copy of the written policies identified in the Program Integrity section of the base contract detailing compliance with:
 - i The False Claims Act, 31 USC §§ 3729, et seq.;
 - ii Administrative remedies for false claims and statements;
 - iii State laws relating to civil or criminal penalties and statements;
 - iv State laws relating to civil or criminal penalties for false claims and statements; and
 - v Whistleblower protections under such laws.
- c The Contractor shall submit, annually, within thirty (30) business days of the IDHW's notification letter, written assurance of compliance with the False Claims Act to the IDHW's Program Integrity Unit.
- d The Contractor may not knowingly have a relationship with the following per 42 CFR § 438.610(a) and (b):
 - i An individual who is 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 presidential Executive Order No.12549 or under guidelines implementing presidential Executive Order No. 12549; or
 - ii An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (a)(1) of the regulation.
- e For the purposes of this section, "Relationship" is defined as follows:
 - i A director, officer, or partner of the Contractor;
 - ii A person with beneficial ownership of five percent or more of the Contractor's equity; or
 - iii A person with an employment, consulting or other arrangement with the Contractor under its contract with the IDHW.
- f The Contractor shall notify the IDHW of any person or corporation that has 5% or more ownership or controlling interest in the Contractor.

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- g The Contractor shall not expend Medicaid funds for providers excluded by Medicare, Medicaid, or SCHIP.

10 Unique Identifier:

- a The Contractor shall require each individually contracted provider to have a unique identifier.

11 Encounter Data:

- a The Contractor shall submit encounter data to the IDHW and/or its designee on all State Plan services. The Contractor shall submit data certifications for all data utilized for the purposes of rate setting (42 C.F.R. 438.604 and 438.606).
- b Data certification shall include certification that data submitted is accurate, complete and truthful, and that all "paid" encounters are for covered services provided to or for enrolled Members.
- c Data submission shall comply with the federal confidentiality requirements of 42 CFR Part 2, and may require the development of Qualified Service Organization Agreements (QSOA).
- d The Contractor shall submit encounter claims data to the IDHW for submittal to the Medicaid Management Information System (MMIS) on a monthly basis, no later than thirty (30) calendar days following the data collection month.
- e In addition, the Contractor shall submit encounter data to the IDHW on a quarterly basis in a flat data file format. These files are due no later than sixty (60) calendar days following the data collection quarter. The IDHW reserves the right to change format requirements at any time, following consultation with the Contractor and retains the right to make the final decision regarding format submission requirements.

12 Record-Keeping:

- a The Contractor shall maintain records in accordance with requirements at 45 CFR § 4.53(a) and (b):
 - i Books, records, documents, and other evidence (hereinafter referred to as records) documenting the costs and expenses of the contract to the extent and in such detail as will properly reflect all net costs (direct and indirect) of labor, materials, equipment, supplies, services, etc., for which payment is made under the contract.
 - ii All medical records pertaining to treatment services and supports provided under the contract.
 - iii All records for the duration of the contract period and for six (6) years after the date the final payment is made to the Contractor or for the duration of contested case proceedings, whichever is longer.
- b At the contract conclusion, the Contractor shall turn over a copy or the originals of all records to the IDHW or a party designated by the IDHW.
- c Medical records shall be transferred to a new Contractor upon request of the IDHW.

13 Access:

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- a The Contractor shall permit any authorized representative of the State of Idaho or the Comptroller General of the United States, or any other authorized representative of the United States Government, to access and examine, audit, excerpt, and transcribe any directly pertinent books, documents, papers, electronic, or optically stored and created records, or other records of the contractor relating to the contract, wherever such records may be located in accordance with 42 CFR § 438.6(g) The Contractor shall permit any authorized representative of the State of Idaho or the Comptroller General of the United States, or any other authorized representative of the United States Government to evaluate through inspection or other means, the quality, appropriateness and timeliness of services performed under the contract per 42 CFR § 434.6(a)(5) . The Contractor shall not impose a charge for audit or examination of the Contractor's records.
- b The Contractor shall provide to the IDHW upon request, all written program records including, but not limited to, statistical information, board and other administrative records, and financial records, including budget, accounting activities, financial statements, and the annual audit.
- c Subcontractors shall comply with all of the requirements of this section for all records related to the performance of the contract.

HH Annual Network Development and Management Plan: The Contractor shall submit to the IDHW an annual Network Development and Management Plan, which contains specific action steps and measurable outcomes that are aligned with the IDHW provider network requirements. The Network Development and Management Plan shall take into account regional needs and incorporate region-wide, network-specific goals and objectives developed in collaboration with the IDHW. At a minimum, the analysis shall be derived from:

- 1 Quantitative data, including performance on appointment standards/appointment availability, eligibility/enrollment data, utilization data including a report of outliers, the network inventory, demographic (age/gender/race /ethnicity) and data.
- 2 Qualitative data (including outcomes data), when available; grievance information; concerns reported by Members; grievance, appeals, and request for hearings data; behavioral health Member satisfaction survey results, and prevalent diagnoses.
- 3 Status of provider network issues within the prior year that were significant or required corrective action by the IDHW including findings from the Contractor's annual administrative review work.
- 4 A summary of network development and management activities conducted during the prior year which includes efforts for developing providers outside the agency/clinic model.
- 5 Plans to correct any current material network gaps and barriers to network development.
- 6 Priority areas for network development and management activities for the following year, goals, action steps, timelines, performance targets, and measurement methodologies for addressing the priorities.
- 7 The participation of stakeholders in the annual network planning process.
 - a The Contractor's Work Plan shall be approved by the IDHW.
 - b The Contractor shall submit progress reports as requested by the IDHW.

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- II (E) Data Tracking and Utilization Information System:** The Contractor shall provide a Data Tracking and Utilization Information System to collect and compile data, analyze the data, generate both electronic and hard copy reports in an Excel format, and store, maintain and manage data as required in this RFP, and outlined in **Attachment 6 - Technical Requirements**. The Contractor shall be responsible for all programming functions and costs associated with the use and maintenance of the system. The Contractor shall adhere to the timelines established in **Attachment 9 - Initial Deliverables**, and **Attachment 10 - Readiness Review**. The Data Tracking and Utilization Information System shall be fully operational within one-hundred twenty (120) calendar days of the effective date of the contract.
- 1 Submit, with your proposal,** a detailed description of your proposed Data Tracking and Utilization Information System.
 - 2 Describe how you will:**
 - a Ensure system is functional and accessible to allow the IDHW to retrieve reports via Secure File Transfer Protocol (SFTP) from the Contractor.
 - b Ensure all of the required data elements identified in the Scope of Work and Reports section are included into the Data Tracking and Utilization Information System.
 - 3 Provide samples, with your proposal,** of your proposed utilization data reports.
- JJ Faith-based Organization:** If Offeror is a faith-based organization describe how it will:
- 1** Segregate contract funds in a separate account;
 - 2** Serve all Members without regard to religion, religious belief, refusal to hold a religious belief, or refusal to actively participate in a religious practice;
 - 3** Ensure that IDHW referred Members' participation in religious activities, including worship, scripture study, prayer or proselytization, is only on a voluntary basis;
 - 4** Notify Members of the religious nature of the organization, their right to be served without religious discrimination, their right not to take part in inherently religious activities, their right to request an alternative provider and the process for doing so;
 - 5** Ensure that contract funds are not expended on inherently religious activities; and
 - 6** Comply with applicable terms of 42 CFR §§ 54 and 54a, and 45 CFR §§ 260 and 1050.
- KK (E) Disaster Recovery Plan:** The Contractor shall provide and maintain a comprehensive Disaster Recovery Plan that identifies how the Contractor will manage services in the event of a catastrophe (disaster, emergency, flooding, power failure, weather conditions, loss of phone systems, etc.). The Disaster Recovery Plan shall include, but is not limited to, how the Contractor will notify the IDHW when the Contractor's site requires the implementation of the Disaster Recovery Plan, how the Contractor will work with IDHW and Behavioral Health network providers and Members if a catastrophe occurs in Idaho, how services will continue with minimal disruption, how data will be safeguarded and accessible, and how Members will continue to receive behavioral health services.
- 1 Submit your Disaster Recovery Plan with your proposal.** In addition to submitting the Disaster Recovery Plan with the proposal, the Contractor may be required to submit a revised Disaster Recovery Plan for review as outlined in **Attachment 10 - Readiness Review**.
 - 2 Submit, with your proposal,** a detailed description of your back-up plan and system to ensure that, in the event of a power failure or outage, the following are in place and functioning:
 - a A back-up system capable of operating the telephone system for the entire time the main system is inoperative, at full capacity, with no interruption of data collection;

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- b A notification plan that ensures the IDHW is notified when the Contractor's phone system is inoperative or a back-up system is being utilized; and
- c Manual back-up procedure for processing requests if the system is down.

3 Describe how you will:

- a Maintain business continuity in the occurrence of unforeseeable events impacting business operations.
- b Maintain and update the Disaster Recovery Plan.
- c Implement the Disaster Recovery Plan in the event of a catastrophe impacting the Contractor's site.
- d Implement the Disaster Recovery Plan in the event of a catastrophe in Idaho.
- e Ensure Members continue to receive behavioral health services with minimal interruption.
- f Ensure data is safeguarded and accessible.
- g Train staff and network providers to the requirements of the Disaster Recovery Plan to ensure all systems remain intact and all files and data are restored within twenty four (24) hours in the event of a disaster.

LL **(E) Reports/Records/Documentation:** The Contractor shall provide reports as outlined in Appendix C - Reports. Reports shall include data current through the respective reporting timeframe and shall be submitted within the required timeframes.

1 Describe how you will:

- a Comply with the reporting requirements in the RFP. **Submit samples** of each required report with your proposal.
- b Ensure reports are accurate and available within the required timelines.
- c Ensure copies of complete and valid provider insurance certificates are maintained for each qualified network provider. The Contractor shall make these copies available to the IDHW upon request.

MM **Contract Transition Plan:** The Contractor shall provide and maintain a Contract Transition Plan that complies with the requirements of this RFP. The objectives of the Contract Transition Plan are to minimize disruption of services provided to the IDHW and to provide for an orderly and controlled transition of the Contractor's responsibilities to a successor at the conclusion of the contract period or for any other reason the Contractor cannot complete the responsibilities of the contract. The Contractor shall submit their Contract Transition Plan as outlined in **Attachment 10 - Readiness Review**. In addition, the Contractor shall submit an updated Contract Transition Plan to the IDHW within one-hundred-eighty (180) calendar days prior to the conclusion of the contract.

1 The Contract Transition Plan shall include, but not be limited to:

- a A realistic schedule and timeline to hand-off responsibilities to the replacement contractor or the IDHW.
- b The staff that shall be utilized during the hand-off of duties and their responsibilities such that there shall be clear lines of responsibility between the Contractor, the replacement contractor and the IDHW.
- c The actions that shall be taken by the Contractor to cooperate with the replacement Contractor and the IDHW to ensure a smooth and timely transition.
- d A plan on how to best inform and keep the Contractor's employees informed during the transition process.

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- e A matrix listing each transition task, the functional unit and the person, agency or Contractor responsible for the task, the start and deadline dates to complete the planned tasks, and a place to record completion of the tasks.
 - f All information necessary for reimbursement of outstanding claims.
- 2 The Contractor shall:
- a Cooperate with the IDHW during the planning and transition of contract responsibilities from the Contractor to a replacement contractor or the IDHW including, but not limited to, sharing and transferring behavioral health Member information and records, as required by the IDHW;
 - b Ensure that Member services are not interrupted or delayed during the remainder of the contract and the contract transition planning by all parties shall be cognizant of this obligation. The Contractor shall:
 - i Make provisions for continuing all management and administrative services and the provision of services to Members until the transition of all Members is completed and all other requirements of this contract are satisfied.
 - ii Designate a transition coordinator who shall interact closely with the IDHW and the staff from the new contractor to ensure a safe and orderly transition, and shall participate in all transition meetings.
 - iii Provide all reports set forth in this contract and necessary for the transition process in Excel or another format accepted by the IDHW.
 - iv Notify providers, subcontractors and Members of the contract termination, as directed by the IDHW, including transfer of provider network participation to the IDHW or its designee. The IDHW shall have final approval of all communications regarding the transition/termination of the contract.
 - v Complete payment of all outstanding obligations for covered services rendered to Members. The Contractor shall cover continuation of services to Members for the duration of the period for which payment has been made as well as for inpatient admissions up until discharge.
 - c Participate on a contract transition planning team as established by the IDHW. The Contractor's contract transition planning team shall include program evaluation staff and program monitoring staff, as well as staff that supports all automated and computerized systems and databases.
 - d Complete all work in progress and all tasks called for by the plan for transition prior to final payment to the Contractor. If it is not possible to resolve all issues during the end-of-contract transition period, the Contractor shall list all unidentified or held items that could not be resolved, including reasons why they could not be resolved, prior to termination of the contract and provide an inventory of open items along with all supporting documentation. To the extent there are unresolved items, the cost to complete these items will be deducted from the final payment. The Contractor shall specify a process to brief the IDHW or replacement contractor on issues before the hand-off of responsibilities.
 - e Notify the IDHW Contract Manager within forty eight (48) hours when issues that could impact the transition process are identified. The notice shall be submitted in writing and include detailed information regarding issues/problems identified and corrective actions taken regarding the plan for transition.

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- f Stop all work as of the contract expiration date or effective date contained in the Notice of Termination. The Contractor shall immediately notify all management subcontractors, in writing, to stop all work as of the contract expiration date or the effective date of the Notice of Termination. Upon receipt of the Notice of Termination, and until the effective date of the Notice of Termination, the Contractor shall perform work consistent with the requirements of this contract and in accordance with the written Contract Transition Plan approved by the IDHW for the orderly transition of Members to another contractor or the IDHW.
- g Unless otherwise directed by the IDHW, the Contractor shall direct subcontracted providers to continue to provide services consistent with the Member's treatment plan or plan of care.
- h Transfer all required telephone numbers associated with the toll-free call center line telephone number(s) to the IDHW or the successor contractor, as directed by the IDHW to allow for the continuous use of the number of Member services and providers.
- i Supply all information necessary for reimbursement of outstanding claims.

NN **(E) Identification of Risks and Constraints:** Based on the Scope of Work detailed in this RFP, identify any risks or constraints that you will need to address prior to or during the performance of the Work; as well as a description of how you will address each one. For example an incomplete Scope of Work can be both a risk and a constraint. How would you mitigate, or overcome, this. Provide your response to this **Section 4.2** on no more than two type-written pages.

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5. COST PROPOSAL

Pricing will be evaluated using a cost model that offers the State the best possible value over the initial term of the contract.

- 5.1 **(E)** Use the format established in **Appendix B** to respond to the Cost Proposal of this RFP, and identify it as **Appendix B - Cost Proposal and Billing Procedure**. Altering the format may cause the cost to be found non-responsive.
- 5.2 The Offeror must provide a fully-burdened rate for the Per Member Per Month (PMPM) cost for each category (dual eligible and non-duals) identified in the Cost Matrix. The Offeror must provide a fully-burdened rate for the Administrative Costs as defined in **Attachment 3 – Definitions** (Administration – Administrative Costs). Administrative Costs shall not exceed fifteen percent (15%) of the total identified PMPM cost. Proposed rates must be justified using the cost analysis contained in Appendix B.
- 5.3 The Contractor must be capable of fully funding all contract costs, including start-up costs, until the IDHW determines the requirements of the readiness review have been met and the contract services commence.

6. PROPOSAL REVIEW AND EVALUATION

- 6.1 The objective of the State in soliciting and evaluating proposals is to ensure the selection of a firm or individual that will produce the best possible results for the funds expended.
- 6.2 All proposals will be reviewed first to ensure that they meet the Mandatory Submission Requirements of the RFP as addressed in **Sections noted with an (M)**. Any proposal (s) not meeting the Mandatory Submission Requirements may be found non-responsive.
- 6.3 The Business and Scope of Work proposal will be evaluated first as either “pass” or “fail,” based on the compliance with those requirements listed in the RFP with an **(M)**. All proposals that meet the requirements will continue in the evaluation process outlined in **Section 6**.
- 6.4 Oral presentations will not be conducted.
- 6.5 The Cost Proposal will only be opened and evaluated for offerors who receive the top three (3) technical scores.
- 6.6 The proposals will be reviewed and evaluated by a Proposal Evaluation Committee as follows:

Consensus Scoring – State appointed evaluators will review proposals submitted using the criteria contained in this RFP, section 6. A single score will be received from the group of evaluators for the proposals they reviewed. The State reserves the right to assign groups of proposals to a subset of evaluators based on the number of proposals received or the complexity of the technical component within the RFP. The number and complexity will be at the sole discretion of the State.

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- 6.7 The scores for the technical proposal section will be normalized as follows: The proposal with the highest overall total technical score will receive a score of 800. Other proposals will be assigned a portion of the maximum score using the formula: $800 \times \frac{\text{technical proposal being evaluated}}{\text{highest technical proposal}}$.
- 6.8 The scores for the Cost Proposal section will be normalized as follows: The cost evaluation will be based on the total cost proposed for required services as itemized in **Appendix B**. The proposal with the lowest overall total cost proposed will receive a score of 200. Other proposals will be assigned a portion of the maximum score using the formula: $200 \times \frac{\text{lowest cost proposal}}{\text{cost proposal being evaluated}}$.

EVALUATION CRITERIA

Mandatory Submission Requirements Met	Pass/Fail
Business Information (Section 3.8)	240 points
Organization and Staffing (Section 3.9)	80 points
Scope of Work (Section 4 & Attachment 6)	480 points
Cost (Appendix B)	200 points
Total Points	1000 points

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APPENDIX A

Scope of Work

(The contractor's proposal will be included in the contract as Appendix A – Scope of Work)

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APPENDIX B

Cost Proposal and Billing Procedure (M/E)

Part 1. Cost Proposal:

The contract shall be a FIRM FIXED FEE, INDEFINITE QUANTITY contract for services specified in the Scope of Work and **Attachment 6 - Technical Requirements**.

The Contractor must be capable of fully funding all contract costs, including start-up costs, until the IDHW determines the requirements of the Readiness Review have been met and the contract services commence.

The information provided in Cost Matrix is the IDHW's best estimate and may vary from actual number of Members serviced and services delivered under the contract. Estimated quantity is for evaluation purposes and is not to be considered a guarantee of actual number of services to be experienced under the contract.

The IDHW shall have the option to amend the PMPM Cost based on actuarial findings.

PMPM Costs: The Offeror's bid shall include two (2) PMPM costs, one for individuals who are dually eligible for Medicare and Medicaid and one for all other Members (non-duals).

Administrative Costs: The Offeror's bid must also provide a fully-burdened rate for the Administrative Costs for dually eligible for Medicare and Medicaid and non-duals). Administrative Costs are defined in **Attachment 3 – Definitions (Administration – Administrative Costs)**. Administrative Costs are capped and may not exceed fifteen (15%) of the PMPM Costs. Bids that include Administrative Costs which exceed the cap of fifteen percent (15%) of the PMPM Costs **will result in the proposal being non-responsive**.

Offerors shall complete the Cost Matrix below by providing the most favorable PMPM rate for the two (2) categories of Members. The cost evaluation will be based on the Annual Total bid for the required services.

Cost Matrix instructions for Offeror for each category of Members: Enter the PMPM Cost and the Administrative Cost for each Item (dual eligible and non-duals). Add the PMPM Cost to the Administrative Costs and enter the total in the Total PMPM Cost. Multiply the Total PMPM Cost by the Unit – Per Eligible Member Per Month, and enter the total into the Monthly Total PMPM Cost. Multiply the Monthly Total PMPM Cost by twelve (12) months and enter the total in the Annual Total for each Item (dual eligible and non-duals).

Cost proposals that include additional narrative, clarifications, or other changes to the cost and billing **will result in the proposal being non-responsive**.

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COST MATRIX

Item	Unit - Per Eligible Member Per Month (PMPM)	PMPM Services Cost	PMPM Administrative Costs (Must not exceed 15% of fixed claims allowance fee)	Total PMPM Cost
Idaho Behavioral Health Plan: dual eligibles	22,175	\$	\$	\$
				Monthly Total PMPM Cost
Monthly Total	22,175 X Total PMPM Cost ▶▶			\$
				Annual Total: Idaho Behavioral Health Plan: dual eligibles
Annual Total	Monthly Total PMPM Cost X 12 ▶▶			\$
Item	Unit - Per Eligible Member Per Month (PMPM)	PMPM Services Cost	Administrative Costs (Must not exceed 15% of fixed claims allowance fee)	Total PMPM Cost
Idaho Behavioral Health Plan: non-duals	200,710	\$	\$	\$
				Monthly Total PMPM Cost
Monthly Total	200,710 X Total PMPM Cost ▶▶			\$
				Annual Total: Idaho Behavioral Health Plan: non-duals
Annual Total	Monthly Total PMPM Cost X 12 ▶▶			\$
Administrative costs may not exceed 15% of the PMPM cost.				

Services shall commence when the Contractor successfully passes the IDHW's readiness review as outlined in **Attachment 9 - Initial Deliverables** and **Attachment 10 - Readiness Review**.

Part 2. Billing Procedure:

The Contractor shall submit deliverables in accordance with established timelines and

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shall submit Encounter Claims to the IDHW's MMIS contractor. Per 42 CFR § 431.55(h) and 42 CFR § 438.808. FFP is not available for amounts expended for providers excluded by Medicare, Medicaid, or SCHIP.

Inquiries, invoices, and deliverables shall be submitted to:

Division of Medicaid
Idaho Behavioral Health Program
3232 Elder Street
Boise, ID 83705
Phone: (208) 364-1813
Fax: (208) 364-1811
E-mail: martellep@dhw.idaho.gov

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APPENDIX C

Reports

The IDHW shall retrieve reports from the Contractor via SFTP by 10:00 a.m. Mountain Time on the 10th business day of the month following the month or quarter when services were provided. All reports based on Member utilization or Member input shall be sorted by duals and non-duals. Complete reports with data and all documentation that supports all summarized reports below shall be provided by the Contractor at the request of the IDHW.

Report Description: Capitation Report. The Contractor shall provide a list of all Members enrolled in Behavioral Health Plan that have had a capitation payment fee paid for them in the current month. The list shall include participant names, identification numbers, and amount of the monthly PMPM fee. The report shall include all capitation fee adjustments made for the current month.

Report Format: Excel

Report Due: Monthly, after capitation processing & reconciling

Report Description: Membership Activity Report . The Contractor shall provide a summary of the average number of Members that they are billing the IDHW for each month for the last twelve (12) months, and a breakdown of Members by three (3) unduplicated age categories 1) ages zero (0) through the month a Member turns eighteen (18), 2) age eighteen (18) to the month a Member turns age twenty one (21), and 3) age twenty one (21) and over.

Report Format: Excel

Report Due: Monthly

Report Description: Claims Encounter Report. The Contractor shall provide a report of all claims paid or denied that includes Member name, birth date, ID number, date(s) of service, CPT codes billed, provider name and ID number, amount paid or denied, and explanation of benefits (EOB) codes used for each claim.

Report Format: Excel

Report Due: Monthly

Report Description: Claims Costs and Access Rates Report. The Contractor shall provide a summary of total amount invoiced to the IDHW, total Members who received behavioral health services each month, claims costs, and actual access rates. This unduplicated report shall cover the most recent twelve (12) month period and shall be sorted by 1) ages zero (0) through the month a Member turns eighteen (18), and 2) age eighteen (18) to the month a Member turns age twenty one (21), 3) age twenty one (21) and over, and 4) a report which combines all age categories.

Report Format: Excel

Report Due: Monthly

Report Description: Access Availability Report. If a provider loss results in a network deficiency, the Contractor shall submit to the IDHW a report listing each deficiency, along with time frames and action steps for correcting each deficiency within thirty (30) days. This report shall include documentation that each Member affected is transitioned to appropriate alternative service providers in accordance with the network notification requirements. The Contractor shall summarize the number of network providers in each county and region and the percentage of Members who have a

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behavioral health provider within: 30 miles of their residence for Ada, Canyon, Twin Falls, Nez Perce, Kootenai, Bannock, and Bonneville counties; and 45 miles of their residence for all other counties in Idaho.

