STATE OF HAWAII

Department of Human Services

REQUEST FOR PROPOSALS (RFP)

COMMUNITY CARE SERVICES PROGRAM (CCS) THAT PROVIDES BEHAVIORAL HEALTH SERVICES TO MEDICAID ELIGIBLE ADULTS WHO HAVE A SERIOUS MENTAL ILLNESS (SMI) OR SERIOUS AND PERSISTENT MENTAL ILLNESS (SPMI)

RFP–MQD–2021-010

Med-QUEST Division
Health Coverage Services Branch

State of Hawaii

Department of Human Services

Med-QUEST Division

Request for Proposals

RFP-MQD-2021-010

COMMUNITY CARE SERVICES PROGRAM (CCS) THAT PROVIDES BEHAVIORAL HEALTH SERVICES TO MEDICAID ELIGIBLE ADULTS WHO HAVE A SERIOUS MENTAL ILLNESS (SMI) OR SERIOUS AND PERSISTENT MENTAL ILLNESS (SPMI)

November 6, 2020

Note: It is the Offeror's responsibility to check the public procurement notice website for any addenda issued to this RFP. The State shall not be responsible for any incomplete proposal submitted as a result of missing addenda, attachments or other information regarding the RFP.

Table of Contents

SECTION 1 – Administrative Overview & RFP Requirements

1.1 Purpose of the Request for Proposals

A) This Request for Proposal (RFP) solicits participation by a qualified health care organization to case manage, authorize, and facilitate the delivery of behavioral health services to Medicaid eligible adults who have serious mental illness (SMI) or serious and persistent mental illness (SPMI), and who are in QUEST Integration (QI) Health Plans. The services shall be provided statewide through a single vendor and shall be collectively referred to as Community Care Services (CCS). A health care organization submitting a proposal in response to this RFP will hereinafter be referred to as "Offeror" or "Offerors", as appropriate. The selected Offeror that is ultimately awarded the resulting contract from this RFP, will hereinafter be referred to as the "Behavioral Health Organization" or "BHO".

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

C) The Department of Health-Adult Mental Health Division (DOH-AMHD) provides services for many individuals in QI Health Plans or uninsured individuals. Only individuals determined to be eligible for Med-QUEST and CCS services under the Department of Human

Services (DHS), and enrolled in a QI Health Plan, may be transitioned into CCS.

D) The Department of Health – Developmental Disabilities Division (DOH-DDD) provides services for persons with intellectual and/or developmental disabilities (I/DD). Most services provided are through the Medicaid 1915(c) Home and Community Based Services (HCBS) Waiver for individuals with I/DD to support these participants to live in their homes and communities through services that promote each person's self-determination, health, community integration, and safety (Section 1915(c) of the Social Security Act). Only individuals determined to be eligible for CCS services under the Department of Human Services (DHS), and enrolled in a QI Health Plan, may be transitioned into CCS.

E) For individuals who meet the criteria for the CCS program and who are in the process of transferring into it, the BHO shall coordinate with DOH-CAMHD, DOH-AMHD, DOH-DDD, the Hawaii State Hospital, a correctional facility, and other agencies involved, to manage and ensure a smooth transition for the individual.

F) If the individual does not meet the criteria for CCS, the QI Health Plans are responsible for administering behavioral health services. The QI Health Plan will conduct a special health care needs assessment to determine behavioral health services needed for each individual member.

G) DHS reserves the right to add new eligibility groups and benefits and to negotiate different or new rates including any such

changes. Services to CCS members under the contract awarded shall commence on the date identified in Section 1.5.

H) Offerors are advised that the entire RFP, any addenda, and the corresponding proposal shall be part of the contract with the awarded Offeror.

I) In accordance with Hawaii Administrative Rules (HAR) § 3-143-608, after-the-fact secondary purchases will not be allowed and there are no planned secondary purchases.

1.2 Authority for Issuance of RFP

A) This RFP is issued under the authority of Title XIX of the Social Security Act, 42 U.S.C. § 1396, et. seq. as amended, the implementing regulations issued under the authority thereof, Hawaii Revised Statutes (HRS) § 346-14, and the provisions of HRS Chapter 103F.

B) All Offerors are charged with presumptive knowledge of all requirements cited by these authorities, and submission of a valid executed proposal by any Offeror shall constitute admission of such knowledge on the part of such Offeror. Failure to comply with any requirement may result in the rejection of the proposal. DHS reserves the right to reject any or all proposals received or to cancel this RFP, according to the best interest of the State.

1.3 RFP Organization

This RFP is composed of 16 sections plus Appendices:

- Section 1: Administrative Overview & RFP Requirements – Provides general information on the purpose of the RFP, the authorities relating to the issuance of the RFP, the use of subcontractors and the organization of the RFP. Provides information on the rules and schedules for procurement

- Section 2: Scope, Background, and BHO's Role in Managed Care – Describes the scope of the RFP, background of the CCS population, and the general roles and responsibilities of the BHO and DHS in the managed care system.

- Section 3: Definitions and Acronyms – Provides the definitions for terms and acronyms used in this RFP.

- Section 4: Covered Benefits and Services – Provides information on behavioral health, community integration, and other services and supports to be provided under the RFP.

- Section 5: Quality, Utilization Management, and Administrative Requirements – Provides information on Quality Strategy, the Quality Assurance and Performance Improvement (QAPI) Program, External Quality Review Organization (EQRO) requirements, and other issues surrounding quality.

- Section 6: BHO Reporting and Encounter Data Responsibilities – Provides information on BHO reporting requirements, submission requirements, and encounter data submission requirements.

- Section 7: BHO Financial Responsibilities – Provides information on BHO reimbursement, provider reimbursement, incentives, and third-party liability.

- Section 8: Provider Network, Provider Credentialing, and Provider Contracts – Provides information on provider network, credentialing, contracting, and provider services requirements.

- Section 9: Eligibility, Enrollment, Disenrollment, and Grievance and Appeals – Provides information on program populations, eligibility, enrollment and disenrollment of Members, notifications to members, member grievances and appeals.

- Section 10: Information Systems and Information Technology – Provides information on information systems requirements.

- Section 11: BHO Personnel – Provides information on BHO personnel requirements.

- Section 12: Program Integrity – Provides information on fraud, waste, and abuse policies, and verification of services.

- Section 13: Readiness Review and Contract Implementation Activities – Provides information on readiness review requirements.

- Section 14: Special Terms and Conditions - Describes the terms and conditions under which the work shall be performed, including penalties for non-compliance and poor performance.

- Section 15: Technical Proposal - Defines the required format of the technical proposal and the minimum information to be provided in the proposal.

- Section 16: Evaluation and Selection – Defines the evaluation criteria and explains the evaluation process.

Various Appendices are included to support the information presented in Sections 1 through 16.

1.4 Issuing Officer and Point of Contact

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

Mr. Jon Fujii
Department of Human Services
Med-QUEST Division
1001 Kamokila Boulevard, Suite 317
Kapolei, Hawaii 96707
Telephone: (808) 692-8083

1.5 RFP Timeline

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

Table 1.5-1: Schedule of RFP Events

Schedule of RFP Events	Date
Issue RFP	November 6, 2020
Orientation	November 20, 2020
Submission of Written Questions	December 4, 2020
Written Responses to Questions	December 11, 2020
Notice of Intent to Propose	December 21, 2020
Proposal Due Date	January 8, 2021
Contract Award	February 8, 2021
Contract Execution Date	March 31, 2021 (Approx)
Date of Implementation of Services to Members	July 1, 2021

1.6 Orientation

A) An orientation in reference to this RFP will be held on the date identified in Section 1.5.

B) The orientation will be held at 1:00 pm (H.S.T.). Interested parties may attend the orientation via teleconference at: Call-In Number: 1-808-829-4853 Conference ID: 701 097 575#.

C) Impromptu questions will be permitted at the orientation and spontaneous answers provided at DHS discretion. However, answers provided at the orientations are only intended as general direction and may not represent DHS' final position, which will be detailed in a formal official response. Formal official responses will be provided in writing. To ensure a written response, any oral questions shall be submitted in writing on the date identified in Section 1.5 in accordance with the process identified in Section 1.8.

1.7 Notice of Intent to Propose

A) Potential Offerors shall submit a Notice of Intent to Propose to the Issuing Officer no later than the date identified in Section 1.5 at 2:00 p.m. (H.S.T.) using the format provided in Appendix B. The Notice of Intent to Propose shall be on the official business letterhead of the Offeror and shall be signed by an individual authorized to commit the Offeror to the work proposed. Submission of a Notice of Intent to Propose is necessary for the Issuing Officer to provide the proposal designated electronic submission site.

B) The Notice of Intent to Propose can be emailed to the following email address with subject line: "The Notice of Intent to Propose for CCS RFP".

Email: rsouza2@dhs.hawaii.gov

1.8 Submission of Written Questions

A) Offerors shall submit all questions in writing via email to the following email address:

Email Address: QUEST_Integration@dhs.hawaii.gov

B) Technical Proposal Questions shall be submitted in the appropriate format provided in Appendix A by 12:00 p.m. (H.S.T.) on the applicable dates identified in Section 1.5.

C) DHS shall respond to the written questions no later than the dates identified in Section 1.5. No verbal responses shall be considered as official.

1.9 Use of Subcontractors

In the event of one proposal submitted jointly or by multiple organizations, one organization shall be designated as the prime Offeror. The project leader shall be an employee of the prime Offeror. All other participants shall be designated as subcontractors. Subcontractors shall be identified by name and by a description of the services/functions they will be performing. The prime Offeror shall be wholly responsible for the entire performance whether-or-not subcontractors are used. The prime Offeror shall sign the contract with DHS.

1.10 Confidentiality of Information

A) DHS shall maintain the confidentiality of proposals only to the extent allowed or required by law, including but not limited to HRS §§92F-13 and 103F-402, and HAR §§ 3-143-604 and 3-143-616.

B) If the BHO seeks to maintain the confidentiality of specific information contained in its proposal, the BHO is responsible for clearly identifying the confidential information and shall mark each page where the confidential information appears as "Proprietary" or "Confidential." An explanation to DHS of how substantial competitive harm would occur if the information were released is required. If the explanation is sufficient, then to the extent permitted by the exemptions in HRS § 92F-13, the affected section may be deemed confidential. Such information shall accompany the proposal, be clearly marked, and shall be readily separable from the proposal to facilitate eventual public inspection of the non-confidential sections of the proposal.

C) DHS shall maintain the confidentiality of the information to the extent allowed by law. Blanket labeling of the entire document as "proprietary," however, shall result in none of the document being considered proprietary.

1.11 Requirements to Conduct Business in the State of Hawaii

A) Offerors are advised that if selected to be awarded the contract under this RFP, the Offeror shall, prior to award of the contract,

furnish proof of compliance with the following requirements of HRS, required to conduct business in the State:

1. HRS Chapter 237, tax clearance
2. HRS Chapter 383, unemployment insurance
3. HRS Chapter 386, workers' compensation
4. HRS Chapter 392, temporary disability insurance
5. HRS Chapter 393, prepaid health care
6. One of the following:
    a. Be registered and incorporated or organized under the laws of the State (hereinafter referred to as a "Hawaii business"); or
    b. Be registered to do business in the State (hereinafter referred to as a "compliant non-Hawaii business").

B) Offerors are advised that there are costs associated with compliance under this Section. Any costs are the responsibility of the Offeror.

C) Proof of compliance may be shown by providing the Certificate of Vendor Compliance issued by Hawaii Compliance Express (HCE).

1.12 Hawaii Compliance Express (HCE)

A) The DHS utilizes the HCE to verify compliance with the requirements to conduct business in the State, upon award of the contract. The HCE is an electronic system that allows vendors/contractors/service providers doing business with the State to quickly and easily demonstrate compliance with applicable laws. It is an online system that replaces the necessity

of obtaining paper compliance certificates from the DOTAX and IRS tax clearance Department of Labor and Industrial Relations (DLIR) labor law compliance, and Department of Commerce and Consumer Affairs (DCCA) good standing compliance. There is a nominal annual fee for the service and is the responsibility of the Offeror. The "Certificate of Vendor Compliance" issued online through HCE provides the registered Offeror's current compliance status as of the issuance date, and is accepted for both contracting and final payment purposes. See website: https://vendors.ehawaii.gov/hce/splash/welcome.html

B) Pursuant to Office of Management and Budget (OMB), 2 CFR Part 180, no award of contract under this RFP shall be made if the Offeror, its subcontractors, and its principals have been suspended or debarred, disqualified or otherwise excluded from participating in this procurement.

1.13 Cost Principles

A) To promote uniform purchasing practices among state purchasing agencies procuring health and human services under HRS Chapter 103F, state purchasing agencies will utilize standard cost principles as outlined on the State Procurement Office (SPO) website. See http://spo.hawaii.gov, search Keyword "Cost Principles". Nothing in this Section shall be construed to create an exemption from any cost principle arising under federal law.

1.14 Campaign Contributions by State and County Contractors

A) Pursuant to HRS § 11-355, campaign contributions are prohibited from specified State or county government contractors during the term of the contract if the contractors are paid with funds appropriated by a legislative body. For more information, refer to the Campaign Spending Commission webpage (http:ags.hawaii.gov/campaign/).

1.15 Documentation

A) Offerors may review information describing Hawaii's Medicaid program by visiting the DHS MQD website: https://medquest.hawaii.gov. All possible efforts shall be made to ensure that the information contained in the website is complete and current. However, DHS does not warrant that the information in the website is indeed complete or correct and reserves the right to amend, delete and modify the information at any time without notice.

1.16 Rules of Procurement

A) No Contingent Fees

1. No Offeror shall employ any company or person, other than a bona fide employee working solely for the Offeror or company regularly employed as its marketing agent, to solicit or secure this contract, nor shall it pay or agree to pay any company or person, other than a bona fide

employee working solely for the Offeror or a company regularly employed by the Offeror as its marketing agent, any fee commission, percentage, brokerage fee, gift, or other consideration contingent upon or resulting from the award of the contract to perform the specifications of this RFP.

B) Discussions with Offerors

1. Prior to the submittal deadline, questions shall be submitted in writing (refer to Section 1.8) and answers shall be provided in the State Procurement Office's Hawaii Awards & Notices Data System (HANDS) site.

2. After the Proposal Submittal Deadline, discussions may be conducted with Offerors whose proposals are determined to be reasonably susceptible of being selected for award, but proposals may be accepted without discussions, in accordance with HAR §3-143-403.

C) RFP Amendments

1. DHS reserves the right to modify, amend, change, add or delete any requirements in this RFP to serve the best interest of the State. DHS reserves the right to issue amendments to the RFP any time prior to the closing date for the submission of the proposals.

2. In addition, addenda may also be made after proposal submission consistent with HAR § 3-143-301(e).

D) Costs of Preparing Proposal

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

E) Provider Participation in Planning

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

F) Disposition of Proposals

1. All proposals become the property of DHS. The successful proposal, excluding inconsistent terms, as determined by DHS, with this RFP, shall be incorporated into the contract. A copy of successful and unsuccessful proposal(s) shall be public record as part of the procurement file as described in HAR § 3-143-616, pursuant to HRS Chapter 103F, after the execution of the contract. DHS shall have the right to use all ideas, or adaptations to those ideas, contained in

any proposal received in response to this RFP. Selection or rejection of the proposal shall not affect this right.

2. According to HAR § 3-143-612, Offerors who submit technical proposals that fail to meet mandatory requirements or fail to meet all threshold requirements during the technical evaluation phase may retrieve their technical proposal within thirty (30) days after its rejection from DHS. After thirty (30) days, DHS may discard the rejected, unclaimed technical proposal.

G) Rules for Withdrawal or Revision of Proposals

1. A proposal may be withdrawn or revised at any time in the DHS proposal designated electronic submission site prior to, but not after, the Proposal Due Date specified in Section 1.5.

2. After the Proposal Due Date as defined in Section 1.5, all proposals timely received shall be deemed firm offers that are binding on the Offerors for ninety (90) days. During this period, an Offeror may neither modify nor withdraw its proposals without written authorization or invitation from DHS.

3. Notwithstanding the general rules for withdrawal or revision of proposals, DHS may request that Offerors submit a final revised proposal in accordance with HAR § 3-143-607.

1.17 Submission of Proposals

A) Each qualified Offeror shall submit only one (1) proposal to provide CCS services statewide. In the event that more than one (1) proposal is submitted, DHS shall reject all proposals. The Proposal Application Identification (Form SPO-H-200) shall be completed and submitted with the proposal (Appendix C). The format and content of the proposal is specified in Section 15.

B) The BHO shall submit both Mandatory and Technical proposals in one (1) single electronic primary folder and a redacted version of the Mandatory and Technical proposals, removing all confidential/proprietary information, in one (1) single electronic redacted version folder to the DHS proposal designated electronic submission site provided by the Issuing Officer. If there are discrepancies between the electronic primary folder and the electronic redacted version folder, the electronic primary folder will be the final version. The Issuing Officer shall receive both electronic primary and redacted version of the Mandatory and Technical proposals no later than 2:00 p.m. (H.S.T.) on the Proposal Due Date specified in Section 1.5.

C) The one (1) single electronic primary folder shall have two (2) subfolders: Mandatory Proposal and Technical Proposal.

D) The BHO shall submit the Mandatory and Technical proposals to the designated electronic submission site as follows:

1. All proposals shall be submitted in a fully searchable Adobe Acrobat Portable File Format (PDF).

2. The PDF submission shall not be password-protected or encrypted.
3. Any forms and/or documents requiring signature(s) shall be scanned into the respective PDF files.

E) The BHO shall place the Mandatory Proposal, as described in Section 15.2, in the Mandatory Proposal subfolder as one (1) PDF file.

F) For the Technical Proposal subfolder, the BHO shall create one (1) PDF file for each evaluation category described in Section 16.5. Each file nomenclature shall be the same as the evaluation category (For example, Section 15.3.D Provider Network [insert Offeror name]). For each evaluation category PDF file submission, the BHO shall include all appendices, graphics and attachments as required in this RFP or to support the responses only for the specific evaluation category. No video shall be included.

G) The BHO shall solely bear the whole and exclusive responsibility for assuring that the documents are received by the Issuing Officer and for assuring the complete, correctly formatted, legible, and timely transmission of all documents. The BHO shall assume all risk that the Issuing Officer receiving equipment and system may be inoperative or otherwise unavailable at the time transmission is attempted.

H) The BHO file submissions to the DHS proposal designated electronic submission site can reviewed or revised until 2:00 p.m. (H.S.T.) on the Proposal Due Date specified in Section 1.5.

I) After the closing date and time, the DHS proposal designated electronic submission site will be closed to prevent further proposal submissions or revisions.

1.18 Multiple or Alternate Proposals

A) Multiple or alternate proposals shall not be accepted. If the Offeror submits multiple proposals or alternate proposals, then all such proposals shall be rejected.

1.19 Mistakes in Proposals

A) In compliance with HAR § 3-143-606, after the submittal deadline, only patent errors may be corrected as provided in this Section. A patent error is an error that would be readily ascertainable by a reasonably knowledgeable person in the field of health and human services. Depending on the circumstances, patent errors may include, but are not limited to arithmetical errors, typographical errors, transposition errors, and omitted signatures.

B) To correct a patent error, the Offeror shall identify the error in the proposal, and establish the following to DHS' satisfaction:

1. That the error identified is a patent error;
2. That the proposed correction constitutes the information intended at the time the proposal was submitted, and not a modification of the proposal based on information received after the submittal deadline; and

3. That the proposed correction is not contrary to the best interest of the purchasing agency or to the fair treatment of other Offerors.

1.20 Rejection of Proposals

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

B) Any proposal offering terms and conditions contradictory to those included in this RFP may be rejected without further notice.

C) A proposal shall be rejected for any one of the following reasons:
   1. Failure to cooperate or deal in good faith (HAR § 3-141-201);
   2. Inadequate accounting system (HAR § 3-141-202);
   3. Late proposals (HAR § 3-143-603);
   4. Proposal is in non-compliance with applicable laws (HAR § 3-143-610(a); or
   5. An Offeror's delivery of proposal after the proposal due date.

D) A proposal shall be rejected for any one of, but not limited to, the following reasons:
   1. Proposal not responsive (HAR § 3-143-610(a)(1)):
      a. Proof of collusion among Offerors, in which case all bids involved in the collusive action shall be rejected and any participant to such collusion shall be barred

from future bidding until reinstated as a qualified Offeror.

2. Applicant not responsible (HAR § 3-143-610(a)(2)):
    a. An Offeror's lack of responsibility and cooperation as shown by past work or services;
    b. An Offeror's being in arrears on existing contracts with the State or having defaulted on previous contracts;
    c. An Offeror's lack of proper provider network and/or sufficient experience to perform the work contemplated, if required;
    d. An Offeror's lack of a proper license to cover the type of work contemplated, if required;
    e. An Offeror in non-compliance with applicable laws.
    f. An Offeror's failure to pay, or satisfactorily settle, all bills overdue for labor and material on former contracts with the State at the time of issuance of this RFP;
    g. An Offeror's lack of financial stability and viability; or
    h. An Offeror's consistently substandard performance related to meeting state requirements from previous contracts.

1.21 Acceptance of Proposals

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

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

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

D) DHS also reserves the right to consider as acceptable only those proposals, excluding inconsistent terms with the RFP, submitted in accordance with all technical requirements set forth in this RFP and which demonstrate an understanding of the requirements.

1.22 Opening of Proposals

A) Proposals, modifications to proposals, and withdrawals of proposals shall be date-stamped and, when possible, time-stamped upon receipt by DHS. All documents so received shall be held in a secure place by DHS and not opened until the Proposal Due Date as described in Section 1.5.

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

1.23 Additional Materials and Documentation

A) Upon request from DHS, each Offeror shall submit any additional materials and documentation reasonably required by the DHS in its evaluation of the proposal.

1.24 Final Revised Proposals

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

1.25 Cancellation of RFP

A) The RFP may be canceled and any or all proposals may be rejected in whole or in part, when it is determined to be in the best interests of the State. The State shall not be liable for any costs, expenses, loss of profits or damages whatsoever, incurred by the Offeror in the event this RFP is canceled, or a proposal is rejected.

1.26 On-Site Visits

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

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

C) After implementation of the contract, DHS shall conduct unannounced on-site visits to the BHO and contracted providers in addition to desk reviews to verify adequate, appropriate, and timely access to services are being provided to the members enrolled in CCS.

1.27 Award Notice

A) A notice of intended contract award, with a statement of findings and decisions, if any, shall be sent to the selected Offeror on or about the Contract Award date identified in Section 1.5. The successful Offeror receiving award shall enter into a formal written contract.

B) The contract award is subject to the available funding. The award of a contract and any allowed renewal or extension thereof, is subject to allotments made by the Director of Finance, State of Hawaii, pursuant to HRS Chapter 37, and subject to the availability of state and federal funds.

C) Any contract arising out of this solicitation is subject to the approval of the Department of Attorney General as to form and to

all further approvals, including the approval of the Governor as required by statute, regulation, rule, order, or other directive.

D) DHS is not liable for any costs incurred prior to the Date of Implementation of Services to Members identified in Section 1.5.

1.28 Protests

A) Offerors may file a Notice of Protest against the awarding of the contract. The Notice of Protest form, SPO-H-801, is available from the State Procurement Office (SPO). Only the following may be protested:

1. DHS's failure to follow procedures established by HRS Chapter 103F;
2. DHS's failure to follow any rule established by HRS Chapter 103F; and
3. DHS's failure to follow any procedure, requirement, or evaluation criterion in the RFP.

B) The Notice of Protest shall be postmarked by the USPS or hand delivered to: (1) the head of DHS conducting the protested procurement; and (2) the procurement officer who is conducting the procurement (as indicated in Table 1.29.B-1 below) within five (5) business days of the postmark of the Notice of Findings and Decisions sent to the protestor. Delivery services other than USPS shall be considered hand deliveries and considered submitted on the date of the actual receipt by DHS.

Table 1.28.B-1: Notice of Protest Delivery

Procurement Officer	Head of DHS
Name: Meredith Nichols	Name: Catherine "Cathy" Betts
Title: Med-QUEST Division Assistant Administrator	Title: Director, Department of Human Services
Mailing Address: P.O. Box 700190 Kapolei, Hawaii 96709-0190	Mailing Address: P.O Box 339 Honolulu, Hawaii 96809-0339
Business Address: 601 Kamokila Boulevard, Room 518 Kapolei, Hawaii 96707	Business Address: 1390 Miller St Room 209 Honolulu, Hawaii 96813

C) All Protests are pursuant to HAR Title 3, Chapter 148.

1.29 Planning Activities Conducted in Preparation for this RFP

A) DHS received information on community needs, best practices, and resources. Planning activities related to this Request for Proposal (RFP) included a Request for Information (RFI) which was posted on the SPO HANDS site on July 21, 2020. DHS received five (5) responses from stakeholders and the public. All responses are available in Med-QUEST website. However, the terms of this RFP are self-contained. Offerors shall not rely on the RFI or responses to the RFI in forming its proposals. The Offeror has the opportunity to ask questions about this RFP pursuant to Section 1.8.

SECTION 2 – Scope, Background, and BHO's Role in Managed Care

2.1 Scope of the RFP

A) The State of Hawaii seeks qualified healthcare organization to case manage, authorize, and facilitate the delivery of behavioral health services to Medicaid eligible adults who have serious mental illness (SMI) or serious and persistent mental illness (SPMI) who are in QUEST Integration (QI) Health Plans. The services shall be provided statewide through a single vendor and shall be collectively referred to as Community Care Services (CCS).

B) The BHO shall assist the State of Hawaii in this endeavor through the tasks, obligations and responsibilities detailed herein.

2.2 Background – Overview of Medical Assistance in Hawaii

A) MQD is the unit within the Department of Human Services (DHS) that administers Hawaii's medical assistance programs. Medicaid, a federal and state partnership program created by Congress in 1965, provides medical assistance benefits to qualified uninsured and underinsured through the QI program.

B) MQD provides most of its healthcare services in a managed care environment for Medicaid beneficiaries. The majority of the Medicaid beneficiaries receive medical, behavioral health, and long-term care services through the QI program, implemented in 2015. Medicaid beneficiaries include pregnant women, children, parents

and caretakers, adults, and individuals who are aged, blind, and/or disabled.

C) Medicaid covers approximately 375,000 individuals. In addition to asset and income limits, the basic eligibility requirements for Medicaid include being: 1) a U.S. citizen or qualified alien; 2) a Hawaii resident; and 3) a person not residing in a public institution such as a prison or the Hawaii State Hospital. Different eligibility categories such as pregnant women and children have different income thresholds and are not subject to an asset limit.

D) At this time, MQD also administers two state-funded programs. They are the aged, blind, and disabled (ABD) program for certain lawfully present non-pregnant adults who are ineligible under Medicaid, and the Breast and Cervical Cancer program. The MQD retains the ability to add new State funded programs. Eligibility requirements are the same as for Medicaid, but there is no U.S. citizenship requirement. Eligible persons are placed in the QI managed care Health Plans. Federal dollars are not claimed for these eligibility groups.

E) MQD is committed to laying the foundation for innovative programs that support and create healthy families and healthy communities through the QI program. MQD has designed the Hawai‘i ‘Ohana Nui Project Expansion (HOPE) initiative, a roadmap to achieve this vision of Medicaid health system transformation. Key strategies of the HOPE initiative and the QI program are: investing in addressing Social Determinants of Health (SDOH); advancing primary care; focusing on prevention and health promotion, disease

management; improving outcomes for high-need, high-cost Medicaid beneficiaries; payment reform and alignment; implementing the framework of a stepped care model and person-centered care approach to health coordination services and behavioral health; and supporting community driven initiatives to improve population health.

2.3 The BHO's Role in Managed Care

A) In Hawaii, those with a behavioral health diagnosis of Serious Mental Illness (SMI) or Serious and Persistent Mental Illness (SPMI) may have difficulty in accomplishing their activities of daily living (ADL) and thus require services beyond basic behavioral health services utilized by individuals without SMI or SPMI. The role of the BHO is to provide intensive services in addition to basic behavioral health services to meet the individual needs of the CCS eligible SMI or SPMI population and maximize health outcomes.

B) Uninsured individuals or those that are legally encumbered with SMI or SPMI receive services through AMHD.

C) The initial population served under this contract will be those currently receiving additional behavioral health services through the BHO.

D) The BHO shall ensure that Members enrolled in the CCS program are assessed to determine behavioral health, substance use disorder (SUD), and community integration services (CIS) needs. All Members shall have case management services provided to access

and facilitate the acquisition and provision of all behavioral health services covered under this agreement. The BHO shall provide each Member with a case manager (CM) who is responsible for the direction, coordination, monitoring and tracking of behavioral health services, SUD services, CIS, and QI Health Plan Health Coordination System (HCS) services, as needed by the Members, as well as setting up a medication regimen, ongoing assessment and management/evaluation of prescribed medications.

E) In accordance with the DHS HOPE initiative, the BHO shall ensure integration of behavioral health services along with their physical and medical needs. The CCS CM shall collaborate with the HCS for services provided as part of the stepped care approach to ensure optimal care to all CCS Members.

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

G) BHO Members retain their primary care provider (PCP) with their assigned QI Health Plan. The BHO shall ensure that the PCP is updated on the Member's BH diagnosis, medication(s), individualized treatment plan (ITP), ongoing care, and close

coordination with the HCS to ensure the Member's medical care is maintained.

H) The BHO is responsible for the delivery of all behavioral health, SUD services and CIS. The BHO will be responsible to coordinate with the QI Health Plan HCS to ensure CCS Members receive necessary and effective medical care. The BHO shall undertake all necessary reviews including utilization reviews to ensure efficacy of services.

I) The BHO shall ensure services are available. The BHO shall be responsible for ensuring access to providers that provide behavioral health, SUD and CIS services state-wide to meet the needs of the BHO's Members.

J) While the BHO is precluded from interfering with Member-provider communications, the BHO is not required to provide, reimburse for, or provide coverage for counseling or referral services for specific services if the BHO objects to the service on moral or religious grounds. In these cases, the BHO shall provide written notification to all of the following:

1. DHS within one-hundred twenty (120) calendar days prior to adopting the policy with respect to any service;
2. DHS with the submission of its proposal to provide services under this RFP;
3. CCS Members to whom DHS will provide information on how and where to obtain such services;
4. Members within thirty (30) calendar days of adopting the policy with respect to any service; and

5. Members and potential Members before and during enrollment.

2.4 BHO Policy Memorandums

A) DHS issues policy memorandums to offer clarity on policy or operational issues or legal changes impacting the BHO. The BHO shall comply with the requirements of all the policy memorandums during the course of the contract and execute each memorandum when distributed by DHS during the period of the contract. The BHO shall acknowledge receipt of the memoranda through electronic mail.

2.5 Overview of DHS Responsibilities

A) MQD is the organizational unit within DHS that is responsible for the operation and administration of the medical assistance programs including QI, CCS, dental and State of Hawaii Organ and Tissue Transplant (SHOTT) programs. For purposes related to this RFP, the basic functions or responsibilities of MQD include:

1. Defining the behavioral health benefits to be provided by the BHO;
2. Developing the rules, policies, regulations, and procedures to be followed under the medical assistance and behavioral health programs administered by DHS;
3. Negotiating and contracting with the BHO;
4. Determining initial and continued eligibility of Members;
5. Enrolling and disenrolling BHO Members;

6. Monitoring the quality of services provided by the BHO and its providers;
7. Reviewing and analyzing utilization of services and reports provided by the BHO;
8. Handling unresolved Member grievances with the BHO;
9. Analyzing the effectiveness of the programs it administers in meeting its objectives;
10. Monitoring the financial status of the BHO;
11. Managing the various information systems;
12. Providing Member eligibility information to the BHO;
13. Reimbursing the BHO through capitation payments; and
14. Imposing civil or administrative monetary penalties and/or financial sanctions for violations of specific contract provisions.

B) DHS shall comply with, and monitor the BHO's compliance with, all applicable state and federal laws and regulations.

C) DHS shall screen and enroll, and periodically revalidate, all network providers in accordance with the requirements of 42 CFR part 455, subparts B and E. Through DHS contract with the BHO, DHS shall ensure that all network providers are enrolled with DHS as Medicaid providers consistent with provider disclosure, screening and enrollment requirements.

SECTION 3 – Definitions and Acronyms

The definitions that follow are used in this Contract.

1. **Abuse** - Any practices that are inconsistent with sound fiscal, business, or medical practice and result in unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or contractual obligations (including the terms of the RFP, contracts and requirements of state and federal regulations) for health care in the managed care setting, incidents or practices of providers that are inconsistent with professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

2. **Activities of Daily Living (ADLs) –** Basic personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, bathing, and transferring.

3. **Acute Care –** Short term medical treatment, usually in an acute care hospital, for individuals having an acute illness or injury.

4. **Adult** - All members age eighteen (18) years or older for community care services (CCS) coverage benefit purposes only.

5. **Advance Directive** - A written instruction, such as a living will or durable power of attorney for health care, recognized under State law relating to provision of health care when the individual is incapacitated.