Report Format: Excel

Report Due: Monthly

Report Description: Authorization for Services Report. The Contractor shall submit a report that identifies all decisions to deny an authorization for services or to authorize a service in an amount, duration, or scope that is less than requested. The report shall include number of requests denied for clinical criteria and reasons for denials, number of requests denied for administrative criteria and reasons for denials, number of approved requests, and average turn-around time to process requests for authorization of services. This report shall cover the most recent twelve (12) month period. Additionally, when requested by the IDHW, the Contractor shall provide copies of any Notices of Decisions electronically.

Report Format: Excel

Report Due: Monthly

Report Description: Complaint Resolution and Tracking Report. The Contractor shall submit a complaint resolution and tracking report that includes the complaint type, number of complaints received, how complaints were received (by phone, written communication), dates received, date of resolution, a description of the resolution, and number and status of complaints awaiting resolution. The report shall include all current complaints whether they are resolved or not. This report shall cover the most recent twelve (12) month period and be sorted by Member and provider.

Report Format: Excel

Report Due: Monthly

Report Description: Grievance Resolution and Tracking Report. The Contractor shall submit a grievance resolution and tracking report that includes the grievance type, number of grievances received, how grievances were received (by phone, written communication), dates received, date of resolution, a description of the resolution, and number and status of grievances awaiting resolution. The report shall include all current grievances whether they are resolved or not. This report shall cover the most recent twelve (12) month period and be sorted by Member and provider.

Report Format: Excel

Report Due: Monthly

Report Description: Provider Satisfaction Summary Report. The Contractor shall submit a summary of provider satisfaction information findings and shall include how the information will be used to improve services to achieve greater satisfaction of this population with the services, administration and operations of the Idaho Behavioral Health Plan.

Report Format: Excel

Report Due: Quarterly

Report Description: Customer Satisfaction Summary Report. The Contractor shall submit a summary of customer satisfaction information findings and shall include how the information will be used to improve services to achieve greater satisfaction of this population with the services, administration and operations of the Idaho Behavioral Health Plan.

Report Format: Excel

Report Due: Quarterly

Report Description: Customer Service: Call Response Report. The Contractor shall submit a

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report summarizing the number of Customer Service calls received each month, categorize the calls from either Member or provider, and include in the report the percentage of calls answered within thirty (30) seconds, daily average time on hold, abandonment rate and time taken to return phone calls.

Report Format: Excel

Report Due: Monthly

Report Description: Customer Service: Response to Written Inquiries Report. The Contractor shall submit a monthly report summarizing the number of written or electronic customer service inquiries received each month, categorize the calls as from either Member or provider, and include in the report the percentage of required response time that was met in business days.

Report Format: Excel

Report Due: Monthly

Report Description: Timeliness of Services Report. The Contractor shall submit a detailed report that includes the following:

Days taken for authorization decision to be formally documented;

Existing Members: waiting time (number of calendar days) for an appointment for non-urgent behavioral health services;

New Members who are initiating behavioral health services and who do not require urgent care: waiting time (number of calendar days) for an appointment for behavioral health services

Existing Members: waiting time (number of hours) for urgent behavioral health services for treatment of specific problems requiring immediate attention;

New Members: waiting time (number of hours) for urgent behavioral health services for treatment of specific problems requiring immediate attention;

Number of referrals made to the emergency IDHW of the Member's local hospital;

Time taken for the Contractor to find a provider, in or out of network, who will agree to treat a Member if the Member cannot find a provider on their own: number of calendar days for non-urgent cases and number of hours for urgent cases.

Report Format: Excel

Report Due: Monthly

Report Description: Provider Enrollment Report. The Contractor shall submit a report that details the number, names, service locations, addresses, zip codes, county and identification numbers of all enrolled providers, by provider type. Each section shall include identification of:

Providers lost and gained;

Prescribers lost and gained;

Prescriber sufficiency analysis;

The name and address of each provider;

Contracted capacity, populations served; and

An analysis of the effect on network sufficiency and progress in accordance with efforts to increase service capacity in areas requiring further development, including barriers encountered and actions planned to eliminate the barriers.

Report Format: Excel

Report Due: Quarterly

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Report Description: Out-of-network Provider Report. The Contractor shall submit a report that details the number, names, service locations, addresses, and identification numbers of all out of network providers authorized to provide services to Members. The Contractor shall provide a report of all claims paid or denied to out-of-network providers that includes Member name, birth date, ID number, date(s) of service, CPT codes billed, provider name and ID number, amount paid or denied, and explanation of benefits (EOB) codes used for each claim.

Report Format: Excel

Report Due: Quarterly

Report Description: Specialty Behavioral Health Service Provider Enrollment Report. The Contractor shall provide an annual report that provides IDHW specialty information about the network including (but not limited to) providers with expertise to deliver services to Members with developmental disabilities, non-English speaking Members, crisis response and other specialties as identified by the IDHW; also information that quantifies the number of qualified specialty providers, including the crisis response providers available within the network.

Report Format: Excel

Report Due: Annually

Report Description: EPSDT Reports. The Contractor shall provide a report of all claims paid or denied for EPSDT requests that includes Member name, birth date, Medicaid identification number, date(s) of service, CPT codes billed, provider name and identification number, amount paid or denied, reason for denial, and explanation of benefits (EOB) codes used for each claim.

Report Format: Excel

Report Due: Monthly

Report Description: Service Utilization Reports. The Contractor shall provide a summary of total amount invoiced to the IDHW based on types of behavioral health services; total Members who received each type of behavioral health service each month; total claims costs; average claims cost per Member; names and Medicaid identification numbers of Members whose claims are more than one standard deviation above the average claims costs; names and Medicaid identification numbers of Members whose claims are more than one standard deviation below the average claims costs; average claims costs per provider; names of each individual provider whose claims are more than one standard deviation above the average and those who are more than one standard deviation below the average; and actual access rates. This unduplicated report shall cover the most recent twelve (12) month period and shall be sorted by 1) ages zero (0) through the month a member turns eighteen (18), and 2) age eighteen (18) to the month a member turns age twenty one (21), 3) age twenty one (21) and over, and 4) a report which combines all age categories. Additionally, the report which combines all age categories will specify each Member's minority affiliation and primary behavioral health diagnoses.

Report Format: Excel

Report Due: Monthly

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Report Description: Level of Care Report. The Contractor shall submit a report of Members' changes in levels of care. The report shall detail the following:

The number of Members who discontinue their behavioral health services. The report shall include the Member names, Member ID numbers, ages, and reasons for dropping out of services.

The number of Members who received inpatient behavioral health services and their names, Member ID numbers, and ages and the names and ID numbers of the hospitals.

The number of Members at each level of care.

Report Format: Excel

Report Due: Quarterly and an annual summary

Report Description: Child and Adult Quality Performance Measures: The Contractor shall provide annual report that provides IDHW the information needed to report timely on national adult and pediatric quality performance measures (relevant to behavioral health) as defined by the Secretary of the Department of Health and Human Services pursuant to 42 USC 1320b-9a and 42 USC 1320b-9b: Children's Pediatric Measures: #21: Follow-up Care for Children Prescribed ADHD Medication, #23: Percentage of discharges for Members six (6) years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Adult Measures: NQF (National Quality Forum) #0418: Screening for Clinical Depression and Follow-Up Plan, NQF #0576: Follow-Up After Hospitalization for Mental Illness, NQF #0105: Antidepressant Medication Management, NQF #N/A: Adherence to Antipsychotics for Individuals with Schizophrenia, NQF #0004: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment.

Report Format: Excel

Report Due: Annual

Report Description: Surveillance Activities Report. The Contractor shall provide the IDHW a quarterly report summarizing the Contractors actions to identify, prevent and detect fraud, waste and abuse, and misuse of Medicaid funds and resources.

Report Format: Excel

Report Due: Quarterly

Report Description: Implementation Project Status Report. In conjunction with establishing and attending project status meetings, the Contractor shall provide written status reports during the implementation process. The report shall include:

Updated Work Plan and responsibility matrix;

Tasks that are behind schedule;

Dependent tasks for tasks behind schedule;

Items requiring the State Project Manager's attention;

Anticipated staffing changes;

Outstanding issues, current status and plans for resolution;

Any issues that can affect schedules for project completion; and

Identification, time frames, critical path effects, resource requirements, and materials for unplanned items.

Report Format: Excel

Report Due: Bi-weekly

Report Description: Contract Transition Status Report. Ninety (90) days prior to the end of the contract, the Contractor shall establish and attend bi-weekly project status meetings with IDHW and provide bi weekly (alternative weeks from meetings) written status reports during the transition process. This report shall include:

Updated transition implementation plan and responsibility matrix;

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Tasks that are behind schedule;
Dependent tasks for tasks behind schedule;
Items requiring the State Project Manager's attention;
Anticipated staffing changes;
Outstanding issues, current status and plans for resolution;
Any information set forth in this contract and necessary for the transition process;
Identification of any issues that can affect schedules for project completion; and
Identification, time frames, critical path effects, resource requirements, and materials for unplanned items.

Report Format: Excel

Report Due: Bi-weekly when transition period has been identified

Report Description: Provider Training Report. The Contractor shall provide the IDHW an annual report summarizing the Contractor's provider training efforts, and the number of providers who participated in the training efforts sorted by provider and county. The report shall also include the overall percentage of the network that participated in each different effort made by the Contractor.

Report Format: Excel

Report Due: Annually

Report Description: Summary of Incentive Payments Report. The Contractor shall provide the IDHW a quarterly report that details each incentive payment, what the incentive payment was for, to whom it was made, and the amount.

Report Format: Excel

Report Due: Quarterly

Report Description: Post Stabilization Services Report. The Contractor shall provide the IDHW with a list of Members who are receiving post-stabilization services, including a report of all claims paid or denied that includes Member name, birth date, Medicaid identification number, dates of service, CPT codes billed, provider name and identification number, amount paid or denied and explanation of benefits (EOB) codes used for each claims.

Report Format: Excel

Report Due: Monthly

Report Description: Hospitalization and Discharge Planning Report: The Contractor shall provide the IDHW with a list of Members and their Member identification numbers, who were admitted to hospitals for behavioral health treatment, including identification of the hospital and number of days the Member was hospitalized, the date that the Contractor contacted the hospital and began discharge planning, the date the discharge plan was completed, the date the Member was discharged and the location to which the Member was discharged.

Report Format: Excel

Report Due: Monthly

Report Description: Third Party Collections Report: The Contractor is required to report annually on the collections from other insurers and provide the information to the IDHW.

Report Format: Excel

Report Due: Annually

Report Description: Community Partners Report: The Contractor shall provide the IDHW a quarterly report that details activities conducted with community partners, as described in this RFP, and the resulting policies, processes and impacts to the Idaho Behavioral Health Plan.

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Report Format: Excel

Report Due: Quarterly

Report Description: Provider Roster Report: The Contractor shall provide the IDHW a quarterly report that lists the Member names and Member identification numbers of Members being served by each provider.

Report Format: Excel

Report Due: Quarterly

Report Description: Indian Health Services (IHS) Encounters Report: The Contractor shall provide the IDHW with a quarterly report of the number of encounters for behavioral health services at IHS locations and the difference between the Contractor's standard reimbursement for those services and the encounter rate.

Report Format: Excel

Report Due: Quarterly

Report Description: Bi-Annual Report: Bi-annually and upon request by the IDHW, in order to comply with Legislative or other inquiries, the Contractor shall provide a written report to the IDHW in order to summarize its progress, and efforts related to fulfilling contract requirements using measurable objectives whenever possible. The Contractor shall identify in the report a summary of its overall progress and identify at least all of the performance metrics requirements. When the customer satisfaction and provider satisfaction survey results are completed as required on an annual basis these will be included in the Bi-annual report which follows their completion. The bi-annual report will also include progress made toward any areas for improvement identified as necessary by the IDHW during the six (6) month period prior to the report, and any other progress identified by the Contractor with regard to contract policy, process and procedures. All recommended improvements should include how the issues will be resolved and implemented, including associated timeframes.

Report Format: Excel

Report Due: Bi-Annually: mid-July and mid-January

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APPENDIX D SPECIAL TERMS AND CONDITIONS

- I. DEFINITIONS. As used in the Contract, the following terms shall have the meanings set forth below:
- A. Contract shall mean the Contract Cover Sheet, these Special Terms and Conditions, State of Idaho Standard Contract Terms and Conditions, and all Attachments identified on the Contract Cover Sheet. The Contract shall also include any negotiated and executed amendment to the Contract or any task order negotiated, executed, and implemented pursuant to provisions of the Contract.
 - B. Contract Manager shall mean that person appointed by the IDHW to administer the Contract on behalf of the IDHW. "Contract Manager" includes, except as otherwise provided in the Contract, an authorized representative of the Contract Manager acting within the scope of his or her authority. The IDHW may change the designated Contract Manager from time to time by providing notice to Contractor as provided in the Contract.
 - C. IDHW shall mean the State of Idaho, Department of Health and Welfare, its divisions, sections, offices, units, or other subdivisions, and its officers, employees, and agents.
- II. CONTRACT EFFECTIVENESS. It is understood that this Contract or any Amendment is effective when it is signed by both parties, or at a later date if specified in the Contract or Amendment. The Contractor shall not render services to the IDHW until the Contract or Amendment has become effective. The IDHW will not pay for any services rendered prior to the effective date of the Contract or Amendment.
- III. REASSIGNMENT OF CONTRACTOR EMPLOYEES The IDHW shall have the right, after having consulted with the Contractor, to require the Contractor to reassign or otherwise remove from the contract any Contractor employee or subcontractor found in good faith to be unacceptable to the IDHW.
- IV. RECORDS AND DATA.
- A. Fiscal Records The Contractor shall maintain fiscal records, including its books, audit papers, documents, and any other evidence of accounting procedures and practices, which sufficiently and properly reflect all direct and indirect costs of any nature expended in the performance of the Contract.
 - B. Records Maintenance The Contractor shall maintain all records and documents relevant to the Contract for three (3) years from the date of final payment to Contractor. If an audit, litigation or other action involving records is initiated before the three (3) year period has expired, the Contractor shall maintain records until all issues arising out of such actions are resolved, or until an additional three (3) year period has passed, whichever is later.
 - C. Termination of Contract If the existence of the Contractor is terminated by bankruptcy or any other cause, all program and fiscal records related to the Contract in Contractor's possession shall become the property of the IDHW and Contractor shall immediately deliver such records to the Contract Manager.

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- D. Records Review All records and documents relevant to the Contract, including but not limited to fiscal records, shall be available for and subject to inspection, review or audit, and copying by the IDHW and other personnel duly authorized by the IDHW, and by federal inspectors or auditors. Contractor shall make its records available to such parties at all reasonable times, at either the contractor's principal place of business or upon premises designated by the IDHW.

V. CUSTOMER SERVICE.

- A. Telephone Contractors who have direct contact with the public in fulfilling this contract shall have their Member line as a published telephone number that is answered by a live voice twenty four (24) hours per day, seven (7) days per week, 365 days per year and is a toll-free line dedicated to Members. An additional toll-free phone line shall be made available for all other customer service calls. The contractor shall endeavor to return customer service calls telephone calls the same day, and shall respond to such calls not later than forty-eight (48) hours or two (2) business days after the initial contact, whichever is later.
- B. Correspondence Except for public records requests, the Contractor shall respond to written correspondence, including e-mail, within two (2) business days. The Contractor shall provide clear, understandable, timely and accurate written information to IDHW customers as required by this Contract.
- C. Policies The Contractor shall treat IDHW staff and customers with respect and dignity, and shall demonstrate a caring attitude to all who ask for assistance. Contractors shall have a written customer service policy that describes how customer service will be incorporated into policies and training.

VI. BINDING EFFECT OF FEDERAL PURCHASE OF SERVICE REGULATIONS. The Contract is subject to the provisions of any relevant federal regulations and any relevant provisions of agreements between the State of Idaho and the United States, including but not limited to State Plans, in effect at the time the Contract is executed, or which thereafter become effective. Such regulations and agreements are on file in the Central Office of the IDHW and are available for inspection by the Contractor during regular business hours.

VII. FEDERAL AND STATE AUDIT EXCEPTIONS. If a federal or state audit indicates that payments to the Contractor fail to comply with applicable federal or state laws, rules or regulations, the Contractor shall refund and pay to the IDHW any compensation paid to Contractor arising from such noncompliance, plus costs, including audit costs.

VIII. COMPLIANCE WITH CERTAIN LAWS.

- A. HIPAA The Contractor acknowledges that it may have an obligation, independent of this contract, to comply with the Health Insurance Portability and Accountability Act (HIPAA), Sections 262 and 264 of Public Law 104-191, 42 USC Section 1320d, and federal regulations at 45 CFR Parts 160, 162 and 164. If applicable, Contractor shall comply with all amendments to the law and federal regulations made during the term of the Contract.
- B. Lobbying
1. The Contractor certifies that none of the compensation under the Contract has been paid or will be paid by or on behalf of the Contractor to any person for influencing or attempting to influence an officer or employee of any governmental agency, a

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member, officer or employee of Congress or the Idaho Legislature in connection with the awarding, continuation, renewal, amendment, or modification of any contract, grant, loan, or cooperative agreement

2. If any funds, other than funds provided by the Contract, have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any governmental agency, a member, officer or employee of Congress or the State Legislature in connection with the Contract, the Contractor shall complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions, and submit a copy of such form to the IDHW.
 3. The Contractor shall require that the language of this certification be included in any subcontract, at all tiers, (including grants, subgrants, loans, and cooperative agreements) entered into as a result of the Contract, and that all sub-recipients shall certify and disclose as provided herein.
 4. The Contractor acknowledges that a false certification may be cause for rejection or termination of the Contract, subject Contractor to a civil penalty, under 31 U.S.C. § 1352, of not less than \$10,000.00 and not more than \$100,000.00 for each such false statement, and that Contractor's execution of the Contract is a material representation of fact upon which the IDHW relied in entering the Contract.
- C. Qualification The Contractor certifies to the best of its knowledge and belief that it and its principals:
1. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from performing the terms of the Contract by a government entity (federal, state or local);
 2. Have not, within a three (3) year period preceding the Contract, been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or contract under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
 3. Are not presently indicted for or otherwise criminally or civilly charged by a government entity (federal, state or local) with commission of any of the offenses enumerated in paragraph 2 of this certification; and
 4. Have not within a three (3) year period preceding the Contract had one or more public transactions (federal, state, or local) terminated for cause or default.
 5. The Contractor acknowledges that a false statement of this certification may be cause for rejection or termination of the Contract and subject Contractor, under 18 U.S.C. § 1001, to a fine of up to \$10,000.00 or imprisonment for up to 5 years, or both.
- D. Faith-Based Organization If the Contractor is a faith-based organization, the contractor and all approved subcontractors shall:

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1. Segregate contract funds in a separate account.
 2. Serve all members without regard to religion, religious belief, refusal to hold a religious belief, or refusal to actively participate in a religious practice.
 3. Ensure that IDHW-referred clients' participation in religious activities, including worship, scripture study, prayer or proselytization, is only on a voluntary basis.
 4. Notify members of the religious nature of the organization, their right to be served without religious discrimination, their right not to take part in religious activities, their right to request an alternative provider and the process for doing so.
 5. Ensure that contract funds are not expended on inherently religious activities.
 6. Comply with applicable terms of 42 CFR Parts 54, 54a, and 45 CFR Parts 260 and 1050.
- E. Tribes If the Contractor is a Tribe, the Contractor and IDHW recognize that services performed pursuant to this Contract by the Contractor and all approved subcontractors within reservation boundaries are subject to applicable laws, ordinances and regulations of the Tribe. Nothing in this Contract should be construed as a waiver of sovereign immunity.

XI. CONFLICT OF INTEREST.

- A. Public Official No official or employee of the IDHW and no other public official of the State of Idaho or the United States government who exercises any functions or responsibilities in the review or approval of the undertaking or carrying out of the Contract shall, prior to the termination of the Contract, voluntarily acquire any personal interest, direct or indirect, in the Contract or proposed Contract.
- B. Contractor The Contractor covenants that it presently has no interest and shall not acquire any interest, direct or indirect, that would conflict in any manner or degree with the performance of its services hereunder. The Contractor further covenants that in the performance of the Contract, no person who has any such known interests shall be employed.

XII. REMEDIES.

- A. Remedial Action Notwithstanding any conflicting provision in the State of Idaho Standard Contract Terms and Conditions, and in addition to any remedies available to the State under law or equity, the State may at its sole discretion require one (1) or more of the following remedial actions, taking into account the nature of the deficiency, if any, of the services or products that do not conform to Contract requirements: (1) require the Contractor to take corrective action to ensure that performance conforms to Contract requirements; (2) reduce payment to reflect the reduced value of services received; (3) require the Contractor to subcontract all or part of the service at no additional cost to the State; (4) withhold payment or require payment of actual damages caused by the deficiency; (5) withhold payment or require payment of an overpayment or duplicate payment; (6) withhold payment or require payment of liquidated damages, as more particularly set forth below; (7) secure products or services and deduct the costs of products or services from payments to the Contractor; or (8) terminate the Contract pursuant to section 2 of the State of Idaho Standard Contract Terms and Conditions. No

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remedy conferred by any of the specific provisions of the Contract is intended to be exclusive of any other remedy, and each and every remedy shall be cumulative and shall be in addition to every other remedy given hereunder, now or hereafter existing at law or in equity or by statute or otherwise. The election of any one or more remedies by either party shall not constitute a waiver of the right to pursue other available remedies.

- B. Liquidated Damages. The IDHW and Contractor agree that it will be extremely impractical and difficult to determine the actual damages that the IDHW will sustain in the event the Contractor fails to perform under the Contract. The State may, in its discretion, assess liquidated damages as more particularly set forth below.

It is the intent of the IDHW to monitor the Contractor's performance in a continuous and ongoing effort to ensure that all requirements are being met in full. The parties acknowledge that actual and consequential damages to the State arising from the failure of the Contractor to comply with the terms of the contract are uncertain and difficult to ascertain. The parties further acknowledge that delays in the Contractor's compliance with the terms of the contract will prevent the IDHW from satisfying certain federal requirements imposed upon the IDHW and that a longer delay or repeated delays by the Contractor are likely to give rise to an increase in the actual and consequential damages to the IDHW, the Contractor's provider network and Medicaid participants, whose health and well-being may be jeopardized. Specifically, the State may be subject to federal recoupment and litigation arising from the failure of the Contractor to satisfy its requirements under the contract and the amount of such damages are not possible to ascertain at the effective date of the contract. Due to the foregoing, the IDHW may, in its discretion, assess the liquidated damages as more particularly described below.

The parties agree that the liquidated damages specified in this section are reasonable. The IDHW shall notify the Contractor in writing of the assessment of liquidated damages, which can be cumulative. Withholding of payment by the IDHW or payment of liquidated damages by the Contractor shall not relieve the Contractor from its obligations under the Contract.

The Contractor shall not be liable for liquidated damages for a failure that results from an occurrence beyond its control. Failure to maintain staffing levels identified in the contract will not be considered an occurrence beyond the Contractor's control with the exception of failure due to acts of God or the public enemy, fires, floods, epidemics, quarantine, restrictions, strikes, or unusually severe weather. Matters of the Contractor's finances shall also not be an occurrence beyond its control.

The assessment of liquidated damages shall not constitute a waiver or release of any other remedy the IDHW may have under this Contract for Contractor's breach of this Contract, including without limitation, the IDHW's right to terminate this Contract, and the IDHW shall be entitled in its discretion to recover actual damages caused by Contractor's failure to perform its obligations under this Contract. However, the IDHW will reduce such actual damages by the amounts of liquidated damages received for the same events causing the actual damages. Amounts due the State as liquidated damages may be deducted by the IDHW from any money payable to Contractor under this Contract, or the IDHW may bill Contractor as a separate item therefor and Contractor shall promptly make payments on such bills.