6. **Adverse Benefit Determination -** Any one of the following:
    a. The denial or restriction of a requested service, including the type or level or service;
    b. The reduction, suspension, or termination of a previously authorized service;
    c. The denial, in whole or part, of payment for a service;
    d. The failure to provide services in a timely manner, as defined in Section 8.1;
    e. The failure of the BHO to act within prescribed timeframes;
    f. For a rural area member or for islands with only one BHO or limited providers, the denial of a member's request to obtain services outside the network:
        1) From any other provider (in terms of training, experience, and specialization) not available within the network;
        2) From a provider not part of a network that is the main source of a service to the member, provided that the provider is given the same opportunity to become a participating provider as other similar providers;
        3) If the provider does not choose to join the network or does not meet the qualifications, the member is given a choice of participating providers and is transitioned to a participating provider within sixty (60) calendar days;
        4) Because the only BHO or provider does not provide the service because of moral or religious objections;
        5) Because the member's provider determines that the member needs related services that would subject

the member to unnecessary risk if received separately and not all related services are available within the network; and

6) The State determines that other circumstances warrant out-of-network treatment.

7. **Ambulatory Care** - Preventive, diagnostic and treatment services provided on an outpatient basis by physicians, nurse practitioners, physician assistants and other PCPs.

8. **Annual Plan Change Period** - A period established by the DHS which occurs annually and is the one scheduled time during which existing members may transfer between health care plans.

9. **Appeal** - A review by the BHO of an adverse benefit determination.

10. **Appointment** – A face-to-face interaction between a provider and a member. This does include interactions made possible using telemedicine but does not include telephone or e-mail interaction.

11. **Authorized Representative –** An individual or organization designated by the member, in writing, with the designee's signature or by legal documentation of authority to act on behalf of a member, in compliance with federal and state law regulations. Designation of an authorized representative may be requested at time of application or at other times as required.

12. **Behavioral Health Services** - The full continuum of services from screening to specialty treatment services to support individuals who have mental health and substance use needs, including those with mild to moderate conditions, emotional disturbance, mental illness, or substance use conditions.

13. **Benchmark –** A target, standard or measurable goal based on historical data or an objective/goal.

14. **Beneficiary** - Any person determined eligible by the DHS and is currently receiving Medicaid.

15. **Benefit Year** – A continuous twelve (12) month period generally following an open enrollment period. In the event the contract is not in effect for the full benefit year, any benefit limits shall be pro-rated.

16. **Capitated Rate** – The fixed monthly payment per member paid by the State to the BHO for which the BHO provides a full range of benefits and services contained in this RFP.

17. **Capitation Payment** – A fixed monthly payment paid per member by the DHS to the BHO for which the BHO provides the defined set of benefits and the payment may be prorated for the portion of the month for which the member was enrolled with the BHO.

18. **The Centers for Medicare & Medicaid Services (CMS)** – The organization within the U.S. Department of Health and Human Services that administers the Medicare and Medicaid programs.

19. **Child and Adolescent Mental Health Division (CAMHD) -** A division of the State of Hawaii Department of Health that provides behavioral health services to children ages three (3) through twenty (20) years who require support for emotional or behavioral development.

20. **Chronic Condition** – Any on-going physical, behavioral, or cognitive disorder, including chronic illnesses, impairments and disabilities. There is an expected duration of at least twelve (12) months with resulting functional limitations, reliance on compensatory mechanisms and service use or needs beyond what is normally considered routine.

21. **Claim** - A document which is submitted by the BHO for payment of health-related services rendered to a member.

22. **Clean Claim** - A claim that can be processed without obtaining additional information from the BHO of the service from a third party. It includes a claim with errors originating in a State's claims system. 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.

23. **Cold-Call Marketing** – Any unsolicited personal contact, whether by phone, mail, or any other method, by the BHO with a potential member, member, or any other individual for marketing.

24. **Community Care Foster Family Home (CCFFH) -** A certified home that provides twenty-four (24) hour living accommodations, including personal care and homemaker services.

25. **Community Integration Services (CIS)** – Pre-tenancy supports and tenancy sustaining services that support members to be prepared and successful tenants in housing that is owned, rented or leased to the individual. Pre-Tenancy supports help to identify the member's needs and preferences, assists in the housing search process, and help to arrange details of the move. Tenancy sustaining services help with independent living sustainability that includes tenant/landlord education, tenant coaching and assistance with community integration and inclusion to help develop natural support networks.

26. **Community Transition Services (CTS) –** A pilot program within the Community Integration Services (CIS) benefit. This program is designed to address eligible beneficiaries' specific health determinants to improve health outcomes and lower healthcare costs. CTS program benefits include transitional case management services, securing house payments, housing quality and safety improvement services and legal assistance. CTS program benefits are authorized by CMS and shall be provided to all beneficiaries who meet CIS eligibility criteria on a voluntary basis.

27. **Contract -** A contract between the BHO and the DHS to provide medical services. A written agreement between the DHS and the contractor that includes the Competitive Purchase of Service (AG Form 103F1 (10/08), General Conditions for Health & Human Services Contracts (AG Form 103F (10/08), Business Associate Agreement, any special conditions and/or Appendices, this RFP, including all attachments and addenda, and the BHO's proposal.

28. **Contract Services -** The services to be delivered by the contractor that are designated by the DHS.

29. **Contractor** - Successful applicant that has executed a contract with the DHS.

30. **Co-Payment** - The amount that a beneficiary or member must pay, usually a fixed amount of the cost of a service.

31. **Covered Services** - Those services and benefits to which the member is entitled under Hawaii's Medicaid programs.

32. **Cultural Competency** – A set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among and between groups and the sensitivity to know how these differences influence relationships with members. This requires a willingness and ability to draw on community-based values, traditions and customs, to devise strategies to better meet culturally diverse member needs, and to work with knowledgeable

persons of and from the community in developing focused interactions, communications and other supports.

33. **Days** - Unless otherwise specified, the term "days" refers to calendar days.

34. **Department of Human Services (DHS)** – Department of Human Services, State of Hawaii, which includes the single state agency responsible for administering the medical assistance program.

35. **Director** - The administrative head of the department of human services unless otherwise specifically noted.

36. **Dual Eligible** – Eligible for both Medicare and Medicaid.

37. **Durable Medical Equipment –** Medical equipment that is ordered by a doctor for use in the home.

38. **Effective Date of Enrollment** - The date from which services are required to be provided to a member by the contracted CCS provider.

39. **Eligibility Determination** - A process of determining, upon receipt of a written request on the Department's application form, whether an individual is eligible for community care services (CCS).

40. **Emergency Medical Condition** – The sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms, substance abuse) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of emergency services or immediate medical attention to result in:

a. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
b. Serious impairment to body functions;
c. Serious dysfunction of any bodily functions;
d. Serious harm to self or others due to an alcohol or drug abuse emergency;
e. Injury to self or bodily harm to others; or
f. With respect to a pregnant woman who is having contractions:
    1) That there is inadequate time to affect a safe transfer to another hospital before delivery; or
    2) That transfer may pose a threat to the health or safety of the woman or her unborn child.

41. **Emergency Medical Transportation** – Ambulance services for an emergency medical condition.

42. **Emergency Room Care** - Emergency services provided in an emergency room.

43. **Emergency Services** – Covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition that is found to exist using a prudent layperson standard.

44. **Encounter** - A record of medical services rendered by a provider to a member enrolled in the BHO on the date of service.

45. **Encounter Data** - A compilation of encounters.

46. **Enrollment** - The process by which an individual, who has been determined eligible, becomes a member in CCS, subject to the limitations specified in the DHS Rules.

47. **Excluded Services** - Health care services that health insurance or plans don't pay for or cover.

48. **External Quality Review Organization (EQRO)** – An organization that meets the competence and independence requirements pursuant to 42 CFR § 438.354 and performs external quality review.

49. **Federal Financial Participation (FFP)** - The contribution that the federal government makes to state Medicaid programs.

50. **Federally Qualified Health Center (FQHC)** – An entity that provides outpatient health programs pursuant to Social Security Act § 1905(l)(2)(B) and is accessible to all community members.

51. **Fee-for-service (FFS)** – A method of reimbursement based on payment for specific services rendered to an individual eligible for coverage under Med-QUEST.

52. **Financial Relationship –** A direct or indirect ownership or investment interest (including an option or nonvested interest) in any entity. This direct or indirect interest may be in the form of equity, debt, or other means and includes an indirect ownership or investment interest no matter how many levels removed from a direct interest, or a compensation management with an entity.

53. **Fraud** - An intentional deception or misrepresentation made by an individual with the knowledge that the deception could result in some unauthorized benefit to that individual or some other individual. It includes any act that constitutes fraud under applicable Federal or State law.

54. **Grievance -** An expression of dissatisfaction from a member, member's representative, or provider on behalf of a member about any matter other than an adverse benefit determination.

55. **Grievance Review** - A State process for the review of a denied or unresolved (dissatisfaction from a member) grievance by the BHO, including instances where the aggrieved party is dissatisfied by the proposed resolution.

56. **Grievance System -** The term used to refer to the overall system that includes grievances and appeals handled at the BHO level with access to the State administrative hearing process.

57. **Habilitative/Habilitation Services** – Health care services that help keep, learn or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

58. **Hawaii Prepaid Medical Management Information System (HPMMIS)** – Federally certified Medicaid Management Information System (MMIS) used for the processing, collecting, analysis and reporting of information needed to support Medicaid and CHIP functions.

59. **Health Care Professional** – A physician, podiatrist, optometrist, psychiatrist, psychologist, dentist, physician assistant, physical or occupational therapist, speech-language pathologist, audiologist, registered or practical nurse, licensed clinical social worker, nurse practitioner, or any other licensed or certified professional who meets the State requirements of a health care professional.

60. **Health Care Provider** – Any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the State.

61. **Health Coordination System (HCS)** – HCS is a service delivery system that applies person-centered practices to accurately assess and document the member's strengths, needs and goals; and coordinate the services and supports that address the

medical, behavioral, wellness, social determinants and long term needs of members with complex medical and social conditions. The QI Health Plan shall have a HCS that collaboratively provides appropriate HCS support across multiple settings and across the continuum of care with the focus on helping the member to meet their health outcomes, support the social aspects of the member's life that contribute to their health, gain personal skills to successfully manage their chronic conditions, and decrease inappropriate utilization.

62. **Health Insurance** - A contract that requires health insurers to pay some or all health care costs in exchange for a premium.

63. **Health Plan** - A plan offered by an insurance company or other organization, which provides different health care benefit packages.

64. **Healthcare Effectiveness Data and Information Set (HEDIS)** - A standardized reporting system for the BHO to report on specified performance measures that are developed by the National Committee for Quality Assurance (NCQA).

65. **HIPAA –** The Health Insurance Portability and Accountability Act that was enacted in 1996. Title I of HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs. Title II, the Administrative Simplification (AS) provisions, requires the establishment of national standards for electronic healthcare transactions and national identifiers for providers, health insurance plans and

employers. The HIPAA AS provisions also address the security and privacy of health information.

66. **Home Health Care -** Limited part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.

67. **Hospice Services -** Services to provide comfort and support for members in the last stages of a terminal illness and their families.

68. **Hospital** - Any licensed acute care facility in the service area to which a member is admitted to receive inpatient services pursuant to arrangements made by a physician.

69. **Hospitalization -** Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

70. **Hospital Outpatient Care** – Care in a hospital that usually doesn't require an overnight stay.

71. **Incentive Arrangement** – Any payment mechanism under which the BHO may receive funds for meeting targets specified in the contract; or any payment mechanism under which a provider may receive additional funds from the BHO for meeting targets specified in the contract.

72. **Independent Activities of Daily Living (IADLs) –** Activities related to independent living, including preparing meals, running errands to pay bills or pick up medication, shopping for groceries or personal items, and performing light or heavy housework.

73. **Indian** - The term "Indians" or "Indian", unless otherwise designated, means any person who is a member of an Indian tribe, as defined in this Section, except that, for the purpose of 25 U.S.C. §§ 1612 and 1613, such terms shall mean any individual who:

a. irrespective of whether he or she lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member, or

b. is an Eskimo or Aleut or other Alaska Native, or

c. is considered by the Secretary of the Interior to be an Indian for any purpose, or

d. is determined to be an Indian under regulations promulgated by the Secretary of Health and Human Services.

74. **Indian Health Care Provider (IHCP)** means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in

Section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).

75. **Indian Tribe** - The term "Indian tribe" means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) [43 U.S.C. § 1601 et seq.], which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

76. **Inquiry** - A contact from a member that questions any aspect of the BHO, subcontractor's, or provider's operations, activities, or behavior, or requests disenrollment, but does not express dissatisfaction.

77. **Long-Term Services and Supports (LTSS)** – A continuum of care and assistance ranging from in-home and community-based services for individuals 65 years or older and individuals with a disability(ies) who need help in maintaining their independence, to institutional care for those who require that level of support.

78. **Managed Care** – A comprehensive approach to the provision of health care that combines clinical services and administrative procedures within an integrated, coordinated system to provide timely access to primary care and other necessary services in a cost-effective manner.

79. **Managed Care Organization (MCO)** – An entity that has, or is seeking to qualify for, a comprehensive risk contract under 42 CFR Subpart A that is: (1) a federally qualified HMO that meets the advance directives requirements under 42 CFR Subpart I; or (2) any public or private entity that meets the advance directives requirements and meets the following conditions:
    a. makes the service it provides to its Medicaid members as accessible (in terms of timeliness, amount, duration, and scope) as those services that are to other Medicaid members within the area served by the entity and
    b. meets the solvency standards of 42 CFR §438.116.

80. **Marketing** – Any communication from the BHO to a member, potential member, or any other individual that can reasonably be interpreted as intending to influence the individual to enroll in the particular BHO, or dissuade them from enrolling into, or disenrolling from, a QI Health Plan.

81. **Marketing Materials** – Materials that are produced in any medium by or on behalf of the BHO and can reasonably be interpreted as intending to market to potential members.

82. **Medicaid** - The following federal/state programs, established and administered by the State, that provide medical care and long-term care services to eligible individuals in the State:
    a. Medicaid under Title XIX of the Social Security Act;
    b. The State children's health insurance program (CHIP) under Title XXI of the Social Security Act; and

c. The Section 1115 demonstration project under Title XI of the Social Security Act (42 U.S.C. subchapters XIX, XXI and XI).

83. Medical Necessity – means those procedures and services, as determined by the department, which are considered to be necessary and for which payment will be made. Medically necessary health interventions (services, procedures, drugs, supplies, and equipment) must be used for a medical condition. There shall be sufficient evidence to draw conclusions about the intervention's effects on health outcomes. The evidence shall demonstrate that the intervention can be expected to produce its intended effects on health outcomes. The intervention's beneficial effects on health outcomes shall outweigh its expected harmful effects. The intervention shall be the most cost-effective method available to address the medical condition. Sufficient evidence is provided when evidence is sufficient to draw conclusions, if it is peer-reviewed, is well-controlled, directly or indirectly relates the intervention to health outcomes, and is reproducible both within and outside of research settings.

84. Medical Services - Except as expressly limited or excluded by the contract, those medical and behavioral health professional services of physicians, other health professionals and paramedical personnel that are generally and customarily provided in the service area and performed, prescribed, or directed by the attending physician or other provider.

85. **Medicare** - The health care insurance program for the aged and disabled administered by the Social Security Administration under Title XVIII of the Social Security Act.

86. **Med-QUEST Division (MQD) –** The offices of the State of Hawaii, Department of Human Services, which oversees, administers, determines eligibility, and provides medical assistance and services for State residents.

87. **Member** – An individual who meets all eligibility requirements for community care services (CCS), and for whom all applicable expenditure shares have been paid.

88. **National Committee for Quality Assurance (NCQA) –** An organization that sets standards, develops HEDIS measures, and evaluates and accredits Health Plans and other managed care organizations.

89. **Network -** A group of doctors, hospitals, pharmacies, and other health care experts hired by the BHO to take care of its members

90. **Non-Participating Provider -** A provider who doesn't have a contract with health insurers or plans to provide services to members.

91. **Nursing Facility (NF) –** A licensed facility that provides appropriate care to persons referred by a physician. Such persons are those who:

a. Need twenty-four (24) hour a day assistance with the normal activities of daily living;

b. Need care provided by licensed nursing personnel and paramedical personnel on a regular, long-term basis; and

c. May have a primary need for twenty-four (24) hours of skilled nursing care on an extended basis and regular rehabilitation services.

92. Participating - When referring to the BHO it means the BHO has entered into a contract with the DHS to provide covered services to members. When referring to a health care provider it means a provider who is employed by or who has entered into a contract with the BHO to provide covered services to members. When referring to a facility it means a facility that has entered into a contract with the BHO for the provision of covered services to members.

93. Participating Provider - A provider who has a contract with health insurers or plans to provide services.

94. Peer Specialist – An individual who has gone through the same or similar life experience as the member, and who will collaborate with the Community Health Worker to address the member's needs in a holistic manner.

95. Physician Services – Services provided by an individual licensed under state law to practice medicine or osteopathy.

96. **Plan -** A benefit provided by employers, unions or other group sponsors to pay for health care services.

97. **Preauthorization -** A decision by health insurers or plans that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Health insurance or plans may require preauthorization for certain services prior to members receiving them, except in an emergency. Preauthorization does not guarantee the health insurer or plan will cover the cost.

98. **Premium -** The amount paid for health insurance every month.

99. **Prepaid Plan** - A Health Plan for which premiums are paid on a prospective basis, irrespective of the use of services.

100. **Prescription Drugs** – Drugs and medications that, by law, require a prescription.

101. **Prescription Drug Coverage** – Health insurance or plan that helps pay for prescription drugs and medications.

102. **Primary Care Physician -** A physician who treats and oversees the health needs of a beneficiary or member.

103. **Primary Care Provider (PCP)** - A practitioner selected by the beneficiary or member, to manage the utilization of health care services, who is licensed in Hawaii and is:

a. A physician, either an M.D. (Doctor of Medicine) or a D.O. (doctor of osteopathy), and must generally be a family practitioner, general practitioner, general internist, pediatrician or obstetrician-gynecologist (for women, especially pregnant women) or geriatrician;
b. An advanced practice registered nurse with prescriptive authority. PCPs have the responsibility for supervising, coordinating and providing initial and primary care to enrolled individuals and for initiating referrals and maintaining the continuity of their care; or
c. A physician's assistant recognized by the State Board of Medical Examiners as a licensed physician assistant.

104. Proposal - The applicant's response to this RFP submitted in the prescribed manner to perform the required services.

105. Protected Health Information (PHI) – As defined in the HIPAA Privacy Rule, 45 CFR § 160.103.

106. Provider - Any licensed or certified person or public or private institution, agency or business concern authorized by the DHS to provide health care, service or supplies to individuals receiving medical assistance.

107. QUEST Integration (QI)- QUEST Integration is the managed care program that provides health care benefits, including long-term services and supports, to individuals, families, and children, both non-aged, blind, or disabled (non-ABD) individuals and ABD

individuals, with household income up to a specified federal poverty level (FPL).

108. **Rehabilitative/Rehabilitation Services -** Health care services that help keep, regain, or improve skills and functioning for daily living that have been lost or impaired because of illness, injury, or disability. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

109. **Representative Payee** - A person or an organization that the United States Social Security Administration appoints to receive the Social Security or SSI benefits for anyone who cannot manage or direct the management of his or her benefits.

110. **Request for Proposal (RFP)** – This Request for Proposal number RFP-MQD-2021-010.

111. **Risk Share –**The losses or gains associated with BHO costs or savings related to expected BHO expenditures that are shared between the BHO and the DHS (see Appendix H). The BHO may separately enter into risk share arrangements with providers.

112. **Rural Health Center (RHC)** - An entity that provides outpatient services in a rural area designated as a shortage area and certified in accordance with 42 CFR Part 491, Subpart A, and as defined in Section 1861(aa)(2) of the Social Security Act.

113. **Service Area** - The geographical area defined by zip codes, census tracts, or other geographic subdivisions, i.e. island, that is served by the participating BHO as defined in its contract with the DHS.

114. **Serious Mental Illness (SMI) or Serious Persistent Mental Illness (SPMI)** – A severe, disabling mental illness which is a mental disorder which exhibits emotional or behavioral functioning that is so impaired as to interfere substantially with a person's capacity to remain in the community without treatment or services of a long—term or indefinite duration. This mental disability is severe and persistent, resulting in a long-term limitation of a person's functional capacities for primary activities of daily living such as interpersonal relationships, homemaking, self-care, employment, and recreation.

115. **Significant Change-** A change that may affect access, timeliness or quality of care for a member (i.e., loss of a large provider group, change in benefits, change in QI Health Plan or BHO operations, etc.) or that would affect the member's understanding and procedures for receiving care.

116. **Skilled Nursing Care -** A level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed practical nurse).

117. **Social Health Determinants (SDOH)** – The conditions in which people are born, grow, live, work and age that shape health. Socio-economic status, discriminations, education, neighborhood

and physical environment, employment, housing, food security, and access to health food choices, access to transportation, social support networks and connection to culture, as well as access to health care are all determinants of health. Hawaii state law recognizes that all state agency planning should prioritize addressing these determinants to improve health and wellbeing for all, including Native Hawaiians (ACT 155 (2014) HRS §226-20).

118. Social Risk Factors (SRF) – Refers to an individual's social and economic barriers to health, such as housing instability or food insecurity.

119. Special Health Care Needs (SHCN) - A member who has chronic physical, behavioral, developmental, or emotional conditions that require health related services of a type or amount that is beyond what is required. For purposes of this RFP, CCS members fall into this population as defined in the QUEST Integration program.

120. Specialist - A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

121. State - The State of Hawaii.

122. **State Fiscal Year (SFY)** - The twelve (12) month period for Hawaii's fiscal year that runs from July 1 through June 30 of consecutive calendar years.

123. **Stepped Care** - The concept of Stepped Care is that individuals can move up or down a continuum of services as needed and that treatment level and intervention will be paired with the individual's level of acuity to provide effective care without overutilization of resources. The goal is to meet individual need at the lowest level possible while ensuring high quality results which allows the system to use limited resources to their greatest effect on a population basis.

124. **Subcontract** - Any written agreement between the BHO and another party to fulfill the requirements of the contract.

125. **Subcontractor** – A party with whom the BHO contracts to provide services and/or conduct activities related to fulfilling the requirements of this RFP and contract.

126. **Telehealth** - As defined by HRS §346-59.1, the use of telecommunications services to encompass four modalities: store and forward technologies, remote monitoring, live consultation, and mobile health; and which shall include but not be limited to real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purpose of delivering enhanced health care services and

information while a patient is at an originating site and the health care provider is at a distant site. Standard telephone contacts, facsimile transmissions, or e-mail text, in combination or by itself, does not constitute a telehealth service for the purposes of this definition

127. Third Party Liability (TPL) – Any person, institution, corporation, insurance company, public, private or governmental entity who is or may be liable in contract, tort or otherwise by law or equity to pay all or part of the medical cost of injury, disease or disability of a member to Medicaid.

128. Urgent Care - The diagnosis and treatment of medical conditions which are serious or acute but pose no immediate threat to life or health, but which require medical attention within 24 hours.

129. Utilization Management Program (UMP) - The requirements and processes established by the BHO to ensure members have equitable access to care, and to manage the use of limited resources for maximum effectiveness of care provided to members.

SECTION 4 – Covered Benefits and Services

4.1 Overview of Covered Benefits

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

B) The BHO shall utilize the definition found in HAR 17-1700.1-2 definition of "medical necessity" in providing behavioral health services pursuant to this contract.

C) The BHO shall be responsible for providing all necessary covered services to all eligible Members. These necessary covered services shall be furnished in an amount, duration, and scope to achieve the purpose for which the services are furnished.

D) The BHO shall assure provisions of a full range of psychiatric and substance use disorder (SUD) inpatient, outreach, treatment, rehabilitation, CIS and crisis response services needed by adults with a diagnosis of SMI/SPMI. The BHO shall coordinate its services and share with the State, the Member's QI Health Plan, and Member's other providers, the results of any identification and assessment of the Member's needs to prevent duplication of services and ensure that services are appropriately provided. Services may be provided or arranged for in a variety of ways such as through natural supports, mental health agencies, general hospitals, family members, consumer help approaches, or through the use of

recovering consumers as paid or volunteer staff. The BHO will provide a person-centered approach using a single case manager for behavioral health needs to provide close coordination with the QI Health Plan HCS to ensure the Member's medical needs are addressed.

E) BHO services shall assist Members to manage their illness, develop the appropriate and necessary living skills and acquire supports and resources they need to maximize their quality of life in the community. The BHO shall ensure that its Members have access to medically necessary services that addresses prevention, diagnosis, and treatment. These services to include, without limitation, the following services as medically necessary:

1. Inpatient behavioral health hospital services;
2. Emergency Department services;
3. Ambulatory Behavioral Health Services and crisis management;
4. Medications and Medication Management;
5. Diagnostic services and treatment to include psychiatric or psychological evaluation and treatment;
6. Medically necessary SUD services;
7. Methadone management services;
8. Intensive Case Management;
9. Partial hospitalization or intensive outpatient hospitalization;
10. Psychosocial Rehabilitation/Clubhouse;
11. Therapeutic Living Supports;
12. CIS;
13. Representative payee;
14. Supported employment;

15. Peer Specialist;
16. Behavioral Health outpatient services; and
17. Other services.

F) The BHO shall have direct access to behavioral health outpatient services as described in Section 4.2.

G) The BHO shall specify what constitutes services that are a "medical necessity" that is no more restrictive than the State Medicaid program, including Quantitative and Non-Quantitative Treatment Limits (QTL) (NQTL), as indicated in state statutes and regulations, the BHO, and other state policies and procedures.

4.2 Coverage Provisions for Behavioral Health Services

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

B) The BHO shall make available triage lines or screening systems, as well as the use of telehealth, e-visits, and/or other evolving and innovative technological solutions, when applicable.

C) The BHO shall submit a detailed plan describing the service delivery system including all current medically necessary behavioral health

services covered by the Hawaii Medicaid program and non-traditional services that will be in place to serve Members. The plan shall be submitted to DHS for review and approval by the date specified in Section 13.3.B. At a minimum, the BHO shall describe how it shall ensure access to the services listed below:

1. Inpatient Psychiatric Hospitalization services (twenty-four-hour care). Services include:
    a. Room and board;
    b. Nursing care;
    c. Medical supplies, equipment and drugs;
    d. Diagnostic services;
    e. Psychiatric services;
    f. Other practitioner services as needed;
    g. Physical, occupational, speech and language therapy;
    h. Post-stabilization services; and
    i. Other medically necessary services.

2. Emergency Department Services:
    a. Any covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish services that are needed to evaluate or stabilize an emergency medical condition;
    b. The emergency medical condition shall be a result of SMI or SPMI diagnosis; and
    c. The BHO may not deny payment for these services when a representative from the BHO instructed the Member to seek emergency services.
3. Ambulatory behavioral health services includes 24-hour, 7 days/week emergency/crisis intervention:

a. Mobile crisis response;
b. Crisis stabilization;
c. Crisis hotline; and
d. Crisis residential services.

4. Medication Management:

   a. Medication evaluation;

   b. Medication counseling and education; and

   c. Psychotropic medications.

5. Diagnostic services including:

   a. Psychological testing;
   b. Psychiatric or psychological evaluation and treatment (including neuropsychological evaluation);
   c. Psychosocial history;
   d. Screening for and monitoring treatment of mental illness and SUD shall include tobacco and alcohol use disorders; and
   e. Other medically necessary behavioral health diagnostic services to include labs.

6. All medically necessary SUD services.

7. Methadone Management Services which include the provision of methadone or a suitable alternative (i.e. LAAM or buprenorphine) as well as outpatient counseling services.

8. Intensive Case Management:
    a. Case assessment;
    b. Case planning (service planning, care planning);
    c. Outreach;
    d. Ongoing monitoring and service coordination; and
    e. Coordination with Member's QI Health Plan and PCP.

9. Partial hospitalization or intensive outpatient hospitalization including:
    a. Medication management;
    b. Prescribed drugs;
    c. Medical supplies;
    d. Diagnostic tests;
    e. Therapeutic services including individual, family, and group therapy and aftercare; and
    f. Other medically necessary services.

10. Psycho-Social Rehabilitation/Clubhouse services including:
    a. Work assessment service;
    b. Intensive day treatment;
    c. Day treatment;
    d. Residential treatment services; and
    e. Social/recreational therapy services.

11. Therapeutic living supports to include specialized residential treatment facilities for CCS Members with SUD.

12. CIS includes:

a. Pre-tenancy Services:

1) Identify eligible individuals;
2) Screening/Assessments;
3) Develop housing support plan;
4) Housing Search;
5) Applications prep and submission;
6) Identify resources/costs for start-up needs;
7) Identify equipment, technology, and other modifications needed;
8) Ensure housing is safe;
9) Moving assistance;
10) Individualized housing crisis plan;
11) Skill and Acquisition development; and
12) Independent living skills/ Financial literacy.

b. Tenancy Services:

1) Individual Housing and Tenancy Sustaining Services;
2) Community Transition Services (CTS);
3) Early identification/intervention for negative behaviors;
4) Education/Training roles and responsibilities of tenant/landlord;
5) Coach on development;
6) Maintenance of relationships between landlords/property managers;
7) Dispute resolution with landlords/neighbors;

8) Advocate & link with advocacy groups to help prevent eviction;
9) Housing recertification process;
10) Update/Maintain housing support and crisis plans;
11) Development of daily living skills and maintaining residence skills to sustain residency;
12) Service Care Coordination;
13) Housing Crisis Management;
14) Training/Education;
15) Financial Literacy; and
16) Relationship building and maintenance.

c. Other Housing & Tenancy Services:

1) Job skills training/employment activities;
2) Peer Supports;
3) Non-Medical Transportation;
4) Support Groups;
5) Caregiver or Family support;
6) Outreach Services;
7) Health Management;
8) Counseling and Therapies;
9) Service Assessments;
10) Service Plan Development;
11) Independent living skills and Financial literacy;
12) Equipment, technology and other modifications;
13) Home Management; and
14) Other Supplemental Services as needed.

13. Representative Payee.

14. Supported employment services including:
    a. Work assessment service;
    b. Pre-employment service; and
    c. Job Coaching.

15. Peer Specialist.

16. Behavioral health outpatient services also include:
    a. Treatment/service planning;
    b. Individual/group therapy and counseling;
    c. Family and collateral therapeutic support and education;
    d. Continuous treatment teams; and
    e. Other medically necessary therapeutic services.

17. Other services:
    a. Other medically necessary practitioner services provided by licensed and/or certified healthcare providers;
    b. Other medically necessary therapeutic services including services which would prevent institutionalization; and
    c. Maintenance of Member's medical assistance eligibility.

D) Adult Members who have a diagnosis of SMI, provisional SMI, SPMI, and SUD, who require diagnosis, treatment and/or rehabilitative services shall receive these services from the BHO. The BHO shall

make decisions regarding admission to treatment programs, continued stay, and discharge criteria based on the most recent edition of the American Society of Addiction Medicine (ASAM) Patient Placement Criteria.

4.3 In Lieu of Services

A) The BHO may cover, for Members, services or settings that are in lieu of services or settings covered under the State plan as follows:
   1. DHS determines that the alternative service or setting is a medically appropriate and cost-effective substitute for the covered service or setting under the State plan;
   2. The Member is not required by the BHO to use the alternative service or setting; and
   3. The approved in lieu of services are authorized and identified in the BHO contract and will be offered to Members at the option of the BHO.

B) The utilization and actual cost of in lieu of services is taken into account in developing the component of the capitation rates that represents the covered State plan services, unless a statute or regulation explicitly requires otherwise.

4.4 Emergency and Post-Stabilization Services

A) The BHO is responsible for providing or ensuring access to emergency services twenty-four (24) hours a day, seven (7) days a week to treat an emergency medical condition related to SMI or SPMI diagnosis. The BHO shall provide education to its Members on

the appropriate use of emergency services, and alternatives for Members to receive non-emergent care outside of the Emergency Department.

B) The contract prohibits the BHO from denying payment for treatment obtained when a Member has an emergency medical condition, including cases in which the absence of immediate medical attention would not result in placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

C) An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the mental health of the individual in serious jeopardy;
2. Serious harm to self or others due to an alcohol or drug abuse emergency; or
3. Injury to self or bodily harm to others.

D) An emergency medical condition shall not be defined or limited based on a list of diagnoses or symptoms.

E) Emergency services include inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition that is found to exist using a prudent layperson's standard. The services shall also be furnished by a provider that is qualified to furnish such services.

F) The BHO shall provide payment for emergency services when furnished by a qualified provider, regardless of whether that provider is in the BHO's network. These services shall not be subject to prior authorization requirements. The BHO shall pay for all emergency services that are medically necessary to be provided on an emergent basis until the Member is stabilized. The BHO shall also pay any screening examination services to determine whether an emergency medical condition exists.

G) The BHO shall base coverage decisions for initial screening examinations to determine whether an emergency medical condition exists on the severity of the symptoms at the time of presentation and shall cover these examinations when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. The BHO shall not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergency in nature.

H) The emergency room physician, or the provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on the BHO, which shall be responsible for coverage and payment. The BHO is responsible for coverage and payment of medically necessary emergency services. The BHO shall not refuse to cover emergency services based on the emergency room provider failing to notify the Member's PCP or the BHO within

ten (10) calendar days of presentation for emergency services. However, the BHO may deny reimbursement for any services provided on an emergent basis to an individual after the provider could reasonably determine that the individual did not have an actual emergency medical condition.

I) The BHO, however, may establish arrangements with a hospital whereby the BHO may send one of its own physicians with appropriate emergency room privileges to assume the attending physician's responsibilities to stabilize, treat, and transfer the Member, if such arrangement does not delay the provision of emergency services.

J) If an emergency screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition does not exist, then the determining factor for payment liability for the screening examination shall be whether the Member had acute symptoms of sufficient severity at the time of presentation. However, in this situation, the BHO shall deny reimbursement for any non-emergent diagnostic testing and treatments provided, with the exception below.

K) When a Member's PCP or other BHO representative instructs the Member to seek emergency services, the BHO shall be responsible for payment for the medical screening examination and other medically necessary emergency services, without regard to whether the condition meets the prudent layperson standard.

L) The Member who has an emergency medical condition shall not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

M) Once the Member's condition is stabilized, the BHO may require pre-certification for hospital admission or prior authorization for follow-up care.

N) The BHO shall be responsible for providing post-stabilization care services twenty-four (24) hours a day, seven (7) days a week, both inpatient and outpatient, related to an emergency medical condition, that are provided after a Member is stabilized in order to maintain the stabilized condition, or, as prescribed in 42 CFR § 438.114, to improve or resolve the Member's condition. Post-stabilization services include follow up outpatient specialist care.

O) The BHO is financially responsible for post-stabilization services obtained from any provider that are not prior authorized or pre-certified by a BHO provider or organization representative, regardless of whether provider is within or outside the BHO's provider network, if these services are rendered to maintain, improve, or resolve the Members' stabilized condition in the following situations:

1. The BHO does not respond to the provider's request for precertification or prior authorization within one (1) hour;
2. The BHO cannot be contacted; or
3. The BHO's representative and the attending physician cannot reach an agreement concerning the Member's care, and a BHO physician is not available for consultation. In this situation,

the BHO shall give the treating physician the opportunity to consult with an in-network physician, and the treating physician may continue with the care of the Member until a BHO physician is reached or one of the criteria outlined below are met.

P) The BHO's responsibility for post-stabilization services that it has not approved shall end when:
   1. An in-network provider with privileges at the treating hospital assumes responsibility for the Member's care;
   2. An in-network provider assumes responsibility for the Member's care through transfer;
   3. The BHO's representative and the treating physician reach an agreement concerning the Member's care; or
   4. The Member is discharged.

Q) In the event the Member receives post-stabilization services from a provider outside of the BHO's network, the BHO is prohibited from charging the Member more than he or she would be charged if he or she had obtained the services through an in-network provider.

4.5 Member Advisory Committee

A) BHO shall establish and maintain a Member advisory committee for Members receiving CCS services. The committee shall include at least a reasonably representative sample of the CCS populations, or other individuals representing those Members, covered under the contract with the BHO.

4.6 Covered Benefit Requirements for Parity in Mental Health and Substance Use Disorders (SUD)

A) The BHO may cover, in addition to services under the State plan, any services necessary for compliance with the requirement for parity in mental health and SUD benefits in 42 CFR Part 438, Subpart K, and the contract identifies the types amounts, duration and scope of services consistent with the analysis of parity compliance conducted by either the DHS or the BHO.

B) If the BHO does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits or includes an aggregate lifetime or annual dollar limit that applies to less than one-third of all medical/surgical benefits provided to Members through a contract with DHS, it may not impose an aggregate lifetime or annual dollar limit respectively, on mental health or SUD benefits.

C) If the BHO includes an aggregate lifetime or annual dollar limit on at least two-thirds of all medical/surgical benefits provided to Members through a contract with DHS, it shall either apply the aggregate lifetime or annual dollar limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health or SUD benefits in a manner that does not distinguish between the medical/surgical benefits and mental health or SUD benefits; or not include an aggregate lifetime or annual dollar limit on mental health or SUD benefits that is more restrictive than the aggregate lifetime or annual dollar limit, respectively, on medical/surgical benefits.

D) If the BHO includes an aggregate lifetime limit or annual dollar amount that applies to one-third or more but less than two-thirds of all medical/surgical benefits provided to Members through a contract with DHS, it shall either impose no aggregate lifetime or annual dollar limit on mental health or SUD benefits; or impose an aggregate lifetime or annual dollar limit on mental health or SUD benefits that is no more restrictive than an average limit calculated for medical/surgical benefits in accordance with 42 CFR § 438.905(e)(1)(ii).

E) The BHO shall not apply any financial requirement or treatment limitation to mental health or SUD benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to Members.

F) If a BHO Member is provided mental health or SUD benefits in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), mental health or SUD benefits shall be provided to the BHO Member in every classification in which medical/surgical benefits are provided.

G) The BHO may not apply any cumulative financial requirements for mental health or SUD benefits in a classification (inpatient, outpatient, emergency care, prescription drugs) that accumulates separately from any established for medical/surgical benefits in the same classification.

H) The BHO may not impose NQTLs for mental health or SUD benefits in any classification unless, under the policies and procedures of the MCP as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification.

4.7 Coverage Provisions for Community Integration Services (CIS) and Community Transition Services (CTS)

A) Pre-tenancy supports

The BHO shall cover the following pre-tenancy support services:

1. Conducting a functional needs assessment identifying the Member's preferences related to housing (e.g., type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain community integration (including what type of setting works best for the individual); and providing assistance in budgeting for housing and living expenses;
2. Developing an individualized plan based upon the functional needs assessment as part of the overall person-centered plan. Identifying and establishing short and long-term measurable goal(s), and establishing how goals will be achieved and how concerns will be addressed;

3. Assisting the Member with connecting to social services to help with finding and applying for housing necessary to support the individual in meeting their medical care needs;
4. Participating in person-centered plan meetings at redetermination and conducting revision plan meetings, as needed; and
5. Providing supports and interventions per the person-centered plan.

B) Tenancy Sustaining Services

The BHO shall cover the following tenancy sustaining services:

1. Service planning support and participation in person-centered plan meetings at redetermination and while conducting revision plan meetings, as needed;
2. Coordinating and linking the Member to services and service providers;
3. Entitlement assistance including assisting Members in obtaining documentation, navigating and monitoring application process, and coordinating with the entitlement agency;
4. Assistance in accessing supports to preserve the most independent living such as individual and family counseling, support groups, and natural supports;
5. Providing supports to assist the Member in the development of independent living skills, such as skills coaching, financial counseling, and anger management;
6. Providing supports to assist the Member in communicating with the landlord and/or property manager regarding the

participant's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager;

7. Coordinating with the Member to review, update and modify housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers; and
8. Connecting the Member to training and resources that will assist the Member in being a good tenant and achieving lease compliance, including ongoing support with activities related to household management.

C) Community Transition Services

The BHO shall cover Community Transition Services. The Community Transition Services (CTS) program within the CIS benefit is designed to address eligible Members' specific health determinants to improve health outcomes and lower healthcare costs. CTS program benefits are authorized by CMS through July 31, 2024 and shall be provided to all Members who meet CIS eligibility criteria on a voluntary basis. CTS benefits shall include:

1. Transitional Case Management Services**.** Services that will assist the individual with moving into stable housing, including assisting the individual in arranging the move, assessing the unit's and individual's readiness for move-in, assisting the individual (excluding financial assistance) in obtaining furniture and commodities. This service is furnished only to the extent it is reasonable and necessary

as clearly identified through a Member's ITP and the Member is unable to meet such expense or when the services cannot be obtained from other sources. Funding related to one-time utility set-up and moving costs provided that such funding is not available through any other program.

2. Securing House Payments. Provide a one-time payment for security deposit and/or first month's rent provided that such funding is not available through any other program. This payment may only be made once for each Member during the life of the demonstration, except for State determined extraordinary circumstances such as a natural disaster. This service is furnished only to the extent it is reasonable and necessary as clearly identified through Member's individualized care and the Member is unable to meet such expense or when the services cannot be obtained from other sources. Modifications to improve accessibility of housing (e.g., ramps, rails) and safety (e.g., grip bars in bathtubs) when necessary to ensure occupant's health and modification is not covered under any other provision such as the Americans with Disabilities Act.

3. Housing Quality and Safety Improvement Services. Repairs or remediation for issues such as mold or pest infestation if repair or remediation provides a cost-effective method of addressing occupant's health condition, as documented by a health care professional, and remediation is not covered under any other program. This service is furnished only to the extent it is reasonable and necessary as clearly

identified through a Member's ITP and the Member is unable to meet such expense or when the services cannot be obtained from other sources.

4. Legal Assistance. Assisting the individual by connecting the Member to expert community resources to address legal issues impacting housing and thereby adversely impacting health, such as assistance with breaking a lease due to unhealthy living conditions. This service does not include legal representation or payment for legal representation.

D) Rules Surrounding CIS Provision

1. The following are prohibited under CIS:
    a. Payment of ongoing rent or other room and board costs;
    b. Capital costs related to the development of housing;
    c. Expenses for ongoing regular utilities or other regular occurring bills;
    d. Goods or services intended for leisure or recreation; and
    e. Duplicative services from other state or federal programs.

E) Other CIS Requirements

1. The BHO shall provide CIS and CTS services in accordance with the prescribed parameters and limitations as part of CCS services as described in this Section 4.7. The BHO shall

comply with all state and federal laws pertaining to the provision of such services, including federal rules on conflict of interest.

2. Regarding conflicts of interest for the CIS population, the BHO case manager conducts the housing assessment and writes the plan of service with the Member. The BHO will maintain contracts with case management/homeless agencies that will provide CIS services for the Member.

3. In addition, all BHO CMs who are providing CIS services shall have the following qualifications in the table below:

Table 4.7.E-1: Qualifications for CMs Providing CIS

Education (standard)	**Experience** (standard)	**Skills** (preferred)	**Services**
Bachelor's degree in a human/social services field; may also be an Associate's degree in a relevant field, with field experience or a high school graduate with field experience* working with homeless or transitional housing individuals. *Field experience may include community outreach; locating individuals on the street; completing homeless assessments - Vulnerability Index - Service Prioritization Decision Assistance Tool (VISPDT); finding short, and long-term housing; assisting individuals to	1-year case management experience, 1-year field experience with a homeless or transitional housing agency, or Bachelor's degree in a related field and similar. field experience.	Knowledge of principles, methods, and procedures of services included under Community Integration Services, or comparable services meant to support client ability to obtain and maintain. residence in independent community settings.	Pre-tenancy supports; tenancy sustaining services as outlined in Section 4.8.

Education (standard)	**Experience** (standard)	**Skills** (preferred)	**Services**
apply for documents, benefits and housing.			

4.8 Community Integration Services (CIS) Eligibility Criteria

The BHO shall link the coordination of services that help Members secure housing with Members' ITP and/or service plans as a way to promote whole person care. Rules surrounding the coordination of CIS, and service descriptions for CIS are described in Section 4.7.

A) Target Population

1. The BHO shall provide CIS to Members eighteen (18) years of age or older if the Member meets the following criteria.

2. Member is expected to benefit from CIS and meets at least one of the following health needs-based criteria, and at meet at least one Health Needs-Based Criteria and one risk factor:
    a. Health Needs-Based Criteria (at least one):
        1) Member is assessed by the BHO to have a behavioral health need which is defined as one or both of the following criteria:
            a) Mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a serious mental illness; and/or

b) Substance use need, where an assessment using American Society of Addiction Medicine (ASAM) criteria where that the Member meets at least ASAM level 2.1 indicating, at minimum, the need for outpatient day treatment for SUD treatment.

2) Member is assessed to have a complex physical health need, which is defined as a long continuing or indefinite physical condition requiring improvement, stabilization, or prevention of deterioration of functioning (including the ability to live independently without support).

b. Risk Factors (at least one):

1) Homelessness, defined as lacking a fixed, regular, and adequate night-time residence, meaning:

a) Has a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; or

b) Living in a supervised publicly or privately-operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local

government programs for low income Members).

2) At risk of homelessness, defined as a Member who will lose their primary nighttime residence:
    a) There is notification in writing that their residence will be lost within 21 days of the date of application for assistance, such that:
        i. No subsequent residence has been identified; and
        ii. The Member does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to or living in a place not meant for human habitation, a safe haven, or an emergency shelter.

3) The Member has a history of frequent and/or lengthy stays in a nursing facility as follows:
    a) Frequent, is defined as more than one contact in the past 12 months; and
    b) Lengthy, is defined as 60 or more consecutive days within an institutional care facility.

3. A bidirectional mechanism will be established to enable the BHO to notify DHS, and vice versa, about Members identified for and receiving various types of CIS services.

B) Assessment

1. The BHO will use a standardized housing assessment tool developed by DHS. Case managers who are licensed social workers or registered nurses will be responsible for conducting assessments and re-assessments to determine whether a Member is eligible for CIS services. Re-assessments will occur, at minimum, every ninety days.

C) Coordination Requirements for CIS and CTS

1. The level of coordination will vary in scope and frequency depending on the Member's intensity of need. The BHO shall develop policies and procedures to ensure the following:
    a. Coordinated provision of CIS and CTS activities and services with the goal of promoting community integration, Member advocacy, optimal coordination and monitoring of resources, and self-sufficiency for Members who meet the eligibility requirements for CIS;
    b. An active, assertive system of outreach is in place that provides the flexibility needed to reach CIS Members requiring services who might not access services without intervention due to language barriers, acuity of condition, dual diagnosis, physical/visual/hearing

impairments, intellectual disability and/or lack of transportation; and

c. In regard to conflict-free case management for the CIS population, the BHO case manager conducts the housing assessment and writes the plan of service with the Member for services. The BHO will maintain contracts with case management/homeless agencies that will provide the CIS services for the Member.

4.9 Coordination with the QI Health Plan Health Coordination System (HCS)

A) The QI Health Plan will have a HCS system that complies with the requirements in 42 CFR § 438.208. The HCS shall provide person-centered services that meet the needs of vulnerable populations [Special Health Care Needs (SCHN) and Expanded Health Care Needs (EHCN)], which includes CCS.

B) The BHO shall provide all behavioral health services including inpatient, outpatient therapy and tests to monitor the Member's response to therapy, and intensive case management. The QI Health Plan HCS will continue to provide all medical services.

C) The BHO shall coordinate with the HCS to ensure provision of medical services specific to the needs of its Members. Person-centered practices and collaboration between the BHO and the HCS are expected to ensure that all CCS Members receive services specific to their individual needs to maximize health outcomes. The BHO shall have business associate's agreements with QI

Health Plans in order to share protected health information including but not limited to claims files and Health Action Plans (HAP). The BHO shall provide DHS with a copy of the business associate agreements within seven (7) calendar days of execution and before any protected health information is shared with the QI Health Plans.

4.10 Coordination with other State Divisions and Affiliated Programs

A) Coordination with the Department of Health's Child and Adolescent Mental Health Division (CAMHD), Adult Mental Health Division (AMHD), and Developmental Disability Division (DDD)

1. The BHO is expected to jointly develop policies and procedures for assuring participation in and integration of service and care planning with the Member and/or guardian consent according to timelines and standards established by DHS with CAMHD, AMHD, and DDD.

2. DHS intends to establish a schedule for the development and implementation of coordination policies and processes. DHS will initially prioritize members with co-occurring chronic, acute, and/or serious conditions. DHS intends to implement this in three phases:
    a. Phase I: Identification of and Access to Data on Joint Members;
    b. Phase II: Development of Joint Care Coordination Standards and Processes; and

c. Phase III: Implementation of Joint Care Coordination Processes.

3. As a part of this process, DHS, the BHO DDD, AMHD, or CAMHD may provide training or education for the QI Health Plans on best practices.

4. This process is expected to be expanded to all Members transitioning from the CAMHD, AMHD and DDD services and programs in subsequent contract years.

5. The BHO will be required to sign an agreement with CAMHD, AMHD, and DDD respectively to operationally define these processes, including:
   a. Exchange of Information;
   b. Referral Procedures; and
   c. Participating in a coordinated, integrated, and individualized patient-centered Transition of care.

6. The BHO shall work with the agencies in transitioning Members in and out of the programs and for coordinating medical and behavioral health services. The BHO is required to coordinate and integrate existing care plans during these transitions. Additionally, the BHO is required to exchange Member data in a timely manner, including, but not limited to, utilization management notifications, Member specific utilization, quality data, information on medication adherence, and cost data.

7. DHS may provide additional guidance during the contract period.

B) Coordination with Department of Health Alcohol and Drug Abuse Division (DOH-ADAD)

1. The BHO shall coordinate with DOH-ADAD, as appropriate. Data use agreements will be required for any disclosure of Medicaid data (Refer to Section 4.10.A above).

C) Hawaii Coordinated Addiction Resource Entry System (CARES)

1. The Hawaii State Department of Health (DOH), Behavioral Health Administration (BHA), Alcohol and Drug Abuse Division (ADAD) and Adult Mental Health Division (AMHD) developed Hawaii CARES. Hawaii CARES is a comprehensive and responsive system of care that aims to provide a Continuum of Care (COC), to deliver and reduce all barriers to SUD, mental health, and co-occurring treatment and recovery support services, as well as crisis intervention and support services.

2. The BHO shall coordinate with Hawaii CARES, as appropriate.

3. Data use agreements will be required for any disclosure of Medicaid data (Refer to Section 4.10.A above).

4.11 Prescription Drugs

A) This service includes medications that are determined medically necessary to optimize the Member's psychiatric and medical condition. Medication management and patient counseling are also included in this service.

B) The BHO shall be permitted to develop a common formulary for CCS. The BHO's formulary shall include over-the-counter medications included in the Medicaid State plan. In accordance with HRS§ 346-59.9 a Member shall not be denied access to, or have any limitations on, any medication that is required to be covered by statute, including antipsychotic medications and continuation of antidepressant and anti-anxiety medications prescribed by a licensed psychiatrist or physician duly licensed in the State for a U. S. Food and Drug Administration (FDA) approved indication as treatment of a mental or emotional disorder.

C) The BHO shall inform its providers in writing, at least thirty (30) calendar days in advance, of any drugs deleted from its formulary. The BHO shall establish and inform providers of the process for obtaining coverage of a drug not on the BHO's formulary. At a minimum, the BHO shall have a process to provide an emergency supply of medication for at least seven (7) days to the Member until the BHO can make a medically necessary determination regarding new drugs.

D) The BHO shall provide the following for all outpatient drugs:

1. Provide coverage of outpatient drugs as defined in the Social Security Act § 1927, 42 U.S.C. § 1396r-8(k)(2), in alignment with standards for such coverage imposed by the Social Security Act § 1927;
2. Report drug utilization data that is necessary for DHS to bill manufacturers for rebates no later than forty-five (45) calendar days after the end of each quarterly rebate period;
3. Report drug utilization information that includes, at a minimum, information on the total number of units of each dosage form, strength, and package size by National Drug Code (NDC) of each covered outpatient drug dispensed or covered by the BHO;
4. Establish procedures to exclude utilization data for covered outpatient drugs that are subject to discounts under the 340B drug pricing program from drug utilization data reports when states do not require submission of managed care drug claims data from covered entities directly;
5. Operate a drug utilization review program that includes prospective drug review, retrospective drug use review, and an educational program as required at 42 CFR Part 456, Subpart K;
6. Provide a detailed description of its drug utilization review program activities to the DHS on an annual basis;
7. Conduct a prior authorization program that complies with the requirements of the Social Security Act § 1927, 42 U.S.C. § 1396r-8(d)(5); and
8. Provide notice for all covered outpatient drug authorization decisions as described in the Social Security Act § 1927, 42

U.S.C. § 1396r-8(d)(5)(A). Under this Section, the BHO may require as a condition of coverage or payment for a covered outpatient drug for which Federal Financial Participation (FFP) is available for the approval of the drug before its dispensing for any medically accepted indication only if the system providing for such approval provides response by telephone or other telecommunication device within twenty four (24) hours of a request for prior authorization.

E) The BHO shall provide both paper and electronic information in a readable file and format specified by DHS or Secretary:
   1. Which generic and name brand medications are covered; and
   2. Information about what tier each medication is on.

F) The BHO shall have an employed or contracted pharmacist geographically located within the State of Hawaii. This person, or designee, shall serve as the contact for the BHO's providers, pharmacists, and Members.

G) DHS may, at a future date, require that Members pay co-payments for prescription drugs and/or may carve-out prescription drug coverage. DHS would provide at least a three (3) month notice for either change.

H) The BHO shall provide formulary drug lists on a website in a machine-readable file and format as specified by the Secretary.

4.12 Case Management System

A) General Requirements

1. In providing case management services, the BHO may employ BHO staff, however, it shall ensure it contracts with case management agencies that agree to accept reimbursement at Medicaid fee-for-service rates where Members entering into the BHO have an established relationship with a case manager and that case manager is not also employed by the BHO. The BHO shall be able to maintain continuity of care. If in the event the BHO is unable to contract with a Member's pre-existing case management provider, the Member has the option to not enter the BHO, or the Member or their authorized representative may waive the requirement to remain with their pre-existing case manager in writing. The BHO is strongly encouraged to provide continuity of care when possible and is required to have coordinated transfer of care when necessary. Contracts shall, at a minimum, be for six (6) months from the date an individual newly enrolls in the BHO and has an established and active relationship with a case manager. The BHO shall ensure an adequate provider network, but is not required to maintain contracts with all providers.

2. Timely access to behavior health services at the Member's location is a key component of effective case management. Timely access shall include 24 hours availability of case

management services. Member's location may include: Emergency Department, doctor's office, or anywhere in the community.

B) System Description

1. Upon enrollment in the BHO, each Member shall be assigned to a case manager. The BHO shall have a Case Management (CM) system to:
    a. Provide the Member with clear and adequate information on how to obtain services and make informed decisions about their own behavioral health, employment and CIS needs;
    b. Provide comprehensive assessment, case planning, ongoing quarterly monitoring of progress toward goals and support towards reaching those goals;
    c. A face-to-face comprehensive behavioral health assessment (BHA), substance use screening, and CIS assessment of all new BHO Members shall occur within twenty-one (21) calendar days of enrollment into the program;
    d. Face-to-face reassessments shall be completed at least annually or sooner if medically necessary;
    e. Assure development of an Individualized Treatment Plan (ITP);
    f. Initial ITP shall be developed and implemented within fourteen (14) calendar days of completing the face-to-face comprehensive BHA after enrollment into the program;

g. ITPs shall be updated every six (6) months or sooner if medically necessary to include a significant change;
h. CIS housing assessment will be done, at minimum, every ninety (90) days;
i. Provide skills development in problem-solving and other skills to remain in/return to the community including housing stabilization and supported employment;
j. Ensure crisis resolution;
k. Coordinate and integrate each Member's behavioral health care with medical services. Collaboration shall include the QI Health Plan HCS, behavioral health provider(s), primary care provider, other providers/agencies as needed, and all assessed services for the Member;
l. Achieve continuity of Members' care and cost effective delivery of services;
m. Assist the Member with behavioral health interventions and obtaining needed services as determined by the interdisciplinary team, as appropriate, and ensure that these services are provided in a timely manner;
n. Coordinate provision of CIS and supported employment activities and services with the goal of promoting community integration, optimal coordination of resources and self-sufficiency for Members who meet the eligibility requirements for CIS services and/or supportive employment services;

o. Ensure that an active, assertive system of outreach is in place to provide the flexibility needed to reach those Members requiring services, such as the homeless or others, who might not access services without intervention due to language barriers, acuity of condition, dual diagnosis, physical/visual/hearing impairments, intellectual disability, lack of transportation;
p. Facilitate Member compliance with recommended medical and behavioral health treatment; and
q. Assist Members with DHS eligibility requirements (for example, verifications) and compliance.

2. The BHO shall demonstrate that it has a CM system to ensure that all Members receive all necessary covered behavioral health services in a person-centered manner. A person-centered manner includes individually identified goals and preferences related to choice of relationships, community participation, employment, access to personal finances, healthcare and wellness, education and others. It shall also promote personal independence.

3. Specifically, the CM services include Member assessment and substance use screening, CIS evaluation, treatment planning, service linkage and coordination, monitoring and Member advocacy (such as completing and filing an application for financial assistance, maintaining Medicaid eligibility and CIS assistance). The service level of case

management will vary depending on the Member's intensity of need.

4. The BHO shall perform an initial face-to-face comprehensive BHA of each enrolled Member to determine and document the behavioral health, SUD, CIS and case management needs of the individual. The comprehensive BHA shall be conducted within twenty-one (21) calendar days of enrollment into the BHO. The BHO shall make subsequent attempts to conduct an initial assessment of each Member's needs if the initial attempt to contact the Member is unsuccessful. If an individual loses eligibility or disenrolled for other reasons and is requesting re-enrollment into the BHO within six (6) months, a comprehensive assessment does not need to be conducted upon re-enrollment unless it has been more than six (6) months since the last assessment.

C) CM System Requirements – Policies and Procedures

The BHO shall have policies and procedures for the following:

1. Coordination, cooperation and transition with community programs that provide services to eligible BHO Members. In the event an eligible individual will be transferred into the CCS program from another agency or community program, the BHO shall work with such agency or community program (for example, DOH-CAMHD, DOH-AMHD, DOH-DDD, the Hawaii State Hospital, or prison) to manage and ensure a smooth transition for the individual, refer to Section 4.14;

2. In cases where the Member has indicated that he/she is receiving services, which are behavioral health benefits, the BHO shall evaluate and determine whether the service is medically necessary. A standard functional assessment form shall be used to determine the types of services the CCS Members will receive. BHO may use its standard functional assessment form while DHS is developing the official form;
3. The BHO's policies and procedures regarding CM information shall include:
    a. How persons (Members, family members and/or guardians, community providers and providers) with proper authorization will access the case management system for Member services or inquiries;
    b. How it will ensure continuity of care with existing case management agencies and ensure the BHO will be able to contract for these services;
    c. A description and a copy of the BHO's assessment tool, which shall include substance use screening, that will be used to gather information on the Member, as well as the frequency of review and updating of the tool (i.e., period of time between reassessment of tool). The assessment tool shall be subject to approval by DHS;
    d. How it will ensure that each Member has an ongoing source of care appropriate to their needs;
    e. How it will coordinate services provided by the BHO to the Member with the services the Member receives from any other MCO, PIHP, PAHP, fee-for-service

Medicaid, and community and social support providers;

f. How information will be exchanged between the BHO, the QI Health Plan, the Member's PCP, and other service providers, including non-contracted providers;
g. How the BHO will notify the Member's PCP of significant changes, sentinel events or crisis situations within seventy-two (72) hours or sooner;
h. How the CM will coordinate with other providers to implement the ITP, refer to Section 4.12.D;
i. A Description of CM activities reporting plan to include:
    1) Encounters including, but not limited to, documentation of physical efforts to locate difficult to contact Members;
    2) Outcomes;
    3) Notification to QI Health Plans;
    4) Emergency Department visits;
    5) Hospital admissions;
    6) Discharge planning; and
    7) Follow up to prevent hospital readmission;
j. A description of proposed caseload assignments for each CM classification, as well as policies and procedures for providing CM as they relate to the Member's needs as in the following table:

Table 4.12.C-1: CM Caseload Assignments

<table>
<tr><th>Licensed Case Managers (QMHPs)</th><th>Unlicensed Case Managers</th><th>Supervision (QMHPs)</th></tr>
<tr><td>Maximum of forty (40) CCS Members in their case load.</td><td>Maximum of twenty-five (25) CCS Members in their case load.</td><td rowspan="3">Licensed case managers can supervise eight (8)** unlicensed case managers caring for no more than two hundred (200) CCS Members.</td></tr>
<tr><td>Case managers assigned Members that are Service Level 3, 4 or 5 shall have a case load less than forty (40) CCS Members based upon the needs of their Members</td><td rowspan="2">Case managers assigned Members that are Service Level 3, 4 or 5 shall have a case load less than twenty-five (25) CCS Members based upon the needs of their Members.</td></tr>
<tr><td>Any licensed case manager who is assigned a CCS Member case load cannot also supervise unlicensed case managers.</td></tr>
<tr><td colspan="3">**Should case managers have a smaller case load than the maximum allowed, supervision can be for up to ten (10) unlicensed case managers; however, the maximum number of Members allowed per supervisor remains unchanged. Should numbers exceed the maximum caseload ratio the CBCM agency shall notify the BHO immediately and provide a written interim plan for coverage during this period.</td></tr>
</table>

k. Unlicensed case managers shall be supervised by a Qualified Mental Health Professional (QMHP) to include: Licensed Physician, Psychologist, Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Mental Health Counselor (LMHC), or Advanced Practice Registered Nurse (APRN); and

l. A description of the CM staffing including job descriptions of the case managers, qualifications, and the type of initial and/or ongoing training and education that it will provide to its case managers;

4. In addition, the CM system shall function to assist the providers in the BHO's network to provide the care needed to bring the Member to an optimum level of recovery/functioning with maximum autonomy, and to prevent relapse. Therefore, the system shall be readily accessible to the Member, not to place unnecessary burdens on the BHO and BHO providers, or compromise good behavioral health care;
5. At a minimum, the BHO shall have policies and procedures in place for the following:
    a. Providing case management to include coordination of behavioral health, SUD services and CIS included in an individual's ITP, as well as coordination of behavioral health and medical services;
    b. Referring Members to other programs or agencies;
    c. Members changing case managers and/or case management providers. All changes shall have clear justification with the approval of the BHO and DHS;
    d. Identifying levels of case management according to Member needs using a service level scoring method approved by DHS and ensuring the required monthly face-to-face case manager contact;
    e. Definitions of the service levels of CM to be employed and a description of the standards for determining the service level of CM a Member shall

receive relative to a continuum with classifications ranging from routine to intensive/complex case management including frequency and type of case management contact;

f. CM services that are considered appropriate to list as encounters include: face-to-face contact with the Member, Member's guardian, Member's family, other involved service providers, telephone calls involving direct communication with the person being called (does not include attempts to get in touch, leaving messages for call backs), and travel time (actual time spent in taking a Member to and from places which shall be treatment related). Below, see Table 4.12.C-2, that provides additional description of CM levels that will be based on the DHS approved service level scoring method;

g. The following table designates the minimum service requirements that may be exceeded as needed on a case-by-case basis:

Table 4.12.C-2: Service Level Requirements

Service Level		Minimum Service Contact Requirement
5	Specialized Intensity	Face-to-face three (3) times per week
4	High Intensity	Face-to-face two (2) times per week
3	Intensive	Face-to-face one (1) time per week
2	Intermediate	Face-to-face every other week
1	Routine	Face-to-face one (1) time per month

h. Telehealth shall only be used in cases where face-to-face visits are strongly contraindicated or where

access to resources are limited; however, does not preclude efforts to conduct face-to-face visits when possible. If telehealth is used in other instances, approval from the BHO shall be obtained. During public health emergencies, there may be additional guidelines that may supersede this requirement;

i. Providing outreach and follow-up activities, especially for Members with special needs (i.e., SUD, homeless, disabled, and homebound Members);

j. Providing in-person follow-up with Members post behavioral health ED visit within seventy-two (72) hours;

k. Providing documentation and data reporting of CM services, encounters and outcomes and adverse event reports;

l. Providing continuity of care when Members transition to other programs (i.e., QI Health Plan, fee-for-service program, Medicare, new services in the treatment plan, new housing/living arrangement);

m. Ensuring continuity of care when Members entering into the BHO have an established relationship with a case manager as described in the Transition of Care Section 4.14; and

n. Ensuring coordination of services the BHO provides to the Member between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays;

6. The following lists other requirements regarding case management services:

a. If CM services are to be subcontracted, submit to DHS for prior approval, the proposed subcontract for the provision of CM services. An oversight and training plan for subcontractors shall also be submitted to DHS for prior approval;
b. The BHO shall provide CM services upon CCS enrollment until a CM agency is chosen by the Member;
c. The BHO may choose to subcontract out CM services however; the BHO shall internally have a CM service team to provide including but not limited to intensive case management to Members assessed at Acuity Level V;
d. The BHO CM service team shall be comprised of the following: psychiatrist, case managers, nurses, and have access to Certified Substance Abuse Counselors (CSAC). The psychiatrist shall be separate from the BHO's medical director;
e. CM providers shall have a psychiatrist or APRN-RX on staff or contracted, who resides in the State, to ensure timely access to direct clinical support and services to their Members upon assignment and for ongoing care. They shall also have access to CSAC services to meet Member needs;
f. CM providers assigned to the Member shall be available 24/7 to respond to after hour telephone crisis calls; and
g. CM providers assigned to the Member shall be required to respond, as necessary, within 1.5 hours to

crisis situations in the community or emergency departments to provide in-person support and possible prevention of unnecessary hospitalization.

D) Individualized Treatment Plan (ITP)

1. An ITP shall be developed for each BHO Member, requiring non-emergent treatment, within fourteen (14) calendar days of the comprehensive assessment conducted upon enrollment. When inpatient treatment is required, the assessment and ITP shall be developed within the timeframes below:
    a. Acute inpatient treatment – generated or updated within twenty-four (24) hours of admission; and
    b. Alternative inpatient treatment – within forty eight (48) hours of admission.