1. **Performance Indicators**

- a) The IDHW reserves the right to monitor the performance of any aspect of the Contract, not just those elements identified in the Performance Indicators

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below. Each Performance Indicator has been assigned a classification of either “Critical” which must be performed at a level of 100%; “Essential” which must be performed at a level of 95%; and “Important” which must be performed at a level of 90%. The thresholds have been determined by the relationship of the Performance Criteria to the Idaho Behavioral Health Plan critical, essential and important standards.

- b) The chart of Performance Indicators below outlines areas that are subject to liquidated damages. Criteria are subject to change based on updated legal or policy mandates. The IDHW shall give the Contractor written notification ten (10) business days prior to any new criteria being added to the chart or any criteria existing in the chart being changed. Such ten (10) day period shall commence upon the date of mailing or electronic transmission of the notice. The IDHW shall maintain a current chart of Performance Indicators and shall provide a copy of the current chart to the Contractor upon written request.

RFP Scope of Work Section	Performance Indicators	Classification	Threshold
A	General Requirements (Pre-implementation and operations and deliverables)	Essential	95%
B	Administration and Operations	Essential	95%
C	Work Plan and Service Implementation	Essential	95%
D	Behavioral Health Services (Recovery oriented system of behavioral health care)	Essential	95%
E	Member Enrollment/Disenrollment	Essential	95%
F	Coverage and Payment for Post-Stabilization Services	Essential	95%
G	Access to Care	Critical	100%
H	Cultural Competency	Essential	95%
I	Customer Service System	Essential	95%
J	Provider Network Development and Management Plan	Essential	95%
K	Provider Network (Standards)	Critical	100%
L	Notification Requirements for Changes to the Network	Essential	95%
M	Provider Training and Technical Assistance	Critical	100%
N	Electronic Health Records	Important	90%
O	Management of Care (Care management and case management functions)	Critical	100%
P	Intake and Assessment	Essential	95%
Q	Treatment Planning/Self-determination & Choice	Essential	95%
R	Primary Care Interface: PCCM and Health	Essential	95%

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	Homes		
S	FQHC and RHC	Essential	95%
T	Indian Health Services	Essential	95%
U	Member Service Transitions	Essential	95%
V	EPSDT	Critical	100%
W	Complaint Resolution and Tracking System	Essential	95%
X	Member Grievances and Tracking System	Critical	100%
Y	Electronic System and Data Security	Critical	100%
Z	Website	Important	90%
AA	Member Information and Member Handbook	Essential	95%
BB	Member Protections/Liability for Payment	Critical	100%
CC	Provider Manual	Essential	95%
DD	Community Partnerships	Critical	100%
FF	Outcomes, Quality Assessment and Performance Improvement Program	Essential	95%
GG	Compliance and Monitoring (Utilization Management)	Essential	95%
II	Data Tracking and Utilization Information System	Critical	100%
KK	Disaster Recovery Plan	Critical	100%
LL	Reports/Records/Documentation	Critical	100%
MM	Contract Transition Plan	Essential	95%

2. **Objective Performance Criteria**

- a) The chart of Performance Indicators above outlines areas that are subject to liquidated damages. Criteria are subject to change based on updated legal or policy mandates. The IDHW shall give the Contractor written notification ten (10) business days prior to any new criteria being added to the chart or any criteria existing in the chart being changes. Such ten (10) day period shall commence upon the date of mailing or electronic transmission of the notice.
- b) If the Contractor considers any new criteria or changes to existing criteria to be a material change to the contract, it must notify the IDHW in writing within the ten (10) business day period set forth above. The Contractor's notice shall include an explanation identifying why it considers the new criteria or changes to be a material change to the contract. For the purpose of Performance Indicator criteria additions and changes, material changes shall be changes that affect the time, scope or cost of the contract. If the Contractor timely provided notification to the IDHW that the new criteria or changes to the Performance Indicator criteria are material, the parties will then negotiate in good faith to add the new criteria or to change existing criteria via written amendment to the contract.

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- c) If the Contractor does not prove notification to the IDHW that new or revised criteria are material within the (10) business days from receipt of written notification from the IDHW, the new criteria or changed criteria will become part of the contract without further action by the parties. The Contractor must comply with new criteria or changes to existing criteria within thirty (30) business days of them becoming part of the contract, whether by written amendment or by failure of the Contractor to provide notice of materiality.
- d) The table of Performance Indicators above is a summary chart of criteria for the performance of the Contractor subject to performance monitoring. Details for each performance indicator are provided in RFP sections identified in the aforementioned summary chart. Each criterion has been assigned a "threshold." Monitoring will determine if the Contractor is operating above or below the established threshold. If the finding is that the Contractor is operating below the established threshold, liquidated damages may be imposed. Liquidated damages will be based on the average amount of time the IDHW must invest to monitor the performance of the Contractor. The average amount of time required is then multiplied by the cost, to the IDHW, for the staff involved. As the Contractor's results continue to fall below the established thresholds, the number of people involved in monitoring performance is increased and the amount of liquidated damages is increased accordingly as illustrated in the table below.
- e) If the Contractor falls below the threshold for the first follow up monitoring, then level one (see table below) liquidated damages will be assessed as more particularly described below. The second (follow up) monitoring that does not meet established thresholds will result in assessment of level two (2) liquidated damages. Level three (3) liquidated damages will be assessed for failure to meet performance criteria for a third (3rd) time and for subsequent failures. Rates imposed upon the Contractor will be calculated using the then current employee and consultant costs established in the records of the State.

DAMAGES	QTY	UNIT		RATE RANGE EXAMPLE		PER DAY COSTS
Level One	1	Day	X	\$290.72-\$345.28	=	\$290.72-\$345.28
Level Two	1	Day	X	\$581.44-\$690.56	=	\$581.44-\$690.56
Level Three	1	Day	X	\$872.16-\$1035.84	=	\$872.16-\$1035.84

- f) The IDHW shall document and discuss liquidated damages with the Contractor prior to the issuance of notice of the imposition of liquidated damages. The Contractor will be notified in writing and the appropriate deduction will be made in the next monthly payment following the expiration of any applicable appeal deadline or other applicable cure or notice periods and in accordance with the contract requirements and limitations. If the next monthly payment is insufficient to fully recover liquidated damages, the IDHW may, in its discretion require full payment by the Contractor of the then

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outstanding liquidated damages or may continue recovering liquidated damages from future payments to the Contractor.

- g) Contractor's submission and the State's payment of an invoice reduced as set forth above shall not limit the remedies afforded to the State under law and pursuant to the Contract.

3. Monitoring Process

- a) The purpose of performance monitoring is to:
 - (1) Determine the degree to which state funded programs and activities are accomplishing their goals and objectives;
 - (2) Provide measurements of program results and effectiveness;
 - (3) Evaluate efficiency in the allocation of resources; and
 - (4) Assess compliance with the contract, laws, and regulations.

Failure to meet the thresholds established for performance monitors constitutes breach of the contract and will initiate remedial action.

- b) The IDHW will engage in ongoing contract monitoring, and this may include performance monitoring of the Contractor, This may include review of documentation as well as onsite monitoring at any operational facilities and business offices that handle any component of the Contract requirements for the Idaho Behavioral Health Plan.
- c) During any form of performance monitoring, the Contractor or any subcontractor or network provider will provide to IDHW any Member's medical records, behavioral health records, logbooks, staffing charts, time reports, claims data, administrative documents, complaints, grievances, and any other requested documents and data as requested when at the sole discretion of the IDHW it is determined to be required to assess the performance of the Contractor, a subcontractor or a network provider.
- d) If monitoring activities are conducted at a network provider location they will be conducted in a manner so as not to disrupt the provision of treatment to Members.
- e) Any monitoring performed, may or may not be scheduled in advance, and may last for several days.
- f) The performance level of the Contractor or a subcontractor or a network provider may affect the frequency of the monitors.
- g) The IDHW reserves the right to monitor any aspect of the contract, not just those elements identified in the Performance Indicators.
- h) Additionally, if the IDHW receives continual unresolved Member or provider network complaints regarding behavioral health service issues, the IDHW will initiate a focused monitoring of that area, utilizing at least one of the performance criteria listed in this document. The IDHW will then follow the reporting, cure period, and appeal process listed below.
- i) Areas in which performance deficiencies have been found may be followed continually, or subsequently re-examined as designated by the IDHW.

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- j) All monitoring is designed and will be performed in accordance with the following standards:
 - (1) Idaho Statutes
 - (2) Idaho Administrative Code
 - (3) Department of Health and Welfare Policies and Procedures
 - (4) SAMHSA guidelines
 - (5) Code of Federal Regulations
 - (6) National Accreditation Standards
 - (7) The RFP and current Idaho Behavioral Health Plan contract

- k) General requirements applicable to all Members will typically be assessed via a randomly selected data review of approximately ten percent (10%) sample of Member files at a provider location. Other requirements, relevant to a segment of the Member population, may be reviewed using a higher percentage, up to one hundred percent (100%) of the records of a sub-population. Areas in which performance deficiencies have been found may be re-examined in the subsequent quarter or follow up period, as designated by the IDHW, in order to gauge progress towards satisfactory performance.

4. **Monitoring Report and Appeal**

The IDHW Contract Monitor will issue a Monitoring Report to the Contractor that identifies in writing the performance indicator(s) monitored, and that summarizes the preliminary results with the Contractor. Upon request by the Contractor, the IDHW will meet with the Contractor within ten (10) business days of their receipt of the Monitoring Report regarding the results. The Contractor may dispute the findings via written appeal to the Contract Monitor within ten (10) business days of issuance of the report. The Contractor must specifically address each disputed finding and justification for the appeal of the finding. The Contractor is required to provide all documents necessary to dispute monitor results with its written appeal. The IDHW will render a final written decision on the appeal to the Contractor within ten (10) business days of receipt of the Contractor's dispute information, unless the parties agree in writing to extend the decision period.

5. **Breach Cure Period**

If the Contractor does not dispute the findings, the Contractor shall have ten (10) business days from the date of the IDHW's monitoring report to cure the deficiencies found by the IDHW. If the Contractor appeals the monitoring report, the Contractor shall have ten (10) business days from the date of the IDHW's final written decision to cure the deficiencies. If the IDHW is not satisfied that the Contractor has resolved the deficiencies, or made substantial progress toward resolution, the IDHW may assess the amounts listed above as liquidated damages for each day the deficiency remains uncured.

- C. Termination for Convenience The IDHW or the Contractor may cancel the Contract at any time, with or without cause, upon one-hundred eighty (180) calendar days written notice to the other party specifying the date of termination.

- D. Effect of Termination Upon termination by the IDHW, Contractor shall: (a) promptly discontinue all work, unless the termination notice directs otherwise; (b) promptly return to the IDHW any property provided by the IDHW pursuant to the Contract; and, (c) deliver or otherwise make available to the IDHW all data, reports, estimates, summaries and such

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other information and materials as may have been accumulated by Contractor in performing the Contract, whether completed or in process. Upon termination by the IDHW, the IDHW may take over the services and may award another party a contract to complete the services contemplated by the Contract. Upon termination for cause, the IDHW shall be entitled to reimbursement from Contractor for losses incurred as a result of the Contractor's breach.

- E. Survival of Terms Any termination, cancellation, or expiration of the Contract notwithstanding, provisions which are intended to survive and continue shall survive and continue, including, but not limited to, the provisions of these Special Terms and Conditions, Sections IV (Records and Data), VII (Federal and State Audit Exceptions), VIII (Compliance with Certain Laws), and the State of Idaho General Terms and Conditions, Sections 9 (Contract Relationship) and 12 (Save Harmless).

XIII. MISCELLANEOUS.

- A. Disposition of Property At the termination of the Contract, Contractor shall comply with relevant federal and state laws, rules and regulations and with federal OMB Circulars concerning the disposition of property purchased wholly or in part with funds provided under the Contract.
- B. Time of Performance Time is of the essence with respect to the obligations to be performed under the Contract; therefore, the parties shall strictly comply with all times for performance.
- C. Headings The captions and headings contained herein are for convenience and reference and are not intended to define or limit the scope of any provision of the Contract.

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APPENDIX E RIDERS

Insurance

For the term of the Contract and until all services specified in the Contract are completed, Contractor shall maintain in force, at its own expense, the following insurance.

Commercial General Liability Insurance and, if necessary, Commercial Umbrella Liability Insurance with a limit of not less than one million dollars (\$1,000,000) each occurrence. Insurance required by this section shall name the State of Idaho, Department of Health and Welfare as an additional insured.

Business Automobile Liability Insurance and, if necessary, Umbrella Liability Insurance with a limit of not less than one million dollars (\$1,000,000) each accident. Insurance required by this section shall name the State of Idaho, Department of Health and Welfare as an additional insured.

Professional Liability Insurance with a limit of not less than one million dollars (\$1,000,000) each occurrence.

Workers' Compensation Insurance which includes Employer Liability Insurance and shall comply with Idaho Statutes regarding Workers' Compensation in the amount of: \$100,000 per accident; \$500,000 disease policy limit; and \$100,000 disease, each employee.

Provide either a certificate of worker's compensation insurance issued by a surety licensed to write worker's compensation insurance in the State of Idaho, as evidence that the contractor has in effect a current Idaho worker's compensation insurance policy, or an extraterritorial certificate approved by the Idaho Industrial Commission from a state that has a current reciprocity agreement with the Industrial Commission prior to the contract being issued.

Prior to performing any services, Contractor shall provide certificates of insurance to the IDHW. The Contractor is also required to maintain current certificates on file with the IDHW and to provide updated certificates upon request. Failure to provide the required certificates of insurance shall constitute a default under this Contract and upon such failure the IDHW may, at its option, terminate the Contract. Insurance required by this section shall be policies or contracts of insurance issued by insurers approved by the IDHW. Insurance certificates shall provide for thirty (30) days' prior written notice to the IDHW of cancellation or material change of such insurance.

Contractor shall further ensure that all policies of insurance are endorsed to read that any failure to comply with the reporting provisions of this insurance, except for the potential exhaustion of aggregate limits, shall not affect the coverage(s) provided to the State of Idaho, Department of Health and Welfare.

Ownership of Information

The IDHW and the United States Department of Health and Human Services shall have unlimited rights to own, possess, use, disclose, transfer, or duplicate all information and data, copyrighted or otherwise, developed, derived, documented or furnished by the Contractor under the Contract.

Certification Regarding Environmental Tobacco Smoke

The Pro-Children Act of 1994 (20 U.S.C. § 6081-84) prohibits smoking in facilities, or in some cases portions of facilities, where certain federally funded services are provided on a routine or regular basis for

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children under the age of 18. The Act applies if funds are being provided through an applicable federal grant, loan, loan guarantee, or contract.

The law applies to public elementary and secondary education and library facilities. It also applies to facilities used for the Head Start program, the WIC program (the supplemental food and nutrition program for women and children), and certain health care services for children.

The smoking prohibition does not apply to private residences, to service providers whose sole source of federal funds is Medicare or Medicaid, or to portions of facilities used for inpatient treatment of individuals who are dependent on or addicted to drugs or alcohol.

Civil money penalties, not exceeding \$1000 for each day of violation, not exceeding the amount of applicable federal funds received, may be imposed for non-compliance. Also, federal funds may be withheld or the award may be terminated. Recipients must certify, as a condition for receiving applicable federal funds, that smoking will not be permitted within facilities, or portions of facilities, covered by the Act.

By signing the Contract, the Contractor certifies that it will comply with the requirements of the Act, and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The Contractor shall include the language of this certification in any subcontract that contains provisions for children's services and shall ensure that all subcontractors shall certify accordingly.

Criminal History Background Checks

IDAPA 16.05.06 Rules Governing Mandatory Criminal History Checks -- These rules have been established to assist in the protection of children and vulnerable adults by requiring criminal history checks for individuals (Contractors, Contractor's employees and all subcontractors) who provide care or service that are financially supported, licensed or certified by the Idaho Department of Health and Welfare.

Contractors, Contractor's employees and all subcontractors are required to complete a criminal history and background check pursuant to IDAPA 16.05.06. Those who have had a fingerprint based criminal history background check through their employment with the Idaho Department of Education, or their employment as a law enforcement officer may be exempt from the fingerprint based check; however, the Contractor must complete at a minimum, an Idaho name based check through the Idaho State Police.

For information on how to obtain a Idaho Department of Health and Welfare criminal history and background check, please go to the IDHW's criminal history check website at <http://chu.dhw.idaho.gov> or call 1-800-340-1246.

Business Associate Agreement

Specific obligations and activities of Contractor to protect confidential information in accord with HIPAA privacy and security requirements in compliance with 45 CFR § 164.504(e).

Contractor agrees to not use or disclose confidential information other than as permitted or required by the Contractor as required by law.

Contractor agrees to use appropriate safeguards to prevent use or disclosure of confidential information other than as provided for by this contract.

Contractor agrees to mitigate, to the extent practicable, any harmful effect that is known to Contractor of a use or disclosure of confidential information by Contractor in violation of the requirements of this contract.

Contractor agrees to report to the IDHW any use or disclosure of confidential information not provided for by this

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contract of which it becomes aware.

Contractor agrees to ensure that any agent, including a subcontractor, to whom it provides confidential information received from, or created or received by the Contractor on behalf of the IDHW, agrees to the same restrictions and conditions that apply through this contract to Contractor with respect to such information.

Contractor agrees to provide access, at the request of IDHW, and in the time and manner as directed by IDHW, to an individual in order to meet the requirements under 45 CFR § 164.524.

Contractor agrees to make any amendment(s) to confidential information that the IDHW directs or agrees to pursuant to 45 CFR § 164.526 at the request of IDHW or an individual.

Contractor agrees to make internal practices, books, and records, including policies and procedures relating to the use and disclosure of confidential information received from, or created or received by Contractor on behalf of the IDHW available to the Secretary of Health and Human Services, in a time and manner designated by the Secretary, for purposes of the Secretary determining IDHW's compliance with the Privacy Rule.

Contractor agrees to document any disclosures of confidential information and information related to such disclosures as would be required for IDHW to respond to a request by an individual for an accounting of disclosures of confidential information in accordance with 45 CFR § 164.528.

Contractor agrees to provide to IDHW or an individual information collected in accordance with this contract, to permit IDHW to respond to a request by an individual for an accounting of disclosures of confidential information in accordance with 45 CFR § 164.528.

Permitted Uses and Disclosures by Contractor

Except as otherwise limited in this contract, Contractor may use or disclose confidential information to perform functions, activities, or services for, or on behalf of, IDHW as specified in the scope of work provided that such use or disclosure would not violate the privacy or security rule if done by IDHW or the minimum necessary policies and procedures of the IDHW.

Contractor may use protected health information to report violations of law consistent with 45 CFR § 164.502(J) (1).

Obligations of IDHW

IDHW shall notify Contractor of any limitation(s) in its notice of privacy practices of IDHW in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Contractor's use or disclosure of confidential information.

IDHW shall notify Contractor of any changes in, or revocation of, permission by an individual to use or disclose confidential information, to the extent that such changes may affect Contractor's use or disclosure of confidential information.

IDHW shall notify Contractor of any restriction to the use or disclosure of confidential information that IDHW has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Contractor's use or disclosure of confidential information.

Permissible Requests by IDHW

IDHW shall not request Contractor to use or disclose confidential information in any manner that would not be permissible under the privacy or security rule if done by IDHW.

Action upon Termination of the Contract

Upon termination of this contract, for any reason, Contractor shall return or destroy all confidential information received from IDHW, or created or received by Contractor on behalf of IDHW.

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In the event that Contractor determines that returning or destroying the confidential information is infeasible, Contractor shall notify the IDHW of the conditions that make return or destruction infeasible. If the IDHW agrees that return or destruction of confidential information is infeasible, Contractor shall extend the protections of this contract to such confidential information and limit further uses and disclosures of such confidential information to those purposes that make the return or destruction infeasible, for so long as Contractor maintains such confidential information.

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ATTACHMENT 1 OFFEROR QUESTIONS

PLEASE DO NOT IDENTIFY YOUR NAME OR YOUR COMPANY'S NAME OR PRODUCT NAMES OF INTELLECTUAL PROPERTY IN YOUR QUESTIONS.

ADD ROWS BY HITTING THE TAB KEY WHILE WITHIN THE TABLE AND WITHIN THE FINAL ROW.

The following instructions must be followed when submitting questions using the question format on the following page.

DO NOT CHANGE THE FORMAT OR FONT. Do not bold your questions or change the color of the font.

Enter the RFP section number that the question is for in the "RFP Section" field (column 2). If the question is a general question not related to a specific RFP section, enter "General" in column 2. If the question is in regards to a State Term and Condition or a Special Term and Condition, state the clause number in column 2. If the question is in regard to an attachment, enter the attachment identifier (example "Attachment A") in the "RFP Section" (column 2), and the attachment page number in the "RFP page" field (column 3).

Do not enter text in column 5 (Response). This is for the State's use only.

Once completed, this form is to be e-mailed per the instructions in the RFP. The e-mail subject line is to state the RFP number followed by "Questions."

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Idaho Behavioral Health Plan

Question	RFP Section	RFP Page	Question	Response
1				
2				
3				
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ATTACHMENT 2 REFERENCES (E)

INSTRUCTIONS TO THE OFFEROR:

Offerors are allowed three (3) completed reference questionnaires. The completed reference questionnaires must be from state Medicaid agencies with knowledge of the offeror's experience providing Medicaid behavioral health managed care services, and the services have been provided within the last three (3) years from the date this RFP was posted to IPRO.

References not received prior to the RFP Closing Date and time will receive a score of "0" for that reference. References outside the three (3) years, and references determined to be from entities or agencies not providing Medicaid behavioral health managed care services, as requested by this RFP, will also receive a score of zero (0) points. **Determination of similar will be made by using the information provided by the reference in Section II of the Reference Questionnaire, General Information and any additional information provided by the reference.**

If more than three (3) qualifying references are received, the first three (3) fully completed references received will be used for evaluation purposes. References will be averaged.

1. Offerors must complete the following information on page 2 of the "Reference's Response To" document before sending it to the Reference for response.
 - a. Print the name of your reference (company/organization) on the "REFERENCE NAME" line.
 - b. Print the name of your company/organization on the "OFFEROR NAME" line.
 - c. Enter the RFP Closing date and time in Instruction 5 (see the INSTRUCTIONS block.)
2. Send the "Reference's Response To" document to your references to complete.

NOTE: It is the offeror's responsibility to follow up with their references to ensure timely receipt of all questionnaires. Offerors may e-mail the RFP Lead prior to the RFP closing date to verify receipt of references.

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REFERENCE QUESTIONNAIRE
REFERENCE'S RESPONSE TO:
RFP Number: IPRO Sicomm.net RFP02482
RFP Title: Idaho Behavioral Health Plan

REFERENCE NAME (Company/Organization): _____

OFFEROR (Vendor) NAME (Company/Organization): _____ has submitted a proposal to the State of Idaho, Department of Health and Welfare, Division of Medicaid, to provide the following services: Medicaid managed behavioral health care services (RFP Title: Idaho Behavioral Health Plan). We've chosen you as one of our references.

INSTRUCTIONS

1. Complete **Section I. RATING** using the Rating Scale provided.
2. Complete **Section II. GENERAL INFORMATION** (*This section is for information only and will not be scored.*)
3. Complete **Section III. ACKNOWLEDGEMENT** by manually signing and dating the document. (*Reference documents must include an actual signature.*)
4. E-mail or fax **THIS PAGE** and your completed reference document, **SECTIONS I through III** to:

RFP Lead: Mary Jepsen – Purchasing Officer
State of Idaho, Division of Purchasing
E-mail: mary.jepsen@adm.idaho.gov
Phone: 208-332-1607
Fax: 208-327-7320

5. This completed document **MUST** be received no later than **12/5/12** at **5:00** p.m. (Mountain Time). Reference documents received after this time will not be considered. **References received without an actual signature will not be accepted.**
6. DO **NOT** return this document to the Offeror (Vendor).
7. In addition to this document, the State may contact references by phone for further clarification if necessary.