2. Using the stepped care approach and person-centered practices, the BHO shall develop the ITP to contain all necessary services specific to the Member's needs as identified by the Member, interdisciplinary team, and the QI Health Plan HCS, if applicable. These services shall include but not be limited to services provided by psychiatrists, psychologists, social workers, advance practice nurses, certified substance abuse counselors, and case managers. The case manager is responsible for development and implementation of the ITP in coordination with the referring agency (i.e., QI Health Plan, DOH-CAMHD, DOH-AMHD, DOH-DDD), PCP, and other involved persons as necessary.

The treatment plan shall be in accord with any applicable State quality assurance and utilization review standards.

3. The BHO shall have policies and procedures for the ITP process that shall include the ITP form.

4. The ITP shall also specify the assessed service level of case management and shall minimally include identification of all necessary services based on the BHA according to the CM and interdisciplinary team, problems, goals, interventions/services to address each problem, frequency/amount and duration of services, and responsible person(s)/disciplines/agency(s) for each intervention.

5. The BHO shall ensure the ITP is person-centered and ensures meaningful participation by the Member and their authorized representative, and as appropriate, family members, significant others, and other informal caregivers, in the ITP development, modification, treatment, and the ITP meetings, provided the Member or their authorized representative has provided written consent to allow these individuals to participate in the treatment and ITP activities described in this Section.

6. The ITP shall be reviewed and updated at least every six (6) months or more frequently if clinically necessary and/or to address significant changes.

E) Coordination of Case Management

1. BHO shall schedule monthly meetings on case reviews with the case managers, QI Health Plan HCS, other State agencies and DHS. Attendance by DHS to this meeting will be decided on a monthly basis.

4.13 Other Services to be Provided

In addition to the behavioral health services listed in Section 4.2, the BHO shall provide certain specialized services. This Section lists the required other services.

A) Member Education

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

2. Member education also includes educating the Members on the concepts of managed care, the scope of behavioral health services available through the BHO and how to obtain BHO services. At a minimum, the BHO shall also provide Members with information on the procedures which Members need to follow related to the BHO's prior

authorization process, utilization of case manager services, informing the BHO of any changes in the Member's status, changing providers, filing a grievance, and notice of off-island travel.

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

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

B) Cultural/Interpretation Services

1. The BHO shall make available to each potential Member and Member, including individuals with Limited English Proficiency (LEP), oral interpretation services sign language services and TDD services. This shall be provided at no cost to the individual. The BHO shall notify its Members and potential Members of the availability of free oral interpretation services for any language, sign language and TDD services, and inform them of how to access these services.

2. The BHO shall meet the following oral interpretation special requirements:

a. Offer oral interpretation services to individuals with LEP regardless of whether the individual speaks a language that meets the threshold of a prevalent non-English language; and
b. Document the offer of an interpreter regardless of whether the individual indicated an ability to provide his or her own, and whether an individual declined or accepted the interpreter service.

3. The BHO shall meet the requirements on written materials in Section 9.7.D.

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

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

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

C) Accessible Transportation Services

1. For the Members who have no means of transportation and who reside in areas not served by public transportation, the BHO shall use the most cost efficient modes of transportation that are available to and from medically necessary behavioral health visits to providers.

2. The BHO shall also provide transportation to Members who are referred to a provider that is located on a different island or in a different service area or state. The BHO may use whatever modes of transportation that are available and can be safely utilized by the Member. In cases where the Member requires assistance, the BHO shall provide for an attendant or assistant to accompany the Member to and from medically necessary visits to the providers.

3. The BHO is responsible for the arrangement and payment of the travel costs for the Member and the attendant or assistant and the lodging and meals associated with off-island or out-of-state travel due to medical necessity.

D) Outreach

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

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

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

3. The BHO contracted psychiatrist shall see Members out in the field or a place agreed upon by the Member who refuse to go to an office or clinic.

4. The BHO shall develop a CM component within their organization that will provide CM services from date of enrollment into the BHO until the Member is assigned to a contracted provider to prevent gap in services. For Members that currently are linked to a CBCM and wish to remain with that provider, the CM will be notified immediately of the Member's enrollment into the BHO.

5. The BHO shall help their Members maintain their medical assistance eligibility.

E) Appointment Follow-up

1. When the BHO refers the Member to another practitioner or service provider for behavioral health services, the BHO shall follow-up to verify that the Member received the needed services.

2. If a behavioral health appointment is made but not kept by the Member, the BHO shall contact the Member to determine the reason and schedule another appointment.

3. When the BHO Member requires services provided by a BHO specialist or other practitioner, the BHO's providers or CM shall coordinate the referral with the QI Health Plan PCP.

4. The BHO shall follow-up with the specialist or other practitioner to verify that the Member received the needed services.

5. Members shall receive a face-to-face case manager visit within two (2) calendar days of discharge from an inpatient psychiatric hospitalization and a visit with their behavioral health provider within seven (7) calendar days following discharge.
6. Members shall receive a face-to-face case manager visit within seventy-two (72) hours of discharge from an Emergency Department visit.

F) Hotline

1. The BHO shall provide toll-free hotline telephone services located in Hawaii, available on a 24-hour a day, 7 days a week basis, to its Members and providers.

2. The hotline information can be used by providers and Members to:
    a. Identify the individual's case manager or BHO provider;
    b. Direct Members to the nearest most appropriate behavioral health delivery site in cases of crisis, urgent or emergency care;
    c. Provide required prior approvals; and
    d. Answer other questions related to treatment of common behavioral health problems and minor emergency care.

3. Non-crisis hotline services may be online or provided through other means with a maximum response time of thirty (30) minutes.

G) Adverse Events Policy/Reporting

1. The BHO shall have policies and procedures in place to identify and address adverse events that occur to their Members.

2. Adverse events include but are not limited to death, suicide attempts, altercations with law enforcement personnel including incarceration, involvement with Adult Protective Services, homicide or attempted harm to others, medication errors, injuries requiring medical attention, and loss of housing.

3. The BHO shall submit to DHS, for review and approval, policies and procedures relating to adverse events by the due date identified in Section 13.3.B.

H) Certification of Physical or Mental Impairment

1. All evaluations for continued eligibility for DHS public assistance programs, and certificates of disability (initial and continued) are done through the DHS Panel.

2. The BHO is not responsible for these evaluations. The BHO is responsible however, to assist the Members to successfully complete the disability paperwork and connect with the evaluating provider.

4.14 Transition of Care

A) The BHO shall coordinate the transition of behavioral healthcare services for newly enrolled Members with the DOH-CAMHD, DOH-AMHD, DOH-DDD, the Hawaii State Hospital, prison, QI Health Plans, and other agencies and organizations involved, since many of the eligible Members already have an established behavioral

health care provider. For some of these individuals, an abrupt change in therapy may be detrimental.

B) Upon the Contract Effective Date identified in Section 1.5, Members receiving medically necessary behavioral health services the day before enrollment into the BHO, the BHO shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided by contract or non-contract providers. The BHO shall provide continuation of such services for ninety (90) calendar days for all Members or until the Member has had an assessment from his or her case manager, had an ITP developed and has been seen by his or her behavioral healthcare specialist. All non-contract providers shall be reimbursed at the Medicaid FFS rates in effect at the time of service delivery.

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

D) To ensure continuity of services and a smooth transition, Members transitioning from DOH-CAMHD and the Hawaii State Hospital shall be enrolled into CCS at service Level V for at least ninety (90) calendar days prior to being transitioned. Prior to the end of the ninety (90) calendar days, a service level assessment shall be done to determine appropriate service level placement. The ITP shall

reflect this assessment, the outcome of the assessment, and include changes or updates, if any.

E) The BHO shall establish guidelines with CAMHD and DHS to facilitate a seamless transition, for Members meeting CCS criteria, from CAMHD to CCS. The BHO shall participate in monthly case review meetings with CAMHD for a twelve (12) month period, after enrollment into CCS, for any Member between the ages of eighteen (18) and twenty one (21) moving from CAMHD directly into CCS, in an effort to ensure a smooth and coordinated service transition into CCS. [For further details regarding Members transitioning to CCS from DOH-CAMHD please refer to the current Memorandum of Agreement (MOA) with DHS.]

F) The BHO shall develop and submit to DHS, for review and approval, policies and procedures that address all transition of care requirements in this RFP by the due date identified in Section 13.3.B.

G) The transition of care policy shall include the following:
    1. The Member has access to services consistent with the access they previously had, and is permitted to retain their current provider for a period of time if that provider is not in the provider network;
    2. The Member is referred to appropriate providers of service that are in the provider network;
    3. The Member's previous provider(s) shall fully and timely comply with requests for historical utilization data from

Member's new provider(s) in compliance with federal and state law;

4. The Member's new provider(s) shall be able to obtain copies of the Member's medical records consistent with federal and state law, as appropriate; and
5. Any other necessary procedures as specified by the Secretary to ensure continued access to services to prevent serious detriment to the Member's health or reduce the risk of hospitalization or institutionalization.

H) The BHO shall provide instructions regarding the process of transition of care and how to access continued services upon transition in the Member Handbook, Section 9.7.C.ll.

4.15 Member & Provider Toll-Free Call Center

A) The BHO shall operate a toll-free call center located in Hawaii to respond to Member and provider questions, comments and inquiries. The toll-free call center services shall be available and accessible to Members and providers from all islands the BHO serves.

B) The toll-free call center shall handle calls from non-English speaking callers, as well as calls from callers who are hearing impaired. The BHO shall develop a process to handle non-English speaking callers.

C) The BHO's toll-free call center systems shall have the capacity to:
   1. Track call center metrics identified by DHS;

2. Allow DHS to monitor remotely; and
3. Have the ability for the calling Member to receive an automatic call back so that the Member does not need to remain on hold.

D) The call center shall be fully staffed between the hours of 7:45 a.m. (H.S.T.) and 4:30 p.m. (H.S.T.), Monday through Friday, excluding state holidays. The call center staff shall be trained to respond to questions in all areas, including, but not limited to, covered services and the provider network.

E) The BHO shall have an automated system or answering service available outside of BHO call-center hours, Monday through Friday, and during all hours on weekends and state holidays. This automated system or answering service shall provide callers with operating instructions on what to do in case of an emergency, shall provide an option to talk directly to a nurse or other clinician and shall include a voice mailbox or other method for callers to leave messages. The BHO shall ensure that the voice mailbox has adequate capacity to receive all messages. The BHO shall ensure that representatives return all calls by close of business the following business day.

F) In addition, the BHO shall have a twenty-four (24) hour, seven (7) day a week, toll-free hotline available to Members and providers, refer to Section 4.13.G. The BHO may use the same number as is used for the call center or may develop a different phone number. This line shall not be automated. There shall be hotline staff available 24/7 to provide information and assistance.

G) The BHO shall comply with call center reporting requirements as outlined in Section 6.5.A.3.

H) The BHO shall submit policies and procedures for the call center to DHS for review and approval in accordance with Section 13.3.B.

4.16 Statewide Service

A) The BHO shall provide the full range of behavioral health services to its Members, Statewide.

4.17 Advance Directive

A) The BHO shall maintain written policies and procedures for advance directives in compliance with 42 CFR §431.20 and 42 CFR § 422.128 and 42 CFR Part 489 Subpart I. For purposes of this Section, the term Medicare Advantage (MA organization) in 42 CFR § 422.128 shall refer to the BHO. Such advance directives shall be included in each Member's medical record.

B) The BHO shall provide these policies to all CCS Members and shall advise Members of:

1. Their rights under the laws of the State of Hawaii, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;
2. The BHO's written policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience. See 42 CFR § 422.128(b)(1)(ii); and

3. The BHO shall inform individuals that complaints concerning noncompliance with the advance directive requirements may be filed with the state survey and licensing agency that is the DOH, Office of Health Care Assurance (OHCA).

C) The information shall include a description of current state law and shall reflect changes in state laws as soon as possible, but no later than ninety (90) calendar days after the effective date of the change.

D) The BHO shall not condition the provision of care or otherwise discriminate against an individual based on whether or not a Member has executed an advance directive. The BHO shall ensure compliance with requirements of the State of Hawaii law regarding advance directives.

E) The BHO shall educate its staff about its advance directive policies and procedures, situations in which advance directives may be of benefit to Members, and the BHO's responsibility to educate and assist Members who choose to make use of advance directives. The BHO shall educate Members about their ability to direct their care using this mechanism and shall specifically designate which staff Members or network providers are responsible for providing this education. The BHO shall provide these policies and procedures to its providers and upon request to CMS and DHS.

F) The The BHO shall work with providers to demonstrate achievement across the following areas:
   1. Higher rates of completion of of advance directives; and

2. Increased likelihood that clinicians understand and comply with Member’s wishes.

SECTION 5 – Quality, Utilization Management, and Administrative Requirements

5.1 Quality

A) Importance of Quality Improvement

1. Quality care is defined as care that is accessible and efficient, provided in the appropriate setting according to professionally accepted standards, and in a coordinated and continuous rather than episodic manner.

2. Quality care includes but is not limited to:
    a. Provision of services in a timely manner with reasonable waiting times for office visits and the scheduling of appointments;
    b. Provision of services in a manner which is sensitive to the cultural differences of Members;
    c. Provision of services in a manner which ensures physical access, reasonable accommodations, and accessible equipment for Members with physical and/or mental disabilities;
    d. Opportunities for Members to participate in decisions regarding their care;
    e. Emphasis on health promotion and prevention as well as early diagnosis, treatment, and health maintenance;
    f. Appropriate use of services in the provision of care by providers;

g. Appropriate use of technology in the provision of care by providers;
h. Appropriate documentation, in accordance with defined standards, of the assessment and treatment of patients;
i. Provision of services in a manner which reflects standards of good practice;
j. Improved clinical outcomes and enhanced quality of life for all Members, while minimizing disparities in health outcomes across demographic sub-groups
k. Consumer satisfaction; and
l. User friendly grievance procedures which resolve issues in a timely manner.

3. Evidence-based continuous Quality Improvement is an important and necessary component of a BHO to ensure that the Members of a BHO are provided with quality care. Quality Improvement helps to ensure the delivery of cost-effective quality care. Quality Improvement provides the BHO with a means of ensuring the best possible outcomes and functional health status of its Members through proactive identification of health care and outcomes gaps, and delivery of the most appropriate level of care and treatment. Quality Improvement includes such important areas as quality assurance, quality measurement, performance improvement, use of practice guidelines, utilization reviews, grievance procedures, and the maintenance of medical records.

4. The governing body of the BHO, usually the Board of Directors, shall be responsible for the quality of care provided. The responsibilities of the governing body include oversight and review of the progress of the BHO's Quality Assurance and Performance Improvement (QAPI) Program, and modifications to the program as needed.

5. The governing body is expected to oversee the Quality Improvement Committee (QIC) of the BHO, which is responsible for implementing the BHO's QAPI program and monitoring as follows:
    a. The QIC shall have regular meetings;
    b. The QIC shall document its activities, findings, and recommendations and ensure follow-up;
    c. The QIC shall be accountable to the governing body and have representation from BHO provider type;
    d. The QIC should be supervised by a senior executive and the Medical Director should have substantial involvement; and
    e. The QIC should be provided with sufficient material resources to carry out its activities.

B) Quality Strategy, Quality Assurance and Performance Improvement Program Background

1. DHS is developing an updated Medicaid Managed Care Quality Strategy (DHS Quality Strategy) in accordance with 42 CFR § 438.340 that will detail goals and objectives for quality management and improvement, as well as specific

quality initiatives that are priorities; DHS Quality Strategy will be updated periodically as necessary and includes the priorities and activities of the CCS program.

2. DHS Quality Strategy shall address the health needs of the entire Member population. DHS Quality Strategy may provide guidance on evidence-based and nationally recommended approaches to addressing the desired goals and objectives for CCS Members.

3. In order to achieve the objectives of DHS Quality Strategy, the BHO shall collaborate with DHS, other State agencies, and as needed with other QI Health Plans, to develop and implement a data-driven, outcomes-based, continuous Quality Assurance and Performance Improvement Program (QAPI) plan focused on rigorous outcome measurement against relevant targets and benchmarks, and that appropriately supports providers and Members in advancing quality goals and health outcomes. This process will include considerations for tracking outcomes and addressing deficiencies when improvement is not occurring.

4. In close alignment with DHS Quality Strategy, DHS will lead, and the BHO shall participate in, a comprehensive quality program. The Quality Program may include one or more work groups tasked with systematically addressing, reporting on challenges with, and participating in a

collaborative approach to advance the goals and objectives of DHS Quality Strategy.

C) Quality Assurance and Performance Improvement (QAPI) Program

1. The BHO shall have an ongoing QAPI Program for all services it provides to its Members that is focused on improving health outcomes through collaborative opportunities and use of evidence-based approaches to achieve quality assurance and improvement.

2. The BHO shall develop and implement a comprehensive QAPI Program that is focused on improving health outcomes through collaborative opportunities and use of evidence-based approaches to achieve quality assurance and improvement.

3. The QAPI Program shall cover all demographic groups, care settings, and types of services. It shall address the delivery and outcomes of behavioral health care, Member safety, and non-clinical aspects of service, including the availability, accessibility, coordination, and continuity of care.

4. The QAPI Program shall consist of the systematic internal processes and mechanisms used by the BHO for its own monitoring and evaluation of the impact and effectiveness of the care/services it provides according to established

standards. The principles of continuous quality improvement shall be applied throughout the process, from developing, implementing, monitoring, and evaluating the QAPI Program to identifying and addressing opportunities for improvement.

5. The BHO will collaborate with DHS, other State agencies such as DOH, and QI Health Plans, to develop an aligned, collaborative QAPI strategy.

6. The QAPI Program shall at a minimum address the following elements and requirements:
    a. A detailed description of the QAPI Program addressing all required program elements;
    b. A discussion of how the BHO will operate the program to implement innovative approaches to support DHS in achieving improved outcomes;
    c. Clearly defined evidence-based approaches to Performance Improvement Projects (PIPs) and other quality improvement efforts that the BHO will implement;
    d. A proposed plan for collaboration across QI Health Plans where expected;
    e. A process to continually evaluate the impact and effectiveness of the QAPI program;
    f. The approach to modifying the QAPI Program to address deficiencies where identified;
    g. A detailed plan for conducting and assessing PIPs, including a demonstration of the alignment between

the BHO's PIPs with other QI Health Plans for DHS-specified PIPs, as applicable, and as further described in 42 CFR § 438.330(d);

h. Collecting and submitting to DHS performance measurement data, including outputs, process and outcome measures, and other qualitative data, as required by DHS;
i. Submitting data as required by DHS that enables DHS to validate and contextualize the BHO's performance on required measures;
j. Establishing mechanisms for detecting both under-utilization and over-utilization of services;
k. Establishing mechanisms for detecting and addressing both under-utilization and over-utilization of prescription drugs including controlled substances;
l. Establishing mechanisms for assessing and addressing the quality and appropriateness of care furnished to CCS Members who belong to other special populations across QI care settings, or Members receiving any type of specialized coordinated services, including but not limited to:
    1. Members with special health care needs;
    2. Members enrolled in the DD/ID 1915(c) waiver;
    3. Members receiving services from other DOH or DHS programs (i.e., Adult Mental Health Division Services);
    4. Members enrolled in D-SNPs; and

5. Members using long-term service supports;

m. Participating in DHS efforts to prevent, detect, and remediate critical incidents, consistent with assuring Member health and welfare per 42 CFR § 441.302;

n. Methods for seeking and incorporating input from, and working with, Members, providers, QI Health Plans, Med-QUEST staff and its designees, community agencies, other State agencies such as DOH, to actively improve the quality of care provided to Members;

o. Methods for improving health outcomes across the continuum of care for the CCS population using evidence-based and nationally recommended quality improvement approaches;

p. Practice guidelines as described in Section 5.1.F;

q. Methods to improve the provider grievances and appeals process; and

r. Use sophisticated IT infrastructure and data analytics to support DHS' vision and goals for quality improvement, measurement and evaluation, including the capability to identify sub-populations experiencing disparities (for example, by age, race, ethnicity, primary language or special populations), use predictive analytics to identify populations at risk for poor health outcomes and high cost, stratify and report metrics at the State and regional or service area level, and by sub-population, and report data at the patient or provider level to DHS as required.

6. The QAPI shall have written policies and procedures that state the BHO's commitment to treating Members in a manner that respects their rights as well as its expectation of Members' responsibilities. The BHO's QAPI program shall meaningfully incorporate a whole person approach to care through optimally integrating the Member's clinical, medical, and behavioral health care teams. It shall designate and specify the roles/responsibilities of a Member's physician and behavioral health practitioner, as well as the oversight of care rendered by the BHO's Quality Improvement Committee and any subcommittee(s).

7. The QAPI shall have established standards for access to and availability of services including standards for triage and travel time, telephone access and availability of appointments, which define the level of urgency and appropriate level of care.

8. The QAPI shall establish standards for the accessibility and availability of case documentation records and the information to be recorded and maintained in the records. A record review system to assess and assure conformance with standards shall be established.

D) QAPI Plan – Submission Requirements

1. The BHO shall submit an annual QAPI Plan for review and approval by DHS. The QAPI Plan shall include definitions of accepted standards of practice and established policies and

procedures. The documentation shall be provided to DHS as part of Readiness Review described in Section 13.3.B and upon request by DHS.

2. The BHO's QAPI Plan shall include a narrative description and a detailed workplan of activities for operationalizing all elements of the QAPI Program that demonstrably reflect its alignment with DHS Quality Strategy.

3. The BHO shall review DHS Quality Strategy regularly for any updates, evaluate its QAPI Plan for alignment, and update it as needed. The BHO shall submit updated QAPI Plans to DHS for review and approval.

4. Each subsequent year's QAPI Plan will be submitted along with a progress report on the current year's QAPI Plan to document the QAPI activities implemented and outcomes achieved for the year, along with remaining gaps and plan of action for the subsequent year as the "QAPI Program Progress Report and Annual Plan Update". The QAPI for each subsequent contract year should be adjusted to address the challenges identified in the prior QAPI report. The final year's QAPI report will not include the subsequent year's QAPI Plan and will be submitted by the BHO within a period of six (6) months of completion or termination of the contract, whichever occurs first.

5. In addition to the annual progress report and plan update, the BHO shall also submit quarterly reports providing QAPI

program updates and changes to the work plan in the QAPI as the "QAPI Program Quarterly Progress and Work Plan Update."

6. Upon request by DHS, the BHO shall submit other information about its QAPI program. Participation in the Quality Program will include informal updates and progress reports, and discussions on strategies, successes and challenges across various QAPI areas; it will provide an opportunity for engagement and collaboration across the BHO and QI Health Plans for planning purposes, and an avenue to seek input from DHS. DHS may ask the BHO to participate in training opportunities.

7. When establishing its QAPI program standards, the BHO shall comply with applicable provisions of federal and state laws and current NCQA Standards/Guidelines for Accreditation of Managed Behavioral Healthcare Organizations.

8. DHS reserves the right to require additional standards or revisions to established standards and their respective elements to ensure compliance with changes to federal or state statutes, rules, and regulations as well as to clarify and to address identified needs for improvement.

E) Performance Improvement Projects (PIPs)

1. As part of its QAPI Program, the BHO shall conduct a minimum of two (2) PIPs year-round in accordance with 42 CFR § 438.330(d). PIP topics may vary from one cycle to the next. The PIPs shall be designed to achieve, through iterative implementation of evidence-based interventions using data-driven quality improvement methods, and ongoing tracking and measurement of both outputs and outcomes, demonstrably significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction.

2. Each PIP shall include a performance measurement strategy using objective quality indicators.

3. Each PIP shall include implementation of interventions to achieve improvement in the access to and quality of care.

4. The PIPs shall follow the "Plan, Study, Do, Act" (PDSA) cycle or other evidence-based methods. The study topics will be approved by DHS. The studies should follow standard quality improvement methods such as having a clearly identified study question and objective; a description of the methods that include the appropriate evidence-based intervention planned, as well as the evidence-based approach for conducting quality improvement; clear implementation plan; measurable indicators of output,

process, and outcomes; valid sampling techniques (where applicable) and accurate data collection, including qualitative data collection where needed; data analysis; and a description of the findings, areas in need of improvement or refinement, and recommendations. The PIP should describe the iterative PDSA cycles and the lessons learned in each cycle that were implemented into the plan for the next cycle.

5. The PIP plan shall include a detailed description of the study question, approach, planned evaluation, and strategy for incorporation of findings into future PDSA cycles; be included in the QAPI Plan; and is subject to review and approval by DHS prior to implementation. Updates on PIP activities, including results and outcomes, shall be provided quarterly and annually, as part of the "QAPI Program Quarterly Progress and Work Plan Update" and "QAPI Program Progress Report and Annual Plan Update."

6. The BHO shall report the status and results of each project to DHS as requested. The BHO shall complete each PIP in the time period determined by DHS so as to allow information on the progress of PIPs in aggregate to produce new information periodically on quality of care according to 42 CFR § 438.330(d)(3).

7. PIPs may be specified by DHS. All DHS-selected PIPs shall be included as part of the BHO's overall QAPI Plan. In these cases, the BHO shall meet the goals and objectives specified

by DHS. The BHO may also submit recommended PIP topics, PIP standards, and proposed PIPs for the selected topics to DHS. DHS has final approval for selected PIP topics and methods.

8. The BHO shall submit to DHS and the EQRO any and all data necessary to enable validation of the BHO's performance under this Section, including the status and results of each project. The BHO shall include in its submission the planned approach to sustaining or increasing improvements beyond the end of the PIP.

F) Practice Guidelines

1. The BHO shall include, as part of its QAPI Program, practice guidelines that meet the following requirements as stated in 42 CFR § 438.236 and current NCQA standards. Each adopted practice guidelines shall be:
    a. Relevant to the needs of the BHO's membership;
    b. Based on valid and reliable clinical evidence, national recommendations, or a consensus of healthcare professionals in the behavioral health field;
    c. Aligned with the goals of this contract, DHS Quality Strategy, and the BHO's QAPI;
    d. Designed as systematic strategies to enhance use and implementation of evidence-based practices in support of addressing disparities, improving quality, enhancing adoption of evidence-based models and

practices, and increased adoption of HIT-based strategies;

e. Adopted in consultation with in-network healthcare professionals;
f. Reviewed and updated periodically as appropriate;
g. Disseminated broadly to all affected providers, and upon request, to Members and potential Members;
h. Evaluated for adoption and implementation through provider-based reporting; and
i. Promoted by the BHO for adoption and implementation through provider-based education activities; practice transformation support including HIT-based strategies; and other incentives.

2. The BHO shall report data on implementation and adoption of each practice guideline across its provider network to DHS quarterly and annually, as part of the "QAPI Program Quarterly Progress and Work Plan Update" and "QAPI Program Progress Report and Annual Plan Update." Where there are gaps in adoption or implementation, the subsequent quarter or year's QAPI Plan will include plans for continued support from the BHO towards greater adoption and implementation.

3. Practice guidelines, policies, and procedures and a list of all current practice guidelines shall be submitted to DHS for review in accordance with Section 13.3.B.

4. Additionally, in compliance with 42 CFR § 438.236, the BHO shall ensure that decisions for utilization management, Member education, coverage of services, and other areas to which the guidelines apply, are consistent with the guidelines.

5. The BHO shall disseminate practice guidelines to Members and potential Members upon request.

6. DHS shall issue guidance as needed and additionally develop practice guidelines based on emerging and evolving clinical practice. DHS may also specify topics for practice guidelines that the BHO shall develop, in collaboration with QI Health Plans as appropriate.

7. The BHO may additionally issue its own practice guidelines. The BHO shall follow current NCQA and BBA standards for adopting and disseminating guidelines. DHS may periodically review the clinical practice guidelines adopted by the BHO, request additional information as needed, and promulgate one or more clinical practice guidelines as a standard of practice.

8. For each practice guideline adopted, the BHO shall:
    a. Describe the clinical, evidentiary, and strategic basis upon which the practice guideline is chosen;
    b. Describe how the practice guideline takes into consideration the needs of the Members;

c. Describe how the BHO shall ensure that practice guidelines are reviewed in consultation with health care providers;
d. Describe the process through which the practice guidelines are reviewed and updated periodically;
e. Describe how the practice guidelines are disseminated to all relevant providers and, upon request, to potential Members;
f. Describe the BHO's strategies to promote adoption and implementation, as well as processes for monitoring; and
g. Describe how the BHO shall ensure that decisions for utilization management, Member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

G) Delegation

1. Contingent upon approval from DHS, the BHO may be permitted to delegate certain QAPI Program activities and functions. However, the BHO shall remain responsible for the QAPI Program, even if portions are delegated to other entities. Any delegation of functions requires:
   a. A written delegation agreement between the delegated organization and the BHO, describing the responsibilities of the delegation and the BHO; and
   b. Policies and procedures detailing the BHO's process for evaluating and monitoring the delegated organization's performance.

2. At a minimum, the following shall be completed by the BHO:
    a. Prior to execution of the delegation agreement there shall be provisions for a site visit and evaluation of the delegated organization's ability to perform the delegated activities;
    b. An annual on-site visit and/or documentation/record reviews to monitor and evaluate the quality of the delegated organization's assigned processes;
    c. The annual on-site visit may be deemed to have occurred if the delegate is accredited by NCQA; and
    d. Ongoing monitoring and evaluation of the content and frequency of reports from the delegated organization.

H) DHS Review of BHO QAPI Program

1. In accordance with 42 CFR § 438.330(e), DHS shall review, at least annually, the impact and effectiveness of the BHO's QAPI Program. The scope of DHS review also includes monitoring of the systematic processes developed and implemented by the BHO to conduct its own internal evaluation of the impact and effectiveness of its QAPI program as well as to effect necessary improvements.
2. The BHO shall actively participate in DHS' review of the QAPI Program and provide requested materials within an agreed upon timeframe. The BHO shall also facilitate DHS' requests for onsite visits to support the review.

3. DHS shall evaluate the BHO's QAPI Program utilizing a variety of methods, including but not limited to:
    a. Reviewing QAPI documents;
    b. Reviewing, validating, and evaluating the QAPI Program reports regularly required by DHS (e.g., Member grievances and appeals reports, provider grievance and claims reports, reports of suspected cases of fraud and abuse, performance measures reports, performance improvement project (PIP) reports, QAPI program description, etc.);
    c. Meeting with the BHO regularly as part of the Quality Program activities, and gathering information on activities, progress, and challenges;
    d. Reviewing, evaluating, or validating implementation of specific policies and procedures or special reports relating to areas such as:
        1) Member rights and protections;
        2) Services provided to CCS Members requiring other types of specialized coordination (e.g. LTSS, special health care needs, CIS, etc.);
        3) Utilization management (e.g., under-utilization and over-utilization of services);
        4) Concurrent review and prior authorization procedures;
        5) Access to care standards, including:
            a) Availability of services
            b) Adequate capacity and services
            c) Continuity and coordination of care

d) Coverage and authorization of services;

6) Structure and Operation Standards, including:

a) Provider selection

b) Member information

c) Confidentiality

d) Enrollment and disenrollment;

7) Grievance systems;

8) Sub contractual relationships and delegation;

9) Measurement and Improvement Standards;

10) Practice guidelines;

11) Health information systems;

e. Conducting on-site reviews to interview BHO staff for clarification, to review records, or to validate implementation of processes/procedures; and

f. Reviewing medical records.

4. DHS may elect to monitor the activities of the BHO using its own personnel or may contract with a qualified designee to perform functions specified by DHS. The BHO shall cooperate and provide the requested information and allow access to the BHO and providers' records. Upon completion of its review, DHS or its designee may submit a report of its findings to the BHO and to DHS. At the request of DHS, the BHO shall develop corrective actions for any identified areas of deficiency.

I) Quality Rating System

1. The BHO shall participate as necessary in any activities needed to support DHS in the design and implementation of a managed care quality rating system in accordance with 42 CFR § 438.334.

J) Performance Measures

1. The BHO shall comply with all DHS quality management requirements to improve performance for DHS established performance measures. Performance measures may be based on CMS core measures or initiatives, DHS priorities, or areas of concern that arise from previous measurements. Performance measures will be aligned with DHS Quality Strategy and shall represent the key metrics that serve as the outputs and outcomes of the BHO's overall QAPI activities, including activities that integrate physical and behavioral healthcare for CCS Members.

2. Clinical measures (e.g., comprehensive diabetes care measures, cardiovascular disease measures), utilization measures (e.g., emergency department visits, hospital readmissions), and other measures of program cost (e.g., total cost of care, primary care spend) may be included, in addition to process measures. DHS may require reporting of performance measure at any level of granularity including Member-, provider-, practice-, health system- or plan-level. The BHO may need to submit additional breakouts for

specific measures such as those that track the implementation and effectiveness of physical and behavioral health integration for CCS Members.

3. The following include types of performance measures that the BHO shall be required to track and provide to DHS:
    a. Clinical and Utilization Quality measures - a set of clinical and utilization measures are required from the BHO each year. DHS shall provide a list of the performance measures each calendar year for the next year's required measures. The measures may be HEDIS measures.
    b. HEDIS-Like measures – a set of measures (both clinical and utilization measures) that are based on HEDIS measure definitions but modified as needed to achieve such goals as alignment with the CMS Medicaid Core Set, or alignment with DHS priorities. DHS shall provide a list of the HEDIS-like performance measures each calendar year for the next year's required measures.
    c. Other nationally developed quality measures - a set of measures (both clinical and utilization measures) with various measure stewards nationally that may or may not be endorsed by NCQA. DHS shall provide a list of nationally developed performance measures each calendar year for the next year's required measures.
    d. Other Homegrown Quality measures – a set of measures (including clinical, utilization, or cost-based measures) that are defined by DHS to track DHS priorities for which a HEDIS, HEDIS-like, or other

nationally defined measure is unavailable, inadequate, or inappropriate. DHS will design these measures as needed and provide the BHO with a format and frequency for reporting.

e. Utilization dashboard - the BHO shall supply information that may include a variety of output measures and performance metrics designed to track volumes of patients or services, including hospital admissions and readmissions, call center statistics, provider network, Member demographics, etc. DHS shall provide a list of the measures and a format and frequency for submission.

4. DHS shall also identify the measures that may be eligible for one or more performance incentive programs as outlined in Section 5.1.K.

5. The BHO shall submit to DHS and the EQRO any and all data necessary to enable validation of the BHO's performance under this Section.

K) Quality Payment Program

1. DHS may implement the Quality Payment Program so that the BHO will be eligible for financial performance incentives or Pay for Performance (P4P) as long as the BHO is fully compliant with all terms of the Contract. All incentives may be in compliance with the Federal managed care incentive

arrangement requirements set forth in 42 CFR § 438.6 and other applicable sub-regulatory guidance.

2. The Quality Payment Program may be comprised of multiple performance measures that will create financial alignment between DHS QUEST Integration (QI) program and CCS program. Performance measures may be focused on:
    a. Integrating physical and behavioral health;
    b. Ensuring care coordination across physical and behavioral health service delivery;
    c. Reducing the total cost of care for CCS enrollees in both the CCS program and the QI program;
    d. Reducing inappropriate utilization of services; and
    e. Improving health outcomes for Members enrolled in CCS.

3. DHS may assign weights to each performance measure. The performance measures and the targets/floors for each performance measure may vary each year, but DHS intends to maintain some consistency in performance measures to trend progress in achieving improved outcomes. Performance measures selected may include quality, Value Based Purchasing (VBP), and other financial metrics of interest. Each performance measure will be calculated independently of other performance measures, to determine if any performance incentive was earned for that performance measure.

4. The Quality Payment Program may be implemented based on a withhold arrangement with potential for the BHO to earn dollars back as the BHO meets performance targets in accordance with 42 CFR § 438.6(b)(3). DHS may also prospectively pay the withheld amount and recover portions of the payment from the BHO that the BHO did not earn back by meeting performance measure targets.

5. The Quality Payment Program may also be implemented as an incentive arrangement program in accordance with 42 CFR § 438.6(b)(2). The incentive arrangement may also be prospectively paid, and DHS may recover portions of the payment from the BHO that the BHO did not earn by meeting performance measure targets.

6. The Quality Payment Program may also be implemented as a shared savings program, where the BHO may be able to share in a portion of savings generated in the QI program for CCS enrollees.

5.2 Physician Incentives

A) The BHO may establish physician incentive plans pursuant to federal and state regulations, including 42 CFR §§ 422.208, 422.210, and 438.6.

B) The BHO shall disclose any and all such arrangements to DHS for review and approval prior to implementing physician incentives, and upon request, to Members. Such disclosure shall include:

1. Whether services not furnished by the physician or group are covered by the incentive plan;
2. The type of incentive arrangement;
3. Details of the value-based purchasing agreement;
4. Methodology used for calculating payout; and
5. Performance evaluation of the program

C) Upon request, the BHO shall report adequate information specified by applicable regulations to DHS, so that DHS can adequately monitor the BHO.

D) If the BHO's physician incentive plan includes services not furnished by the physician/group, the BHO shall ensure adequate stop loss protection to individual physicians and provide to DHS proof of such stop loss coverage, including the amount and type of stop loss.

E) Physician incentive plans may not provide for payment, directly or indirectly, either to a physician or to physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

5.3 Accreditation Status

A) The BHO shall be accredited by the National Committee for Quality Assurance (NCQA) no later than the end of the first contract year. The BHO shall maintain continuous accreditation throughout the Contract period, with no lapse in accreditation. The BHO shall proactively seek reaccreditation as needed to prevent lapses.

B) The BHO shall notify DHS of any changes in its accreditation status including, but not limited to, application, rejection, or renewal within seven (7) days.

C) Failure to obtain accreditation by the required date or failure to maintain accreditation thereafter shall be considered non-performance of contract in Section 14.21 which may result in the Termination of the Contract in Section 14.16.

D) In accordance with 42 CFR § 438.332(b)(1), the BHO shall submit and/or authorize NCQA to submit accreditation review information to DHS, including:
   1. The most recent accreditation review;
   2. Accreditation status, survey type, and level (as applicable);
   3. Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and
   4. Expiration date of the accreditation.

5.4 Non-Duplication Strategy

A) In accordance with 42 CFR § 438.360, DHS may use information from a Medicare and/or a private accreditation review to avoid duplication with the review of select standards required under an external quality review. This option may be used at the discretion of DHS. DHS will define the use of this option in DHS policies and in DHS Quality Strategy if DHS decides to use this option. DHS may waive certain EQRO validation activities based on the BHO's NCQA accreditation.

5.5 External Quality Review/Monitoring

A) DHS contracts with an EQRO to perform, on an annual basis, an external, independent review of the quality outcomes of, timeliness of, and access to the services provided for CCS Members by the BHO.

B) The BHO shall cooperate with DHS-contracted EQRO in the External Quality Review (EQR) activities performed by the EQRO to assess the quality of care and services provided to Members and to identify opportunities for BHO quality improvement. To facilitate this review process, the BHO shall provide all requested QAPI Program related documents and data to the EQRO.

C) The EQRO shall monitor the BHO's compliance with all applicable provisions of 42 CFR Part 438, Subpart E. Specifically, the EQRO may provide the following activities as described in 42 CFR §§ 438.358 and 438.602(e):

1. Validation of network adequacy during the preceding twelve (12) months to comply with requirements set forth in 42 CFR §§ 438.68 and 438.14(b)(1).
2. Validation of PIPs required by DHS;
3. Validation of BHO performance measures required by DHS; and
4. A review, conducted within the previous three-year period, to determine compliance with standards established by DHS concerning access to care, structure and operations, and quality measurement and improvement.

D) The BHO shall submit to DHS and the EQRO its corrective action plans, which address identified issues requiring improvement, correction or resolution.

E) The BHO shall participate in any additional activities undertaken by the EQRO for DHS, which may include but are not limited to:

1. Administration, analysis, and reporting the results of the CAHPS® Consumer Survey. DHS may modify this schedule based upon its needs. The EQRO shall provide an overall report of survey results to DHS. DHS and the BHO shall receive a copy of their BHO-specific raw data by island;
2. Administration, analysis, and reporting of the results of the Provider Satisfaction Survey. DHS may modify this schedule based upon its needs. The EQRO shall provide an overall report of survey results to DHS. DHS and the BHO shall receive a copy of their BHO-specific raw data by island;
3. Providing technical assistance to the BHO to assist them in conducting activities related to the mandatory and optional EQR activities according to 42 CFR § 438.310(c)(2);
4. Assisting with the quality rating of the BHO consistent with 42 CFR § 438.334;
5. Administration, analysis, reporting of the results of the Encounter Data Validation (EDV) study per 42 CFR § 438.358(c)(1), and optional activities related to external quality review. The EQRO is responsible for validating encounter data by using information derived during the preceding twelve (12) months reported by the BHO. The EQRO will be responsible for developing the methodology,

generating and issuing the questionnaires, collecting data, and conducting a comparative analysis. Finally, the EQRO shall furnish a special report that summarizes the results to DHS and the BHO; and

6. Assisting with the quality rating of BHO, PIHPs, and PAHPs consistent with 42 CFR § 438.334.

5.6 Conduction of, or Participation in, Case Study Interviews, Surveys, or Other External Reviews

A) DHS or its designee may conduct case study interviews. These could require that key individuals involved with the programs (including representatives of the BHO, association groups and consumer groups) identify what was expected of the program, changes needed to be made, effectiveness of outreach and enrollment, and adequacy of the BHO in meeting the needs of the populations served. The BHO shall cooperate in the interview process by allowing selected individuals to meet with and discuss the issues with DHS representatives.

B) DHS or its designee may conduct surveys of Members and providers, to determine overall satisfaction with the BHO, the quality of care received and the overall behavioral health status of the Members. These surveys may be conducted annually, utilizing appropriate sampling techniques, covering Member satisfaction, and provider satisfaction. DHS shall share the results of the survey with the BHO.

C) Participation in DHS surveys will not preclude the BHO from conducting its own surveys. DHS may require the BHO to conduct quality of life and other annual Member surveys with its Members as part of their quality program. If surveys are conducted by the BHO, survey results shall be disclosed to DHS, and to Members upon request.

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

5.7 Utilization Management Program (UMP)

A) The BHO shall have in place a utilization management program (UMP) that is linked with and supports the BHO's QAPI Program. The UMP shall be developed to assist the BHO in objectively and systematically monitoring and evaluating the necessity, appropriateness, efficiency, timeliness and cost-effectiveness of care and services provided to Members. The UMP shall be used by the BHO as a tool to continuously improve quality clinical care and services as well as maximize appropriate use of resources.

B) DHS may validate that BHO's utilization management, concurrent review, and prior authorization procedures, and conduct ongoing evaluation and monitoring activities to ensure that these are being implemented with an understanding of the behavioral health

benefits allowed under the BHO and taking into consideration the medical necessity of the services for the Member.

C) As part of the UMP, the BHO shall define its implementation of medically necessary services in a manner that:
   1. Is no more restrictive than the definition of Medical Necessity services as defined in Section 3; and
   2. Addresses the extent that the BHO covers services related to the Member's ability to attain, maintain, or regain functional capacity; and improve health outcomes.

D) The BHO shall have a written UMP description, a corresponding workplan, UMP policies and procedures, and mechanisms to implement all UMP activities. The UMP description and workplan may be separate documents or may be integrated as part of the written QAPI Program description and workplan. The description, workplan, policies, and procedures shall be submitted for DHS review in accordance with Section 13.3.B.

E) The BHO's UMP shall include structured, systematic processes that employ objective evidenced-based criteria to ensure that qualified licensed health care professionals make utilization decisions regarding medical necessity and appropriateness of care in a fair, impartial, and consistent manner.

F) The BHO shall ensure that applicable evidence-based criteria are applied with consideration given to the characteristics of the local delivery system available for specific Members as well as Member-specific factors, such as age, co-morbidities, complications,

progress of treatment, psychosocial situation, and home environment.

G) The BHO shall also have formal mechanisms to evaluate and address new developments in technology and new applications of existing technology for inclusion in the benefit package to keep pace with changes and to ensure equitable access to safe and effective care.

H) The BHO shall annually review and update all UMP criteria and application procedures in conjunction with review of the BHO's clinical practice guidelines, disease management programs, and evaluation of new technologies. Practitioners with appropriate clinical expertise shall be involved in developing, adopting, and reviewing the criteria used to make utilization decisions. The BHO shall provide UMP criteria to providers and shall ensure that Members and providers seeking information about the UMP process and the authorization of care/services have access to UMP staff.

I) The BHO's utilization review/management activities shall include:
   a. Prior authorization/pre-certifications;
   b. Concurrent reviews;
   c. Retrospective reviews;
   d. Discharge planning;
   e. Care Coordination; and
   f. Pharmacy Management.

J) The UM plan shall include policies and procedures to evaluate care management, sites of service, level of care, triage, benefit

coverage and cost of benefits to determine if they are clinically appropriate to the behavioral healthcare needs of the Members.

K) The BHO shall conduct a Concurrent Review process. Concurrent review requirements shall be made available to appropriate providers. There shall be no retrospective denial(s). The BHO shall proactively work with provider(s) to ensure Member's timely access to care, inclusive of a Member's continuation of care not limited to hospital services, post-acute services, transitional services, and DME and supplies.

L) The UMP shall include mechanisms to detect under-utilization, over-utilization, and inappropriate utilization as well as processes to address opportunities for improvement. The BHO shall perform:

1. Routine, systematic monitoring of relevant utilization data;
2. Routine analysis of all data collected to identify causes of inappropriate utilization patterns;
3. Implementation of appropriate interventions to correct any patterns of potential or actual under-utilization or over-utilization; and
4. Systematic measurement of the effectiveness of interventions aimed at achieving appropriate utilization.

M) The BHO shall evaluate and analyze practitioners' practice patterns, and at least on an annual basis, the BHO shall produce and distribute to the Member's care team, profiles comparing the average medical care utilization rates of the Members of each behavioral health care team to the average utilization rates of all BHO Members. Additionally, feedback shall be provided to

providers when specific utilization concerns are identified, and interventions to address utilization issues shall be systematically implemented.

N) The BHO shall ensure that pharmaceutical management activities promote the clinically appropriate use of pharmaceuticals and as described in Section 5.1.C.6 There shall be policies, procedures, and mechanisms to ensure that the BHO has criteria for adopting pharmaceutical management procedures and that there is clinical and scientifically based evidence for all decisions. The policies must include an explanation of any limits or quotas and an explanation of how prescribing practitioners must provide information to support an exceptions request.

O) The BHO shall ensure that it has processes for determining and evaluating classes of pharmaceuticals, pharmaceuticals within the classes, and criteria for coverage and prior authorization of pharmaceuticals. The BHO shall ensure that it has processes for generic substitution, therapeutic interchange, and step-therapy protocols.

P) The BHO shall not develop a compensation structure that creates incentives for the individuals or entities conducting UMP activities to deny, limit, or discontinue medically necessary services to any Member.

5.8 Authorization of Services

A) The BHO shall have in place written prior authorization/pre-certification policies and procedures for processing requests for initial and continuing authorization of services and prescription medication in a timely manner. The procedures shall be developed to reduce administrative burden on providers.

B) The BHO shall utilize any DHS-required standardized format for authorization of services.

C) The BHO shall submit the policies and procedures for DHS review in accordance with Section 13.3.B.

D) The BHO's prior authorization requirements shall comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR § 438.910(d).

E) A Member shall be able to make a request to the BHO for the provision of a service. As part of these prior authorization policies and procedures, the BHO shall have in effect mechanisms to:
   1. Ensure consistent application of review criteria for authorization decisions; and
   2. Consult with the requesting provider when appropriate.

F) The BHO shall ensure that all prior authorization and pre-certification decisions, including but not limited to any decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, shall be

made by a health care professional who has appropriate clinical expertise in addressing the Member's behavioral health needs.

G) Medical necessity approvals may be made by licensed clinical staff or unlicensed staff under the supervision of licensed staff. Medical necessity denials shall be made by licensed clinical staff. All denials shall be reviewed and approved by the BHO medical director.

H) The BHO shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. The BHO may place appropriate limits on a service based on criteria such as medical necessity, or for utilization control, provided that:

1. The services furnished can reasonably be expected to achieve their purpose; and
2. The services supporting Members with ongoing or chronic conditions are authorized in a manner that reflects ongoing need for such services.

I) The BHO shall not require prior authorization of emergency services but may require prior authorization of post-stabilization services as specified in Section 4.4.

J) The BHO is required to provide services for all enrolled Members in an amount, duration and scope that is no less than the amount, duration and scope for the same services provided under FFS for all enrolled Members.

K) The BHO shall ensure providers are active participants in discharge planning. In cases where Members do not meet criteria for inpatient stay or the BHO's concurrent review denies additional inpatient days, the BHO shall assure the provider participates actively in determining the disposition of the Member.

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

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

an expedited authorization determination and provide notice as expeditiously as the Member's health condition requires but no later than seventy two (72) hours after receipt of the request for service. The BHO may extend the seventy-two (72) hour timeframe by up to an additional fourteen (14) calendar days if the Member requests an extension, or if the BHO justifies to DHS a need for additional information, and the extension is in the Member's best interest. If the BHO extends the time frame, it shall give the Member written notice of the reason for the decision to extend the time frame and inform the Member of the right to appeal if he or she disagrees with that decision. The BHO shall issue and carry out its determination as expeditiously as the Member's health condition requires and no later than the date the extension expires.

3. The BHO shall notify the requesting provider and give the Member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

A) Service authorization decisions not reached within the timeframes specified above and in accordance with DHS policy guidance shall constitute a process failure, and not automatically deemed an adverse action.

B) The BHO's prior authorization requirements shall comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR § 438.910(d).

C) DHS is committed to increasing standardization and decreasing administrative burden for providers, QI Health Plans, and the BHO. DHS consequently established the Administrative Simplification Initiative.

D) The BHO shall actively participate in efforts that are led by DHS and the DHS Medical Director. The BHO may also be required to submit best practice recommendations to DHS upon request. DHS may require the BHO to implement administrative simplification best practices.

5.9 Administrative Requirements

A) Medical Records Standards

1. In alignment with its QAPI Program, the BHO shall establish medical records standards as well as a record review system to assess and assure conformity with standards. These standards shall be consistent with the minimum standards established by DHS identified below:
    a. Require that the medical record is maintained by the provider;
    b. Assure that DHS personnel or personnel contracted by DHS shall have access to all records, as long as access to the records are needed to perform the duties of this contract for information released or exchanged pursuant to 42 CFR § 431.300. The BHO shall be responsible for being in compliance with any

and all state and federal laws regarding confidentiality;

c. Provide DHS or its designee(s) with prompt access to Members' medical records;
d. Provide Members with the right to request and receive a copy of his or her medical records, and to request they be amended, as specified in 45 CFR Part 164; and
e. Allow for paper or electronic record keeping.

2. As part of the record standards, the BHO shall require that providers adhere to the following requirements:
   a. All medical records are shared and maintained in a detailed and comprehensive manner in accordance with professional standards;
   b. All medical records are maintained in a manner that permits effective professional medical review and medical audit processes;
   c. All medical records are maintained in a manner that facilitates adequate follow-up treatment;
   d. All medical records shall be legible, signed and dated;
   e. Each page of the paper or electronic record includes the patient's name or ID number;
   f. All medical records contain Member demographic information, including age, sex, address, home and work telephone numbers, marital status and employment, if applicable;
   g. All medical records contain information on any adverse drug reactions and/or food or other allergies,

or the absence of known allergies, which are posted in a prominent area on the medical record.

h. All forms or notes have a notation regarding follow-up care, calls or visits, when indicated;

i. All medical records contain the Member's past medical history that is easily identified and includes serious accidents, hospitalizations, operations and illnesses. All medical records include the provisional and confirmed diagnosis(es);

j. All medical records contain medication information;

k. All medical records contain information on the identification of current problems (i.e., significant illnesses, medical conditions and health maintenance concerns);

l. All medical records contain information about consultations, referrals, and specialist reports;

m. All medical records contain information about emergency care rendered with a discussion of requirements for physician follow-up;

n. All medical records contain discharge summaries for: (1) all hospital admissions that occur while the Member is enrolled; and (2) prior admissions as appropriate;

o. All medical records include documentation as to whether or not the Member has executed an advance directive, including an advance mental health care directive;

p. All medical records shall contain written documentation of a rendered, ordered or prescribed

service, including documentation of medical necessity; and

q. All medical records contain documented Member visits, which includes, but is not limited to:
    1) A history and physical exam;
    2) Treatment plan, progress and changes in treatment plan;
    3) Laboratory and other studies ordered, as appropriate;
    4) Working diagnosis(es) consistent with findings;
    5) Treatment, therapies, and other prescribed regimens;
    6) Documentation concerning follow-up care, telephone calls or visits, when indicated;
    7) Documentation reflecting that any unresolved concerns from previous visits are addressed in subsequent visits;
    8) Documentation of any referrals and results thereof, including evidence that the ordering physician has reviewed consultation, and other diagnostic test results/reports filed in the medical records, and evidence that consultations and significantly abnormal results specifically note physician follow-up plans;
    9) Hospitalizations and/or Emergency Department visits, if applicable; and
    10) All other aspects of patient care, including ancillary services.

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

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

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

6. All case documentation records shall meet NCQA behavioral health guidelines for treatment record review. Records shall be maintained in a detailed, comprehensive, and organized manner which conform to good professional medical practice, permit effective professional medical

review and medical audit processes and which facilitate an adequate system for follow-up treatment. All entries shall be legible, signed, and dated.

7. Confidentiality of the records shall be maintained. Upon enrollment, the BHO shall ensure that confidential Member records are accessible only to authorized persons, in accordance with written consent granted by a Member or a Member's representative or with applicable state or federal laws, rules or regulations. Subcontractors and other network providers are not required to obtain subsequent written consent from the Member before providing access to the records, as long as access to the records is needed to perform the duties of this contract and to administer the program. Approval is also not needed for access by authorized DHS personnel or personnel contracted by DHS (refer to Section 14.17).

8. The BHO shall have a basic system in place that provides for continuity of care and case management.

9. As part of its medical records standards, the BHO shall comply with medical record retention requirements in Section 14.5.

10. The BHO shall submit its medical records standards to DHS for review in accordance with Section 13.3.B.

B) Second Opinion

1. The BHO shall provide for a second opinion in any situation when there is a question concerning a diagnosis, the options for the treatment of a behavioral health condition when requested by the Member, any Member of the health care team, a parent(s) or legal guardian(s), or a DHS social worker exercising custodial responsibility. A qualified health care professional within the network shall provide the second opinion or the BHO shall arrange for the Member to obtain a second opinion outside the provider network. The second opinion shall be provided at no cost to the Member.

C) Out-of-State/Off Island Coverage

1. If behavioral health treatments or services required by the Member are not available in the State or on the island where the Member resides, the BHO shall provide for these services whether off-island or out-of-state. This includes referrals to an out-of-state or off-island specialist or facility, transportation to and from the referral destination for an off-island or out-of-state destination, lodging, and meals for the Member and any needed attendant(s). However, if the service is available on a Member's island of residence, the BHO may require the Member to obtain the needed services from specified providers as long as the provider is in the same geographic location as the Member, and the Member

can be transferred. The BHO shall coordinate with DHS as needed for any out-of-state referrals.

2. Behavioral health services rendered outside of the United States or in a foreign country are not covered for Members.

3. Out-of-state emergency behavioral health services for Members are covered under the BHO, if approved by DHS.

4. An "emergency medical condition" is defined in the Social Security Act § 1932, 42 U.S.C. 1396u-2(b)(2)(C) as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to body functions or serious dysfunction of any bodily organ or part." The BHO may use this definition and the definition for "emergency services" under 42 U.S.C. 1396u-2(b)(2)(B) to determine whether the services provided out-of-state qualify as emergency services. "Emergency services" under 42 U.S.C. 1396u-2(b)(2)(B) means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that: are furnished by a provider that is qualified to furnish such services under the Social Security Act subchapter XIX; and are needed to evaluate or stabilize an emergency medical condition (as defined in 42 U.S.C. 1396u-

2(b)(2)(C). If emergency services, as defined above, are provided, the BHO shall be responsible for covering all emergency services related to behavioral health. Prior authorization shall not be required for behavioral health emergencies.

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

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

D) Claim Processing Capabilities

1. The BHO shall comply with claims processing requirements listed in Section 7.2.A. The claim processing function and its key personnel shall be located in the State of Hawaii. The BHO shall operate a Member and provider toll-free call center located in the State of Hawaii, as described in

Section 4.15. For providers, this call center shall respond to provider questions, comments and inquiries regarding claims submission and status. The provider toll-free call center services shall be available and accessible to CCS providers from all islands.

E) Administrative Coordination Meeting

1. The BHO shall have a quarterly meeting with the QI Health Plans, DOH and other State entities as needed, and DHS representatives to discuss and resolve various issues, such as claims, coordination of services, continuity of care, data sharing, and other administrative issues.

2. DHS will make final decisions on administrative issues that cannot be resolved by BHO and QI Health Plans.

SECTION 6 – BHO Reporting and Encounter Data Responsibilities

6.1 Overview

A) The BHO shall comply with all reporting requirements established by DHS. Reporting requirements include data submitted to DHS in disaggregated format, as well as aggregated reports that may include quantitative and qualitative data, as well as identifying information.

B) With regard to aggregated reporting requirements, the BHO shall submit reports based on DHS Report Manual ("Report Manual"), published by DHS and incorporated by reference into this Contract; and when requested, participate in a collaborative process with DHS and QI Health Plans, as appropriate, to update DHS Report Manual to ensure consistent usage of reporting specifications and interpretation of data definitions for all required reports.

C) The BHO shall submit to DHS all requested reports in time frames and intervals identified in the Report Manual. Reports are expected to provide detailed analysis by the BHO, where applicable, including identified trends, successes, risks, and mitigation.

D) DHS reserves the right to modify the required Report Manual at any time. DHS will provide the BHO with a minimum of one full reporting cycle to incorporate substantive changes to reporting requirements to the extent feasible. Should reporting changes or new reporting requirements be driven by state or federal requirements, timelines

may be modified to ensure compliance with established state or federal deadlines.

E) Data and reports received from the BHO shall be used for the administration of the Medicaid program, including but not limited to monitoring, evaluation, public reporting, capitation rate setting, releasing financial withholds, implementing financial penalties, and assessing financial incentives.

F) DHS may also share information on the BHO's performance with QI Health Plans to promote transparency, behavioral health integration, and sharing of benchmarks/best practices. DHS shall publicly report measures in formats such as report cards or score cards that include a variety of metrics, consumer guides, public reports, or otherwise, on MQD's website in accordance with 42 CFR § 438.602(g).

6.2 Report Descriptions – General Information

A) The BHO shall provide to DHS managerial, financial, delegation, utilization, quality, Program Integrity and enrollment reports in compliance with 42 CFR § 438.604 and in accordance with the Report Manual described in Section 6.1.

B) The BHO shall provide reporting to meet all federal regulations for Medicaid managed care programs as set forth in 42 CFR Part 438 and comply with all revised reporting requirements implemented by CMS during the Contract period. The BHO shall submit to DHS all data including encounter data, data to support Medical Loss Ratio

(MLR) calculation, rate certification, risk solvency, data to demonstrate provider availability and accessibility of services, including network adequacy, ownership and control, and any other data requested by DHS.

C) Additionally, the BHO shall provide necessary data, other information, or documentation as required by DHS to support verification, auditing, or contextualization of information submitted in reports to DHS. Information may also be requested by DHS to support its required and ad hoc reporting to CMS or other state or federal agencies. As needed, the BHO shall provide access to all medical records for DHS review and follow-up. Any reviews may be conducted by DHS or delegated to the EQRO. The BHO shall allow DHS and/or the EQRO to conduct any reviews of documentation both on-site and remotely.

D) Appendix M includes the current reports required to be submitted by the BHO. DHS may add, delete, or change any reports, or reporting time frames, as needed to ensure adequate oversight of contractual, state, and federal requirements.

E) Reports, at a minimum, cover the following topics, although additional reporting requirements may be implemented as needed. Specific federally required reports are explicitly identified and described within each section. However, each section may include additional reports at DHS' discretion.

6.3 Provider Network and Services Reports

A) Reports on Provider Network and Services include submission of assessments of behavioral network provider network adequacy, distribution, access, and capacity; provider education & training; geographic and timely accessibility to services; provider suspensions and terminations; provider grievances and claims; and participation in, maturity status, and receipt of incentives related to Value-Based Purchasing. Select reports within this Section are described below.

1. Provider Network Adequacy Verification Report

a. To assure compliance with 42 CFR § 438.207 and 42 CFR §438.604, the BHO must submit a Provider Network Adequacy Verification Report demonstrating that it offers an appropriate range of behavioral health services that is adequate for the anticipated number and needs of its Members; and that the network of providers is sufficient in number, mix, and geographic distribution to meet the needs of Members in the service area; in accordance with DHS standards for access to care specified in Section 8.1. The report shall be submitted in the format specified by DHS; DHS may require both aggregate metrics, and provider-level reporting for this report.

b. An adequate provider network requires an appropriate ratio of providers accepting Medicaid members and Members residing within a given travel time or

distance. However, in addition to meeting a minimum ratio, an adequate network shall meet the needs of all Members. Members that require care in specific languages, or those with a physical or behavioral disability accommodations, shall reside within a certain travel time or distance of a general practitioner and various specialists that can provide that accommodation. Provider decisions and limits on accepting new patients shall be considered in determining the true availability and the capacity of the network in serving Members. Therefore, the BHO is required to use Geographic Information Systems (GIS) or similar software to describe the geographic distribution of its provider network, in relation to the geographic distribution of its Members.

c. The BHO is expected to use spatial analytics and mapping to conduct a series of analyses that are used to report on DHS-required metrics for the Provider Network Adequacy Verification Report including, but not limited to, network adequacy considering provider-to-Member ratios alone, provider-to-Member ratios after accounting for driving time requirements, provider-to-Member ratios after restricting the network to providers accepting CCS Members, and provider-to-Member ratios after restricting the network to providers who offer services in specific non-English languages. The BHO is expected to use driving distance, rather than straight-line distance, to calculate all driving times. The analytic

methodology shall be submitted with the report and is subject to verification by DHS. DHS may ask for additional supporting information such as maps and analytic outputs.

d. The BHO shall use the Provider Network Adequacy Verification Report to certify the adequacy of its network for the CCS Members by provider type, including geographic access standards specified in Section 8.1. Geographic access standards may, in part, be met via telehealth access as specified in Section 8.1.E and reported as such by the BHO in the Provider Network Adequacy Verification Report.

e. The BHO shall also provide a narrative that describes the BHO's strategy to maintain or augment its provider network, that includes the following considerations:
    1) The numbers of network providers who are not accepting new patients;
    2) 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;
    3) Access to services via telehealth, considering Members' technological and technical capacity to avail themselves of telehealth services;
    4) Current network gaps and the methodology used to identify them;

5) Immediate short-term interventions when a gap occurs including expedited or temporary credentialing; and
6) Interventions to fill network gaps and barriers to those interventions.

f. The Provider Network Adequacy Verification Report shall be submitted at a minimum as specified in the reporting timetable, but shall also be submitted as an ad hoc report under the following circumstances:
   1) Upon request by DHS;
   2) Upon changes in services, benefits, geographic service area, composition of or payment to its provider network; and
   3) Any time there has been a significant change in the BHO's operations that would affect adequate provider capacity and services.

g. For purposes of this report, a significant change is defined as any of the following:
   1) A loss of providers in a specific specialty where another provider in that specialty is not available on the island; or
   2) A loss of a hospital.

2. Timely Access Report

a. To assure compliance with Timely Access standards in Section 8.1, and per 42 CFR § 438.206, the BHO shall

submit a Timely Access Report that monitors the time that lapsed between a Member's initial request for care and when the care was delivered, using a DHS-approved methodology. DHS may also specify the methodology used to gather data for the report. The Timely Access Report shall independently verify the provision of timely care for each type of contractually required timeframe of care. The BHO may be required to submit a variety of metrics per DHS specifications, and parsed by provider type/class (e.g., psychiatris, psychologists, therapists, etc.) as requested; DHS may compare the BHO's data to national standards and benchmarks and set targets. The BHO shall be required to cure deficiencies in performance when identified. If the BHO does not meet timely access in any one area (i.e., for a particular type of specialist), DHS may require additional data collection to support closer monitoring in that area.

3. Provider Suspensions, Terminations, and Program Integrity Education Report

    a. The BHO shall notify DHS within three (3) business days of any provider suspensions and terminations, both voluntary and involuntary because of suspected or confirmed fraud or abuse. The immediate notification shall include provider's name, provider's specialty, reason for the action and the effective date of the suspension or termination. Per 42 CFR § 438.608, the BHO shall also submit a Provider Suspensions,

Terminations, and Program Integrity Education Report in order for DHS to adequately monitor information about changes in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the BHO. This report shall include information on actions taken against any providers with whom the BHO refuses to enter into, or renew, an agreement (as noted in Section 8.2); all provider suspensions and terminations; as well as providers who were offered education on one or more Program Integrity topics or who voluntarily separated from the BHO in lieu of suspension or termination actions.

4. Provider Grievances and Claims Report

   a. Per 42 CFR § 438.66(c), the BHO shall submit its provider grievances and appeals logs to support DHS monitoring of BHO performance in addressing provider complaints. BHO shall provide DHS with metrics specified by DHS, and as required, record-level data on provider complaints, grievances and appeals. DHS shall use the data submitted to monitor a variety of contractual and federal requirements including, but not limited to, volume, rate, and types of grievances and appeals filed, as well as appropriate BHO response including timeliness of resolution of cases. DHS shall

track claims processing metrics as part of this report to monitor the BHO's compliance with 42 CFR § 447.46.

6.4 Covered Benefits and Services Reports

A) Reports on Covered Benefits and Services include submission of comprehensive information on identification, engagement, case management, participation, services, utilization, and quality of care delivered to CCS beneficiaries, including reports on special populations such as CIS. Select reports within this Section are described below.