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Section I. RATING

Using the Rating Scale provided below, rate the following numbered items by circling the appropriate number for each item:

Category	Score
Poor or Inadequate Performance	0
Below Average	1 – 3
Average	4 – 6
Above Average	7 - 9
Excellent	10

Circle **ONE** number for each of the following numbered items:

1. Rate the overall quality of the vendor's services:

10 9 8 7 6 5 4 3 2 1 0

2. Rate the response time of this vendor:

10 9 8 7 6 5 4 3 2 1 0

3. Rate how well the agreed upon, planned schedule was consistently met and deliverables provided on time. *(This pertains to delays under the control of the vendor):*

10 9 8 7 6 5 4 3 2 1 0

4. Rate the overall customer service and timeliness in responding to customer service inquiries, issues and resolutions:

10 9 8 7 6 5 4 3 2 1 0

5. Rate the knowledge of the vendor's assigned staff and their ability to accomplish duties as contracted:

10 9 8 7 6 5 4 3 2 1 0

6. Rate the accuracy and timeliness of the vendor's billing and/or invoices:

10 9 8 7 6 5 4 3 2 1 0

7. Rate the vendor's ability to quickly and thoroughly resolve a problem related to the services provided:

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10 9 8 7 6 5 4 3 2 1 0

8. Rate the vendor's flexibility in meeting business requirements:

10 9 8 7 6 5 4 3 2 1 0

9. Rate the likelihood of your company/organization recommending this vendor to others in the future:

10 9 8 7 6 5 4 3 2 1 0

Section II. GENERAL INFORMATION

1. Please include a brief description of the Medicaid managed behavioral health care services provided by this vendor for your business:

2. During what time period did the vendor provide these services for your business?

Month:_____ Year:_____ to Month:_____ Year:_____

Section III. ACKNOWLEDGEMENT

I affirm to the best of my knowledge that the information I have provided is true, correct, and factual:

Signature of Reference

Date

Print Name

Title

Phone Number

E-mail address

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ATTACHMENT 3 DEFINITIONS

Action	Action means the denial or limited authorization of a requested service; termination, suspension, or reduction of a previously authorized service, the denial in whole or in part of a payment for service; or the failure to act upon a request for services in a timely manner.
Administration (Administrative Costs)	Includes, but is not limited to, start up costs, operating and personnel expenses, such as salaries, profit, supplies, travel, quality improvement; recruiting, enrolling, and maintaining a behavioral health provider network; hiring, training, and maintaining sufficient staff to implement, administer, and manage the Idaho Behavioral Health Plan; verifying eligibility for Members and providers; claims processing and prior authorization of services when required; maintaining and reporting claims data; monitoring claims and reporting patterns of potential overutilization, fraud, and abuse to the IDHW; providing Customer Service for Members and providers; paying providers; and participating in the IDHW's Appeal and Fair Hearing processes when required by the IDHW. For the purposes of the managed care model of service delivery all aspects of case management and care management are also included as administrative costs.
Adverse Determination	An admission, availability of care, continued stay, or other health care service that has been reviewed, and based upon the information provided, does not meet requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service is therefore denied, reduced, suspended, delayed, or terminated.
Americans with Disabilities Act of 1990 (ADA)	The Americans with Disabilities Act prohibits discrimination against people with disabilities in employment, transportation, public accommodation, communications, and governmental activities. The ADA also establishes requirements for telecommunications relay services.
Appeal	Appeal means a clear expression by the Member, or the Member's authorized representative, following a decision by the Contractor, that the Member wants the opportunity to present his or her case to the IDHW.
Assessment	A process that integrates information from various sources, including test information when available; a process for evaluating behavior, psychiatric constructs, and/or characteristics of individuals for the purpose of making decisions regarding classification, selection, placement, diagnosis, or intervention.
Capitated Payment	A monthly payment to the Contractor on behalf of each Member for the provision of behavioral health services under this contract. Payment is made regardless of whether the Member receives services during the month.

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CAFAS/PECFAS	The Child and Adolescent Functional Assessment Scale ® (CAFAS) is a standardized tool used for assessing a youth's day-to-day functioning across critical life subscales and for determining whether a youth's functioning improves over time. The CAFAS is for school-age children, kindergarten through the 12 th grade or ages 5 to 17 years old. The Pre-school and Early Childhood Functional Assessment Scale® (PECFAS) is for children of pre-school age, 4 to 7 years-old, or who have psychosocial delays. Idaho Medicaid uses the tool to establish eligibility criteria for rehabilitative behavioral health services. http://www.fas.outcomes.com/
Care Management	Care management is the overall system of medical and psychosocial management encompassing, but not limited to: utilization management, care coordination, discharge planning following restrictive levels of care, continuity of care, care transition, quality management, service verification.
Case Management	Case Management is a collaborative process of planning, facilitation, and advocacy for options and services to meet a Member's needs through communication and available resources to promote high quality, cost-effective outcomes. Qualified staff provides Case Management services to assist Members in gaining timely access to the full range of needed services.
Centers for Medicare and Medicaid Services (CMS)	The agency within the U.S. Department of Health and Human Services that provides administration and funding for Medicare under Title XVIII, Medicaid under Title XIX, and the Children's Health Insurance Program under Title XXI of the Social Security Act. This agency was formerly known as the Health Care Financing Administration (HCFA).
CHIP	The Children's Health Insurance Program was created in 1997 by Title XXI of the Social Security Act.
Claim	A request for payment for benefits received or services rendered.
Clean Claim	A claim that has no defect or impropriety (including any lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim. It does not include a claim from a provider who is under investigation for fraud or abuse or a claim under review for medical necessity.
Code of Federal Regulations (CFR)	The CFR is the codification of the general and permanent rules published in the Federal Register by the executive IDHWs and agencies of the Federal Government. It can be found at: http://ecfr.gpoaccess.gov/cgi/t/text/textidx?c=ecfrandtpl=%2Findex.tpl
Complaint (General)	A General Complaint is considered to be an expression of dissatisfaction logged by a participant, a participant's authorized representative or a provider concerning the administration of the plan and services received. Actions subject to a General Complaint include, at a minimum, dissatisfaction with the benefit plan, a provider, a participant, or the way in which the Contractor or subcontractor administers the plan. The contractor has sole responsibility for resolving and tracking General Complaints.
Continuum of Care	A comprehensive spectrum of services organized into a coordinated and

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	integrated network to meet the multiple and changing needs of emotionally and behaviorally challenged children and their families and adults. It is essential that all providers support and are connected with local community partners, including family-run organizations, youth support groups, and natural helpers such as faith-based organizations to ensure continuity of services and appropriate aftercare supports.
Co-Occurring Disorders (COD)	The presence of mental and addictive disorders. Members said to have COD have one or more addictive disorders as well as one or more mental disorders.
Core Services	The essential services necessary to provide triage level of screening, assessment, and initial treatment for behavioral health issues.
Corrective Action Plan (CAP)	A plan designed to ameliorate an identified deficiency and prevent recurrence of that deficiency. The CAP outlines all steps/actions and timeframes necessary to address and resolve the deficiency.
CPT®	Current Procedural Terminology®, current version, is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. DHHS designated the CPT code set as the national coding standard for physician and other health care professional services and procedures under HIPAA.
Credentialing	The Contractor's process for verifying and monitoring providers' licensure, liability insurance coverage, liability claims, criminal history and Drug Enforcement Administration (DEA) status. ID Code § 56-255 requires behavioral health agencies to be nationally accredited.
Crisis	A crisis is a sudden or unexpected behavior in a person that indicates the presence of acute psychiatric symptoms and the need for immediate action by a psychiatrist or members of an interdisciplinary team. Acute psychiatric symptoms include suicidal thoughts, threats or attempts; active delusions; active hallucinations; fugue states; threats of harm to self or others; violence; and sudden changes in mental status.
Cultural Competence	The U.S. Department of Health and Human Services, Office of Minority Health defines cultural and linguistic competence as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. "Culture" refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups. "Competence" implies having the capacity to function effectively as a participant and an organization within the context of the cultural beliefs, behaviors, and needs presented by Members and their communities. Cultural affiliations may include, but are not limited to race, preferred language, gender, disability, age, religion, deaf and hard of hearing, sexual orientation, homelessness, and geographic location. The requirements for cultural competency are described at 42 CFR §438.206(c)(2).
Denied Claim	A claim for which no payment is made to the network agency by the Contractor for any of several reasons, including but not limited to, the claims

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	is for non-covered services, the agency or Member is ineligible, the claims is a duplicate of another transaction, or the claim has failed to pass a significant requirement (or edit) in the claims processing system.
Department of Health and Human Services (DHHS)	The U.S. government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. DHHS provides oversight for more than 300 programs, covering a wide spectrum of activities, including medical and social science research; preventing outbreaks of infectious diseases; assuring food and drug safety; over-seeing Medicaid, Medicaid, and CHIP; and providing financial assistance for low-income families.
Drug Testing	Drug testing involves a urinalysis to detect the presence of alcohol or drugs in the Member.
Duplicate Claim	A claim that is either a total or a partial duplicate of services previously paid.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	A federally-required Medicaid benefit for individuals under the age of 21 years that expands coverage for children and adolescents beyond adult limits to ensure availability of: 1) screening and diagnostic services to determine physical or mental defects and 2) health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered (45 CFR § 440.40(b)). EPSDT requirements help ensure access to all medically necessary health care services within the federal definition of "medical assistance".
Electronic Health Record	A computer-based record containing health care information. This technology, when fully developed, meets provider needs for real-time data access and evaluation in medical care. Implementation increases the potential for more efficient care, speedier communication among agencies, and management of managed care organizations.
Encounter Data	Records of medically-related services rendered by an agency to a PAHP Member on a specified date of service. This data is inclusive of all services for which the PAHP has any financial liability to an agency.
Enrollee	As used in this RFP, an enrollee means a Medicaid Member who is enrolled in the Idaho Medicaid Management Information System (MMIS) and does not belong to an excluded population.
Evidence-Based Practice	The U.S. Department of Health and Human Services defines an evidence-based practice as one in which strategies supported by scientific research are identified, assessed, and implemented. Evidence-based interventions have demonstrated positive outcomes in several research studies to assist individuals in achieving their desired goals of health and wellness.
Federal Financial Participation (FFP)	Also known as federal match or the percentage of federal matching dollars available to a state to provide Medicaid and CHIP services. The Federal Medical Assistance Percentage (FMAP) is calculated annually based on a formula designed to provide a higher federal matching rate to states with lower per capita income.

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Federally Qualified Health Center (FQHC)	An entity that receives a grant under Section 330 of the Public Health Service Act, as amended to provide primary health care and related diagnostic services to individuals on a sliding fee schedule. The FQHC may also provide dental, optometric, podiatry, chiropractic, and behavioral health services.
Fiscal Year (FY)	The term refers to the budget year. The federal fiscal year (FFY) is October 1 through September 30. The State fiscal year (SFY) is July 1 through June 30.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or State law. Fraud may include deliberate misrepresentation of need or eligibility, providing false information concerning costs or conditions to obtain reimbursement or certification, or claiming payment for services which were never delivered or received.
GAIN®	The Global Appraisal of Individual Needs ® is an integrated series of measures and computer applications designed to support a number of treatment practices, including initial screenings; brief interventions; referrals; standardized clinical assessments for diagnosis, placement, and treatment planning; monitoring of changes in clinical status, service utilization, and costs; and subgroup- and program-level needs assessment and evaluation. http://www.chestnut.org/Li/gain/index.html
Grievance	Grievance means an expression of dissatisfaction challenging the Contractors action
Healthcare Effectiveness Data and Information Set (HEDIS)	HEDIS is a set of performance measures developed by the National Committee for Quality Assurance (NCQA). The measures were designed to help health care purchasers understand the value of health purchases and measure plan (e.g., PAHP) performance.
HIPAA	Health Insurance Portability and Accountability Act
ICD-9-CM ®	International Classification of Diseases, Revision, 9 th Clinical Modification® identifies diagnoses. The Contractor shall move to the ICD-10-CM as it becomes effective.
IDHW	The Idaho Department of Health and Welfare
Idaho Administrative Procedures Act (IDAPA)	Idaho Administrative Code refers to the administrative rules governing the IDHW. IDHW rules are contained in IDAPA 16, and can be found at: http://adm.idaho.gov/adminrules/rules/idapa16/16index.htm
Medicaid	A means tested federal-state entitlement program enacted in 1965 by Title XIX of the Social Security Act. Medicaid offers federal matching funds to states for costs incurred in paying health care providers for serving eligible individuals.
Medicaid Management	Mechanized claims processing and information retrieval system that all

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Information System (MMIS)	Medicaid programs are required to have and must be approved by the Secretary of DHHS. This system pays claims for Medicaid services and includes information on all Medicaid providers and enrollees.
Medicare	The federal medical assistance program in the United States, authorized in 1965 by Title XVIII of the Social Security Act, to address the medical needs of U.S. citizens 65 years of age and older and some people with disabilities under the age of 65.
Member	A Medicaid recipient who is subject to mandatory enrollment or is currently enrolled in the Contractor's coverage under the contract for the Idaho Behavioral Health Plan. 42 CFR § 438.10(a).
Member Bill of Rights	The Members' Bill of Rights is itemized at 42 CFR §438.100
Network	As used in this RFP, "network" is a group of participating behavioral health agencies and individual practitioners linked through contractual arrangements to the PAHP to supply a range of behavioral health care services. The term "provider network" is also used.
Network Adequacy	Refers to the network of behavioral health care providers for the PAHP (whether in-or out-of-network) that is sufficient in numbers and types of providers to ensure that all services are accessible to Members without unreasonable delay. Adequacy is determined by a number of factors, including, but not limited to, agency/Member ratios, geographic accessibility and travel distance, waiting times for appointments, and hours of agency operations.
Notice	Notice means a written statement of the action the Contractor has taken or intends to take, the reasons for the action, the Member's right to file a Grievance and request a fair hearing with the IDHW, and the procedures for exercising that right.
Notice of Action	Notification of the Member by the Contractor, of the action they have taken or intend to take regarding denial or limit of authorization of a requested service; termination, suspension, or reduction of a previously authorized service; the denial, in whole or in part, of a payment for service; or the failure to act upon a request for services in a timely manner.
Performance Improvement Projects (PIPs)	Projects to improve specific quality performance measures through ongoing measurements and interventions that result in significant improvement, sustained over time, with favorable effects on health outcomes and Member satisfaction.
Performance Measures	Performance measures are specific, operationally defined performance indicators that utilize data to track performance, quality of care, and to identify opportunities for improvement in care and services.
Per Member Per Month (PMPM) Rate	The PMPM rate paid to the Contractor for the provision of behavioral health services to enrolled Members. PMPM refers to the amount of money paid or received on a monthly basis for each enrolled Member.
Post-stabilization	In accordance with 42 CFR §438.114(a), post- stabilization services are

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Services	covered services related to an emergency medical condition, that are provided after an enrollee is stabilized in order to maintain, improve, or resolve the Member's stabilized condition.
Practitioner	As used in this RFP, an individual who is qualified to provide behavioral health services within the scope of his or her practice and licensure and/or certification and in accordance with state and federal regulations.
Prepaid Ambulatory Health Plan (PAHP)	In accordance with 42 CFR § 438.2, a PAHP is an entity that: Provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and Does not have a comprehensive risk contract.
Primary Care Services	Health care and laboratory services customarily furnished by, or through, a primary care provider (PCP) for diagnosis and treatment of acute and chronic illnesses, disease prevention and screening, health maintenance, and health promotion, either by the PCP or through appropriate referral to specialists and/or ancillary providers.
Primary Care Provider (PCP)	An individual physician, licensed nurse practitioner, or licensed practitioner of the healing arts (a licensed physician, physician assistant, nurse practitioner, or clinical nurse specialist; the nurse practitioner and clinical nurse specialist must have experience prescribing medications for psychiatric disorders) responsible for the management of a Member's health care, who is licensed and certified in one of the following general specialties: family practice, pediatrics, internal medicine and pediatrics, or obstetrics/gynecology. The PCP is the Member's point of access for preventive care or an illness and may treat the Member directly, refer the Member to a specialist (secondary/tertiary care), or admit the Member to a hospital.
Professional Standards/ Industry Standards	The generally accepted requirements followed by the members of an industry and the ethical or legal duty of a professional to exercise the level of care, diligence, and skill prescribed in the code of practice of his or her profession, or as other professionals in the same discipline would in the same or similar circumstances.
Protected Health Information (PHI)	Individually-identifiable health information that is maintained or transmitted in any form or medium and for which conditions for disclosure are defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 45 CFR §160 and 164.
Quality	As it pertains to the independent assessor's quality review, the degree to which the Contractor increases the likelihood of desired health outcomes of its Members through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.

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Quality Management (QM)	<p>The ongoing process of assuring that the delivery of covered services is appropriate, timely, accessible, available, medically necessary, in keeping with established guidelines and standards, and reflective of the current state of medical and behavioral health knowledge.</p>
Readiness Review	<p>This term refers to the two (2) phase process where the IDHW assesses the Contractor's ability to fulfill the requirements of the Contract through confirmation of the work described in the Attachment 9 – Initial Deliverables and Attachment 10 – Readiness Review. Such review may include, but is not limited to, review of proper licensure, operational protocols, Contractor standards, and systems. The review may be completed as a desk review, on-site review, or combination of the two, and may include interviews with pertinent personnel so that the IDHW can make an informed assessment of the Contractor's ability and readiness to render services.</p>
SAMHSA	<p>Substance Abuse and Mental Health Services Administration</p>
Screening	<p>Screening is a systematic examination or assessment, using a standardized tool, to determine the existence of certain physical or mental illnesses or conditions or addiction disorders.</p>
Second Opinion	<p>Subsequent to an initial medical opinion, a second opinion is an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally recommending a proposed health service, to assess the clinical necessity and appropriateness of the initial proposed health service.</p>
Serious Mental Illness (SMI)	<p>In accordance with 42 CFR § 483.102(b)(1), a person with SMI: Currently or at any time during the year, has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified in the DSM-IV-TR; and Has a functional impairment that substantially interferes with or limits one (1) or more major life activities. Functional impairment is defined as difficulties that substantially interfere with or limit role functioning with an individual's basic daily living skills, instrumental living skills, and functioning in social, family, vocational or educational contexts. Instrumental living skills include maintaining a household, managing money, getting around the community, and taking prescribed medication. An adult who met the functional impairment criteria during the past year without the benefit of treatment or other support services is considered to have a serious mental illness.</p>
Serious and Persistent Mental Illness (SPMI)	<p>In order to be considered as having a SPMI, a Member must have a medically documented history, over a period of at least 1 year, of the existence of a serious and persistent mental disorder. The diagnosis must meet the following criteria: The evidence shows that continuing treatment , psychosocial support(s), or a highly structured setting diminishes the symptoms and signs of the mental disorder. The evidence shows that the Member has achieved only marginal adjustment despite their diminished symptoms and signs. "Marginal adjustment" means that that the Member's adaptation to the requirements of daily living and their environment is fragile; that is, they have minimal</p>

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	<p>capacity to adapt to changes in their environment or to demands that are not already part of their daily life.</p> <p>Changes or increased demands would likely lead to an exacerbation of their symptoms and signs and to deterioration in their functioning; for example, they would be unable to function outside a highly structured setting or outside their home.</p> <p>Similarly, because of the nature of their mental disorder, they could experience episodes of deterioration that require them to be hospitalized or absent from work, making it difficult for them to sustain work activity over time.</p> <p>Definition taken from: Federal Register/Vol. 75, No. 160/Thursday, August 19, 2010/Proposed rules</p>
<p>Serious Emotional Disturbance (SED)</p>	<p>An emotional or behavioral disorder, or a neuropsychiatric condition which results in a serious disability, and which requires sustained treatment interventions, and causes the child's functioning to be impaired in thought, perception, affect or behavior. A disorder shall be considered to "result in a serious disability" if it causes substantial impairment of functioning in family, school or community. A substance abuse disorder does not constitute, by itself, a serious emotional disturbance, although it may coexist with serious emotional disturbance. ID Code § 16-2403.</p>
<p>Service Authorization</p>	<p>The review and consistent authorization or denial of a request by the Member, or the Member's authorized representative, for a service covered under this contract to be provided. 42 CFR § 438.210</p>
<p>Stakeholder</p>	<p>A person, group, or organization that has a direct or indirect investment, share, or interest in an organization, project, or system because it can affect or be affected by the actions, objectives, and policies of the organization, project, or system. Stakeholders include, but are not limited to, rule makers, the State Legislature, professional associations, providers of services, payers of services, funding sources, regulators, Members, and the families of Members.</p>
<p>Substance Use Disorder (including Substance Dependence and Substance-related Disorder)</p>	<p>Substance Use Disorder includes substance dependence and substance abuse, according to the DSM-IV-TR. Substance use disorders are one(1) of two (2) subgroups of the broader diagnostic category of substance-related disorders;</p> <p>Substance Dependence: Marked by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues to use alcohol or other drugs despite significant related problems. The cluster of symptoms can include: tolerance, withdrawal or use of a substance in larger amounts or over a longer period of time than intended, persistent desire or unsuccessful efforts to cut down or control substance use, a great deal of time spent in activities related to obtaining or using substances or to recover from their effects, relinquishing important social, occupational or recreational activities because of substance use, and continuing alcohol or drug use despite knowledge of having a persistent or recurrent physical or</p>

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	<p>psychological problem that is likely to have been caused or exacerbated by such use as defined in the DSM-IV-TR.</p> <p>Substance-related Disorders: Include disorders related to the taking of alcohol or another drug of abuse, to the side effects of a medication and to toxin exposures. They are divided into two (2) groups: the Substance Use Disorders and the Substance-Induced Disorders as defined in the DSM-IV-TR.</p>
System Defect	<p>A system defect is an identified error with the system where the system is not operating according to the approved design or requirements. System defects are not the same as other issues related to human error, or training. They are errors introduced by a component of the system.</p>
Urgent Behavioral Health Care	<p>For the purposes of this RFP care that is necessary due to a behavioral health condition that, after applying the prevailing behavioral health standards of judgment and practice within the community, would require immediate behavioral health intervention because of the Member's acute symptoms that have the potential to become an emergency health condition that would place the health or safety of the Member, or someone else, in serious jeopardy in the absence of behavioral health treatment for the Member. Conditions needing urgent behavioral health care include, but are not limited to, significant emotional distress, suspected or obvious psychotic break, or mental trauma.</p>
Utilization Management	<p>The process of managing costs and use of services through effective planning and decision-making to assure that services provided are appropriate and cost-effective; it is composed of the following elements:</p> <ul style="list-style-type: none"> deciding who will be served assessing service needs and identifying desired outcomes deciding what services to provide selecting service providers and determining costs implementing, monitoring, changing and terminating services
Utilization Review	<p>An element of utilization management, it is the evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, facilities, and practitioners under the provisions of the applicable health benefits plan. It involves a set of techniques used by or on behalf of purchasers of health care benefits to manage the cost of health care before its provision by influencing patient-care decision making through case-by-case assessments of the appropriateness of care based on professional and industry standards. Utilization review is done at the individual Member level as well as a system level.</p>

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ATTACHMENT 4 FINANCIAL INFORMATION

Offerors are required to provide copies of their latest two years of audited financial statements (for privately held companies) or SEC form 10-K (for publicly held companies) along with a current D&B Comprehensive Insight Plus credit report or current Experian ProfilePlus report, and the appropriate NAICS code or SIC code (<http://www.census.gov/cgi-bin/sssd/naics/naicsrch?chart=2007>.) The State will use the RMA Annual Statement Studies, Financial Ratio Benchmarks in its evaluations of financial information.

1 For privately held companies or non-profit organizations, if audited financial statements are not available, the latest two years of unaudited financial statements using the Statement of Operations (4B) or Statement of Activities (4C) AND a Balance Sheet (4A) as provided in attachments to the RFP, AND a current D&B Comprehensive Insight Plus credit report or current Experian ProfilePlus report. Offerors submitting unaudited financial statements must include an explanation as to why audited financials are not available, and must use the financial document formats as provided in Attachments to this RFP. All unaudited financial statements submitted must include the signature on each statement of a Principal of the submitting entity ensuring the validity and accuracy of the financial information being provided.

2 Offerors should provide one of the three following groups of financial information:

Latest two years of audited financial statements AND current D&B Comprehensive Insight Plus credit report or current Experian ProfilePlus report

OR

For Publicly held corporations only: Latest two years of SEC Form 10-K AND current D&B Comprehensive Insight Plus credit report or current Experian ProfilePlus report

OR

Latest two years of unaudited financial statements, using the Statement of Operations (4B) or Statement of Activities (4C) AND the Balance Sheet (4A) formats as provided in Attachments to the RFP, AND a current D&B Comprehensive Insight Plus credit report or current Experian ProfilePlus report

3 The offeror should stamp "Trade Secret" or "Confidential" on each page of financial information that it does not want released. The information will be held in confidence to the extent that law allows.

4 State agencies will be exempt from submitting financial information and the score assigned will be zero (no points.)

5 All financial statements must be for the exact organization submitting the proposal. The financial statements cannot be combined or consolidated with the information from any entity other than the company submitting the proposal. If the offeror's name on the proposal does not match the name on the financial statements and the name on the credit report, the proposal will receive a score of zero (no points) for **all** financial ratios and the credit score.

6 The State will evaluate the information provided using the ratios listed to answer the following questions:

Can the company meet its short-term financial obligations?

Current Ratio (Current Assets/Current Liabilities)

Quick Ratio (Cash and Cash Equivalents plus Net Trade Receivables¹ /Current Liabilities)

Working Capital (Net Sales² /Net Working Capital³)

How well does management control expenses and manage resources?

¹ Net Trade Receivable = Trade Receivable net of allowance for bad debt

² Net Sales = Sales less Returns

³ Net Working Capital – Current Assets – Current Liabilities

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Return on Equity (Profit before Taxes/Tangible Net Worth⁴) *100

Return on Investment (Profit before Taxes/Total Assets)*100

Credit Report Score

To what degree does the company use debt to finance its operations?

Debt/Worth (Total Liabilities/Tangible Net Worth)

Fixed/Worth (Net Fixed Assets⁵/Tangible Net Worth)

⁴ Tangible Net Worth = Total Equity less Intangible Assets

⁵ Net Fixed Assets = Fixed Assets less Accumulated Depreciation

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ATTACHMENT 4A BALANCE SHEET E (if applicable)

	Year ending (most recent year)	Year ending (2nd most recent year)
Assets		
Current Assets		
Cash and Cash Equivalents ¹		
Receivables, net of allowance for doubtful accounts ²		
Inventories ³		
Prepaid Expenses ⁴		
Total Current Assets	\$ -	\$ -
Long-Term Investments⁵		
Property, Plant and Equipment, net of depreciation⁶		
Intangible Assets⁷		
Total Assets	\$ -	\$ -
Liabilities and Owners' Equity		
Current Liabilities		
Accounts Payable ⁸		
Notes Payable ⁹		
Interest Payable ¹⁰		
Income Taxes Payable ¹¹		
Accrued Salaries, Wages, Other Liabilities ¹²		
Deposits Received from Customers ¹³		
Current Portion of Long-Term Debt ¹⁴		
Total Current Liabilities	\$ -	\$ -
Long Term Debt		
Notes, Loans and Bonds Payable ¹⁵	\$ -	\$ -
Owners' Equity		
Capital Stock ¹⁶		
Additional Paid In Capital ¹⁷		
Retained Earnings ¹⁸		
Total Owners' Equity	\$ -	\$ -
Total Liabilities and Owners' Equity	\$ -	\$ -

I have reviewed these financial statements and to the best of my knowledge:

- the reports do not contain any false, materially important statements nor do they omit a necessary material fact.
- the financial statements, and any other financial information furnished in the report, fairly present in all material respects the financial conditions, results of operations, and cash flows of the company in regards to the periods presented in the report.
- the company has designed disclosure controls and procedures to guarantee that material information in regards to the company and any subsidiaries is made known to me by others within those entities.

To be signed by Owner, President, CEO, CFO, Executive Director or other individual authorized to act on behalf of the

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organization.

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ATTACHMENT 4B
STATEMENT OF OPERATIONS
E (if applicable)

	Year ending (most recent year)	Year ending (2nd most recent year)
Revenues	\$ -	\$ -
Expenses:		
Cost of products and services		
Selling, general and administrative		
Depreciation and amortization		
Total expenses	-	-
Operating income (loss)	\$ -	\$ -
Interest expense		
Interest income		
Other items, net		
Income (loss) before income taxes	\$ -	\$ -
Provision for income taxes		
Net Income (loss)	\$ -	\$ -

I have reviewed these financial statements and to the best of my knowledge:

- the reports do not contain any false, materially important statements nor do they omit a necessary material fact.
- the financial statements, and any other financial information furnished in the report, fairly present in all material respects the financial conditions, results of operations, and cash flows of the company in regards to the periods presented in the report.
- the company has designed disclosure controls and procedures to guarantee that material information in regards to the company and any subsidiaries is made known to me by others within those entities.

To be signed by Owner, President, CEO, CFO, Executive Director or other individual authorized to act on behalf of the organization.

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ATTACHMENT 4C
Statement of Activities (for Non-Profit organization)
E (if applicable)

	Year ending (most recent year)	Year ending (2nd most recent year)
SUPPORT AND REVENUES		
Contributions	\$	\$
Fundraising		
Fed Grants		
Foundation Grants		
Contracts		
Other grants and contracts		
Interest and Dividends		
Miscellaneous Income		
Total Support and Revenue	\$	\$
EXPENSES		
Program Services		
Program 1		
Program 2		
Total Program Expenses	\$	\$
Supporting Services		
General and Administrative		
Fundraising		
Membership		
Total Supporting Expenses	\$	\$
Total Expenses	\$	\$
NET INCREASE (DECREASE) in NET ASSETS	\$	\$

(Instructions: For the most recent year, group expenses by whether they are direct program expenses (such as client services) or expenses for program support (such as Board expenses or fundraising expenses). If an expense benefits more than one category (such as rent, utilities, salaries or insurance), prorate it over all of the applicable programs by a rational basis, as shown in the following examples: 1) For rent and utilities, the percentage of the building used by each program; 2) For salaries, the cost of the time each staff member devotes to each program; 3) For insurance, the percentage each program contributes to the total assets or liabilities of the organization; also could use labor costs for this. For the 2nd most recent year, enter total costs for all categories in the column labeled "2nd most recent year".)

I have reviewed these financial statements and to the best of my knowledge:

- a) the reports do not contain any false, materially important statements nor do they omit a necessary material fact.
- b) the financial statements, and any other financial information furnished in the report, fairly present in all material respects the financial conditions, results of operations, and cash flows of the company in regards to the periods presented in the report.
- c) the company has designed disclosure controls and procedures to guarantee that material information in regards to the company and any subsidiaries is made known to me by others within those entities.

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To be signed by Owner, President, CEO, CFO, Executive Director or other individual authorized to act on behalf of the organization.

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ATTACHMENT 4D CONSOLIDATED BALANCE SHEET EXPLANATIONS

Cash and Cash Equivalents: This line item refers to cash and all items that could be quickly converted to a known amount of cash, such as: stocks, money market accounts or investments (such as certificates of deposit) that are within 3 months of their maturity date.

Receivables, net of allowance for doubtful accounts: Amounts of money due from customers or other debtors, subtracting the amount you believe you will be unable to collect.

Inventories: Value of property held for sale, or of the materials you will use to make a product that will be for sale.

Prepaid Expenses: Expenses for goods or services that you expect to use within a year, such as: prepaid insurance, rent paid in advance, prepaid advertising or prepaid postage.

Long-Term Investments: The value of any investment with a maturity date more than 12 months from the date of the balance sheet, such as: certificates of deposits with more than 12 months to maturity, bonds, or other notes.

Property, Plant and Equipment, net of depreciation: The value of durable property used in the regular operations of the business, such as: land, buildings, machinery, furniture and tools. Subtract the accumulated depreciation.

Intangible Assets: The value of any resource that lacks physical substance yet has significant value, such as patents, copyrights or franchises.

Accounts Payable: Amounts owed to a creditor for delivered goods or completed services.

Notes Payable: The total of all loans that are due within the next 12 months.

Interest Payable: All interest due on the balance sheet date.

Income Taxes Payable: Any income taxes owing as of the balance sheet date.

Accrued Salaries, Wages, Other Liabilities: Any salaries, wages, benefits and/or employment taxes earned but not paid as of the balance sheet date.

Deposits Received from Customers: Amount received from customers as deposits for merchandise that the company has not delivered as of the balance sheet date.

Current Portion of Long-Term Debt: The total of the payments due within the next 12 months on all loans, notes or other debts whose final due date is more than 12 months from the balance sheet date.

Long-Term Debt: Notes, Loans and Bonds Payable: The total value of all loans, notes, bonds and other debts whose final due date is more than 12 months from the balance sheet date. (Do not include any portion already listed under #14.)

Capital Stock: Ownership shares of a corporation authorized by its Articles of Incorporation.

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Additional Paid-In Capital: Other money invested into a company by a shareholder, without getting more shares.

Retained Earnings: The part of a company's earnings that it does not distribute, but keeps for future needs.

TOTAL ASSETS MUST EQUAL TOTAL LIABILITIES AND OWNERS' EQUITY

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ATTACHMENT 5 NETWORK PROVIDER SUBCONTRACTS

All provider subcontracts shall include, but not be limited to, the following provisions:

1. The name and address of the subcontractor.
2. The method and amount of compensation, reimbursement, payment, or other considerations provided to the provider.
3. Identification of the population to be served by the provider, including the number of Members the provider is expected to serve.
4. The methods by which the amount, duration, and scope of covered behavioral health services are determined.
5. The term of the provider's subcontract, including beginning and ending dates, and procedures for extension, termination, and renegotiation.
6. Specific provider subcontract duties relating to coordination of benefits and determination of third-party liability.
7. Identification of Medicare and other third-party liability coverage and requirements for seeking Medicare or third-party liability payments before submitting claims and/or encounters to Contractor, when applicable.
8. Maintenance of a cost record keeping system such that the Contractor can report monthly to the IDHW a summary of the total amount invoiced, total members who received behavioral health services each month and claims costs.
9. Compliance with the requirements in the Contractor QA and UM plans and QA program.
10. Uniform terms and conditions of the contract.
11. Assumption of full responsibility for all tax obligations, worker's compensation insurance, and all other applicable insurance coverage obligations required in this Contract, for itself and its employees, and that the IDHW shall have no responsibility or liability for any taxes or insurance coverage.
12. Incorporation by reference of the Medicaid Provider Handbook and the Contractor's Provider Manual and language that the provider subcontract complies with all requirements stated in this Contract.
13. Compliance with encounter reporting and claims submission requirements in accordance with the Contractor's Provider Manual, including payment withhold provisions and penalties for non-reporting, untimely reporting, or inaccurate reporting.
14. The right of a provider to appeal a claims dispute in accordance with the Contractor's Provider Manual.
15. Assistance to Members to understand their right to file grievances and appeals in accordance with the Contractor's Provider Manual shall be provided by the provider.
16. Compliance by the subcontract with audits, inspections and reviews in accordance with the Contractor's Provider Manual, including any reviews the Contractor or the IDHW may conduct.
17. Cooperation of the provider with the Contractor, other providers and/or State employees in scheduling and coordinating its services with other related service providers that deliver services to Members.
18. Facilitation by the provider of another provider's reasonable opportunity to deliver services, and the prohibition of any commission or condoning of any act or omission by the provider that interferes with, delays, or hinders service delivery by another provider by State employees.
19. Timely implementation by the provider of the IDHW or Contractor decisions related to a grievances, Member appeal, or claims dispute.
20. Compensation to Members or entities that conduct UM activities is not structured to provide incentives for the Member or entity to deny, limit, or discontinue medically necessary services to any behavioral health Member, according to 42 CFR § 438.12(e).

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21. When applicable, submission of the National Outcome Measures to the IDHW, including access to services, engagement in services, independent and stable housing, employment, and employment training rates.
22. When applicable, Members reaching the age of majority are provided continuity of care without service disruptions or mandatory changes in providers.
23. The IDHW's definition of medically necessary covered behavioral health services and the IDHW levels of care are provided.
24. A requirement that the providers assess the cultural and linguistic needs of the service area, and deliver services that address these needs to the extent resources are available.
25. The subcontractor acknowledges that it is aware of the False Claims Act (sections 3729 through 3733 of title 31, United States Code). In addition, any provider that either receives or makes annual Medicaid payments of at least five million dollars (\$5,000,000) acknowledges that they are required to comply with Title 42, United States Code, Section 1396a(a), paragraph (68) as amended by the Deficit Reduction Act of 2005. The provider specifically acknowledges its responsibility regarding employee education about the False Claims Act and State laws pertaining to civil or criminal penalties for false claims and statements and whistleblower protections under such laws.
26. To document each item or service for which reimbursement is claimed, at the time it is provided, in compliance with documentation requirements of ID Code § 56-209(h)(2), the applicable rules and this agreement. Such records shall be maintained for at least five (5) years after the date of services or as required by IDAPA. Upon reasonable request, the IDHW, the U.S. Department of Health and Human Services or their agencies shall be given immediate access to, and permitted review and copy any and all records relied on by the provider in support of services billed. The term "immediate access" shall mean access to the records at the time the written request is presented to the subcontractor.
27. To certify by the signature of the subcontractor or designee, including electronic signatures on a claim form or transmittal document, that the items or services claimed were actually provided and medically necessary or necessary due to the Member's behavioral illness, were documented at the time they were provided, and were provided in accordance with professionally recognized standards of health care, applicable Contractor and the IDHW rules and this agreement. The subcontractor shall be solely responsible for the accuracy of claims submitted, and shall immediately repay the Contractor for any items or services the Contractor or the subcontractor determines were not properly provided, documented, or claimed. The subcontractor must assure that they are not submitting a duplicate claim under another program or provider type.
28. The subcontractor acknowledges that Medicaid is a secondary payer and agrees to first seek payment from other sources as required by IDAPA.
29. Subcontractors agree to accept Medicaid payment for any item or service as payment in full and agrees to make no additional charge to the Member except that specifically allowed by Medicaid. The subcontractor further agrees: that if required, to submit requests for prior authorization before the time or service is provided. The subcontractor agrees not to bill the Contractor or the Member if a required request for prior authorization is not timely submitted; not to bill the Member unless the time or service is not covered or approved for payment by the Contractor and the Member has agreed to be responsible for payment prior to receiving the item or services. The subcontractor agrees not to bill the Contractor or the Member if a third party payment is made to the subcontractor unless the third party payment is less than the amount the Contractor would pay. The subcontractor shall not refuse to furnish services on account of a third party's potential liability for the services (42 CFR § 447.20)
30. To comply with the advance directives requirement of 42 CFR § 489, Subpart 1, and 42 CFR § 417.436(d), when applicable.
31. To protect the confidentiality of identifying information that is collected, used or maintained about a Member. Confidential information shall only be released with appropriate written

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authorization of the Member, according to IDAPA 16.05.01, "Use and Disclosure of Department Records," and 42 CFR § 431.300.

32. In no way shall any official, employee, or agent of the State of Idaho be in any way personally liable or responsible for any term of this agreement, whether expressed or implied, not for any statement, representation or warranty made in connection with this agreement.

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ATTACHMENT 6

TECHNICAL REQUIREMENTS: ELECTRONIC SYSTEMS, DATA SECURITY PLAN AND WEBSITE REQUIREMENTS

(E)

The Contractor for the Idaho Behavioral Health Plan shall perform all of the following requirements under the contract with the Idaho Department of Health and Welfare directly. All tasks in the Technical Requirements are part of the Scope of Work and should be included in the Offeror's response to the Idaho Behavioral Health Plan proposal.

I. Medicaid Management Information System (MMIS):

- A. Provide the necessary computer hardware, software, phone lines, modems, and any other connectivity equipment required to establish and maintain an internal computer system to receive, track, report, reconcile, protect, and transmit information from and to the IDHW's Medicaid Management Information System (MMIS) and to any future Idaho MMIS during this contract period, at no expense to the IDHW or the state's MMIS contractors.
- B. Accept and transmit secure SFTP data exchanges from and to the state's MMIS to support the scope of work associated with this contract. This includes, but is not limited to HIPAA standard electronic data interchange (EDI) transactions. All costs for establishing and maintaining data exchanges with the MMIS, including costs to extract, transform, and load (ETL) data for use in the contractor's automated system shall be at no cost to the state, or to the state's MMIS vendors.
- C. Test and validate successful receipt and transmission of data with the MMIS during the contract implementation phase. Any expenses incurred by the successful bidder or the MMIS to support pre-implementation testing and validation will be the sole responsibility of the contractor.
- D. In the event the IDHW should change MMIS systems or contractors during the term of this contract, the successful proposer will be expected to accommodate this change and establish all required interfaces, file transfers, and data exchanges with the new MMIS vendor at no additional cost to the State or to the MMIS vendor.
- E. Provide the IDHW access to the Contractor's data base(s) to facilitate contract monitoring activities. Methods of monitoring shall be determined by the IDHW.
- F. Accommodate a ten (10) digit Medicaid ID (MID) number. The Contractor shall be able to do this for encounter claim because MMIS validates the ten (10) digit MID first before it applies its duplication logic.
- G. If a change is due to a Federal, State, Legislative or policy change it will be at no charge to the IDHW or the MMIS vendors
- H. Submit Encounter claims to the IDHW MMIS contractor.
- I. Accept a true 834 eligibility file and return a true 834 response file.
- J. Accept a true 820 transaction (payment file)

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- K. Be compliant with CMS HIPAA standard transaction set. (Current version 5010).
- L. Be ICD-10 compliant as stated in 45 CFR 162.

II. (E) Electronic System Requirements:

- A. Equipment: The Contractor shall provide the necessary computer hardware, software, phone lines, modems, and any other connectivity equipment required to establish and maintain a system with the capability to receive and process Secure File Transfer Protocol (SFTP) data necessary to this contract. The Contractor shall have a server with a SFTP.
- B. Reports: The IDHW will retrieve monthly and quarterly report files containing the prior month or quarter's current information from the Contractor using SFTP. The IDHW will retrieve the reports by 10:00 a.m. Mountain Time on the tenth (10th) calendar day of the month following the month or quarter services were provided. The Contractor will be required to have a server running software capable of SFTP file transmissions in order to support this process.
- C. Data Transfer System: For SFTP data file transfers, the Contractor shall implement and maintain a data system capable of interfacing with the IDHW current system
 - 1. System Requirements: The Contractor's data system shall meet the following requirements for a SFTP site:
 - a) IDHW approved;
 - b) Contractor hosted or by a third party at the Contractor's expense;
 - c) Server with a SFTP;
 - d) Secure Socket Layer (SSL) 128-bit encryption or stronger;
 - e) Easy to use, maintain, and troubleshoot;
 - f) Contractor software (i.e., any software that will run at IDHW) shall be compatible with the latest supported versions of Windows;
 - g) Reliable;
 - h) Assure qualified Contractor staff are trained to use and maintain the data system.
 - 2. Contractor Responsibilities: The Contractor shall:
 - a) Provide accessibility to ongoing services, including operational contact names, phone numbers and e-mail addresses, hours/days of physical operation, and hours of access.
 - b) Notify the IDHW immediately upon identification of network hardware or software failures and sub-standard performance.
 - c) Notify the IDHW at least sixty (60) calendar days prior to the installation or implementation of software and hardware upgrades or replacements.
 - d) Develop and implement quality management and assurance best practices, which conform to IEEE/EIA 12207.0-1996, IEEE/EIA Standard-Industry Implementation of ISO/IEC 12207:1995, Standard for Information Technology-Software Life Cycle Processes, consistent with industry standard principles and processes that should include:
 - (1) Recurring process reengineering evaluation;
 - (2) Continuous performance measurement and improvement through the use of technical reviews, internal audits, and vendor score cards; and

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- (3) Vendor staff training and motivation for achieving higher quality standards.
 - e) Conduct triage with the IDHW to determine severity level of deficiencies or defects and determine timelines for fixes.
 - f) Ensure that all internet, intranet and extranet applications are compliant with Section 508 of the Rehabilitation Act of 1973, as amended by 29 U.S.C. § 794d, and 36 CFR § 1194.21 and 36 CFR § 1194.22.
- D. Website: The Contractor shall develop and maintain an Internet website for members and providers, as approved by the IDHW.
 1. The website shall be available twenty-four (24) hours a day, seven (7) days a week.
 2. The Contractor shall include and maintain the website with the following most current and updated information provided in both English and Spanish:
 - a) Descriptions of Idaho Behavioral Health Plan services available and how to access them;
 - b) Contractor contact information;
 - c) Customer Service contact via electronic mail (e-mail) address;
 - d) Frequently asked questions including definitions;
 3. The Contractor shall submit drafts of any Idaho Medicaid specific website content to the IDHW for review and approval prior to posting the information on the website.
 4. The Contractor shall update the website within five (5) business days of receipt of IDHW accepted content changes.
 5. The Contractor shall assure qualified staff is trained and available to perform the following:
 - a) Support the website;
 - b) Update the information on an ongoing basis;
 - c) Maintain functionality of the website.
- E. Web Applications: The Contractor shall provide the following Web Applications:
 1. User-friendly interface with intuitive layout and flow.
 2. Warranty and maintenance plan.
 3. All computer, network and communication hardware used to support the hosted application.
 4. Viral scanning programs involved with the communications portion of the application.
 5. The system shall allow a minimum of 250 concurrent users to access the system at the same time. Concurrent client requests are same millisecond client initiated clicks, and not server sessions. (Concurrent Users)
 6. The system shall be maintained and upgraded on a regular basis including service packs, patches and operating system updates.
 7. The system shall have an average availability (up time) greater than 98% of the time for twenty-four (24) hours, except for scheduled maintenance.
 8. The system will be built to have adequate response time for editing, print initiation, and navigation between screens. The proposed solution will provide expected response times along with a plan to monitor and improve times as needed.
 9. The system will have adequate response times for record searches, retrievals and query functions based on the complexity of request. The proposed solution will provide expected response times for typical queries, along with a plan to monitor and improve times as needed.

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10. Ensure the proposed solution(s) will use graphical user interface(s) (GUI), for subsystems and functions accessed by all users. Characteristics of easy navigation that shall be incorporated and will include but not limited to the following:
 - a) Drop-down menus;
 - b) Application-specific toolbars;
 - c) Auto population of persistent data;
 - d) Direct links to help, reference information, manuals and documentation;
 - e) Short-cut and function key functionality;
 - f) Mouse-over captions for all icons and data elements;
 - g) Navigation menus, fields, and page tabs;
 - h) Auto skips from field to field so that the cursor moves automatically to the next field as soon as the last character in the previous field is completely filled; and
 - i) "Forward" and "Back" navigation.
11. Ensure that the proposed solution(s) will provide within the GUI presentation layer a one-click tab, toolbar or button to navigate from any subsystem or function to any other subsystem or function within the system. This functionality shall allow the user to invoke the navigation link and move to and from the related subsystem without losing any data entered on a partially completed record or transaction.
12. Ensure that the proposed solution(s) will drill down or navigate directly to specific information based on field contents. For example, from a claim or PA Provider ID field, double click to navigate directly to a view of detailed information regarding the Provider.
13. Ensure that the proposed solution(s) will provide one-click access to online context-sensitive Help screens and resources. The Help menu will be accessible from all subsystems, windows, tabs and frames, and will include at least the following components:
 - a) General information;
 - b) User Manuals link;
 - c) System documentation link;
 - d) Data Element Dictionary;
 - e) Provider Handbooks; and
 - f) Other IDHW defined resources.
 - g) Ensure that GUI fields apply formatting rules, and do not truncate data content.
 - h) Ensure that the proposed solution(s) will provide user configurable resolution, font and color choices.
 - i) Ensure that the proposed solution(s) will deliver the functionality to organize multiple open windows using standard Windows® methods, such as cascade and tile.
 - j) Ensure that the proposed solution(s) is fully functional using Microsoft Internet Explorer 6.0 or newer. All third party (e.g. java, shockwave, plug-ins) products required for the proposed solution are fully functional using Microsoft Internet Explorer 6.0 or newer
 - k) Ensure documentation is provided for any configuration or modifications to the provided solution, third party (e.g. java, shockwave, plug-ins) products, web browser, desktop or laptop computer.