1. Community Integration Services Report

a. Per 42 CFR § 438.330, and to support reporting and evaluation per Hawaii's Section 1115 demonstration project, the BHO shall submit a Community Integration Services (CIS) Report that allows DHS to monitor and evaluate mechanisms used by the BHO to identify populations eligible for CIS, and assess the quality, quantity, appropriateness, and cost of care furnished to beneficiaries in the CIS program. The BHO may be required to submit both process and outcome metrics. DHS may require both beneficiary-level and aggregate reporting of CIS data from the BHO in a format specified by DHS. DHS reserves the right to consolidate the beneficiary-level reporting for this report with beneficiary-level reporting for other DHS-required reports.

2. Behavioral Health Services Report

    a. Per 42 CFR § 438.330, the BHO shall submit a Behavioral Health Services Report that allows DHS to monitor and evaluate mechanisms used by the BHO to assess the quality, quantity, appropriateness, and cost of care furnished to CCS Members, including efficacy of sentinel incident reporting, tiered by Service Level as defined in Section 4.12.C. The BHO may be required to submit both process and outcome metrics, and reporting may include additional stratifications as determined by DHS. DHS may require both beneficiary-level and aggregate reporting of data from the BHO in a format specified by DHS. DHS reserves the right to consolidate the beneficiary-level reporting for this report with beneficiary-level reporting for other DHS-required reports.

3. Case Management Services Report

    a. Per 42 CFR § 438.330, the BHO shall submit a Case Management Services Report that allows DHS to monitor and evaluate mechanisms used by the BHO to assess volume and cost of case management services furnished to CCS Members, tiered by service level, as defined in Section 4.12.C. The BHO may be required to submit both process and outcome metrics, and reporting may include additional stratifications as determined by

DHS. DHS may require both beneficiary-level and aggregate reporting of data from the BHO in a format specified by DHS. DHS reserves the right to consolidate the beneficiary-level reporting for this report with beneficiary-level reporting for other DHS-required reports.

6.5 Member Services Reports

A) Reports on Member Services include submission of data on Member grievances and appeals, information on beneficiary eligibility for and inclusion in various programs, and demographic changes. Other beneficiary-level data shall include total cost of care indicators, total spend and spend by categories, and beneficiary attribution to providers. Select reports within this Section are described below.

1. Member Grievances and Appeals Report

a. Per 42 CFR § 438.66(c), the BHO shall submit its Member grievances and appeals logs to support DHS monitoring of BHO compliance with 42 CFR § 438, Subpart F. BHO shall provide DHS with metrics and record-level data on Member grievances and appeals. DHS shall use the data submitted to monitor a variety of contractual, state, and federal requirements including, but not limited to, volume, rate, and types of grievances and appeals filed, as well as appropriate BHO response including timeliness of resolution, and administrative disposition of cases.

2. Provider or Enrollee Satisfaction Survey Report

    a. The BHO shall provide data to enable DHS to monitor BHO performance, in accordance with 42 CFR § 438.66(c), including results from any enrollee or provider satisfaction survey conducted by BHO. The BHO shall provide a copy of the survey results to DHS, along with any additional information necessary to contextualize the findings of the survey. This reporting requirement is separate from any enrollee or provider surveys, including any surveys conducted by DHS.

3. Call Center Report and Remote Monitoring

    a. To satisfy 42 CFR § 438.66(c), the BHO shall provide data and access to DHS as needed to monitor BHO's performance in providing customer service to its enrollees. The BHO shall provide DHS with the ability to monitor calls to the BHO's Member and provider call center as described in Section 4.15 to assure BHO performance across a number of aspects of call quality monitoring. In addition, the BHO shall provide required data via the Call Center Report to monitor various quality attributes such as, but not including, call volume, timeliness, and responsiveness. DHS may compare the BHO's data to national standards and benchmarks and set targets. The BHO shall be required to cure deficiencies in performance when identified.

6.6 Quality Reports

A) Reports on Quality include submission of quality-related plans and reports related to the QAPI program, SDOH, PIPs, and quality and performance metrics required by DHS. Reports on accreditation will also be submitted in this Section. Select reports within this Section are described below.

1. Accreditation Status Report

a. In compliance with 42 CFR § 438.332(b), the BHO shall submit an Accreditation Status Report to provide status updates on the BHO's accreditation status as required in Section 5.3. The BHO shall provide DHS a copy of its most recent accreditation review, including:
   1) Accreditation status, survey type, and level;
   2) Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and
   3) Expiration date of the accreditation.

b. If the BHO is currently applying for re-accreditation, the BHO shall provide timely status updates on its renewal status. These updates shall detail activities undertaken and provide a synopsis of any issues that arise that may impede the accreditation process.

2. Quality Assessment and Performance Improvement (QAPI) Reports

    a. Per 42 CFR § 438.330 and as noted in Section 5.1, the BHO shall submit quarterly and annual QAPI reports as noted below:
        1) QAPI Quarterly Progress and Work Plan Update; and
        2) QAPI Progress Report and Annual Plan Update.

    b. The BHO's medical director shall review these reports prior to submittal to DHS. The QAPI Plan submitted at the start of the contract shall not include a progress report component, and the QAPI Progress Report submitted at end of the contract shall not include a plan update component. QAPI work plans and progress reports shall meet submission requirements noted in Section 5.1 and be submitted using templates and formats specified by DHS. As noted in Section 5.1, the QAPI work plans and progress reports shall incorporate disparities reporting and a work plan to address identified disparities, supporting DHS compliance with 42 CFR § 438.340.

3. Quality and Performance Measurement Report

    a. Per 42 CFR § 438.330 and as described in Section 5.1, DHS shall collect performance measurement data from the BHO. DHS may require both beneficiary-level and

aggregate reporting of quality and performance measurement data from the BHO in a format specified by DHS. For each measure, DHS may require one or more rates or stratifications. These reports shall cover the period from January 1 to December 31, unless otherwise specified by DHS; DHS shall specify the list of measures to be reported for each calendar year. The EQRO shall annually perform report validation on DHS-selected measures; if DHS-selected measures include HEDIS measures, the validation shall also ensure the BHO's compliance with HEDIS methodology. The EQRO shall validate measures selected for inclusion in pay for performance programs, as described further in Section 5.

4. Performance Improvement Project (PIP) Report

   a. Per 42 CFR § 438.330 and as described in Section 5.1.E, DHS shall collect reports on the BHO's PIPs. A PIP report shall be submitted annually for each PIP conducted by the BHO during the year. PIP reports shall include elements noted in Section 5.1.E and shall be independently validated by the EQRO on an annual basis, to ensure compliance with CMS protocols, and DHS policy, including timeline requirements. Status reports on PIPs may be requested more frequently by DHS.

6.7 Utilization Management Reports

A) Reports on Utilization Management include submission of data on utilization and prior authorizations, parity in provision of services, over- and under-utilization of services, and drug utilization reviews. In addition, DHS shall include reporting on overall utilization and spending on primary care, and measures assessing relative utilization and spend across services (for example, Nursing Home vs. HCBS utilization). Select reports within this Section are described below.

1. Mental Health and Substance Use Disorder Parity Report

    a. Per 42 CFR § 438.3(n), the BHO shall submit documentation to demonstrate its compliance with 42 CFR, Part 438, Subpart K, Parity in Mental Health and Substance Use Disorder Benefits. Accordingly, the BHO shall provide a Mental Health and Substance Use Disorder Parity Report as required by DHS.

    b. This report is used by DHS to ensure that behavioral health or mental health/substance use disorder (MH/SUD) services are provided by the BHO in a manner that is comparable to, or not any more stringent than, medical/surgical (M/S) and basic MH/SUD services provided by the QI Health Plan, as per the Medicaid Parity Final Rule and the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008.

c. The Mental Health and Substance Use Disorder Parity Report shall be submitted in the format provided by DHS which includes, but is not limited to the following:
    1) Aggregate lifetime and annual dollar limits;
    2) Financial requirements or treatment limitations applied by the plan;
    3) Copayments, coinsurance, deductibles, and out-of-pocket maximums imposed;
    4) Quantitative Treatment Limits (QTLs) set by the plan; and
    5) Non-Quantitative Treatment Limits (NQTLs) set by the plan.

d. In addition, DHS may require additional analyses of data if the BHO is a part of a QI Health Plan.

e. The BHO shall provide the data required by DHS and any additional supporting documentation for Readiness Review (Section 13.3.B) and thereafter, upon request.

2. Provider Preventable Conditions

a. To comply with 42 CFR § 447.26, the BHO shall report all identified provider-preventable conditions (PPCs) through encounter data submissions. The mechanism for reporting shall be specified by DHS; the BHO will be required to flag encounters associated with PPCs by Claim Reference Numbers (CRNs).

3. Drug Utilization Review (DUR) Report

a. Per 42 CFR § 438.3, the BHO shall provide a detailed description of its drug utilization review program activities to DHS on an annual basis, including the mechanisms it has in place to detect the underutilization and overutilization of drugs. The BHO shall submit its mechanism to detect and appropriately address both underutilization and overutilization of drugs and the results of this process.

b. Specifically, the BHO is required to describe:
   1) The BHO's process for screening prescription drug claims to identify problems such as therapeutic duplication, drug-disease contraindications, incorrect dosage or duration of treatment, drug allergy, and clinical misuse or abuse.
   2) The BHO's retrospective review of claims data to identify patterns of fraud, abuse, gross overuse, or medically unnecessary prescription medication use.
   3) The BHO's protocols for implementing corrective actions when issues are identified using the screening and review processes described above.

c. The DUR Report shall describe the BHO's prescribing patterns, findings from the screenings and retrospective reviews conducted, corrective actions taken and results, and cost savings resulting from the DUR program. DHS

will specify the report format and any additional metrics to be submitted. DHS may compare the BHO's data to national standards and benchmarks and set BHO targets. The BHO shall be required to cure deficiencies in performance when identified.

4. Report of Over-Utilization and Under-Utilization of Services

    a. The BHO shall submit reports on overutilization and underutilization of services per 42 CFR § 438.66 that describe the BHO's required mechanism to detect and appropriately address both underutilization and overutilization of services, and the results of this process. The report shall trend various metrics as specified by DHS. DHS may compare the BHO's data to national standards and benchmarks and set BHO targets. The BHO shall be required to cure deficiencies in performance when identified.

5. Prior Authorizations Reports – Medical and Pharmacy

    a. To enable DHS to assure that BHO coverage and authorization of services are compliant with 42 CFR § 438.210(c) and 42 CFR § 438.404, and as allowed by 42 CFR § 438.66(c), the BHO shall provide DHS with metrics and record-level data on prior authorizations for medical and pharmacy benefits. DHS shall use the data submitted to monitor a variety of contractual, state, and federal requirements including, but not limited to,

number and types of requests for prior authorizations, volume and justification for denials and deferrals by the BHO if applicable, information on any appeals received, instances of inappropriate or inconsistent application of the prior authorization policies, and timely decision making and notification of decisions around prior authorization. DHS may compare the BHO's data to national standards and benchmarks and set BHO targets. The BHO shall be required to cure deficiencies in performance when identified.

6.8 Administration, Finances, and Program Integrity Reports

A) Reports on Administration, Finances and Program Integrity include submissions of reports on Fraud, Waste, and Abuse; employee suspensions and terminations; financial reporting; TPL cost avoidance; required BHO disclosures; encounter data reconciliation; Medicaid Contract reporting, recoveries, reconciliation of encounter data to financial summaries; MLR; and overpayments. Select reports within this Section are described below.

1. Medical Loss Ratio Report

a. MLR standards are established to ensure the BHO is directing a sufficient portion of the capitation payments received from DHS to services and activities that improve health in alignment with DHS' mission. The BHO shall submit an annual MLR Report in compliance with 42 CFR § 438.74, 42 CFR § 438.8, and 42 CFR §

438.604. In this report, the BHO shall calculate and report an MLR as described below. The BHO shall provide data on the basis of which DHS determines compliance with the MLR requirement.

b. The BHO shall calculate and report the MLR in accordance with the following:
    1) The MLR experienced for the BHO in a reporting year is the ratio of the numerator, as defined in 42 CFR § 438.8(e) to the denominator, as defined in 42 CFR § 438.8(f);
    2) Each expense shall be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense shall be pro-rated and parsed between types of expenses;
    3) Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, shall be reported on pro rata basis;
    4) Expense allocation shall be based on a generally accepted accounting method that is expected to yield the most accurate results;
    5) Shared expenses, including expenses under the terms of a management contract, shall be apportioned pro rata to the contract incurring the expense;

6) Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, shall be borne solely by reporting entity and are not to be apportioned to the other entities;
7) The BHO may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible;
8) The credibility adjustment is added to the reported MLR calculation before calculating any remittances, if applicable;
9) The BHO may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible;
10) If the BHO's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards;
11) The BHO will aggregate data for all Medicaid eligibility groups covered under the contract;
12) The BHO shall provide a remittance for an MLR reporting year if the MLR for that reporting year does not meet the minimum MLR standard of eighty-five (85) percent or higher;
13) The BHO shall require any third party vender providing claims adjudication activities to provide all underlying data associated with MLR reporting to the BHO within one hundred eighty (180) days of the end of the MLR reporting year or within

thirty (30) days of being requested by the BHO, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting; and

14) Any retroactive changes to capitation rates after the contract year end will need to be incorporated into the MLR calculation. In instances where DHS makes a retroactive change to the capitation payments for an MLR reporting year where the report has already been submitted to DHS:
    a) The BHO shall re-calculate the MLR for all reporting years affected by the change;
    b) The BHO shall submit a new MLR report for each reporting year affected by the change, meeting the applicable requirements; and
    c) The BHO shall submit a new report incorporating the change within 30 days of the capitation rate adjustment payment by DHS.

c. The BHO and its subcontractors shall retain all MLR data for a period of no less than ten (10) years in accordance with 42 CFR § 438.3 (u). The BHO shall attest to the accuracy of the calculation of the MLR in accordance with MLR standards when submitting required MLR reports.

2. Overpayments Report

a. The BHO is required to recover and report all overpayments. "Overpayment" as used in this Section is defined in 42 CFR § 438.2. Per 42 CFR § 438.608, the BHO is responsible for the prompt reporting of overpayments identified or recovered, specifying the overpayments due to potential fraud, and reporting on all its recoveries of overpayments to DHS.

b. The overpayment shall be reported in the reporting period in which the overpayment is identified. In addition, once recovery of overpayments is completed, the BHO shall replace the encounter data to reflect the correct payment amounts. It is understood the BHO may not be able to complete recovery of overpayment until after the reporting period. However, the BHO shall properly account for any outstanding recovering in future reports, so that all overpayment activities are fully disclosed to DHS and addressed in the encounter data submitted by the BHO.

c. The BHO shall report to DHS the full overpayment identified. The BHO may negotiate and retain a lesser repayment amount with the provider, however, the full overpayment amount shall be used:
    1) By the BHO, when submitting replacement encounter data; and
    2) By DHS, when setting capitation rates for the BHO.

d. The BHO shall also maintain documentation of the education and training provided in addition to reporting the recovered amounts. Education and training given to providers as part of the BHO program integrity efforts may be reported to DHS in the Provider Suspensions, Terminations, and Program Integrity Education report.

e. The overpayments report will document all overpayments, and all recovered and pending recovery amounts. It will specify/distinguish those overpayments which were identified as fraud, waste, and abuse, from all the rest of the overpayments included in the report. It will additionally identify the Claim Reference Numbers (CRNs) of encounters impacted by overpayments investigations and document the BHO's submission of a revised encounter based on the revised paid amounts for each encounter. Where recoveries are unable to be reflected in re-processed encounter data, the BHO will list those specific recovery amounts as an itemized list in the report.

f. The BHO will check the reporting of overpayment recoveries for accuracy and will provide an accuracy report to DHS upon request. The BHO will certify that the report contains all overpayments.

3. Disclosure of Information on Annual Business Transactions

a. The BHO shall also submit information on ownership and control pursuant to 42 CFR §455.104, as it applies to the BHO, and as it applies to the BHO's subcontractors as required by 42 CFR § 438.230. At its discretion, DHS may conduct an evaluation of disclosures reported for the purpose of determining their adverse impact, if any, on the fiscal soundness and reasonableness of program costs submitted to DHS.

b. Specifically, the BHO shall disclose information on the following types of transactions:
    1) Any sale, exchange, or lease of any property between the BHO and a party in interest;
    2) Any lending of money or other extension of credit between the BHO and a party in interest; and
    3) Any furnishing for consideration of goods, services, including management services, or facilities between the BHO and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

c. The BHO shall include the following information regarding the transactions listed above:
    1) The name of the party in interest for each transaction;
    2) A description of each transaction and the appropriate quantities or units involved;

3) The total dollar value of each transaction during the fiscal year; and
4) Justification of the reasonableness of each transaction.

d. For the purposes of this Section, a party in interest, as defined in Section 1318(b) of the Public Health Service Act, is:
   1) Any director, officer, partner, or employee responsible for management or administration of the BHO; any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of the BHO; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than five percent (5%), of the BHO; and, in the case of a BHO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable state corporation law;
   2) Any organization in which a person described above is director, officer or partner; has directly or indirectly a beneficial interest of more than five percent (5%) of the equity of the BHO; or has a mortgage, deed of trust, note, or other interest valuing more than five percent (5%) of the assets of the BHO;

3) Any person directly or indirectly controlling, controlled by, or under common control with the BHO; and
4) Any spouse, child, or parent of an individual described in the foregoing bullets.

e. In addition, annually and within thirty (30) days after any change in ownership of the BHO, the BHO shall update DHS on the following information:
   1) The name and address of any person, individual or corporation, with an ownership or controlling interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities shall include as applicable primary business address, every business location, and P.O. Box address(es);
   2) In the case of an individual, date of birth and Social Security Number;
   3) Other tax identification number for a corporation with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity, or in any subcontractor in which the disclosing entity, fiscal agent, or managed care entity has a five (5) percent or more interest;
   4) Whether the person, individual, or corporation with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity is related to another person with ownership or control interest in the disclosing entity as a

spouse, parent, child, or sibling; or whether the person, including an individual or corporation, with an ownership or control interest in any subcontractor in which the disclosing entity, fiscal agent, or managed care entity has a five (5) percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling;

5) The name of any other disclosing entity, fiscal agent, or managed care entity in which an owner of the disclosing entity, fiscal agent, or managed care entity has an ownership or control interest;
6) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity, fiscal agent or managed care entity; and
7) The identity of any individual who has an ownership or control interest in the BHO, or is an agent or managing employee of the provider, and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX Services Program since the inception of those programs.

4. Medicaid Contract Report

a. The BHO shall submit an annual Medicaid Contracting Report to DHS, the State of Hawaii Department of

Commerce and Consumer Affairs Insurance Division, and the Hawaii State Legislature, no later than one-hundred eighty (180) days following the end of the State Fiscal Year (SFY). The content of the Medicaid contracting report shall include the information required from the HRS § 103F-107.

5. Encounter Data/Financial Summary Reconciliation Report

    a. Per 42 CFR § 438.604, the BHO shall submit encounter data to DHS as described in Section 6.11. Reported encounter data will be considered part of the data on the basis of which DHS certifies the actuarial soundness of capitation rates to the BHO. The BHO shall submit an Encounter Data/Financial Summary Reconciliation Report to support DHS's requirement to validate the accuracy and completeness of encounter data, as required in 42 CFR § 438.818, and as defined in Section 6.11.

6. BHO Financial Report

    a. Per 42 CFR § 438.3(m) and 42 CFR § 438.604, the BHO shall submit audited financial reports specific to the CCS contract. The BHO shall, in accordance with generally accepted accounting practices, prepare audited financial reports that adequately reflect all direct and indirect expenditures, and management and fiscal practices related to the BHO's performance of services under this

contract. The audit shall be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.

b. Financial information submitted to DHS as part of this report shall be analyzed and compared to industry standards and standards established by DHS to ensure the financial solvency of the BHO. Additionally, the BHO shall submit data to enable DHS to ensure that the BHO has made adequate provision against the risk of insolvency as required under 42 CFR § 438.116.

c. DHS may also monitor the financial performance of the BHO with onsite inspections and audits, and request any other data as needed.

7. Prescription Drugs Rebates Report

a. For all covered outpatient drugs, as described in 42 CFR § 438.3(s) and in accordance with Section 4.11 the BHO shall:
    1) Report drug utilization data that is necessary for DHS to bill manufacturers for rebates no later than 45 calendar days after the end of each quarterly rebate period;
    2) Report drug utilization information that includes, at a minimum, information on the total number of units of each dosage form, strength, and package size by National Drug Code (NDC) of each covered

outpatient drug dispensed or covered by the BHO; and

3) Establish procedures to exclude utilization data for covered outpatient drugs that are subject to discounts under the 340B drug pricing program from drug utilization data reports if DHS does not require submission of managed care drug claims data from covered entities directly.

8. Fraud, Waste and Abuse Report

a. In order to comply with 42 CFR § 438.608(a)(7), the BHO shall promptly referral any potential or suspected fraud, waste, or abuse identified to DHS or any confirmed fraud, waste, or abuse directly to DHS Medicaid Fraud Control Unit. In addition to providing prompt notifications to DHS, the BHO shall submit Fraud, Waste, and Abuse Reports that include, at a minimum, the following information on all alleged fraud, waste, and abuse cases:

1) A summary of activities related to all fraud, waste and abuse investigations during the reporting period, including but not limited to those that resulted in a referral to DHS;

2) For all cases referred to DHS, information on fraud, waste, and abuse detection and investigation conducted, the administrative disposition of the case(s), any disciplinary action imposed before and after the filing of the referral,

the approximate dollars involved in each incident, and the total approximate dollars impacted during the reporting period;

3) For all cases referred to DHS, where credible evidence of fraud, waste, or abuse was found, a summary of remediation and resolution activities undertaken during the period including but not limited to the training provided, provider monitoring and profiling activities, review of providers' provision of services (under-utilization and over-utilization of services), and verification of service (VOS) with Members to whom services were delivered, a summary of the results of the VOS performed with Members as described in Section 12.2, and any other steps taken to remedy the situation; and
4) Metrics to evaluate trends in program integrity activities of the BHO.

b. DHS reserves the right to request additional summary or case-specific data as needed. The BHO and its sub-contractors shall retain all Fraud, Waste and Abuse data for a period of no less than ten (10) years in accordance with 42 CFR § 438.3 (u).

6.9 Other Data Collection

A) The BHO shall submit the following data to DHS as required to improve the performance of the Contract:

1. Enrollment and disenrollment data;
2. Member grievance and appeal logs;
3. Provider complaint and appeal logs;
4. Results of any Member satisfaction survey conducted by the BHO;
5. Results of any provider satisfaction survey conducted by the BHO;
6. Medical management committee reports and minutes from the BHO; and
7. Customer service performance data.

B) The BHO shall submit any other data, documentation, or information relating to the performance of the BHO's obligations under this contract as requested by DHS or the federal government.

6.10 Specialized Reporting

A) The BHO may recommend other reporting that it generates for internal use that would also be useful for DHS to review.

B) DHS may require the BHO to prepare and submit special or "ad hoc" reports for the administration of the State Medicaid Program. In addition, the BHO shall comply with all additional requests from DHS, or its designee, for additional data, information and reports for the administration of the State Medicaid Program.

C) DHS shall give the BHO reasonable and sufficient notice prior to the submission of ad hoc reports to DHS. The notice shall be reasonable relative to the nature of the ad hoc report requested

by DHS. At a minimum, DHS shall give the BHO five (5) business day's notice prior to submission of an ad hoc report.

D) In the event the BHO is under a corrective action plan (CAP), the BHO may be required to submit certain reports more frequently than stated in this Section.

6.11 Encounter Data Reporting

A) Encounter Data General Requirements

1. DHS collects and uses encounter data for many reasons such as audits, investigations, identifications of improper payments, and other program integrity activities; federal reporting (42 CFR § 438.242(b)(1)); rate setting and risk adjustment; analysis of denial patterns; verification of reported quality measure data prior to release of withhold, incentive payments; service verification, managed care quality improvement program, policy analysis, executive and legislative decision making, and assessment of utilization patterns and access to care; hospital rate setting; pharmacy rebates; and research studies.

2. The BHO shall ensure that data received from providers and other subcontractors is accurate and complete by verifying the accuracy and timeliness of reported data; screening the data for completeness, logic, and consistency; and collecting service information in standardized format. The BHO shall

make all collected data available to DHS, and upon request, to CMS.

3. The BHO shall maintain appropriate systems and mechanisms to obtain all necessary data from its health care providers and subcontractors to ensure its ability to comply with all encounter data reporting requirements. The failure of a health care provider or subcontractor to provide the BHO with necessary encounter data shall not excuse the BHO's noncompliance with this requirement.

4. The BHO shall submit encounter data for all services rendered to Members under this contract, including encounters where the BHO determined no liability exists, and whether the encounter was processed as paid or denied, along with any adjustments, or voids of encounter records previously submitted.

5. The BHO shall submit encounter data even if the BHO did not make any payment for a claim, including claims for services to Members provided under subcontract, capitation or special arrangement with another facility or program. Encounters related to value added services or additional benefits offered by the BHO shall be submitted, and appropriately flagged to enable them to be distinguished and parsed as necessary.

6. The BHO shall submit encounter data for all services provided under this contract to Members who also have Medicare or other TPL coverage, if a claim has been submitted to the

BHO. Encounter data for services paid by Medicare or other TPL shall be flagged to indicate source of payment.

7. The BHO shall create claims, and submit encounter records, for direct services rendered to beneficiaries by BHO personnel that may otherwise be delegable to providers in the community. Examples of such services include care or service coordination, housing coordination, case management, outreach efforts, medication reconciliation, and quality improvement activities. These costs shall be captured by the BHO as part of its General Ledger.

8. The BHO shall submit encounter data to DHS at least once per month in accordance with the requirements and specifications defined by DHS and included in the HPMMIS Health Plan Manual ("Health Plan Manual"), published by DHS and incorporated by reference into this contract. DHS may periodically update the Health Plan Manual with ninety (90) calendar days written notice to the BHO. The Health Plan Manual may be changed with less than ninety (90) calendar days notice by mutual agreement of the BHO, QI Health Plans, and DHS. The BHO shall, upon receipt of such notice from DHS, provide notice of changes to subcontractors.

9. The BHO shall submit an encounter submission form to accompany every certified encounter submission; the template for the form shall be provided by DHS to standardize the reconciliation process; the encounter

submission form will be used by the BHO to provide DHS with a high level summary of submitted encounters, including total claims, total claim lines, and total paid amounts by service category for all encounters included within a certified submission.

10. Encounters shall be submitted via a DHS designated electronic mechanism such as a SFTP service and will be used to create a database that may be used for purposes described previously. DHS may edit encounter records to assure consistency and readability.

11. Encounter data shall be submitted to DHS at a minimum monthly, no later than the end of the month following the month when the financial liability was processed (i.e. paid, denied, voided, or adjusted/corrected). The BHO shall submit one hundred percent (100%) of encounter data within fifteen (15) months from the date of service, including all adjusted and resubmitted encounters.

12. The BHO shall continue reporting encounter data once per month beyond the term of the Contract as processing and reporting of the data is likely to continue due to lags in time in filing source documents by subcontractors and providers.

13. The BHO and its subcontractors shall retain all encounter data for a period of no less than ten (10) years in accordance with 42 CFR § 438.3(u). Provisions shall be made by the BHO

to maintain permanent history by service date for those services identified as "once-in-a-lifetime."

14. Encounter data submitted by the BHO may also be submitted by DHS to an all-payer claims database (APCD), or the BHO may be required to directly submit encounter data for all services rendered to Members under this contract to an APCD. Encounter data submitted by the BHO may additionally be submitted to other agencies including but not limited to CMS as determined by DHS to support program integrity and other reporting functions that are directly related to the administration of the State Medicaid program.

B) Encounter Data Submission Content and Format

1. Encounters shall be certified for completion and accuracy and submitted by the BHO as required in 42 CFR §§ 438.604 and 438.606 and as specified in this Section concurrently with each upload.

2. The BHO and its subcontractors shall exclusively utilize the submission formats defined in the Health Plan Manual for the electronic communication of all encounter records submitted. Additionally, the BHO and its subcontractors shall follow the instructions and guidelines set forth in the most current versions of ICD-10-CM, HCPCS, CPT, and other standard nomenclature and classification systems. When submitting encounter records, the BHO shall adhere to all requirements specified in the Health Plan Manual.

3. Submitted encounters shall pass all DHS HPMMIS system edits and audits as specified in the Health Plan Manual or as sent out in communications from DHS to the BHO. Submitted encounters shall not be a duplicate of a previously submitted and accepted encounter unless submitted as an adjustment or void per HIPAA transaction standards. The BHO shall make changes or corrections to encounter data and/or any systems, processes, or data transmission formats as needed to comply with DHS' data quality standards.

4. The BHO shall develop mechanisms to flag encounters to support a variety of reporting requirements. For example, the BHO will need to flag encounters tied to PPCs, as noted in Section 6.7. The BHO may be asked to flag encounters tied to specific programs or authorities to enable DHS to meet reporting and evaluation requirements.

5. The BHO shall make an adjustment to encounters within 30 days when the BHO discovers the data is missing, incorrect, no longer valid, or some element of the encounter not identified as part of the original encounter needs to be changed, except as noted otherwise.

6. If DHS discovers errors or a conflict with a previously adjudicated encounter claim, the BHO shall be required to adjust or void the encounter claim within thirty (30) days of notification by DHS, or if circumstances exist that prevent

the BHO from meeting this time frame, a specified date shall be approved by DHS.

7. In the event that an audit, investigation, or litigation by the BHO, DHS, recovery audit contractor (RAC), federal entity, other State contracted auditor, or other agency results in a recovery payment or payments inaccurately or inappropriately made to a provider or providers, the BHO shall submit an amended encounter record(s) to DHS within sixty (60) days of the recovery or by a timeframe determined and approved by DHS if the sixty (60) day period is not operationally feasible. In cases where Overpayments are identified, the BHO's amended encounter record shall include a BHO paid amount that reflects the amount that should have been paid, regardless of the actual paid amount remaining greater than the allowed amount after recoveries.

8. The BHO shall uniquely identify encounters paid under fee-for-service, capitated, and bundled arrangements for its network providers. For capitated arrangements, the BHO shall report each service encounter, including those that resulted in a zero payment, when applicable. For bundled payments, the BHO shall submit encounter details on each service provided; each service rendered during an encounter shall be parsed into service lines to enable accurate computation of service utilization in these settings. Capitation detail records shall be required for each provider and enrollee combination for each time period in which a capitation payment is made to the provider. For encounters

not uniquely tied to a payment (for example, encounters for services rendered under a capitation arrangement), the BHO shall submit a Medicaid fee-for-service equivalent valued amount for the encounter.

C) Accuracy, Completeness and Timeliness of Encounter Data Submissions

1. The BHO shall submit accurate, complete, and timely encounter data to DHS in accordance with the requirements and specifications defined by DHS and included in the HPMMIS Health Plan Manual ("Health Plan Manual"), published by DHS and incorporated by reference into this contract.

2. As noted in Section 6.11, DHS shall conduct encounter data validation to assure accuracy, timeliness, and completeness for the populations served by the BHO under this contract for up to the three most recent and complete years prior to the rating period.

3. The BHO will conduct encounter data reconciliation against its General Ledger to assure accuracy, timeliness, and completeness using definitions, protocols, and timelines specified in the Reporting Manual.

4. The encounter data reconciliation process interval will be set at the beginning of each contract year and be no more frequent than quarterly and no less frequent than annually.

The reconciliation protocol will be described in detail detailed in the Reporting Manual.

5. DHS will determine the overall extent of the discrepancy between encounter data submitted and accepted within HPMMIS and BHO's General Ledger amounts, and determine whether the discrepancies are within the discrepancy tolerance thresholds of successfully accepted encounters captured by DHS; discrepancy tolerance thresholds for each interval and twelve (12) month encounter data submission will be revised annually by DHS.

6. For any discrepancies noted, the BHO shall have the opportunity to correct errors and resubmit the encounter data, submit revised encounter/general ledger reconciliations, and additionally provide an explanation for any remaining discrepancies during the error resolution period. DHS will review any explanation(s) provided, conduct its reviews, and make a final determination on whether the BHO has exceeded the discrepancy threshold for the interval that cannot be justified for reasons other than encounter data quality and completeness.

7. Except under circumstances where DHS determines that the BHO has exceeded the discrepancy threshold for the interval in a manner that is justifiably unrelated to the BHO, DHS shall use the submitted and accepted encounter data captured within HPMMIS for rate setting and other purposes. Should DHS determine that the BHO has exceeded the

discrepancy threshold in a manner that is justifiably unrelated to the BHO, the original or updated data provided in the BHO encounter/general ledger reconciliation summary (whichever is applicable) will be considered.

8. In subsequent years of the contract, the error resolution period may be rescinded. If rescinded, the final determination on whether the BHO's encounter data submission has exceeded the discrepancy tolerance threshold will be made based on the calculated discrepancy value for that interval without further opportunity for error resolution by the BHO, and the submitted and accepted encounter data captured within HPMMIS will be used for rate setting and other purposes.

9. DHS reserves the right to change its encounter data validation process at any time, with at least sixty (60) day notice to the BHO.

10. Withholds may be applied by DHS as needed to improve operational effectiveness in one or more areas. When applied to encounter data submissions, withholds will be based on the interval(s) established for the contract year.