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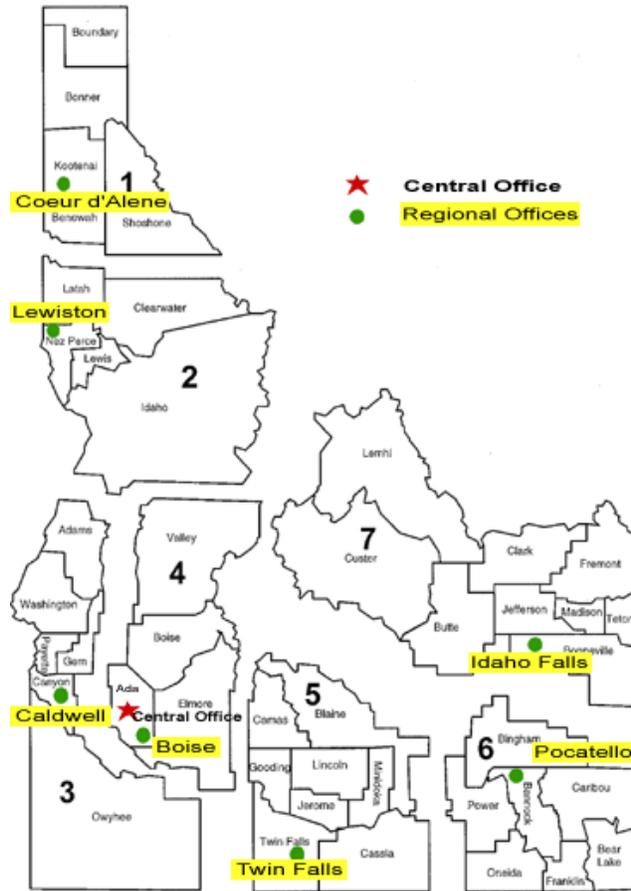
- F. Security Access and Maintenance: The system furnished will be an Application Service Provider (ASP) model where a contractor hosts the application and data. The Contractor shall provide the following WEB site security:
1. Provide user access through multiple access rights, role-based security.
 2. Provide security, data protection and recovery plans.
 3. Ensure unauthorized users do not gain access to data records.
 4. Meet or exceed all applicable standards for security including but not limited to HIPAA.
 5. Provide twenty-four (24) hours a day, seven (7) days a week system maintenance and support service, upgrades, consultation, training and technical support.
 6. Scheduled maintenance hours for the Idaho application should occur between midnight and 6:00 a.m. Mountain Time.
 7. The database shall be backed up on a regular schedule, at least once each day.
 8. The system shall restrict access to resources to only those users who have been granted a particular security role. The application shall provide tests for authentication (generally a login process) and authorization (determines whether a user has the required role to access a resource). (Role Based Security)
 9. The system shall be configurable to allow multiple access rights, and security levels based on the user account.
 10. The system may allow for authentication through username and password.
 11. The system may allow for authentication through role-based access control.
 12. The systems may allow for authentication through a shared core service (that also provides authentication for other applications).
 13. The system shall maintain audit records detailing access to the system and modification of records. Audit records should include (at a minimum) date, time, user, record ID, and action performed. (Auditing)
 14. The system shall have the ability to record audit records to an external database.
 15. The system shall use SSL encryption for communication over the Internet.
 16. Employ user-configurable online and batch audit trail functionality that provides electronic capture and storage of audit trail information related to all data inputs and uploads, changes and modifications, inquiries, authorizations, access requests, archive and retrieval processes, and log files, and make them available for inquiry. This shall include:
 - a) Identification of the date and time of any input, change, and access request, and the date and time the change is to become effective;
 - b) Identification of User IDs of any individuals accessing, inquiring, making, or approving any changes to the proposed solution;
 - c) Identification of the changed data by element name;
 - d) Identification of changed data, both before and after the change; Identification of edits encountered and their outcomes for all proposed solution processes;
 - e) Documented reasons for inputs, changes, inquiries, access requests, and other functions (when applicable), including standard codes and free form text fields;
 - f) Online real-time querying, retrieving, and report generation of all audit trail and audit history information by authorized users; and
 - g) Online real-time viewing and printing of all audit trail and audit history information by authorized users.

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- G. Electronic System and Data Security Plan: The Contractor shall submit an Electronic System and Data Security Plan, which will be reviewed, modified if necessary and accepted by the IDHW during the start of the contract, as outlined in Attachment 9 - Initial Deliverables. The submitted Electronic System and Data Security Plan shall address at least the following:
1. Adherence to the IDHW's Use and Disclosure of IDHW Records rules promulgated in IDAP A 16.05.01, which is available at the following link: <http://adm.idaho.gov/adminrules/rules/idapa16/16index.htm>
 2. Outline the implementation and maintenance of the proposed physical and logical security infrastructure and procedures that ensure the IDHW's requirements are met or exceeded;
 3. Detail the methods that ensure integrity of the system and data;
 4. Assure timely and reliable access to information;
 5. Prevent unauthorized access, use, disclosure, disruption, modification, or destruction of data;
 6. Protect the confidentiality of Protected Health Information (PHI) both active and data at rest, and adhere to 45 CFR §§ 160, 162, and 164, as amended;
 7. Identify industry trends and consistently apply best practices in security measures as they are identified;
 8. Define the approach to identifying and implementing security updates to all components of the proposed solution;
 9. Define a process by which the Electronic System and Data Security Plan is jointly reviewed and updated by the IDHW and the Vendor on a schedule defined by the IDHW;
 10. Safeguard against abuse of all data stored in the proposed solution and all related components;
 11. Safeguard against the release of information without proper IDHW consent;
 12. Detect and report irregular or suspect activities to the designated IDHW resource.
 13. Restrict physical access to vendor facilities, including off-site storage;
 14. Implement accountability controls that create audit trails of physical and system access, including unauthorized access attempts;
 15. Track and document security updates implemented by the Vendor; and
 16. Protect system resources against viruses, worms, or any other malicious electronic attack from external sources.

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ATTACHMENT 7 IDAHO DEPARTMENT OF HEALTH AND WELFARE REGIONAL MAP



Seven Regions of IDHW and the Counties Within Them

<i>Region</i>	<i>Counties</i>
Region 1	Boundary, Bonner, Kootenai, Shoshone, Benewah
Region 2	Latah, Clearwater, Nez Pearce, Lewis, Idaho
Region 3	Adams, Washington, Payette, Gem, Canyon, Owyhee
Region 4	Valley, Boise, Ada, Elmore
Region 5	Camas, Blaine, Gooding, Lincoln, Minidoka, Jerome, Twin Falls, Cassia
Region 6	Power, Bingham, Caribou, Bannock, Oneida, Franklin, Bear Lake
Region 7	Bonneville, Teton, Madison, Jefferson, Fremont, Clark, Butte, Custer, Lemhi

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ATTACHMENT 8 MEMBERS' RIGHTS

The Contractor for the Idaho Behavioral Health Plan shall perform all of the following requirements under the contract with the Idaho Department of Health and Welfare directly. All tasks in Attachment 8 – Members' Rights are mandatory, are part of the scope of work, and shall be addressed in responses to the Idaho Behavioral Health Plan proposal.

Contractor shall comply with any applicable Federal and State laws that pertain to participant rights, and ensure that its staff and affiliated providers shall abide by those rights when furnishing services to Members. 42 CFR § 438.100(a)(2)

Contractor shall adopt methods and procedures that require each participant to be treated with respect and with due consideration for his or her dignity and privacy. 42 CFR § 438.100(b)(2)(ii)

Contractor shall adopt methods and procedures that guarantee each participant the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the participant's condition and ability to understand. 42 CFR § 438.100(b)(2)(iii)

Contractor shall adopt methods and procedures that guarantee each participant the right to participate in decisions regarding his or her health care, including the right to refuse treatment. 42 CFR § 438.100(b)(2)(iv)

Contractor shall adopt methods and procedures that guarantee each participant the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. 42 CFR § 438.100(b)(2)(iv)

Contractor shall adopt methods and procedures that guarantee each participant the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR § 164.524 & .526. 42 CFR § 438.100(b)(2)(vi).

Contractor shall adopt methods and procedures that guarantee each participant the freedom to exercise his or her rights, and that the exercise of those rights does not adversely affect the way Contractor and its providers treat the participant. 42 CFR § 438.100(c)

Contractor shall take whatever steps are necessary to comply with applicable Federal and State laws (such as, Title VI of the Civil Rights Act of 1964; The Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and Titles II and III of the Americans with Disabilities Act); and other laws regarding privacy and confidentiality. 42 CFR § 438.100(d)

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ATTACHMENT 9 INITIAL DELIVERABLES

Initial deliverables shall be submitted within the identified timeframes in preparation for the two (2) phase readiness review process. The review and approval of deliverables is an iterative process not to exceed the final due date. The following deliverables must be reviewed and accepted by the IDHW:

Deliverable	# of calendar days due after contract effective date for review, testing, and/or approval	Review by IDHW & return to Contractor for revisions	Contractor revisions - return to IDHW	Final version due
Brochures/information packets	90	10 days	5 days	120 days
Data Tracking/Utilization Information System test reports	90	10 days	5 days	120 days
Website content related to Idaho's Behavioral Health Plan	90	10 days	5 days	120 days
Description of Call Center operations; publication of number	90	10 days	5 days	120 days
Policies and Procedures for Provider Network	90	10 days	5 days	120 days
Policies and Procedures for Contractor	90	10 days	5 days	120 days
Network Development/Enrollment Plan	90	10 days	5 days	120 days
Plan for federally required system Update to ICD-10	90	10 days	5 days	120 days
Compliance Program Plan	90	10 days	5 days	120 days
Work Plan	10	10 days	5 days	60 days
Service Transition Plan for Members and Providers	90	10 days	5 days	120 days
Provider Agreement Template	90	10 days	5 days	120 days
Transition Plan	90	10 days	5 days	120 days

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ATTACHMENT 10 READINESS REVIEW

Phase 1 (Within 90 calendar days of contract effective date)			Phase 2 (Within 180 calendar days of contract effective date)	
Task	Next Step	Completed	Task	Completed
Statewide network behavioral health providers established	Agreements or contracts signed		Network providers transitioned and trained – ready to provide services	
*Policies and Procedures	Approved by the IDHW		Contractor's staff and behavioral health providers have information and are trained to all requirements	
Brochures and information packets	Approved by the IDHW & ready for distribution		Brochures/information packets distributed to Members (at least twenty (20) calendar days prior to start of services)	
*Customer service system	<p>Customer Service System Plan is in place and is approved by the IDHW</p> <p>Automated call distribution system is functioning and being tested</p> <p>Customer Service System staff on board or in process of hire</p>		<p>Automated call distribution system tested and ready for live calls</p> <p>Publication of call center phone number</p> <p>Customer Service System staff hired and trained to all requirements</p>	
*Complaint Resolution and Tracking System	Complaint Resolution and Tracking System approved by the IDHW		Contractor staff trained to requirements	
Member Grievance Resolution and Tracking System	Member Grievance and Resolution Tracking System approved by the IDHW		Contractor staff trained to requirements	
Claims Payment System	Provider Claims System approved by the IDHW		<p>System passes user acceptance testing with no major defects</p> <p>Clean claims accurately processed and defect tracking enabled.</p>	
Data	System operational		Test reports run and are	

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tracking/utilization information system	and includes required data fields for reports		accurate Contractor's staff and behavioral health network providers trained to requirements	
Website	Website developed and has IDHW approved content related to Idaho's Behavioral Health Plan		Website tested and functional – staff in place and trained to support and maintain website	
*Electronic systems	Electronic Systems & Data Security Plan accepted by the IDHW Electronic systems in production – capable of receiving and processing Secure File Transfer Protocol (SFTP) Data		Electronic system interfaces with the IDHW's current system Receiving and processing eligibility data from the IDHW IDHW able to access and retrieve required reports	
*Quality Assurance	Quality Assurance Plan approved by the IDHW		Customer Service Satisfaction surveys approved Staff trained to all requirements	
*Disaster Recovery	Business Continuity, Disaster Recovery and Risk Management Plan approved by the IDHW		Contractor's staff and Behavioral Health network providers trained to requirements	
*Service Transition Plan	Service Transition Plan approved by the IDHW		Service Transition Plan in place	
* Work Plan	Implementation Plan approved by the IDHW		Implementation Plan tasks completed. Contractor ready to provide Behavioral Health services per the contract.	
Contract Transition Plan	Contract Transition Plan approved by the IDHW		Contract Transition Plan in place	

*Submitted with proposal.

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ATTACHMENT 11 FQHC and RHC ENCOUNTERS SFY 11

Exhibit 3
Summary of FQHC and RHC
Data book v9.1

NPI	Encounter Rate	Total Encounters	MH Encounters
1003988825	\$122.94	4	0
1023030848	\$82.22	1,159	4
1043387426	\$94.77	3,190	0
1104869965	\$145.66	360	3
1114955630	\$93.48	6,008	0
1124283254	\$84.32	4,531	0
1154320752	\$110.55	3,411	88
1245267467	\$119.58	567	2
1295734796	\$110.55	1,793	3
1326002650	\$82.22	1,813	5
1336135136	\$294.00	58	0
1366542391	\$84.32	549	0
1376662486	\$87.03	4,839	30
1427057926	\$110.55	356	7
1427062181	\$156.69	1,408	0
1588666945	\$110.55	366	4
1598763849	\$105.94	2,221	0
1629077235	\$110.55	1,483	0
1710915897	\$241.08	1,697	813
1740223502	\$124.39	718	4
1760402663	\$97.46	186	0
1780625632	\$156.69	1,624	40
1821153362	\$110.55	276	1
1831179696	\$142.76	5,011	59
1881659357	\$82.22	750	1
1881734135	\$156.69	537	17
1962580027	\$134.43	8,167	38
1972673218	\$84.32	3,199	137

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ATTACHMENT 12 FULL CONTINUUM OF CARE AS DESCRIBED BY IDAHO BEHAVIORAL HEALTH STAKEHOLDERS

Idaho Medicaid has actively worked with stakeholders since 2004 in an attempt to describe and define components of the service system that are needed in order to establish a full continuum of behavioral health care. Many of the services they have identified are not State Plan services but may eventually be established through 1915b(3) waiver services. Other services identified by stakeholders may most appropriately be provided in the private sector either through organizations that are peer run or faith-based or through private enterprises.

Assertive Community Treatment (ACT), Intensive Case Management Services and Wraparound

Assertive Community Treatment (ACT)

ACT consists of proactive interventions provided to adults with serious, disabling mental illness for the purpose of increasing community tenure, elevating psychosocial functioning, minimizing psychiatric symptomatology, and ensuring a satisfactory quality of life. Services include the provision and coordination of treatments and services delivered by multidisciplinary teams using an active, assertive outreach approach and including comprehensive assessment and the development of a community support plan, ongoing monitoring and support, medication management, skill development, crisis resolution, and accessing needed community resources and supports.

Intensive Case Management

Intensive case management is an intensive community rehabilitation service for individuals at-risk of hospitalization or for crisis residential or high acuity substance abuse services. Services include: crisis assessment and intervention; individual restorative interventions for the development of interpersonal, community coping and independent living skills; development of symptom monitoring and management skills; medication prescription, administration and monitoring; and treatment for substance abuse or other co-occurring disorders. Intensive case management also includes coordinating services, referral, follow-up, and advocacy to link the individual to the service system. Services can be provided to individuals in their home, work or other community settings. Services may be provided by a team or by an individual case manager.

Wraparound

Wraparound is an intensive and individualized care management process for youths with serious or complex needs. During the wraparound process, a team of individuals who are relevant to the well-being of the child or youth (e.g., family members, other natural supports, service providers, and agency representatives) collaboratively develop an individualized plan of care, implement this plan, and evaluate success over time. The wraparound plan typically includes formal services and interventions, together with community services and interpersonal support and assistance provided by friends, kin, and other people drawn from the family's social networks.

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The team convenes frequently to measure the plan's components against relevant indicators of success. Plan components and strategies are revised when outcomes are not being achieved.

Assessment and Evaluation (State Plan service)

Assessment and evaluation define or delineate the individual's mental health/substance use disorder diagnoses and related service needs. Assessment and evaluation services are used to document the nature of the individual's behavioral health status in terms of interpersonal, situational, social, familial, economic, psychological, substance abuse and other related factors. These services include at least two major components: 1) screening and evaluation (including medical, bio-psychosocial history; home, family, and work environment assessment; and physical and laboratory studies/testing and psychological testing as appropriate); and 2) a written report on the evaluation results to impart the evaluator's professional judgment as to the nature, degree of severity, social-psychological functioning, and recommendations for treatment alternatives

Case Management (State Plan service: "Service Coordination") This service provides supportive interventions to assist individuals to gain access to necessary medical, habilitative, rehabilitative and support services to reduce psychiatric symptoms, address substance abuse disorders, and develop optimal community living skills. Service Coordination needs are assessed and documented on the comprehensive treatment plan to meet the individual's specific needs. Service Coordination services may include coordinating services, referral, follow-up, and advocacy to link the individual to the service system and to coordinate the various system components to assure that the multiple service needs of the individual are met. Service Coordination may also provide assistance for obtaining needed services and resources from multiple agencies (e.g., Social Security, Medicaid, Prescription Assistance Programs, food stamps, housing assistance, health and mental health care, child welfare, special education, etc.), advocating for services, and monitoring care. Case management also assists in the transition of adolescent consumers as they age out of the children's system and into the adult system and the transition to adulthood.

Designated Examinations and Dispositions

A designated examination is a personal examination of a proposed patient to determine if the proposed patient is: (i) mentally ill; (ii) likely to injure himself or others or is gravely disabled due to mental illness; and (iii) lacks capacity to make informed decisions about treatment and should be involuntarily committed to the Idaho Department of Health and Welfare (IDHW). A designated examiner must be a psychiatrist, psychologist, psychiatric nurse, social worker or other mental health professional designated in rule and specially qualified by training and experience in the diagnosis and treatment of mental illness. A dispositioner is a designated examiner employed by or under contract with the IDHW to determine the least restrictive appropriate location for care and treatment of involuntary patients.

Intensive Outpatient Treatment

Home-Based Mental Health Services

Intensive home-based treatments are time-limited intensive therapeutic and supportive interventions delivered in the home. They are intended to prevent hospitalization. These

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services are available twenty-four hours a day, seven days a week. Services are multi-faceted in nature and include: situation management, environmental assessment interventions to improve individual and family interactions, skills training, self and family management, and independent living skills training.

Intensive Outpatient Substance Use Disorder Treatment

This service provides a time limited, multi-faceted approach treatment for persons who require structure and support to achieve and sustain recovery. Intensive outpatient treatment consists of group and family counseling, job preparedness, relapse prevention, and education.

Illness Self-Management and Recovery Services

Illness self-management uses structured techniques and strategies for managing mental illness/substance use disorders and ongoing self-assessment and self-monitoring to facilitate recovery from mental illnesses/substance use disorders. Several manualized self-management programs have been developed in recent years, including programs designed to help members identify internal and external resources for facilitating recovery, and then use these tools to create their own, individualized plan for successful living.

Inpatient Psychiatric Hospitalization (State Plan service)

The goal of inpatient care is to stabilize the individual displaying the acute symptoms. This service is available for individuals who are in direct danger to self or others, and/or in acute crisis, including substance use withdrawal. This service provides twenty-four (24) hour care in a hospital requiring short-term, intensive, medically supervised treatment, consistent with the individual's needs. Services provided in an acute psychiatric hospital include, but are not limited to, psychiatric care, monitoring of medication, health assessment, nutrition, therapeutic interventions, observation, case management and professional consultation.

Medication Management (State Plan service)

Medication Management/Pharmacological Management

Medication management is a pharmacotherapy service provided by a psychiatrist, physician or other individual licensed to prescribe medications to assess and evaluate the individual's presenting conditions and symptoms, medical status, medication needs and/or substance abuse status. This includes evaluating the necessity of pharmacotherapy or other alternative treatments, prescribing, preparing, dispensing, and administering oral or injectable medication. Informed consent must be obtained for each medication prescribed.

Medication Administration/Monitoring

Medication services are goal-directed interventions to administer and monitor pharmacological treatment. Oral, injectable, intravenous, or topical medications and treatments are administered and their positive and negative effects monitored. This includes medications used to treat substance use disorders or addiction. There is a focus on educating and teaching individuals and members of their support system as to the effects of medication and its impact on alcohol/drug

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abuse/dependence and/or mental illness. Counseling related to medication management and case coordination with other practitioners involved with the individual is necessary to assure continuity of care. These are primarily face-to-face services contacts, rendered as both facility-based and "in vivo."

Drug Screenings (State Plan service)

Laboratory screenings are used to treat behavioral health and medical disorders and provide pharmacologic management. Tests may include, but are not limited to: urinalysis, other formal drug screenings and blood tests.

Peer Support Services

Peer support services provide an opportunity for individuals to direct their own recovery and advocacy process and to teach and support each other in the acquisition and exercise of skills needed for management of symptoms and for utilization of natural resources within the community. This service provides structured, scheduled activities that promote socialization, recovery, self-advocacy, development of other natural supports, and maintenance of community living skills. Trained and certified consumers actively participate in decision-making and the operation of the programmatic supports.

Prevention Services

The goal of this service is to prevent suicide, mental illness, and/or substance use disorders. Prevention activities include various strategies aimed at educating the community at large and selective educational and informational strategies for certain individuals who are at greatest risk for suicide, mental illness and/or substance use disorder. A system of prevention involves clear boundaries and expectations, and a comprehensive scope of pro-social activities and educational services designed to increase protective factors and reduce risk factors among all in a community (universal). One of the keys to prevention of suicide, mental illness and substance use disorders is training "gatekeepers" in how to recognize the early signs and symptoms. Gatekeepers are those individuals that have frequent contact with moderate to high risk populations.

Early Intervention Services for Children and Adolescents

Early intervention services are designed to address problems or risk factors that are related to mental illness and substance use disorders. These services are designed to provide information, referral and education regarding symptoms and treatment to assist the individual in recognizing the risk factors for mental illness and substance use disorders. Early intervention and education is an organized service that may be delivered in a wide variety of settings. Early intervention may include time-limited respite care services.

Psychiatric Emergency and Crisis Intervention Services (24/7 with open door access)

Crisis Intervention/Mobile Crisis (State Plan service)

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Crisis intervention services are immediate, crisis-oriented services designed to ameliorate or minimize an acute crisis episode and to prevent inpatient psychiatric hospitalization or medical detoxification. Services are provided to adults, adolescents and their families or support systems who have suffered a breakdown of their normal strategies or resources and who exhibit acute problems or disturbed thoughts, behaviors or moods. The services are characterized by the need for highly coordinated services across a range of service systems. Crisis intervention services should be available on a 24-hour, seven-day per week basis. Services can be provided by a mobile team or by a crisis program in a facility or clinic. Crisis intervention services include: crisis prevention, acute crisis services, and support services.

Crisis Residential Treatment/Respite Care Services

Crisis residential treatment services provide 24 hour supports for adults for the purpose of ameliorating a crisis in the least restrictive setting while trying to maintain the person's linkages with their community support system. Services include: continuous and close supervision, medical, nursing and psychiatric services and referral to community-based services. Crisis residential treatment services are provided in non-hospital setting. Crisis residential lengths of stay generally should not exceed 10 days.

Critical Time Intervention

Critical Time Intervention (CTI) is an empirically supported, time-limited case management model designed to prevent homelessness and other adverse outcomes in people with mental illness following discharge from hospitals, shelters, prisons and other institutions. This transitional period is one in which people often have difficulty re-establishing themselves in satisfactory living arrangements with access to needed supports. Focused, time-limited assistance during this critical period can have enduring positive impacts.

Psychotherapy (including trauma-informed care, cognitive behavioral therapy and outpatient substance use disorder treatment.) (State Plan service)

Individual

Individual counseling consists of various evidence-based professional therapeutic interventions and is used to address an individual's alcohol or drug abuse and/or emotional, behavioral or cognitive problems. Personal trauma, family conflicts, responses to medication, connecting with and utilizing natural supports, and other life adjustments reflect a few of the many issues that may be addressed. Services may be provided in various settings.

Group

Group psychotherapy consists of therapeutic interventions provided to a group of children, adolescents or adults to address an individual's alcohol or drug abuse and/or emotional, behavioral or cognitive problems. Personal trauma, family conflicts, responses to medication, and other life adjustments reflect a few of the many issues that may be addressed. Services may be provided in various settings. Group size should be at least three or more, but fewer than 10 individuals.

Family Psychotherapy for Children and Adolescents

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Interventions directed toward an individual and family to address emotional or cognitive problems which may be causative/exacerbating of the primary mental disorder or have been triggered by the stress related to coping with mental and physical illness, alcohol and drug abuse, and psychosocial dysfunction. Personal trauma, family conflicts, family dysfunction, self-concept responses to medication, and other life adjustments reflect a few of the issues that may be addressed. Includes Multi-Systemic Therapy (MST), Functional Family Therapy (FFT) and Parenting with Love and Limits (PLL).

Alcohol and Drug Residential Treatment

This service is a twenty-four hour residential rehabilitation treatment for adults or adolescents with chronic alcoholism or drug dependency who lack an adequate social support system and need supervised treatment to achieve a substance-free lifestyle and explore and instill ways of functioning in a work setting, within the family, and in the community in accordance with the individual's treatment plan. Services include: medication administration, case management and monitoring and individual and group recovery-based services. Some individuals may be experiencing and be monitored for minor detoxification.

Supported Employment, including Vocational Rehabilitation when needed

Supported Employment

Supported employment provides on the job supports in an integrated work setting with ongoing support services for adults with the most severe disabilities for whom competitive employment: a) has not traditionally occurred; b) has been interrupted or intermittent as a result of severe disability; and c) who, because of the nature and severity of their disability, need intensive supported employment services in order to perform work. Activities are performed by a job coach and/or job specialist/case manager in conjunction with a job developer to achieve a successful employment outcome.

Job Preparedness

Job preparedness consists of activities directed at assisting individuals to develop skills to gain and maintain employment. Job preparedness services include: providing instruction in the areas of resume writing, job application preparation, and appropriate job interview responses. These activities also emphasize the importance of being ready to seek and hold employment is discussed, including proper nutrition, cleanliness, and physical appearance, allocating daily costs, and taking prescribed medication.

Supported Housing (housing first, etc.)

Supported housing is a safe and secure place to reside which is affordable to consumers and permanent as long as the consumer pays the rent and honors the conditions of the lease. In some models, consumers **are not** required to participate in services to keep their housing, although they are encouraged to use services. Supported housing should be individualized services available when the consumer needs them and where the consumer lives.

Transportation

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Transportation services are used to move individuals to and from covered medically necessary medical or behavioral health examinations, treatment and services. This service may be provided in staff-driven vehicles, or by assistance with the cost or process of arranging for and/or using public or private transportation.

24-hour Out-of-Home Treatment Interventions for Children and Adolescents

Residential Treatment

Time limited services are designed to assist children or adolescents to develop skills necessary for successful reintegration into the family or transition into the community. Residential treatment centers provide an interdisciplinary psychotherapeutic treatment program on a 24-hour basis to eligible recipients. Services provided in this setting include: individual, groups and family therapy, behavior management, skill building and recreational activities. Services must be rehabilitative and provide access to necessary treatment services in a therapeutic environment.

Treatment Foster Care

Time limited community based treatment services provided to children or adolescents who are placed in 24-hour supervised, trained and surrogate family settings. Intensive therapeutic foster care services incorporate clinical treatment services, which are behavioral, psychological and psychosocial in orientation. Services must include clinical interventions by the specialized therapeutic foster parent(s) and a clinical staff person. Services included in individualized care plans are designed to assist the child or adolescent to develop skills necessary for successful reintegration into the natural family or transition into the community. The family living experience is the core treatment service.

Day Treatment/Partial Care Services and Partial Hospitalization

a. Day Treatment for Children and Adolescents

A non-residential treatment program designed for children and adolescents who may be at high risk of out-of-home placement. Therapeutic Day Treatment services are a coordinated and intensive set of therapeutic, individual, family, multi-family and group services and social recreational services. Day Treatment Services provide a minimum of three hours of structured programming per day, two-to-five times a week, based on acuity.

b. Partial Care (State Plan service)

A distinct and organized intensive ambulatory treatment service offering less than 24-hour daily care that is reasonable and necessary for the diagnosis or active treatment of the individual's condition, reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization.

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ATTACHMENT 13 ELECTRONIC HEALTH RECORDS

- A** The Contractor shall provide a description of how and when Electronic Health Records (EHR) will be implemented within the provider network. The description should include a discussion of how the Contractor intends to address the following elements with network providers:
- 1** Assistance in defining what it needs from an electronic health record system; facilitate development of goals for the use of the EHR.
 - 2** Assistance in conducting a readiness assessment including, but not limited to, the following areas:
 - a** Organizational culture
 - b** Management and Leadership
 - c** Operational
 - d** Technical
 - e** Assistance in development of a plan for EHR implementation.
 - 3** Facilitation/assistance in reviewing and documenting existing workflows, including how information contained in medical records is created, maintained and exchanged. This process can assist in the determination of the key features needed in an EHR. It also helps identify business process changes to be made and specific inefficiencies that can be corrected prior to implementation.
 - 4** Assistance in determining the most efficient, effective way to handle conversion of existing data.
 - 5** Facilitation/assistance in identifying other systems requiring integration, if any.
 - 6** Facilitation/assistance with workflow redesign activities, including clinic policies and procedures, job descriptions and scheduling and billing workflows
 - 7** Facilitation/ assistance in understanding and documenting total costs related to EHR implementation.
 - 8** Facilitation/assistance in documenting provider/practice requirements for EHR system, including registry functionality and report generation capability.
 - 9** Reporting functionality should include (from HRSA Health IT Adoption Toolbox):
 - a** Identification of a subpopulation of Members
 - b** Viewing and manipulation of data
 - c** Exporting data
 - d** Creating notifications for Members and providers
 - e** Tracking quality measures
 - 10** Ensuring EHRs used by network providers meet the Commission for Certification for Health Information Technology (CCHIT) 2011 Behavioral Health EHR Certification Criteria and EHRs used by eligible providers meet the certification criteria regulations of 45 CFR Part 170.
 - 11** Ensuring that EHRs used by network providers can interface with the Idaho Health Data Exchange.
 - 12** Assisting any eligible network provider in achieving meaningful use of the EHR system and qualifying for the Medicare or Medicaid Meaningful Use incentives.
 - 13** Ensuring policies and procedures are in place to comply with the HIPAA privacy and security regulations of 45 CFR Part 160 and Part 64, Subparts A and C.

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ATTACHMENT 14 RECOVERY AND RESILIENCY MODELS

Recovery Model

The Idaho Department of Health and Welfare (IDHW) is committed to the recovery model as expressed by the National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation in December 2004.

In working with behavioral health stakeholder groups, including other state agencies, the IDHW believes in the policy statement from the Substance Abuse and Mental Health Services Administration within the U.S. Department of Health and Human Services (SAMHSA) on the topic of recovery:

“...partnering with people in recovery from mental and substance use disorders to guide the behavioral health system and promote individual-, program-, and system-level approaches that foster health and resilience; increase permanent housing, employment, education, and other necessary supports; and reduce barriers to social inclusion.”

Member empowerment is an essential ingredient of recovery along with community reintegration and normalization of the life environment. Empowered recovery enables Members to be not only in charge of their illness but also in charge of their lives. Techniques promoting health literacy, written individualized care plans, self-management skills and early symptom education, and peer and group education are various approaches to promote empowerment.

Major contributors to the opportunity for Member recovery involve the inclusion of the Member, parent or legal guardian of youth Members, and family and advocates in a broad range of decisions from service planning to resource planning. Other aids to Member recovery involve the availability of Member-driven and Member-run programs, services and activities developed in conjunction with Members and their families, and recovery support services.

The ten fundamental components of recovery as defined by the SAMHSA include the following:

Self-Direction: Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.

Individualized and Person-Centered: There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.

Empowerment: consumers have the authority to choose from a range of options and to participate in all decisions – including the allocation of resources – that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.

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Holistic: Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.

Non-Linear: Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which the person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.

Strengths-Based: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and emerge in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust based relationships.

Peer Support: Mutual support – including the sharing of experiential knowledge and skills and social learning – plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles and community.

Respect: Community, systems, and societal acceptance and appreciation of consumers – including protecting their rights and eliminating discrimination and stigma – are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.

Responsibility: consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.

Hope: Recovery provides the essential and motivating message of a better future – that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process.

The recovery model may not be appropriate for all Members at all times. Implementation of a recovery model does not mean that behavioral health professionals can simply wait for people to seek help. Members with serious mental illness, serious persistent mental illness or substance use disorders often do not seek help and/or may need assertive community treatment programs and outreach to help engage them in the services they need. The system must serve Members for whom recovery is not a present reality. The recovery model does not eliminate the need for intensive services over long periods of time for some Members. However, hospitalization and the restriction of Member civil rights are used only as a last resort.

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Resiliency Model

The Medicaid-reimbursed child and adult behavioral health systems have to date developed similar conceptual frameworks and language. This doesn't mean that the IDHW fails to recognize the real and important differences between the needs and developmental trajectories of children and adults, and services designed to support them. Medicaid recognizes that the recovery model assumes a degree of self-determination and personal responsibility that does not apply globally to children and youth.

Resilience may be defined as "the dynamic process encompassing positive adaptation within the context of significant adversity"¹ and incorporates Member characteristics, family/caregiver resources, and assets outside the family. Two core concepts of resilience that can enhance the implementation of system of care principles are the specification of risk and protective factors that can be useful in involving Members (and their guardians) and refining services, and provision of a solid base of information for prevention and early intervention programming.

Towards this goal, staff working with children, youth and their families do well to utilize a "recovery and resilience model" in delivering appropriate behavioral health services. The most effective behavioral health services are those that are integrated with services provided by other human services agencies and are designed to support children and youth in remaining in or returning to an appropriate home or non-restrictive community environment where each Member can develop a healthy sense of identity and well-being, and can succeed in school, the family and the community. Furthermore, it is most effective when at-risk children and youth are proactively identified with traits or risk factors warranting early intervention.

[Luthar, Suniya S.](#); Cicchetti, Dante; Becker, Bronwyn (2000). "[The Construct of Resilience: A Critical Evaluation and Guidelines for Future Work](#)". *Child Development* **71** (3): 543–562. doi:10.1111/1467-8624.00164. PMC 1885202. PMID 10953923. <http://www.pubmedcentral.nih.gov/articlerender.fcgi?tool=pmcentrez&artid=1885202>. Retrieved 2011-04-14. "Resilience refers to a dynamic process encompassing positive adaptation within the context of significant adversity."

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ATTACHMENT 15 INFANT & TODDLER MENTAL HEALTH

Infant and Early Childhood Mental Health is also known as social and emotional development. It is defined by the Center on the Social Emotional Foundations for Early Learning (CSEFEL) as “the developing capacity of the child from birth through 5 years of age to form close and secure adult and peer relationships; experience, regulate, and express emotions in socially and culturally appropriate ways, and explore the environment and learn—all in the context of family, community, and culture.” Further, the foundational skills during the first five years, according to Shonkoff & Phillips (2000), are necessary in order for children to develop relationships, build friendship, cope with anger and frustration, manage emotions and resolve conflicts. Positive or negative experiences during these early years affect mental and physical health for a lifetime. Infant and Early Childhood Mental Health is a specialty area that requires very specific skills, competencies and education.

It has been shown through research that a child’s trajectory for social and emotional development can be altered with appropriate identification and early intervention (Shonkoff & Phillips, 2000). CSEFEL offers a Pyramid Model for supporting social and emotional competence in infants and young children with a foundation of supportive policies and a competent workforce. Tier two (promotion) supports healthy relationship development. Tier three (prevention) high quality learning environments and positive outcomes. Tier four focuses on targeted support. Tier five is intensive intervention.

Children and families possess unique characteristics. According to The National Scientific Council on the Developing Child and the National Forum on Early Childhood Policy and Programs publications *Maternal Depression Can Undermine the Development of Young Children (2009)*, *Excessive Stress Disrupts the Architecture of the Developing Brain (2005)*, and *Mental Health Problems in Early Childhood Can Impair Learning and Behavior for Life (2008)*. <http://developingchild.harvard.edu/>. The following information will support the recommendations on the matrix outlining the components for an Infant and Early Childhood Mental Health System of Care.

Establish Credentials of Providers (Workforce Development)

In the absence of national accreditation for Infant and Early Childhood Mental Health, Idaho is moving toward the highest standard with competency guidelines and an endorsement process developed by Michigan Association for Infant Mental Health (MI AIMH), adopted by 11 additional states, and accepted by the World Association of Infant Mental Health. This endorsement provides an organized system to verify education and competencies of service providers. The Idaho Association of Infant Mental Health (AIM Early Idaho <http://www.aimearlyidaho.org/>), a nonprofit organization, is licensed to endorse professionals. With this in mind, a description of the levels of endorsement is attached. Also attached is a timeline for building workforce capacity.

Description of Recommended Modalities

Family-Centered Care

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Family-centered service recognizes that each family is unique; that the family is the constant in the child's life; and that they are the experts on the child's abilities and needs. The family works with service providers to make informed decisions about the services and supports the child and family receive. In family-centered service, the strengths and needs of all family members are considered. [1]

Family-centered service reflects a shift from the traditional focus on the biomedical aspects of a child's condition to a concern with seeing the child in context of their family and recognizing the primacy of family in the child's life. The principles argue in favour of an approach that respects families as integral and coequal parts of the health care team. [1] This approach is expected to improve the quality and safety of a patient's care by helping to foster communication between families and health care professionals.

1.^ a b Pamela J. Kovacs; Melissa Hayden Bellin; David P. Fauria (2006). "Family-Centered Care ", *Journal of Social Work in End-Of-Life & Palliative Care*, Volume 2, Issue 1 July 2006, pages 13 - 27

Dyadic Model:

Dyadic Developmental Psychotherapy is a treatment approach for families that have children with symptoms of emotional disorders, including Complex Trauma and disorders of attachment.[1] It was originally developed by psychologist Daniel Hughes as an intervention for children whose emotional distress resulted from earlier separation from familiar caregivers.[2][3] Hughes cites attachment theory and particularly the work of John Bowlby as theoretical motivations for dyadic developmental psychotherapy.[3][4][5] However, other sources for this approach may include the work of Stern,[6] who referred to the attunement of parents to infants' communication of emotion and needs, and of Tronick,[7] who discussed the process of communicative mismatch and repair, in which parent and infant make repeated efforts until communication is successful.

Dyadic developmental therapy principally involves creating a "playful, accepting, curious, and empathic" environment in which the therapist attunes to the child's "subjective experiences" and reflects this back to the child by means of eye contact, facial expressions, gestures and movements, voice tone, timing and touch, "co-regulates" emotional affect and "co-constructs" an alternative autobiographical narrative with the child. Dyadic developmental psychotherapy also makes use of cognitive-behavioral strategies. The "dyad" referred to must eventually be the parent-child dyad. The active presence of the primary caregiver is preferred but not required.

Becker-Weidman, A., & Hughes, D., (2008) "Dyadic Developmental Psychotherapy: An evidence-based treatment for children with complex trauma and disorders of attachment," *Child & Adolescent Social Work*, 13, pp.329-337

2.^ Hughes, D. (2003). Psychological intervention for the spectrum of attachment disorders and intrafamilial trauma. *Attachment & Human Development*, 5, 271–279

3.^ a b c d e f g h i Hughes D (2004). "An attachment-based treatment of maltreated children and young people". *Attachment & Human Development* 3: 263–278.
<http://www.attachmentcoalition.org/DDP.pdf>.

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4. ^ Bretherton, I., (1992) "The origins of attachment theory," *Developmental Psychotherapy*, 28:759-775.
5. ^ Holmes, J. (1993) *John Bowlby and Attachment Theory*, London: Routledge ISBN 0-415-07729-X
6. ^ Stern, D., 1985"> Stern, D. (1985) *The Interpersonal World of the Infant*. New York: Basic
7. ^ Tronick, E., & Gianino, A., 1986"> Tronick, E.,& Gianino, A. (1986). "Interactive mismatch and repair". *Zero to Three*, 6(3):1-6.

Evidence Based Practice – Coaching

The use of coaching as an adult learning strategy has been described by early childhood special educators, occupational therapists, physical therapists, and speech-language pathologists as a practice to support families of children with disabilities as well as practitioners in early childhood programs. Campbell (1997) defined the role of the early intervention practitioner as that of a coach rather than a direct therapy provider. Hanft & Pilkington (2000) encouraged early childhood practitioners to reconsider their role “to move to a different position alongside a parent as a coach rather than lead player” (p. 2) since this allows for more opportunities to promote development and learning than direct intervention by the therapist or educator. Rush (2000) noted that a practitioner-as-coach approach provides the necessary parent supports to improve their child’s skills and abilities rather than work directly with the child.

Table 1

Definitions of the Five Key Characteristics of Coaching

Joint Planning	Agreement by both the coach and learner on the actions to be taken by the coach and/or learner or the opportunities to practice between coaching visits.
Observation	Examination of another person’s actions or practices to be used to develop new skills, strategies, or ideas.
Action	Spontaneous or planned events that occur within the context of a real-life situation that provide the learner with opportunities to practice, refine, or analyze new or existing skills.
Reflection	Analysis of existing strategies to determine how the strategies are consistent with evidence-based practices and may need to be implemented without change or modified to obtain the intended outcome(s).

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Feedback

Information provided by the coach based on direct observations of the learner by the coach, actions reported by the learner, or information shared by the learner to expand the learner's current level of understanding about a specific evidence-based practice.

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ATTACHMENT 16 WEB INFRASTRUCTURES FOR TREATMENT SERVICES (WITS)

The Web Infrastructures for Treatment Services (WITS) is a client management system. WITS has been approved as a medical health record which will benefit providers. Division of Behavioral Health's Children and Adult Mental Health programs currently uses the WITS system for client management and data collection as does the Substance Use Disorder provider network.

WITS is a web based and open-source application designed to meet the growing needs to capture patient treatment data and satisfy mandatory government reporting requirements for the planning, administration, and monitoring of Behavioral Health Treatment Programs. Originally sponsored by SAMHSA's Center for Substance Abuse Treatment (CSAT) and State AOD Agencies, WITS facilitates cooperation and collaboration among treatment providers by enabling the sharing of client treatment information via the web.

Although originally designed as a substance use disorder treatment services data collection and management system, WITS has evolved as an advanced Behavioral Health Electronic Health Record System (EHR) to meet the growing needs of organizations and government institutions. As an EHR system, WITS is capable of handling multiple simultaneous users and thousands of patient's records. With a feature rich set of tools, WITS can assist in creating and managing patients, staff, facilities and agencies collecting treatment data, complete with the safety and security of HIPAA compliant software.

WITS—a Certified EHR Technology

WITS v13.1 has received Office of the National Coordinator (ONC) Meaningful Use Certification as a "Complete EHR technology" in an ambulatory setting. This certification was completed by InfoGard Laboratories EHR Certification Body, who is authorized to test and certify Electronic Health Records (EHRs) to the applicable certification criteria adopted by the Secretary under Subpart C of Part 170, Part II, and Part III as stipulated in the Standard and Certification Criteria Final Rule.

WITS 13.1 Cert. (Cert #IG-2595-11-0155) is 2011/2012 compliant and has been certified by an ONC-ATCB in accordance with the applicable certification criteria adopted by the Secretary of Health and Human Services. This certification does not represent an endorsement by the U.S. Department of Health and Human Services or guarantee the receipt of incentive payments.

What does this mean?

This means that current and future customers may utilize the WITS platform to prove meaningful use beginning in 2012. This certification is the core requirement necessary for an EHR to enable eligible providers to qualify for funding under the American Recovery and Reinvestment Act (ARRA). This version of WITS will give any eligible professional a certified product that will help facilitate achieving Stage 1 meaningful use.

Since May 2011, approximately 3000 hours of analysis and development have been spent achieving the goal of obtaining certification. The IDHW's WITS contractor has analyzed and added enhancements to WITS for certification which included General Criteria (170.302), Ambulatory Criteria, (170.304), and Ambulatory Clinical Quality Measures. Specific certification information can be found on the Office of the National Coordinator for Health Information Technology.

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The IDHW's WITS contractor has gained much understanding about this certification and process during the last several months and are making the information and functionality available to our customers. WITS, as a certified EHR technology, is the first step. In the next few months, it will be up to WITS customers and their eligible providers to begin using WITS in a meaningful way, to obtain Centers for Medicare and Medicaid Services (CMS) incentive money.

What's next?

The WITS contractor's number one goal over the last six months has been to obtain Meaningful Use certification for WITS as soon as possible. The federal intent of Stage One Meaningful Use certification was to lay the ground work for standards and interoperability. Many WITS customers know that these requirements did not necessarily focus directly on the needs of and meaning to Behavioral Health providers. For these reasons, the WITS contractor chose to focus on the platform and basic requirements, building components that could be configured and added to by WITS customers. Over the coming months, the WITS contractor will be working with WITS customers to determine their goals for Meaningful Use implementation, and the extent to which the base functionality will meet their needs. The WITS contractor will have the opportunity to further customize each instance to better integrate the Meaningful Use features into each customer's specific business processes. As with any WITS enhancement, there may be opportunities to share the cost of various enhancement initiatives with other interested customers.

What has changed?

To meet the requirements for Meaningful Use, a variety of new features, roles, modules, screens and fields have been added to WITS. All of the changes were made in the base code of WITS and enabled in the Standard site for certification testing purposes (see Steps for WITS becoming a certified EHR technology). Now that WITS is a certified EHR technology, many features will be available in base for all customers, where those customers use base functionality. The majority of changes have been implemented and are accessible using roles, which will be controlled by the WITS Administrator.

These enhancements were designed to pass Meaningful Use requirements. As customers become familiar with the new functionality, we are assuming some will want to modify some things to fit an individual State's workflow. As with any change request to the system, an enhancement can be done at a cost. Depending on the change requested, a re-certification cost may be required.

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ATTACHMENT 17 VALUES-BASED DESIGN AND DELIVERY OF BEHAVIORAL HEALTH SERVICES AND SUPPORTS

Idaho Medicaid behavioral health services embrace the philosophy that the most effective and appropriate behavioral health services are those that are tailored to meet the needs of each Member who needs treatment and/or support. One of the major reasons the IDHW has chosen to implement a managed care plan for behavioral health services is to allow more flexibility in the design and funding of these services for Medicaid beneficiaries. Through the implementation of the Idaho Behavioral Health Plan, the focus of behavioral health service delivery can continue to promote the philosophy of recovery and rehabilitation throughout the continuum of care spectrum. This incorporates into its policies and practices the following values:

- Self-Determination
- Empowering Relationships
- Meaningful Roles in Society and
- Eliminating Stigma and Discrimination

The Idaho Behavioral Health Plan philosophy, which incorporates these values, contains the following principles related to the delivery of behavioral health services and supports:

Members choose their health professional to the extent possible and appropriate. Policies support the involvement of the Member, and those significant in the Member's life as appropriate, in decisions about services provided to meet the Member's behavioral health needs.

Policies relate to the Member's interaction with the plan's administrator as well as the Member's interaction with providers of direct service and including but not limited to those, such as case managers or workers in the corrections system, who assist the Member in treatment planning.

To the extent possible, the plan administrator works with all providers serving an Member or the Member's family to blend and coordinate the services provided. Eliminating both gaps in service and duplication are crucial to the provision of appropriate and cost-effective services.

To the extent possible, adults with behavioral health issues live and work in normal community environments and fully participate in the life of the community. Therefore services for people who have behavioral health issues focus on helping the person to maintain his or her home environment and on promoting his or her recovery.