6.12 Report Submission

A) Report Submission General Requirements

1. To support communication between the BHO and DHS, the BHO shall submit a listing, in writing, of the designated BHO staff developing and/or submitting required reporting to DHS.

2. The BHO agrees to provide DHS with the reports CMS has requested or requests in the future. The BHO shall provide any additional reports requested by DHS.

3. The BHO shall respond to any DHS request for information or documents within the timeframe specified by DHS in its request. If the BHO is unable to respond within the specified timeframe, the BHO shall immediately notify DHS in writing and shall include an explanation for the inability to meet the timeframe and a request for approval of an extension of time. DHS may approve, within its sole discretion, any such extension of time upon a showing of good cause by the BHO. To avoid delayed responses by BHO caused by a high volume of information or document requests by DHS, both parties shall devise and agree upon a functional method of prioritizing requests so that urgent requests are given appropriate priority.

4. As noted in Section 6.2, DHS may wish to conduct follow-up reviews of BHO data, documentation, or medical records,

and may delegate reviews to the EQRO. For all reviews, including reviews of medical records, the BHO shall submit information prior to the scheduled review and arrange for DHS and/or the EQRO to access records through on-site review and provision of a copy of the requested records. The BHO shall submit this information within sixty (60) days of notification or sooner should circumstances dictate an expedited submission of records.

B) BHO Certification

1. The BHO shall certify the accuracy, completeness, and truthfulness of any reports and data, including but not limited to, encounter data, data upon which payment is based, and other information required by DHS, that may be submitted to determine the basis for payment from the state agency as required in 42 CFR §§ 438.604 and 438.606. The BHO shall certify that it is in substantial compliance with the contract and provide a letter of certification attesting to the accuracy, completeness, and truthfulness of the data submitted based on best knowledge, information, and belief, and thereby certify that no material fact has been omitted from the certification and submission. The BHO shall submit the letter of certification to DHS concurrent with the certified data and document submission. In the case of two (2) or more reports or encounter data submissions in one month, the BHO shall submit an equal number of letters of certification, with one letter of certification corresponding to each report or encounter data batch submitted to DHS. The

certifications are to be based on best knowledge, information, and belief of the following BHO personnel.

2. The data shall be certified by:
    a. The BHO's Chief Executive Officer (CEO);
    b. The BHO's Chief Financial Officer (CFO); or
    c. An individual who has delegated authority to sign for, and who reports directly to, the BHO's CEO or CFO.

3. The BHO shall require claim certification from each provider submitting data to the BHO. Source, content, and timing of certification shall comply with the requirements set forth in 42 CFR §§ 438.604 and 438.606.

4. BHO non-compliance as specified above will be considered a breach of contract and subject to sanctions as described in Section 14.21.

C) Follow-Up by BHO, Corrective Action Plans, and Policies and Procedures

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

2. Unless otherwise stated, the BHO shall have thirty (30) days from the date of receipt of a DHS report to respond to DHS's request for follow-up, actions, information, etc. The BHO's response shall be in writing and address how the BHO resolved the issue(s). If the issues(s) has/have not been

resolved, the BHO shall submit a Corrective Action Plan including the timetable(s) for the correction of problems or issues to DHS. In certain circumstances (i.e., concerns or issues that remain unresolved or repeated from previous reviews or urgent quality issues), DHS may request a ten (10) day plan of correction as opposed to the thirty (30) Day response time.

3. If the BHO fails to cure the deficiency as ordered, the Department shall have the right to assess a remedy set forth in Section 14.21.

SECTION 7 – DHS and BHO Financial Responsibilities

7.1 Capitation Rates

A) Overview of the Rate Structure

1. This Section describes the rate structure and the guidelines for rate setting.

2. Capitation payments may only be made by DHS and retained by the BHO for enrolled Members. For any given behavioral health Member, DHS will pay a capitation rate as one of four base rates. Rates shall be pro-rated for partial month enrollments. Rates shall be based on age as described below.
   a. Medicaid Only: < 40
   b. Medicaid Only: 40 and older
   c. Medicare Eligible: < 40
   d. Medicare Eligible: 40 and older

3. All behavioral health services listed in Section 4.2, Coverage Provisions for Behavioral Health Services, shall be provided as part of the capitation rate except for those listed below:
   a. Representative payee;
   b. Supported employment; and
   c. Peer Specialist.

4. These services shall be reimbursed by the BHO and submitted to DHS for reimbursement monthly via an invoice. DHS shall

reimburse the BHO for direct services provided. No additional charges may be submitted for reimbursement.

5. The capitation rates will comply with applicable sections in 42 CFR Part 438, including but not limited to 42 CFR §§ 438.4(b)(7), 438.4(b)(8), 438.4(b)(9), 438.5(b), 438.5(c), 438.5(d), 438.5(e), 438.5(f), 438.6(b)(3), 438.6(c), 438.6(d), 438.7(b), 438.7(c)(1), 438.7(c)(2), 438.8, 438.74.

B) Risk Share Program

1. DHS shall implement and manage a risk share program with the BHO. This risk share program with DHS sharing in risk may have any of the following characteristics, among other characteristics:
   a. Involve BHO losses, savings, or both;
   b. Include stepped risk sharing percentages based on increasing levels of losses or savings; and
   c. Similar or different risk share percentages between losses and savings.

2. The risk share program details will be available in Appendix H. The risk share program and parameters will be reviewed and may be adjusted each contract year.

C) Rate Development

1. DHS shall provide all Offerors with capitation rates with supporting documentation. The Offeror shall submit any

questions regarding capitation rates by the date identified in Section 1.5.

2. DHS may modify the capitation rates based upon updated claims experience, fee schedule changes, change in benefits or any other material change.

3. The BHO shall submit proof of payment of the Health Insurance Provider Fees (HIPF). After DHS actuary reviews the HIPF submissions, DHS will reimburse the BHO accordingly. This process will apply to both retrospective and prospective HIPF activities.

D) Future Rate Setting

1. Subject to limitations imposed by CMS, legislative direction or other outside influence for which DHS shall comply, it is the intent of DHS to publish revised rates each CY throughout the term of the contract. DHS specifically does not commit to any particular methodology or formula, or to any particular benchmark or objective, for rate revisions.

7.2 Provider and Subcontractor Reimbursement

A) General Requirements

1. The BHO may reimburse its providers and subcontractors in any manner, subject to federal rules. However, this does not preclude additional payments such as for a health home or

financial incentives for performance. The BHO shall have an incentive to promote electronic claims submission.

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

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

4. The BHO shall pay its subcontractors and providers on a timely basis, consistent with the claims payment procedures described in the Social Security Act § 1902, 42 U.S.C. 1396a(a)(37)(A). The BHOs shall allow providers at least one year to submit claims for reimbursement.

5. This Section requires that ninety percent (90%) of claims for payment (for which no further written information, authorization, or substantiation is required in order to make payment) are paid within thirty (30) calendar days of the date of receipt of such claims and that ninety-nine percent (99%) of claims for payment are paid within ninety (90) calendar days of the date of receipt of such claims. The date of receipt is the date the agency receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of

the check or other form of payment. The BHO and the provider may, however, agree to an alternative payment schedule, provided this alternative payment schedule is reviewed and approved by DHS.

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

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

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

B) Indian Health Care Providers (IHCPs)

1. For Indian health care providers (IHCPs), the BHO shall meet the requirements of timely payment for all Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as I/T/U) providers in its network, including the paying of 90% of all clean claims from practitioners (i.e. those who are an individual or group practice or who practice in shared health facilities) within thirty (30) calendar days of the date of receipt; and paying 99% of all clean claims from practitioners (who are in individual or group practice or who practice in shared health facilities) within ninety (90) calendar days of the date of receipt.

2. Indian health care providers, whether participating or not, be paid for covered services provided to Indian Members, who are eligible to receive services at a negotiated rate between the BHO and IHCP or, in the absence of a negotiated rate, at a rate not less than the level and amount of payment the managed care entity would make for the services to a participating provider that is not an IHCP.

3. IHCPs which are enrolled as an FQHC but are not participating providers of the BHO shall be paid an amount equal to the amount the BHO would pay a FQHC that is a network provider but is not an IHCP, including any supplemental payment from DHS to make up the difference between the amount the BHO pays and what the IHCP FQHC would have received under FFS.

4. When an IHCP is not enrolled as an FQHC, regardless of whether it participates in the BHO network, it has the right to receive its applicable encounter rate published annually in the Federal Register by the Individuals and Households program (HIS), or in the absence of a published encounter rate, the amount it would receive if the services were provided under the State Plan's FFS payment methodology.

7.3 Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) Reimbursement

A) The BHO shall reimburse non-contracted FQHCs and RHCs at rates no less than the Medicaid fee schedule if those providers are necessary for network adequacy. The BHO shall not be required to cover services at an FQHC or RHC if that provider is not contracted and not required for network adequacy. The BHO shall reimburse contracted FQHCs or RHCs for PPS eligible services at the PPS rate provided annually by DHS. Any other payment methodology to these providers requires prior approval by DHS.

B) DHS shall calculate and reimburse FQHC/RHC's for any retroactive settlements involving a change in scope of services that result in an increased PPS rate that is not incorporated into the capitation rates. The BHO shall reimburse the FQHC/RHC the annual PPS increase when provided by DHS. This annual increase will be incorporated into the capitation rates. DHS shall perform reconciliation and make any necessary supplemental payments to FQHCs and RHCs.

7.4 Daily Rosters and BHO Reimbursement

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

B) DHS shall make capitation payments, with each payment being for a month's services, to the BHO for each enrolled Member in the BHO beginning on the Contract Effective Date identified in Section 1.5. Capitation payments shall be in the amounts listed in the BHO's contract with DHS. Certain services required under this contract, but not eligible for federal financial participation or otherwise provided on a limited basis, such as crisis services only, may be paid on a fee-for-service basis.

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

D) DHS shall calculate and claim for the appropriate federal matching dollars amounts after Institution for Mental Diseases (IMD) services are paid for and encounters are submitted to DHS, when a Member aged 21-64 years receives inpatient treatment in an IMD. This applies to IMDs as defined in 42 CFR § 435.1010, so long as the

facility is a hospital providing psychiatric or substance use disorder crisis residential services, and length of stay in the IMD is for a long term stay of more than fifteen (15) calendar days during the period of the monthly capitation payment.

E) DHS shall make additional capitation payments or recover capitation payments from the BHO as a result of retroactive enrollments and retroactive dis-enrollments.

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

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

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

I) The BHO and any subcontractor is required to report to DHS within sixty (60) calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract.

7.5 Assessment and Collection of Fees and Penalties

A) BHO shall comply with the financial responsibilities listed in Appendix I.

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

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

7.6 Third Party Liability (TPL)

A) Background

1. TPL refers to any other health insurance plan or carrier (i.e., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance and worker's compensation) or program, that is, or may be, liable to pay all or part of the health care expenses of the Member.

2. Pursuant to the Social Security Act § 1902, 42 U.S.C. 1396a(a)(25), DHS authorizes the BHO as its agent to identify legally liable third parties and treat verified TPL as a resource of the Member.

3. The BHO shall collect and retain TPL.

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

B) TPL - DHS Responsibilities

1. DHS shall:
    a. Be responsible for coordination and recovery of accident and workers' compensation subrogation benefits;
    b. Collect and provide Member TPL information to the BHO. TPL information shall be provided to the BHO via the daily TPL roster; and
    c. Conduct TPL audits every six (6) months to ensure TPL responsibilities are being completed by the BHO.

C) TPL – BHO Responsibilities

1. The BHO shall do the following related to Third Party Liability (TPL), including:
    a. The activities and obligations, and related reporting responsibilities, are specified in the contract or written agreement between the BHO and the subcontractor;

b. How the BHO will reduce payments based on payments by a third party for any part of a service;
c. Whether DHS or the BHO retains the TPL collections; and
d. How DHS monitors to confirm that the BHO is upholding contractual requirements for TPL activities.

2. The BHO shall coordinate health care benefits with other coverages, both public and private, which are or may be available to pay medical expenses on behalf of any Member.

3. The BHO shall seek reimbursement from all other liable third parties to the limit of legal liability for the health services rendered. The BHO shall retain all health insurance benefits collected, including cost avoidance.

4. The BHO shall follow the mandatory pay and chase provisions described in 42 CFR § 433.139(b)(3).

5. In addition, the BHO shall:
   a. Continue cost avoidance of the health insurance plan's accident and workers' compensation benefits;
   b. Report all accident cases incurring medical and medically related dental expenses in excess of five-hundred dollars ($500) to DHS;
   c. Provide a list of medical and medically related dental expenses, in the format requested by DHS, for recovery purposes. "RUSH" requests shall be reported within three (3) business days of receipt and "ROUTINE" requests within seven (7) business days of receipt.

Listings shall also include claims received but not processed for payments or rejected;

d. Provide copies of claim forms with similar response time as the above;
e. Provide listings of medical and medically related dental expenses (including adjustments, e.g., payment corrections, refunds, etc.) according to the payment period or "as of" date. Adjustments shall be recorded on the date of adjustment and not on the date of service;
f. Inform DHS of TPL information uncovered during the course of normal business operations;
g. Provide DHS with monthly reports of the total cost avoidance and amounts collected from TPLs within thirty (30) calendar days of the end of the month;
h. Develop procedures for determining when to pursue TPL recovery; and
i. Provide health care services for Members receiving motor vehicle insurance liability coverage at no cost through the Hawaii Joint Underwriting Plan (HJUP) in accordance with HRS § 431:10C-401 et. seq.

SECTION 8 – Provider Network, Provider Credentialing, and Provider Contracts

8.1 Provider Network

A) Provider Network - General Provisions

1. The BHO shall have their own provider network for provision of behavioral health services for their Members. In-person services shall be available twenty-four (24) hours a day, seven (7) days a week, throughout the State.

2. The BHO shall have an adequate network of providers for their Members to have timely access to medically necessary behavioral health services, as described in Sections 8.1.B - 8.1.D. The BHO's provider network shall meet network adequacy no later than sixty (60) calendar days after the Contract Effective Date as specified in Section 1.5.

3. The BHO shall develop and maintain a provider network that is sufficient to ensure that all medically necessary covered services are accessible and available. At a minimum, this means that the BHO shall have sufficient providers to ensure all access and appointment wait times defined in Sections 8.1.C and 8.1.D are met. This network of providers shall provide the benefits defined in Section 4.

4. Upon execution of the CCS contract and any time there is a significant change (as defined in Section 3) in the BHO's

operations that impacts services, the BHO shall notify DHS within ten (10) calendar days and submit documentation to demonstrate that it offers or continues to offer the following:

a. An appropriate range of preventive and specialty services that is adequate for the anticipated number of Members for the service area; and
b. Maintenance of a network of providers that is sufficient in number, mix, and geographic distribution, and that shall include the following provider types:
    1) Physicians, including specialists;
    2) Hospitals;
    3) Pharmacies; and
    4) Behavioral health providers.

5. The BHO shall maintain a website and provide an accurate listing of participating network providers in paper form upon DHS or Member request, that includes the following information:
    a. Name/group affiliations;
    b. Specialties, as appropriate;
    c. Contact information (telephone/text, email);
    d. Website URL, as appropriate;
    e. Location/Street address;
    f. If they are accepting new Members;
    g. Cultural and linguistic capabilities, including languages (including ASL) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training;

h. Accommodations for Members with physical disabilities, including offices, exam room(s) and equipment; and
i. Telehealth option – Provider has the ability to provide services using telecommunications and information technology to provide access to health assessment, diagnosis intervention, consultation, supervison and information across distance.

6. Provider network information shall be maintained as follows:
   a. Electronic provider directory shall be updated no later than thirty (30) calendar days after the BHO receives the updated provider information;
   b. In addition, it shall comply with 42 CFR § 438.10(h)(4) and be available in a machine-readable file and format as specified by the Secretary of the U.S. Department of Health and Human Services; and
   c. Paper provider directories shall be updated at least monthly, including at the very minimum that the directory is current as of a specific date.

7. The BHO is responsible for assuring that Members have access to providers listed below. The BHO shall ensure the provision of the following services related to the ability for Members to attain, maintain, and/or regain functional capacity, including, but not limited to:
   a. Behavioral healthcare specialist services as provided by psychiatrists, psychologists, social workers, certified substance abuse counselors, and advance practice nurses trained in psychology;

b. Case management;
c. Inpatient behavioral health hospital services;
d. Outpatient behavioral health hospital services;
e. Mental health rehabilitation services;
f. SUD services;
g. Day treatment programs;
h. Psychosocial rehabilitation (PSR)/Clubhouse;
i. Pharmacies;
j. Laboratory Services;
k. Crisis services: mobile crisis response and crisis residential services;
l. Interpretation services;
m. CIS;
n. Representative payee;
o. Supported employment; and
p. Peer Specialist.

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

9. Members shall have choice of available behavioral health providers within the BHO's provider network in their geographic area. A Member's geographic area is the area circumscribed with a radius set by the distance reached in thirty (30) minutes driving time for urban areas, or sixty (60) minutes driving time for rural areas, from the Member's current place of residence. If the BHO is unable to provide adequate behavioral health services to a particular Member within its network or on the island of residence, the BHO shall

adequately, and in a timely manner, provide these services out-of-network or transport the Member to another island to access the covered services for as long as the BHO's network is unable to provide the Member with behavioral health services on the island of residence as described in Section 5.9.C.

10. The BHO shall notify the out-of-network providers providing covered services to its Members that payment by the BHO is considered as "payment-in-full" and that those providers cannot "balance bill" or otherwise request payment from the Members for the covered services.

11. The following applies regarding Indian health care providers (IHCPs):
    a. The BHO shall demonstrate that there are sufficient IHCPs participating in the provider network to ensure timely access to services available under the contract from such providers for Indian enrollees who are eligible to receive services;
    b. Indian enrollees are permitted to obtain covered services from out-of-network IHCPs from whom the enrollee is otherwise eligible to receive such services;
    c. The BHO shall permit an out-of-network IHCP to refer an Indian enrollee to a network provider";
    d. The BHO shall exempt from premiums any Indian who is eligible to receive or has received an item or service furnished by an IHCP or through referral under contract health services; and

e. The BHO shall exempt from all cost sharing any Indian who is currently receiving or has ever received an item or service furnished by an IHCP or through referral under contract health services.

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

B) Provider Network – Establishment, Maintenance, and Provider Selection

1. The BHO shall establish and maintain a provider network that meets Member needs and adequacy requirements in all of the following areas:
    a. Member enrollment and enrollment projections;
    b. Expected utilization of services given the characteristics and healthcare needs of Members;
    c. Number and types of providers (such as specialists, or those with particular experience and training) required to provide necessary behavioral health services;
    d. Number of network providers not accepting new Members;
    e. Geographic location of providers and Members considering distance, travel time, means of transportation ordinarily used by Members; and

f. Access for Members with disabilities.

2. The BHO shall ensure that providers provide physical access, reasonable accommodations, and accessible equipment for Members with physical and/or mental disabilities.

3. The BHO may not discriminate for the participation, reimbursement, or indemnification of any provider 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.

4. The BHO shall not discriminate against providers serving high-risk populations or those that specialize in conditions requiring costly treatments. This is not to be construed as: (a) requiring that the BHO contract with providers beyond the number necessary to meet the needs of its Members; (b) precluding the BHO from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or (c) precluding the BHO from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Members.

5. The BHO is not required to contract with every willing provider.

6. The BHO shall have written policies and procedures for the selection and retention of providers.

7. If the BHO declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for its decision.

8. The BHO shall ensure that the provider network is sufficient through the duration of the contract to meet all of the services required by its Members. The BHO shall proactively ensure adequate access to services. This includes identifying any areas in the network of providers participating with the BHO where increased providers would further benefit Members, and actively recruit new providers. The BHO will notify DHS of any provider that leaves the network, and the BHO shall fill any acquired deficiencies in the network. The BHO is encouraged to contract with the clinic from which the individual receives medical care when possible to better integrate the delivery of medical and behavioral health care.

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

10. The BHO shall not include in its network any providers or providers whose owners or managing employees have been excluded from participation by the U. S. Department of Health and Human Services, Office of Inspector General

(OIG), Section 1128 or Section 1128A of the Social Security Act, Federal health care programs, or have been excluded by DHS from participating in the Hawaii Medicaid program and all other DHS Medicaid programs.

11. The BHO shall be responsible for routinely checking Federal exclusion lists to include but not limited to the List of Excluded Individuals and Entities (LEIE) maintained by the OIG.

12. The BHO shall immediately terminate any provider(s) or affiliated provider(s) whose owners or managing employees are found to be excluded or become excluded.

13. The BHO shall report provider application denials or termination to DHS where individuals were on the exclusions list to include denial of credentialing for fraud related concerns as they occur. The BHO shall utilize the format provided by DHS.

14. The BHO is prohibited from employing or contracting, directly or indirectly, for the provision of health care, utilization review, medical social work, or administrative services with any individual or entity that is, (or is affiliated with a person/entity that is) debarred, suspended, or excluded, or would (or is affiliated with a person/entity that would) provide services through an individual or entity that that is debarred, suspended, or excluded, from participating in procurement activities under the Federal Acquisition

Regulation (FAR) or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

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

16. If a behavioral health provider terminates or ceases participation in the BHO's provider network the BHO shall send written notice to the Members who were seen on a regular basis by the provider. This notice shall be issued within fifteen (15) calendar days after receipt or issuance of the termination notice to each Member who was seen on a regular basis by the terminated provider. The BHO shall be responsible for ensuring a seamless transition for the Member so that continuity of care is preserved until a new behavioral health provider has been selected.

17. The BHO may execute network provider agreements, pending the outcome of screening, enrollment, and revalidation, of up to one hundred twenty (120) days but shall terminate a network provider immediately upon notification from DHS that the network provider cannot be enrolled, or the expiration of the one hundred twenty (120)

day period without enrollment of the provider, and notify affected Members.

18. The BHO shall comply with any additional provider selection requirements established by DHS.

19. The BHO shall submit documentation on which DHS bases its determination that the BHO complied with DHS's requirements for availability and accesibility of services, including the adequacy of the provider network.

C) Availability of Providers

1. The BHO shall give assurances and provide supporting documentation that demonstrates that it has the capacity and sufficient amount of network providers to serve the expected enrollment in accordance with DHS standards for access and timeliness of care.

2. The BHO shall monitor the number of Members cared for by its providers and shall ensure timely access to medically necessary behavioral health services and to maintain quality of care. The BHO shall have a sufficient network to ensure Members can obtain needed health services within the acceptable wait times, taking into account the urgency of need for services. The acceptable wait times are:
    a. Emergency medical situations - Immediate care (twenty-four (24) hours a day, seven (7) days a week) and without prior authorization;

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

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

4. The BHO shall establish policies and procedures to ensure that network providers comply with these acceptable wait times; monitor providers regularly to determine

compliance; and take corrective action if there is a failure to comply.

5. The BHO shall post and maintain on the internet an accurate listing of participating providers and who is accepting new patients.

6. The BHO shall have policies and procedures regarding the availability of providers demonstrating compliance with the provisions of Section 8.1, and submit such policies and procedures as required in Section 13.3.B.

D) Geographic Access of Providers

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

Table 8.D.1-1: Geographic Access Standards

	Urban*	**Rural**
Hospitals	30-minute driving time	60-minute driving time
Emergency Services Facilities	30-minute driving time	60-minute driving time
Mental Health Providers	30-minute driving time	60-minute driving time
Pharmacies	15-minute driving time	60-minute driving time
24-Hour Pharmacy	60-minute driving time	N/A
*Urban is defined as the Honolulu Metropolitan Statistical Area (MSA)		

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

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

4. The BHO shall provide assurances, with supporting documentation, that it has the capacity to serve the expected enrollment in its service area in accordance with DHS standards for access and timeliness of care.

E) Telehealth Services

1. The BHO may use telehealth as a tool for facilitating access to needed services in a clinically appropriate manner that are not available within the BHO's Provider Network and in accordance with HRS § 346-59.1.

Telehealth providers shall be licensed in Hawaii to receive reimbursement for telehealth services under Medicaid.

2. The BHO shall:
    a. Require a Provider to be physically present with a Member, unless the Provider determines that it is Medically Necessary to provide telehealth services;
    b. Not require a Provider to be employed by another Provider or agency to provide telehealth services that is not required if that service were provided in person;
    c. Not Require a Provider to be part of a telehealth network; and
    d. Have and implement policies and procedures that follow all federal and state security and procedure guidelines. The policies and procedures shall incorporate DHS policies and procedures for the proper use and security for telehealth, including but not limited to confidentiality and data integrity, privacy and security, informed consent, privileging and credentialing, reimbursement, and technology.

3. The BHO may leverage telehealth in its Request for Exception to DHS network adequacy standards, as appropriate and approved by DHS. The BHO may not consider access to telehealth providers for meeting network adequacy standards, unless approved by DHS as part of an exception to network requirements.

8.2 Provider Credentialing, Recredentialing and Other Certification

A) Requirements

1. The BHO shall demonstrate that its network providers are credentialed as required under 42 CFR §438.214. The BHO will follow the most current NCQA credentialing and recredentialing standards including delegation and provider monitoring/oversight, but reserves the right to require approval of standards and thresholds set by the organization (e.g. with regards to performance standards, office site criteria, medical record keeping, complaints triggering on-site visits). The BHO shall also meet requirements of the RFP related to appointment availability (Section 8.1.C) and medical record keeping (Section 5.9.A).

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

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

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

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

6. The BHO shall submit its credentialing, recredentialing and other certification policies and procedures to DHS for review and approval by the due date identified in Section 13.3.B.

B) Provider Enrollment

1. The BHO providers shall enroll as a Hawaii Medicaid provider, enter into a provider agreement with, and preform all applicable screening on every provider furnishing, billing, ordering, referring & prescribing services under this contract as described in 42 CFR Part 455, Subpart B and the latest version of the Medicaid Provider Enrollment Compendium,

unless an exception applies as described herein or in other memorandum.

2. The BHO shall ensure that all providers furnishing, billing, ordering, referring and prescribing services are enrolled with DHS as a Medicaid provider, unless an exception applies as described herein or in other policy memorandum.

C) Program Integrity Rules Governing Provider Agreements

1. The BHO may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the Title XX Services Program. In addition, the BHO may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required above.

2. The BHO may execute network provider agreements, pending the outcome of DHS screening, enrollment, and revalidation for up to 120 days, but shall terminate a network provider immediately upon notification from DHS that the network provider cannot be enrolled, or the expiration of one 120 day period without enrollment of the provider, and notify affected enrollees.

3. The BHO shall notify DHS through its Provider Suspension and Termination report identified in Section 6.3 of any providers that the BHO refuses to enter into or renew an agreement.

4. The BHO is prohibited to knowingly have: a subcontractor; a network provider; or a network provider affiliated with a person or entity; who is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

8.3 Provider Contracts

A) Provider Contract Requirements

1. All contracts between providers and the BHO shall be in writing. The BHO's written provider contracts shall include all of the elements described in Appendix N.

2. The BHO shall ensure providers' performance and compliance with what is listed in the provider contracts. The BHO shall conduct periodic reviews or audits as needed to ensure that providers are in compliance with all the terms and conditions of their contracts.

3. The BHO may agree to an addendum to an already executed provider contract if the addendum and the provider agreement together include all requirements described in Appendix N.

The addendum shall clearly state that if the terms and conditions in the addendum and the provider agreement conflict, the terms and conditions in the addendum shall apply.

4. The BHO shall submit to DHS for review and approval a model for each type of provider contract ten (10) days after the effective date of the Contract in accordance with Section 13.3.B.

5. In addition, the BHO shall submit to DHS the signature page of all finalized and executed contracts in accordance with Section 13.3.B.

6. The BHO shall continue to solicit provider participation throughout the contract term when provider network deficiencies are found.

7. Requirements for contracts with subcontractors (non-providers) are addressed in Section 14.4.

8.4 Provider Services

A) Provider Education

1. The BHO shall be responsible for educating the providers about managed care and all program requirements. The BHO shall conduct provider education sessions, either one-on-one or in a group setting, for all contracted providers during the two (2) month period prior to the Date of Implementation of Services to Members identified in Section 1.5. The BHO shall conduct

education sessions at least every six (6) months for their contracted providers after identified in Date of Implementation of Services to Members in Section 1.5.

2. The BHO shall provide one-on-one education to providers who are not fulfilling program requirements as outlined in the provider agreements and the provider manual (refer to Section 8.4). One-on-one provider education includes educating providers on how to process their specific claims for payment. Specifically, the BHO shall educate providers on:
    a. The BHO's referral process and prior authorization process;
    b. The role of the PCP, if applicable;
    c. Claims processing;
    d. Availability of interpreter, auxiliary aids, and services for their patients;
    e. Availability of service coordination services and how to access these services;
    f. Role of care coordination team, service coordination team and the Hale Ola;
    g. The availability of programs that support Members and providers including but not limited to CIS, CoCM, CSC services, RHPs, Project ECHO, access to SDOH supports for Members, and the Regional Enhanced Referral Network;
    h. The ways in which the BHO will support provider-level quality improvement initiatives, including practice guidelines, and available access to resources and incentives;

i. Members' rights and responsibilities, including the right to file a grievance or appeal and how a provider can assist Members;
j. Reporting requirements;
k. Circumstances and situations under which the provider may bill a Member for services or assess charges or fees;
l. The BHO's medical records documentation requirements including the requirement that this documentation shall be tied to claims submission or encounter data;
m. The LAN framework and opportunities available to participate in VBP models including mechanisms to leverage BHO support to build capacity for VBP participation;
n. Methods the BHO will use to update providers on program and BHO changes (e.g., monthly newsletters, etc.);
o. Requirements for participating in and receiving payments from, as applicable, the BHO's quality program; and
p. The provider grievance, complaints, and appeals process.

3. Additionally, the BHO shall provide the following information on the Member Grievance System to all providers and subcontractors at the time they enter into a contractual relationship with the BHO:
    a. The Member's right to file grievances and appeals and their requirements, and timeframes for filing;

b. The Member's right to a State administrative hearing, how to obtain a hearing and rules on representation at a hearing;
c. The availability of assistance in filing a grievance or an appeal;
d. The Member's right to have a provider or authorized representative file a grievance and/or an appeal on his or her behalf, provided he or she has provided written consent to do so;
e. The toll-free numbers to file a grievance or an appeal; and
f. When an appeal or hearing has been requested by the Member, the right of a Member to receive benefits while the appeal or hearing is pending and that the Member may be held liable for the costs of those benefits if the BHO's adverse action is upheld.

4. The BHO shall ensure that the providers are aware of their responsibilities for compliance with the Americans with Disabilities Act (ADA), including how to access interpreter and sign language services as described in Section 4.13.B.

5. The BHO shall develop provider education curricula and schedules that shall be submitted to DHS for review and approval in accordance with the timeframes in accordance with Section 13.3.B.

6. The BHO shall educate network providers about how to access the formulary on the BHO website. In addition, the BHO may

allow network providers access to the formulary through a free, point-of-care web-based application accessible on smart phones, tablets, or similar technology. The formulary shall also identify preferred/non-preferred drugs, Clinical Prior Authorizations, and any preferred drugs that can be substituted for non-preferred drugs. The BHO shall ensure that the providers have access to its current formulary that is updated at least monthly.

8.5 Provider Grievance and Appeals Process

A) The BHO shall have policies and procedures for a provider grievance system that includes provider grievances and provider appeals. Provider grievances and provider appeals shall be resolved within sixty (60) days of the day following the date of submission to the BHO. The BHO shall give providers thirty (30) days from the decision of the grievance to file an appeal. Providers may utilize the provider grievance system to resolve issues and problems with the BHO (this includes a problem regarding a Member).

B) A provider, either contracted or non-contracted, may file a provider grievance. Below are some examples of items that may be filed as a provider grievance:
    1. Benefits and limits, for example, limits on behavioral health services or formulary;
    2. CCS eligibility and enrollment;
    3. BHO issues, including difficulty contacting the BHO or its subcontractors due to long wait times, busy lines, etc.; problems with the BHO's staff behavior; delays in claims

payments; denial of claims; claims not paid correctly; or other BHO issues.

4. Issues related to availability of health services from the BHO to a Member, for example delays in obtaining or inability to obtain emergent/urgent services, medications, specialty care, ancillary services such as transportation, medical supplies, etc.;
5. Issues related to the delivery of behavior health services; and
6. Issues related to the quality of service, for example, the provider reports that another provider did not appropriately evaluate, diagnose, prescribe or treat the Member, the provider reports that another provider has issues with cleanliness of office, instruments, or other aseptic technique was used, the provider reports that another provider did not render services or items which the Member needed, or the provider reports that the BHO's specialty network cannot provide adequate care for a Member.

C) The BHO shall log all provider grievances and report to DHS in accordance with the report to be determined in the reporting package described in Section 6.

D) The grievance and appeals process shall provide for the timely, detailed, and clearly explained resolution of any disputes between the BHO and provider(s).

E) The BHO shall submit provider grievance system policies and procedures to DHS for review and approval in accordance with Section 13.3.B.