Children live and develop most normally in a family environment. Thus behavioral health services for children are most appropriately directed toward helping a child and the child's family develops and maintains a stable environment for the child.

In the delivery of all behavioral health services and supports exploration should be done of the use of emerging technology as a way to extend the services of behavioral health professionals, particularly into rural areas of the state in which behavioral health services are not readily available to Members.

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ATTACHMENT 18 TRAUMA INFORMED CARE

Most individuals seeking public behavioral health services and many other public services, such as homeless and domestic violence services, have histories of physical and sexual abuse and other types of trauma-inducing experiences. These experiences often lead to mental health and co-occurring disorders such as chronic health conditions, substance use disorders, eating disorders, and HIV/AIDS, as well as contact with the criminal justice system.

Trauma Informed Care is an evidence-based practice that teaches service providers and their organizations about the triggers and vulnerabilities of trauma survivors. Trauma Informed Care helps providers to provide care to trauma survivors more effectively, while avoiding re-traumatization. This best-practice include understanding trauma and its effects, creating safe physical and emotional space, supporting consumer choice and control, and integrating trauma-informed care across service systems.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

TF-CBT is a clinic-based, short-term treatment (16 to 20 sessions) for children, ages 4 to 18 who have significant behavioral and emotional problems that are related to traumatic life events, even if they do not meet full diagnostic criteria for post traumatic stress disorder (PTSD). TF-CBT is an evidence-based model of psychotherapy that combines trauma-sensitive interventions with cognitive behavioral therapy. Individual sessions with the child and parent as well as joint parent-child sessions are provided. Treatment results in significant reduction in PTSD and depressive symptoms.

Websites for trauma care:

National Center for Trauma-Informed Care

<http://www.samhsa.gov/nctic/trauma.asp>

Trauma-Informed Care and Trauma Services

National Child Traumatic Stress Network

www.NCTSN.org

How to Implement Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Administration for children and families

www.hhs.gov

Trauma focused CBT: Addressing the mental health of sexually abused children

Homeless Resource Center; Guarino, Kathleen

<http://homeless.samhsa.gov/Resource/Trauma-Informed-Care-101-46857.aspx>

Trauma-Informed Care 101

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ATTACHMENT 19 BEHAVIORAL HEALTH CLAIMS EXPERIENCE (SFY11)

This Attachment contains a historical review of expenditures for state fiscal year 2011. This information was developed for the Idaho Department of Health and Welfare (IDHW) via a contract for actuarial services. While the source data was reviewed for reasonableness, it has not been audited. Neither the IDHW nor its contractor makes any representations or warranties regarding this data. Bidders must not place any reliance on this data that would result in the creation of any duty or liability under any theory of law by the IDHW or its contractor to a bidder. Bidders must rely on their own experts in drawing conclusions from these summaries.

The IDHW currently administers two benefit plans for Medicaid participants known as the Basic Plan and the Enhanced Plan. The Basic Plan is for children and working age adults without special health care needs. The Enhanced Plan provides for more intensive and extensive services for those individuals who are aged, disabled or who have special health care needs (includes individuals diagnosed as SED or SPMI).

The IDHW wishes to merge these two Plans with respect to the provision of Behavioral Health services and emerge with a managed care program with two capitated rates, one for individuals who are eligible for both Medicare and Medicaid (dual eligibles- who are currently receiving benefits under the Enhanced Plan) and one for all other Medicaid eligibles (non-duals).

The following tables are included:

Exhibit	Description
2-Medicaid	Behavioral Health - Basic and Enhanced All Medicaid (non-duals)
2-Dual	Behavioral Health - Duals
2a-B-All	Behavioral Health - Basic All Medicaid
2a-B-Child	Behavioral Health - Basic Child Medicaid
2a-B-Adult	Behavioral Health - Basic Adult Medicaid
2b-E-All	Behavioral Health - Enhanced All Medicaid

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2b-E-Child Behavioral Health - Enhanced Child Medicaid

2b-E-Adult Behavioral Health - Enhanced Adult Medicaid

Mental Health – State Plan Service

Exhibit 2-1

Mental Health Carveout - Basic and Enhanced (Duals excluded)

Average Members

200,766

SFY11

Paid	Procedures	Units	PMPM	Paid/Proc	Paid/Unit
Mental Health Grouping					
Eval - Nontherapist	\$1,027,915	7,919	90,994	\$0.43	\$129.80
Eval - Therapist	\$4,112,114	29,518	225,057	\$1.71	\$139.31
Eval - Therapist Interactive	\$135,813	950	6,525	\$0.06	\$142.93
Psych Testing	\$469,475	4,048	8,804	\$0.19	\$115.97
Indiv Therapy 20-30	\$908,324	19,951	20,175	\$0.38	\$45.53
Indiv Therapy 45-50	\$12,754,699	210,714	212,743	\$5.29	\$60.53
Indiv Therapy 75-80	\$1,059,892	12,248	12,421	\$0.44	\$86.53
Indiv Therapy w/mm 20-30	\$90,950	1,214	1,643	\$0.04	\$74.93
Indiv Therapy w/mm 45-50	\$5,462	56	69	\$0.00	\$97.93
Indiv Therapy w/mm 75-80	\$206	2	2	\$0.00	\$101.39
Fam therapy w/patient	\$908,909	18,289	69,982	\$0.38	\$49.70
Fam therapy w/o patient	\$260,324	5,263	18,852	\$0.11	\$49.46
Med Management	\$1,352,757	25,479	25,668	\$0.56	\$53.09
Indiv Skills Training-HQ mod	\$103,123	5,432	43,161	\$0.04	\$18.99
Psych Rehab Service	\$48,976,043	522,912	4,318,824	\$20.33	\$93.66
Psych Rehab Service-U1 mod	\$392	3	24	\$0.00	\$128.93
Targeted Case Management	\$2,608,359	76,853	237,095	\$1.08	\$33.94
Community Reintegration	\$5,396,298	96,434	475,711	\$2.24	\$55.96
Neuropsychological Testing	\$486,044	2,321	5,725	\$0.20	\$209.39
Total MH Groupings	\$80,657,101	1,039,608	5,773,473	\$33.48	\$77.58
Total MH Not Mapped	\$5,349,316	124,993	1,001,190	\$2.22	\$42.80
Substance Abuse	\$2,078,747	43,918	287,743	\$0.86	\$47.33
Total Services For Capitation	\$88,085,165	1,208,518	7,062,406	\$36.56	\$72.89

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Services for Management Incentive

Paid	Admits	Cases	PMPM	Paid/Admit	Paid/Case
Inpatient Admissions	\$23,583,838	4,033	N/A	\$9.79	\$5,847.60

Mental Health – State Plan Service

Exhibit 2-2

Mental Health Carveout - Duals Non-MMCP

Average Members

22,236

SFY11

Paid	Procedures	Units	PMPM	Paid/Proc	Paid/Unit
Mental Health Grouping					
Eval - Nontherapist	\$486,809	3,383	43,088	\$1.82	\$143.90
Eval - Therapist	\$690,395	4,985	38,857	\$2.59	\$138.49
Eval - Therapist Interactive	\$3,308	37	173	\$0.01	\$90.60
Psych Testing	\$36,629	374	785	\$0.14	\$97.89
Indiv Therapy 20-30	\$219,057	4,548	4,625	\$0.82	\$48.16
Indiv Therapy 45-50	\$2,092,245	36,289	36,834	\$7.84	\$57.66
Indiv Therapy 75-80	\$266,990	3,146	3,233	\$1.00	\$84.87
Indiv Therapy w/mm 20-30	\$17,602	263	265	\$0.07	\$67.02
Indiv Therapy w/mm 45-50	\$1,121	12	13	\$0.00	\$92.16
Indiv Therapy w/mm 75-80	\$61	1	1	\$0.00	\$60.60
Fam therapy w/patient	\$32,540	628	2,502	\$0.12	\$51.84
Fam therapy w/o patient	\$3,495	69	264	\$0.01	\$50.68
Med Management	\$565,129	10,781	10,902	\$2.12	\$52.42
Indiv Skills Training-HQ mod	\$72,418	3,668	29,832	\$0.27	\$19.74
Psych Rehab Service	\$13,980,417	172,646	1,239,459	\$52.40	\$80.98
Psych Rehab Service-U1 mod	\$345	4	30	\$0.00	\$85.13
Targeted Case Management	\$2,435,963	74,944	215,311	\$9.13	\$32.50
Community Reintegration	\$2,179,357	35,975	192,036	\$8.17	\$60.58
Neuropsychological Testing	\$15,204	90	231	\$0.06	\$168.46
Total MH Groupings	\$23,099,086	351,842	1,818,442	\$86.57	\$65.65
Total MH Not Mapped	\$1,617,070	53,205	412,072	\$6.06	\$30.39
Substance Abuse	\$405,356	8,932	56,678	\$1.52	\$45.38
Total Services For Capitation	\$25,121,512	413,979	2,287,192	\$94.15	\$60.68

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Mental Health – State Plan Service

Exhibit 2a

Mental Health Carveout - Basic All Medicaid

Average Members

163,688

SFY11

Paid

Mental Health Grouping

	Procedures	Units	PMPM	Paid/Proc	Paid/Unit	
Eval - Nontherapist	\$65,038	550	5,745	\$0.03	\$118.33	\$11.32
Eval - Therapist	\$1,046,311	8,263	57,112	\$0.53	\$126.63	\$18.32
Eval - Therapist Interactive	\$58,859	406	3,043	\$0.03	\$145.10	\$19.34
Psych Testing	\$152,744	1,234	2,785	\$0.08	\$123.76	\$54.85
Indiv Therapy 20-30	\$113,995	2,637	2,677	\$0.06	\$43.23	\$42.58
Indiv Therapy 45-50	\$2,678,300	44,313	44,758	\$1.36	\$60.44	\$59.84
Indiv Therapy 75-80	\$206,442	2,375	2,403	\$0.11	\$86.92	\$85.90
Indiv Therapy w/mm 20-30	\$13,248	176	181	\$0.01	\$75.08	\$73.39
Indiv Therapy w/mm 45-50	\$745	7	9	\$0.00	\$104.96	\$81.64
Indiv Therapy w/mm 75-80	\$0	-	-	-	\$0.00	
Fam therapy w/patient	\$206,474	4,200	15,931	\$0.11	\$49.16	\$12.96
Fam therapy w/o patient	\$47,586	989	3,502	\$0.02	\$48.13	\$13.59
Med Management	\$149,625	2,817	2,863	\$0.08	\$53.11	\$52.27
Indiv Skills Training-HQ mod	\$2,974	230	1,129	\$0.00	\$12.92	\$2.63
Psych Rehab Service	\$499,532	5,596	44,023	\$0.25	\$89.27	\$11.35
Psych Rehab Service-U1 mod	\$0	-	-	-	\$0.00	
Targeted Case Management	\$33,413	842	2,988	\$0.02	\$39.70	\$11.18
Community Reintegration	\$26,323	430	2,317	\$0.01	\$61.22	\$11.36
Neuropsychological Testing	\$100,425	442	1,148	\$0.05	\$227.13	\$87.48
Total MH Groupings	\$5,402,032	75,507	192,613	\$2.75	\$71.54	\$28.05
Total MH Not Mapped	\$575,026	10,908	45,999	\$0.29	\$52.72	\$12.50
Substance Abuse	\$1,115,636	23,893	157,354	\$0.57	\$46.69	\$7.09
Total Services For Capitation	\$7,092,695	110,308	395,966	\$3.61	\$64.30	\$17.91

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Mental Health – State Plan Service

Exhibit 2a1

Mental Health Carveout - Basic Child Medicaid

Average Members

145,461

SFY11

Paid

Mental Health Grouping

		Procedures	Units	PMPM	Paid/Proc	Paid/Unit
Eval - Nontherapist	\$40,140	357	3,546	\$0.02	\$112.45	\$11.32
Eval - Therapist	\$834,629	6,575	45,740	\$0.48	\$126.93	\$18.25
Eval - Therapist Interactive	\$52,902	336	2,724	\$0.03	\$157.60	\$19.42
Psych Testing	\$137,829	1,081	2,504	\$0.08	\$127.50	\$55.04
Indiv Therapy 20-30	\$100,202	2,334	2,374	\$0.06	\$42.92	\$42.21
Indiv Therapy 45-50	\$2,233,287	37,014	37,392	\$1.28	\$60.34	\$59.73
Indiv Therapy 75-80	\$142,102	1,642	1,653	\$0.08	\$86.55	\$85.95
Indiv Therapy w/mm 20-30	\$9,064	121	123	\$0.01	\$75.11	\$73.86
Indiv Therapy w/mm 45-50	\$641	6	7	\$0.00	\$105.28	\$90.24
Indiv Therapy w/mm 75-80		\$0	-	-		\$0.00
Fam therapy w/patient	\$189,744	3,863	14,650	\$0.11	\$49.12	\$12.95
Fam therapy w/o patient	\$46,695	970	3,436	\$0.03	\$48.11	\$13.59
Med Management	\$73,589	1,390	1,415	\$0.04	\$52.93	\$52.02
Indiv Skills Training-HQ mod	\$682	45	301	\$0.00	\$15.28	\$2.26
Psych Rehab Service	\$391,870	4,241	34,534	\$0.22	\$92.40	\$11.35
Psych Rehab Service-U1 mod		\$0	-	-		\$0.00
Targeted Case Management	\$5,202	161	466	\$0.00	\$32.26	\$11.15
Community Reintegration	\$23,065	384	2,030	\$0.01	\$60.01	\$11.36
Neuropsychological Testing	\$94,845	415	1,081	\$0.05	\$228.67	\$87.74
Total MH Groupings	\$4,376,488	60,935	153,977	\$2.51	\$71.82	\$28.42
Total MH Not Mapped	\$472,539	8,469	36,991	\$0.27	\$55.80	\$12.77
Substance Abuse	\$546,974	12,168	76,458	\$0.31	\$44.95	\$7.15
Total Services For Capitation	\$5,396,001	81,572	267,426	\$3.09	\$66.15	\$20.18

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Mental Health – State Plan Service

Exhibit 2a2

Mental Health Carveout - Basic Adult Medicaid

Average Members

18,227

SFY11

Paid	Procedures	Units	PMPM	Paid/Proc	Paid/Unit	
Mental Health Grouping						
Eval - Nontherapist	\$24,897	193	2,199	\$0.11	\$129.22	\$11.32
Eval - Therapist	\$211,682	1,687	11,372	\$0.97	\$125.44	\$18.61
Eval - Therapist Interactive	\$5,956	70	319	\$0.03	\$85.12	\$18.65
Psych Testing	\$14,915	153	281	\$0.07	\$97.40	\$53.09
Indiv Therapy 20-30	\$13,793	302	303	\$0.06	\$45.64	\$45.53
Indiv Therapy 45-50	\$445,013	7,299	7,366	\$2.03	\$60.96	\$60.42
Indiv Therapy 75-80	\$64,340	733	750	\$0.29	\$87.75	\$85.79
Indiv Therapy w/mm 20-30	\$4,184	56	58	\$0.02	\$75.02	\$72.39
Indiv Therapy w/mm 45-50	\$105	1	2	\$0.00	\$103.10	\$51.55
Indiv Therapy w/mm 75-80	\$0	-	-	-	-	\$0.00
Fam therapy w/patient	\$16,729	338	1,281	\$0.08	\$49.54	\$13.06
Fam therapy w/o patient	\$891	18	66	\$0.00	\$48.82	\$13.52
Med Management	\$76,036	1,427	1,448	\$0.35	\$53.29	\$52.51
Indiv Skills Training-HQ mod	\$2,292	186	828	\$0.01	\$12.35	\$2.77
Psych Rehab Service	\$107,662	1,355	9,489	\$0.49	\$79.46	\$11.35
Psych Rehab Service-U1 mod	\$0	-	-	-	-	\$0.00
Targeted Case Management	\$28,211	680	2,521	\$0.13	\$41.46	\$11.19
Community Reintegration	\$3,257	46	287	\$0.01	\$71.38	\$11.35
Neuropsychological Testing	\$5,581	27	67	\$0.03	\$203.82	\$83.38
Total MH Groupings	\$1,025,544	14,572	38,636	\$4.69	\$70.38	\$26.54
Total MH Not Mapped	\$102,487	2,439	9,008	\$0.47	\$42.02	\$11.38
Substance Abuse	\$568,662	11,725	80,896	\$2.60	\$48.50	\$7.03
Total Services For Capitation	\$1,696,694	28,736	128,540	\$7.76	\$59.05	\$13.20

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Mental Health – State Plan Service

Exhibit 2b

Mental Health Carveout - Enhanced All Medicaid

Average Members

37,078

SFY11

Paid	Procedures	Units	PMPM	Paid/Proc	Paid/Unit
Mental Health Grouping					
Eval - Nontherapist	\$962,877	7,369	85,249	\$2.16	\$130.66
Eval - Therapist	\$3,065,804	21,256	167,945	\$6.89	\$144.24
Eval - Therapist Interactive	\$76,955	545	3,481	\$0.17	\$141.31
Psych Testing	\$316,731	2,814	6,019	\$0.71	\$112.55
Indiv Therapy 20-30	\$794,329	17,315	17,498	\$1.79	\$45.88
Indiv Therapy 45-50	\$10,076,399	166,401	167,985	\$22.65	\$60.55
Indiv Therapy 75-80	\$853,450	9,873	10,018	\$1.92	\$86.44
Indiv Therapy w/mm 20-30	\$77,702	1,037	1,462	\$0.17	\$74.90
Indiv Therapy w/mm 45-50	\$4,717	49	60	\$0.01	\$96.91
Indiv Therapy w/mm 75-80	\$206	2	2	\$0.00	\$101.39
Fam therapy w/patient	\$702,436	14,089	54,051	\$1.58	\$49.86
Fam therapy w/o patient	\$212,738	4,274	15,350	\$0.48	\$49.77
Med Management	\$1,203,133	22,662	22,805	\$2.70	\$53.09
Indiv Skills Training-HQ mod	\$100,150	5,201	42,032	\$0.23	\$19.25
Psych Rehab Service	\$48,476,511	517,316	4,274,801	\$108.95	\$93.71
Psych Rehab Service-U1 mod	\$392	3	24	\$0.00	\$128.93
Targeted Case Management	\$2,574,946	76,011	234,107	\$5.79	\$33.88
Community Reintegration	\$5,369,975	96,004	473,393	\$12.07	\$55.93
Neuropsychological Testing	\$385,618	1,879	4,577	\$0.87	\$205.21
Total MH Groupings	\$75,255,069	964,101	5,580,860	\$169.14	\$78.06
Total MH Not Mapped	\$4,774,290	114,085	955,191	\$10.73	\$41.85
Substance Abuse	\$963,111	20,024	130,389	\$2.16	\$48.10
Total Services For Capitation	\$80,992,470	1,098,210	6,666,441	\$182.03	\$73.75

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Mental Health – State Plan Service

Exhibit 2b1

Mental Health Carveout - Enhanced Child Medicaid

Average Members

23,326

SFY11

Paid	Procedures	Units	PMPM	Paid/Proc	Paid/Unit	
Mental Health Grouping						
Eval - Nontherapist	\$473,324	3,864	41,829	\$1.69	\$122.50	\$11.32
Eval - Therapist	\$2,208,742	15,241	121,091	\$7.89	\$144.92	\$18.24
Eval - Therapist Interactive	\$70,029	470	3,151	\$0.25	\$149.15	\$22.23
Psych Testing	\$264,255	2,358	5,090	\$0.94	\$112.08	\$51.92
Indiv Therapy 20-30	\$601,081	13,393	13,540	\$2.15	\$44.88	\$44.39
Indiv Therapy 45-50	\$7,586,904	125,594	126,825	\$27.10	\$60.41	\$59.82
Indiv Therapy 75-80	\$512,942	5,980	6,082	\$1.83	\$85.77	\$84.34
Indiv Therapy w/mm 20-30	\$50,550	669	1,084	\$0.18	\$75.53	\$46.63
Indiv Therapy w/mm 45-50	\$3,550	37	47	\$0.01	\$97.24	\$76.10
Indiv Therapy w/mm 75-80	\$122	1	1	\$0.00	\$120.00	\$120.00
Fam therapy w/patient	\$657,280	13,249	50,629	\$2.35	\$49.61	\$12.98
Fam therapy w/o patient	\$205,005	4,172	14,892	\$0.73	\$49.14	\$13.77
Med Management	\$584,915	11,000	11,097	\$2.09	\$53.17	\$52.71
Indiv Skills Training-HQ mod	\$41,986	2,112	18,265	\$0.15	\$19.88	\$2.30
Psych Rehab Service	\$35,625,342	362,580	3,143,255	\$127.27	\$98.26	\$11.33
Psych Rehab Service-U1 mod	\$150	1	8	\$0.00	\$148.00	\$18.50
Targeted Case Management	\$205,967	6,062	18,236	\$0.74	\$33.98	\$11.29
Community Reintegration	\$3,446,793	64,859	303,919	\$12.31	\$53.14	\$11.34
Neuropsychological Testing	\$358,991	1,739	4,258	\$1.28	\$206.41	\$84.31
Total MH Groupings	\$52,897,928	633,381	3,883,297	\$188.98	\$83.52	\$13.62
Total MH Not Mapped	\$3,432,207	71,146	648,729	\$12.26	\$48.24	\$5.29
Substance Abuse	\$366,512	7,902	49,542	\$1.31	\$46.38	\$7.40
Total Services For Capitation	\$56,696,648	712,429	4,581,567	\$202.55	\$79.58	\$12.37

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Mental Health – State Plan Service

Exhibit 2b2

Mental Health Carveout - Enhanced Adult Medicaid

Average Members

13,752

SFY11

Paid	Procedures	Units	PMPM	Paid/Proc	Paid/Unit
Mental Health Grouping					
Eval - Nontherapist	\$489,553	3,506	43,421	\$2.97	\$139.64
Eval - Therapist	\$857,061	6,015	46,854	\$5.19	\$142.50
Eval - Therapist Interactive	\$6,926	75	331	\$0.04	\$92.29
Psych Testing	\$52,477	456	929	\$0.32	\$114.99
Indiv Therapy 20-30	\$193,247	3,922	3,958	\$1.17	\$49.28
Indiv Therapy 45-50	\$2,489,495	40,806	41,160	\$15.09	\$61.01
Indiv Therapy 75-80	\$340,508	3,893	3,936	\$2.06	\$87.46
Indiv Therapy w/mm 20-30	\$27,152	368	378	\$0.16	\$73.76
Indiv Therapy w/mm 45-50	\$1,167	12	13	\$0.01	\$95.91
Indiv Therapy w/mm 75-80	\$84	1	1	\$0.00	\$82.77
Fam therapy w/patient	\$45,156	840	3,423	\$0.27	\$53.78
Fam therapy w/o patient	\$7,733	102	458	\$0.05	\$75.50
Med Management	\$618,218	11,662	11,708	\$3.75	\$53.01
Indiv Skills Training-HQ mod	\$58,164	3,089	23,767	\$0.35	\$18.83
Psych Rehab Service	\$12,851,169	154,737	1,131,545	\$77.88	\$83.05
Psych Rehab Service-U1 mod	\$242	2	16	\$0.00	\$119.40
Targeted Case Management	\$2,368,979	69,949	215,872	\$14.36	\$33.87
Community Reintegration	\$1,923,182	31,145	169,475	\$11.65	\$61.75
Neuropsychological Testing	\$26,627	140	318	\$0.16	\$190.27
Total MH Groupings	\$22,357,141	330,720	1,697,564	\$135.48	\$67.60
Total MH Not Mapped	\$1,342,083	42,939	306,462	\$8.13	\$31.26
Substance Abuse	\$596,599	12,123	80,847	\$3.62	\$49.21
Total Services For Capitation	\$24,295,822	385,781	2,084,873	\$147.23	\$62.98

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ATTACHMENT 20 STATE MEDICAID DIRECTOR LETTERS

The State Medicaid Director Letters can be accessed as a separate attachment on the Sicomm.net Request for Proposals solicitation page.

1, SMDL #10-024

Re: Health Homes for Enrollees with Chronic Conditions

2, SMDL #12-002

Re: Policy Considerations for Integrated Care Models