SECTION 9 – Eligibility, Enrollment, Disenrollment, and Grievance and Appeals

9.1 Program Populations

A) Basic Criteria – QI Membership & Eligibility

1. Potential CCS Members shall first be enrolled in a QI Health Plan. Participation in the CCS program is voluntary.

2. All Members enrolled in the CCS program shall meet the following basic eligibility criteria:
    a. Be a U.S. citizen or legal resident alien entering the U.S. before August 22, 1996 or allowed to participate in Medicaid under provisions of the Personal Responsibility and Work Reconciliation Act of 1996 (P.L. 104-193) and subsequent amendments of those provisions;
    b. Be an adult (age 18 and over);
    c. Intend to reside in the State of Hawaii;
    d. Provide a verified Social Security Number (SSN);
    e. Enrolled with a QI Health Plan; and
    f. Not reside in a public institution, including a correctional facility and the Hawaii State Hospital.

B) Hawaii QUEST Integration (QI)

1. The QI program is a statewide program providing managed care services to all of Hawaii's Medicaid population.

2. QI is a statewide Medicaid demonstration project (Social Security Act Section 1115 waiver) that provides a package of medical, dental, behavioral health, and Long-Term Services and Support (LTSS) benefits to individuals meeting the Medicaid financial and non-financial eligibility requirements for individuals and families. Description of the individual's eligibility and benefits for QI are found in HAR, Title 17, Med-QUEST Division (1700 series).
    a. Medicaid Covered Populations:
        1) Children Group (HAR Chapter 17-1715);
        2) Former Foster Care Children Group (HAR Chapter 17-1715.1);
        3) Pregnant Women Group (HAR Chapter 17-1716);
        4) Parents and Other Caretaker Relatives Group (HAR Chapter 17-1717);
        5) Individuals receiving Transitional Medical Assistance (HAR Chapter 17-1717.1);
        6) Adults Group (HAR Chapter 17-1718);
        7) Aged, Blind, and Disabled Group (HAR Chapter 17-1719);

8) Non-citizens or refugees receiving Refugee Medical Assistance (HAR Chapter 17-1723.2); and

9) Individuals with breast and cervical cancer receiving Coverage of Individuals with Breast and Cervical Cancer (HAR Chapter 17-1733.1).

b. Non-Medicaid Covered Populations:

1) Individuals who are aged, blind, or with a disability, ineligible for Medicaid due to citizenship status, and legally reside in Hawaii, and meet the eligibility requirements for the State Funded Aged, Blind, and Disabled Program (HAR Chapter 17-1719.1); and

2) Individuals with breast and cervical cancer who are ineligible for Medicaid due to citizenship status and meet the eligibility requirements for the State Funded Coverage of Individuals with Breast and Cervical Cancer (HAR Chapter 17-1734.1).

c. Excluded Populations:

1) Individuals excluded from participation in managed care under this contract include those who are:

a) Repatriates (HAR Chapter 17-1723.3);

b) Medicare Savings Program Members and Qualified Disabled Working Individuals not eligible for full Medicaid benefits (HAR Chapter 17-1722); and

c) Enrolled in the State of Hawaii Organ and Tissue Transplant Program (SHOTT) (HAR Chapter 17-1737).

2) Individuals who are residents of the State applying to enter the QI program from an inpatient facility located in the continental U.S. or U.S. Territories shall not be enrolled in a QI health plan until they return to the State of Hawaii and are determined eligible for medical assistance by DHS.

9.2 Eligible BHO/CCS Members

A) General Requirements

1. Members enrolled in a QI Health Plan, who meet criteria for the CCS program, shall be eligible to receive the specialized behavioral health services described in this RFP (see Section 4.2). All CCS Members shall first be enrolled in a medical assistance program. In such a case, the QI Health Plan shall be relieved of its responsibility for providing behavioral health services including psychotropic medications but shall remain responsible for providing non-behavioral health services.

2. If a QI Member is provisionally determined to be SMI/SPMI through the DHS evaluation process and currently meets the CCS eligibility criteria, the Member will be enrolled with the BHO until an evaluation is completed to determine continued eligibility. Upon enrollment with the BHO, as explained above, the QI Health Plan is no longer responsible for the individual's

behavioral health services. However, the QI Health Plan shall remain responsible for all medical services.

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

4. If the program is expanded to include other populations, a process will be established by DHS to determine eligibility that will minimally require meeting clinical criteria in Section 9.2.D.

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

B) Serious Mental Illness (SMI) or Serious and Persistent Mental Illness (SPMI)

1. Persons who are determined to have a diagnosis of Serious Mental Illness (SMI) or Serious and Persistent Mental Illness (SPMI) are defined as adults who, as the result of a mental disorder, exhibit emotional, cognitive, or behavioral functioning which is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or services of a long-term or indefinite duration. In these persons, their mental disability is serious and persistent resulting in a long-term limitation in their functional capacities for primary activities of daily living such as interpersonal relationships, self-care, homemaking, employment, and recreation. Criteria for designation of a

person who has a diagnosis of SMI/SPMI can be found in Section 9.2.D.

C) Evaluation and Referral to the BHO

1. Upon determination that a QI Member would benefit from BHO services, the QI Health Plan shall refer the Member to DHS through use of the referral process (Appendix D, CCS Referral Form and Instructions) for an evaluation to determine eligibility for the BHO.

2. Adults with a SMI/SPMI diagnosis who are unstable and moderate-high risk are eligible for additional intensive services if the adult:
    a. Demonstrates the presence of a qualifying diagnosis for at least twelve (12) months or is expected to demonstrate the qualifying diagnosis (as found in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for the next twelve (12) months; and
    b. Meets at least one (1) of the following criteria demonstrating instability and/or functional impairment:
        1) Clinical records demonstrate that Member is unstable under current treatment or plan or care; and
        2) Requires protective services or intervention by housing/law enforcement officials.

3. Provisional Eligibility. If an adult does not meet the eligibility criteria but is determined by DHS' medical director or designated person that additional services are medically necessary for the adult's health and safety, the adult might obtain provisional eligibility. Each of such cases will be evaluated on a case-by-case basis for provisional eligibility.
4. DHS reserves the right to modify eligible CCS clinical criteria and will notify the BHO of all criteria changes for feedback and discussion prior to implementation.

5. A QI Health Plan shall submit CCS referrals to DHS. To expedite the referral process, the QI Health Plan shall review for the following:
    a. Designated DHS referral form is completely filled out by a qualified mental health professional (QMHP) [see Appendix D];
    b. The Member's Primary Diagnosis is an eligible SMI/SPMI CCS diagnosis (see Section 9.2.D); and
    c. Documentation submitted with the referral supports SMI/SPMI CCS eligible diagnosis and functional impairment consistent with eligibility criteria (i.e. psychiatric assessment, hospital admission and discharge summaries, psychiatric provider progress notes and other pertinent documents).

6. If, after review, it is unclear if the QI Member would benefit from BHO services, additional information may be requested by DHS or the referral will be denied. The cost of completing the forms and obtaining documentation is the responsibility

of the QI Health Plan. DHS may allow a fee-for-service (FFS) provider to submit a referral packet under extenuating circumstances.

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

8. The evaluation results and the enrollment date into the BHO will be provided to the Member's QI Health Plan, referring DOH agency and the BHO within five (5) working days of determination. DHS will provide the enrollment date which will be five (5) working days after notification of the determination, or earlier to meet the needs of the Member as determined by DHS. The BHO assumes responsibility for all behavioral health services for the Member on the enrollment date specified by DHS. If denied, the referring provider has the right to resubmit the referral with additional information that clearly documents the Member's eligibility. The BHO shall verify enrollment with DHS and the Member's QI Health Plan before providing services.

D) Eligible Diagnoses

1. Substance Induced Psychosis:
    a. Alcohol Induced Psychosis (F10.15x, F10.25x, F10.95)
    b. Opioid Induced Psychosis (F11.15x, F11.25x, F11.95x)
    c. Cannabis Induced Psychosis (F12.15x, F12.25x, F12.95x)
    d. Sedative Induced Psychosis (F13.15x, F13.25x, F13.95x)
    e. Cocaine Induced Psychosis (F14.15x, F14.25x, F14.95x)
    f. Other Stimulant Induced Psychosis (F15.15x, F15.25x, F15.95x)
    g. Hallucinogen Induced Psychosis (F16.15x, F16.25x, F16.95x)
    h. Inhalant Induced Psychosis (F18.15x, F18.25x, F18.95x)
    i. Other Substance Induced Psychosis (F19.15x, F19.25x, F19.95x)
2. PTSD (F43.1x)
3. Schizophrenia (F20.x, includes Schizophreniform disorder F20.81)
4. Schizoaffective Disorder (F25.x)
5. Delusional Disorder (F22)
6. Bipolar Disorder (F30.xx, F31.xx)

7. Major Depressive Disorder, Severe (F32.3, F33.2, F33.3)
8. Borderline Personality Disorder (F60.3)

E) Coordination of Benefits Agreement (CBA)

1. The BHO is responsible for coordination of benefits for Members dually eligible for Medicaid and Medicare. The BHO is required to enter into a CBA with Medicare and participate in the automated claims crossover process.

F) Eligibility Verification

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

9.3 Enrollment with the BHO

A) Referral Process

1. Potential Members of the BHO may be identified by any of the following:
    a. Referrals from the QI Health Plan;
    b. Referrals from the Hawaii State Hospital for individuals who are being discharged;
    c. Referrals from DOH-AMHD, DOH-CAMHD, or DOH-DDD;

d. Referrals from the Department of Public Safety for individuals who are being discharged from their correctional facility;
e. Referrals from DHS for those young adults (18 years or older) who are being discharged from the Hawaii Youth Correctional Facility; or
f. Self-referring individuals to the BHO or making first contact with the BHO through crisis services.

2. All referrals for potential BHO Members will be subject to the SMI and SPMI referral and evaluation process described in Section 9.2.C.

3. There is no enrollment cap for the BHO.

4. Once a Member has been evaluated to meet the criteria for SMI/SPMI determination by DHS, the Member will be enrolled with the BHO. Enrollment into the CCS program is the sole responsibility of DHS.

5. The enrollment date, which is five (5) working days after the notification of approval pursuant to the referral process described in Section 9.2.C, or earlier, based upon the Member's behavioral health needs, shall be noted on the determination form. Upon enrollment with the BHO, the QI Health Plan shall be relieved of its responsibility for providing all behavioral health services to its Member. Until the BHO enrollment date, the QI Health Plan retains responsibility for providing the behavioral health services.

6. Members who are enrolled with the BHO and who are later determined to no longer meet the criteria for SMI/SPMI shall be referred back to DHS by the BHO. The BHO will request disenrollment for these Members. The process for disenrollment from the BHO is described in Section 9.6. The BHO will review the Member's treatment status at least every six (6) months to determine if SMI/SPMI continued eligibility criteria are met.

B) Re-Evaluation Process

1. At the time of eligibility determination, a re-evaluation date is set by DHS. Prior to this re-evaluation date, the BHO shall submit a newly filled out CCS Referral Form (Appendix D) with supporting documents for DHS to review. If it is determined that the Member continues to meet eligibility criteria as outlined in Section 9.2.D, DHS may set another re-evaluation date as needed. If it is determined that the Member no longer meets eligibility criteria, the process for disenrollment will begin as outlined in Section 9.6.

C) Involuntary Commitment

1. The BHO shall be responsible for providing behavioral health services to Members who have been involuntarily committed for evaluation and treatment under provisions of HRS Chapter 334, to the extent that these services are deemed necessary by the BHO's utilization review procedures. In the event that

court ordered diagnostic, treatment or rehabilitative services are not determined to be medically necessary, the costs of continuing care under court order shall be borne by the BHO.

9.4 Notification of Enrollment

A) General Requirements

1. DHS shall provide the Member with written notification of enrollment into the BHO. This notice shall serve as verification of enrollment until the Member receives a membership card from the BHO.

2. The BHO shall provide the new Member a confirmation of enrollment and other pertinent informational material, (listed in Section 9.4.B, within fifteen (15) calendar days of enrollment.

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

B) DHS and BHO Responsibilities

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

2. The BHO:
    a. Is responsible for accepting new Members in the order received from DHS, without restriction, unless authorized by the Centers for Medicare & Medicaid Services (CMS), up to the limits set under the contract;

    b. Is prohibited from discriminating against enrolled Members on the basis of health status or need for health care services;

    c. Is prohibited from discriminating against enrolled Members on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability; and

    d. Is prohibited from using any policy or practice that has the effect of discriminating against enrolled Members on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability.

3. Upon receipt of the information from DHS, the BHO shall enroll the Member and perform the necessary procedures to ensure that the Member is provided access to care. The following describes the responsibilities of the BHO upon enrollment of a Member:
    a. Assign a Member number to the Member. This may be the Member's Medicaid ID number;

    b. Assign a case manager to each Member on the date of enrollment, whether it be from the BHO's CM component or a CM provider as described in this Section. For Members that already have a case manager in the community, the BHO shall maintain this relationship. If the Member or case manager in the community is not interested in continuing this relationship, then the BHO shall perform transition of care as described in Section 4.14;

    c. Explain the role of the case manager to the Member and the procedures to be followed to obtain needed services. Provide the Member with a listing of the providers. Orient and familiarize, then provide each Member with a Member handbook which explains the operations of the plan including the procedures to follow to make an appointment, obtain emergency services, change BHO providers or prescribing psychiatrist, understand and exercise Member rights and responsibilities, file a complaint and grievance procedures, how to exercise an advance directive, etc.; all the information to understand and effectively utilize the services available;

d. Assist the Member in the selection of a provider and explain the role and responsibilities of the behavioral health provider and/or the CM, as applicable and the procedures to be followed to obtain needed services. The BHO shall maintain the Member with their current provider, if applicable. If the Member does not select or does not have their own behavioral health provider from the provider network within ten (10) calendar days of enrollment, the BHO shall identify a provider for the Member;

e. Explain the confidentiality policies related to the Member's case documentation records (which includes treatment records);

f. Explain to the Member the information that needs to be provided by the Member to the BHO and DHS upon changes in the status of the Member including marriage, divorce, birth of a child, adoption of a child, death of a spouse or child, acceptance of a job, obtaining other health insurance, etc.;

g. Issue membership card(s) to the enrolled Members with adequate information for providers to identify the following:

    1) Member number;
    2) Member name;
    3) Effective date;
    4) Benefit, e.g. behavioral health services only;
    5) Crisis hotline;
    6) Toll-free telephone number;

7) Third Party Liabilities (TPL's);
8) Eligibility renewal date; and

h. Provide information on how to contact their designated CM or CM agency/entity.

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

9.5 Re-Enrollment into the BHO

A) Individuals, who are disenrolled from the BHO and request services after an absence from the BHO or regain Medicaid eligibility within six (6) months are not required to be re-evaluated to be re-enrolled unless DHS or the BHO determines it is necessary, or a six (6) month re-evaluation is due.

B) Re-enrollment will be effective from the date the Member is re-enrolled into the QI Health Plan and/or requested date by the BHO. Re-enrollment will not be retroactive to the date of the last disenrollment. The BHO will be expected to assist Members with maintaining eligibility.

C) Automatic re-enrollment will occur for Members who were disenrolled solely because of the loss of Medicaid eligibility for a period of two (2) months or less.

9.6 Disenrollment from the BHO

A) General Requirements

1. DHS shall be the sole authority allowed to disenroll a Member from the BHO. Reasons for disenrollment include, but are not limited to the following:
    a. Member loses Medicaid eligibility;
    b. No contact with Member for total of three (3) months;
    c. Documentation of Member's refusal of services;
    d. Member no longer meets eligibility criteria as per Section 9.2.C;
    e. Member resides in another state;
    f. Death of the Member;
    g. Incarceration of the Member;
    h. Transfer of the Member to a long-term care nursing facility or Intermediate Care Facilities for individuals with Intellectual Disabilities (ICF-ID).
    i. Member is waitlisted at an acute hospital for a long-term care bed;
    j. Member is sent out-of-state for medical treatment by DHS or the BHO and DHS or the QI Health Plan will assume responsibility for the behavioral health care needs of the Member;
    k. Member is admitted to the Hawaii State Hospital; and
    l. Member provides false information with the intent of enrolling in a DHS program under false pretenses.

2. To assure DHS that the BHO does not request disenrollment other than the reasons listed above in Section 9.6.A.1, the list the BHO submits to DHS shall include the reason for disenrollment. The BHO shall provide documentation justifying the disenrollment of a Member upon the request of DHS.

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

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

5. In cases where DHS fails to make a disenrollment determination within thirty (30) calendar days of the disenrollment request from the BHO, the disenrollment is considered approved for the effective date that would have

been established had DHS made a determination within the specified timeframe.

6. Members may be disenrolled from the BHO if they no longer meet the criteria for enrollment. Members or their authorized representative may request disenrollment from the BHO at any time either orally or in writing. Members shall be disenrolled from the BHO at the end of the month and responsibility for behavioral health services will revert to the QI Health Plan. Only DHS may disenroll Members from the BHO.

7. The Member may seek redress through the BHO's grievance system before DHS makes a decision on the Member's request for disenrollment, the BHO shall complete its review of the grievance in time to permit the disenrollment to be effective no later than the first day of the second month following the month in which the Member requests disenrollment or the BHO refers the request to DHS.

8. The BHO transition plan will be given to the QI Health Plan in order to ensure continuity of care prior to disenrollment. DHS will provide to the QI Health Plan written notification of the disenrollment from the BHO. Upon disenrollment from the BHO, the QI Health Plan assumes responsibility for providing all medical and behavioral health services within the established QI Health Plan behavioral health benefit limits.

9. The BHO shall not request disenrollment of a Member for discriminating reasons including, but not limited to, the following:
    a. Pre-existing medical conditions;
    b. Missed appointments;
    c. Changes to the Member's health status;
    d. Utilization of medical services;
    e. Diminished mental capacity; and
    f. Uncooperative or disruptive behavior resulting from the Member's special needs except where the Member's continued enrollment with the BHO seriously impairs the BHO's ability to furnish services to either the Member or other Members.

B) Members Who No Longer Meet the Criteria for SMI

1. Members who are enrolled in the BHO and who the BHO determines no longer meet the criteria for SMI shall be referred to DHS. DHS shall determine whether the Member no longer meets the criteria using the same process described in Section 9.2.C.

2. If the Member no longer meets the criteria for enrollment in the BHO, they shall be disenrolled from the BHO at the end of the month in which the determination is made and responsibility for care shall be assumed by the QI Health Plan. The QI Health Plan shall receive notification of the disenrollment from the BHO. Upon disenrollment from the BHO, the QI Health Plan assumes responsibility for providing

the medically necessary mental health, drug abuse, and alcohol abuse services needed by the individual.

3. For Members who have not maintained contact for a period of one (1) month, the CM provider shall refer the Member to the BHO CM component. The BHO then has two (2) months to re-establish contact with the Member. If at the end of the two (2) month period there is no contact, the Member will be placed on a disenrollment list to be submitted to DHS.

C) Criminal Commitment

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

D) State Mental Health Hospital

1. Upon admission into the Hawaii State Hospital, the individual shall be disenrolled from the BHO.

9.7 Notification to Members of Services, Responsibilities, and Rights

A) Communication to Members

1. The BHO shall communicate information to Members about covered benefits and services, such as operations of the BHO, how to make an appointment, obtain emergency services, change BHO providers or prescribing psychiatrist, Member rights and responsibilities, how to file a grievance or appeal, etc. See requirements for written materials in Section 9.7.D.

B) Notification of Changes in Member Status

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

    b. It is expected that not all Members will remember to provide DHS with the information on changes to their status. Therefore, the BHO shall forward such information to DHS on a timely basis and inform the Member of his or her responsibility to report changes directly to DHS. The BHO shall complete the required

1179 form for changes in Member status and forward or fax the information to the designated representative on a daily basis.

2. Changes in Status.
    a. The following are examples of changes in the Member's status that may affect the eligibility of the Member:
        1) Death of the Member or family member (spouse or dependent);
        2) Marriage;
        3) Divorce;
        4) Adoption;
        5) Change in Medicaid and CCS eligibility status (i.e., no longer meets eligibility criteria);
        6) Change in address (i.e., moved out of state);
        7) Institutionalization (i.e., imprisonment or long-term care facility, State hospital);
        8) TPL coverage, especially employer-sponsored or Medicare;
        9) Legal encumbrances - conditional release, jail diversion, released on conditions and mental health court or receiving services from DOH-AMHD; and
        10) Change in income.

C) Member Education and Member Handbook

1. General Requirements.

   a. The BHO shall use the guidelines in this Section to develop a handbook to serve as a summary of benefits and coverage and include information to provide better understanding to ensure that Members can effectively utilize the services provided by the BHO. A booklet or pamphlet shall explain in more detail the procedures to be followed by the Member and the responsibility of the Member. It shall be provided to each Member within ten (10) calendar days of enrollment and annually thereafter.

   b. A copy of the handbook shall be submitted to DHS for review and approval in the timeframe described in Section 13.3.B.

   c. Handbook information provided to the Member is considered to be provided if the BHO:
      1) Mails a printed copy of the information to the Member's mailing address;
      2) Provides the information by email after obtaining the Member's agreement to receive the information by email;
      3) Posts the information on its website and advises the Member in paper or electronic form that the information is available on the Internet and

includes the applicable Internet address, provided that Members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or

4) Provides the information by any other method that can reasonably be expected to result in the Member receiving that information.

2. State Guidelines and Minimum Requirements for Member Handbook.

3. The following is the minimum information and DHS developed guidelines to be included in the handbook to ensure understanding of how to effectively utilize the services available:
    a. Description of the role and selection of a BHO provider;
    b. A provider directory that includes the names, location, telephone numbers of, and non-English languages spoken by contracted providers in the Member's service area including identification of providers that are not accepting new patients;
    c. Any restrictions on the Member’s freedom of choice among network providers;
    d. CM system: role and selection of a CM and how to access CM services;
    e. Description of the behavioral health services provided by the BHO that includes amount, duration, and scope of benefits, in sufficient detail, to ensure Member’s understanding of the benefits to which they are entitled,

and how to access any benefits provided by DHS, outside the BHO;

f. Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits;
g. Description of the Member rights and responsibilities, including the Member's right to obtain available and accessible services and the right to be furnished health care services in accordance with 42 CFR §§ 438.206 through 438.210;
h. Notification of the Member's right to be provided with written notice of any significant change, defined by DHS, at least thirty (30) calendar days before the intended effective date of the change;
i. Notification that Members have access to the providers that have contracts with the BHO;
j. Description of the Member's rights and protections as specified in 42 CFR §438.100;
k. Authorization requirements for obtaining behavioral health services;
l. Information on how to change behavioral health providers;
m. Explanation of how to make an appointment;
n. Notification that the BHO will report to DHS changes in status and family composition;
o. Notification that the BHO will report to DHS any third-party liability;
p. Explanation of a Member's right to file a grievance and appeal;

q. Description of the Member's access to the administrative hearing process;
r. Toll-free number to call for questions and assistance and 24- hour crisis line;
s. Explanation of the use of the membership card;
t. Notice of penalties for fraudulent activities;
u. Explanation of how Members may obtain benefits from out-of-network, out-of-state behavioral health services, out-of-state behavioral health services;
v. Information on advance directives;
w. Explanation of cost sharing, if any;
x. Description of how and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost sharing, and how transportation is provided. For a counseling or referral service that the BHO does not cover because of moral or religious objections, the BHO need not furnish information on how and where to obtain the service. DHS shall provide information on how and where to obtain the service;
y. Explanation of the confidentiality of Member information;
z. Information on individuals' rights as it pertains to the Health Care Privacy Act;
aa. Notice that failure to pay for non-covered services will not result in loss of Medicaid benefits;
bb. Information on the availability of Ombudsman Program services for Members;

cc. Information on the extent to which, and how, after-hours and emergency services are provided, including the following:
    1) What constitutes an urgent and emergency medical condition, emergency services, post-stabilization services in accordance with 42 CFR §422.113(c);
    2) The fact that prior authorization is not required for emergency services;
    3) The process and procedures for obtaining emergency services, including the use of the 911 telephone systems or its local equivalent;
    4) The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered herein; and
    5) The fact that a Member has a right to use any hospital or other appropriate health care setting for emergency services;

dd. Information on the Member grievance system policies and procedures, as described in Section 9.8. This description shall include the following:
    1) The right to file a grievance and appeal with the BHO;
    2) The requirements and timeframes for filing a grievance or appeal with the BHO;
    3) The availability of assistance in filing a grievance or appeal with the BHO;

4) The toll-free numbers that the Member can use to file a grievance or an appeal with the BHO by phone;
5) The right to a State administrative hearing, the method for obtaining a hearing, and the rules that govern representation at the hearing;
6) Notice that if the Member files an appeal or a request for a State administrative hearing within the timeframes specified for filing, the Member may request a continuation of benefits as described in Section 9.8.K, and be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the Member; and
7) Any appeal rights that DHS chooses to make available to providers to challenge the failure of the BHO to cover a service.

ee. Additional information that is available upon request, including information on the structure and operation of the BHO, and information on physician incentive plans as set forth in 42 CFR §§ 422.208, 422.210, and 438.6, refer to Section 5.2;

ff. Information on how to access auxiliary aids and services, including additional information in alternative formats or language;

gg. Information on how to report suspected fraud or abuse;

hh. Includes detail that in the case of a counseling or referral service that the BHO does not cover because of moral or religious objections, the BHO shall inform Members that

the service is not covered and how Members can obtain information from DHS about how to access those services;

ii. In addition, Members shall be provided DHS-developed Member notices from the BHO;

jj. Information about the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit and how to access component services if individuals under age 21 entitled to the EPSDT benefit are enrolled in the BHO;

kk. Information about how and where to access any benefits provided by DHS, including EPSDT benefits delivered outside the BHO, if any; and

ll. The BHO is required to use the handbook and notices to describe the transition of care policies for Members and potential Members.

D) Language and Format Requirements for Written Materials

1. The BHO shall use easily understood language and formats for all Member written materials. All written material shall be based on guidelines outlined by the DHS in this RFP.

2. The BHO shall make all written materials available in alternative formats and through auxiliary aids and services in a manner that takes into consideration the Member's special needs and potential Members with disabilities or limited English proficiency. The BHO shall notify all Members and potential Members in a manner and format that is easily understood, including in all written materials, a large print tagline, that information is readily accessible and available in

alternative formats and through auxiliary aids and services and provide information on how to access those formats, at no cost to the Member. In addition, the BHO shall notify all Members that all written materials are available in alternative formats and through auxiliary aids and services, upon request, for Members with disabilities, at no cost to the Member.

3. The BHO shall make sure that all Members are notified that written translation is available in prevalent languages, and how to access this service. The BHO shall make all written information for Members available in the prevalent non-English languages spoken by Members and potential Members, identified by DHS, including languages that comply with Section 1157 of the Patient Protection and Affordable Care Act. This may change at the DHS' discretion. If any changes are made, DHS shall notify the BHO. When the BHO is aware that the Member needs written information in one of these alternate languages, the BHO shall send all written information in this language (not English) to that Member within seven (7) calendar days of the request or next business day. The BHO may provide information in other prevalent non-English languages based upon its Member population as required in Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d, 45 CFR Part 80 which include taglines, as well as large print explaining the availability of written translation, oral interpretation and the toll-free, Teletypewriter Telephone/Text Telephone (TTY/TDY) customer service telephone number, to understand the information provided.

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

5. The BHO shall certify that a qualified individual has reviewed the translation of the information into the different languages for accuracy. The BHO shall submit certification and translation of information into different languages to DHS for review and approval by the due date identified in Section 13.3.B.

6. All written materials shall be worded such that the materials are understandable to a Member who reads at the 6th (6.9 or below) grade reading level. Suggested reference materials to determine whether this requirement is being met are the:
    a. Fry Readability Index;
    b. PROSE The Readability Analyst (software developed by Education Activities, Inc.);
    c. McLaughlin SMOG Index; or
    d. Flesch-Kincaid Index.

7. All written material including changes or revisions shall be submitted to DHS for prior approval before being distributed. The BHO shall also receive prior approval for any changes in

written materials provided to the Members before distribution to Members.

8. All written material for Members and potential Members shall be printed in a font size no smaller than twelve (12) point.

9. All electronic information provided to Members shall be as follows:
    a. In a format that is readily accessible;
    b. On the BHO's website in locations that are prominent and readily accessible;
    c. Electronically retained and printed; and
    d. Consistent with the content and language requirements as outlined in Section 9.7.D;

10. The BHO shall notify Members that all electronic information available in paper form, upon request, free of charge. The BHO shall provide the information in paper form within five (5) business days of the request.

E) Member Rights

1. The BHO shall have written policies and procedures regarding the rights of Members and shall comply with any applicable federal and state laws and regulations that pertain to Member rights. These rights shall be included in the Member Handbook described in Section 9.7.C. At a minimum, said policies and procedures shall specify the Member's right to:
    a. Be treated with respect and with due consideration for the Member's dignity and privacy;

b. Have all records and medical and personal information remain confidential;
c. Receive information on available treatment options and alternatives, and presented in a manner appropriate to the Member's condition and ability to understand;
d. Participate in decisions regarding his or her health care, including the right to refuse treatment;
e. Be free from any form of restraint or seclusion as a means of coercion, discipline, convenience or retaliation, as specified in federal regulations on the use of restraints and seclusion;
f. Request and receive a copy of his or her medical records pursuant to 45 CFR Parts 160 and 164, subparts A and E, and request to amend or correct the record as specified in 45 CFR §§ 164.524 and 164.526; and
g. Freely exercise his or her rights, including those related to filing a grievance or appeal, and that the exercise of these rights shall not adversely affect the way the Member is treated.

9.8 Member Grievance and Appeals System

A) General Requirements

1. The BHO shall have a formal grievance system that is consistent with the requirements of the State of Hawaii and 42 CFR Part 438, Subpart F. The Member grievance system shall include an inquiry process, a grievance process and appeals process. In addition, the BHO's grievance system shall

provide information to Members on accessing the State administrative hearing system. The BHO shall require that Members exhaust its internal grievance system prior to accessing the State administrative hearing system.

2. The BHO shall use templates developed by DHS for communication to Members regarding grievance system processes. DHS shall issue these templates to the BHO.

3. The BHO shall develop policies and procedures for its grievance system and submit these to DHS for review and approval by the due date identified in Section 13.3.B. The BHO shall submit an updated copy of these policies and procedures within thirty (30) calendar days of any modification for review and approval. Changes shall be approved by DHS prior to implementation.

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

5. The BHO shall give Members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and a toll-free number that has adequate TTY/TTD and interpreter capability.

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

7. The BHO shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made and reviewed by a healthcare professional that has appropriate behavioral health, medical, and clinical, knowledge and expertise in treating the Member's condition or disease. All denials of medical, behavioral health, and LTSS shall be reviewed and approved by the BHO medical director. In addition, all administrative denials for children under the age of twenty-one (21) shall be reviewed and approved by the BHO medical director.

8. The BHO shall ensure that individuals who make decisions on grievances and appeals were not involved in any previous level of review or decision-making, nor is a subordinate of any individual involved in such previous level review or decision-making, and who is a healthcare professional with the appropriate clinical expertise, as determined by DHS, in

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

treating the Member's condition or disease. In addition, these individuals shall take into account all comments, documents, records and other information submitted by the Member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. This requirement applies specifically to reviewers of:

a. An appeal of a denial that is based on a lack of medical necessity;
b. A grievance regarding denial of expedited resolution of an appeal; or
c. A grievance or appeal that involves clinical issues.

9. A Member, a Member's authorized representative, or a provider acting on behalf of the Member with the Member's authorization, is deemed to have exhausted the BHO's grievance and appeal process if the BHO fails to adhere to the notice and timing requirements set by DHS, and may file for a State administrative hearing.

B) Record Keeping – Grievance and Appeals

1. The BHO shall maintain records of its Members' grievances and appeals for a period of no less than ten (10) years in accordance with 42 CFR § 438.3(u) and this RFP's requirements for recordkeeping and confidentiality of Members' medical records.

2. The record of each grievance or appeal shall contain, at a minimum, all of the following information:
    a. A general description of the reason for the appeal or grievance;
    b. The date the appeal or grievance was received;
    c. The date of each review or, if applicable, review meeting;
    d. The resolution information for each level of the appeal or grievance, if applicable;
    e. The date of resolution at each level, if applicable; and
    f. Name of the covered person for whom the appeal or grievance was filed.

3. The record shall be accurately maintained in a manner accessible to DHS and available upon request to CMS.

4. The contract requires that the BHO and the BHO's subcontractors retain, as applicable, Member grievance and appeal records in 42 CFR § 438.416, for a period of no less than ten (10) years.

C) Inquiry Process

1. The BHO shall have an inquiry process to address all inquiries. As part of this process, the BHO shall ensure that, if at any point during the contact, the Member expresses a complaint of any kind, the inquiry becomes a grievance or appeal and the BHO shall give the Member, a Member's authorized representative, or a provider acting on behalf of the Member

with the Member's consent, their grievance and appeal rights. The inquiry can be in writing or as a verbal request over the telephone.

D) Member Authorized Representative – Grievance and Appeals

1. Members shall be allowed to authorize another person to represent their interests during any stage of the grievance system process as their grievance and appeals authorized representative. The authority of the grievance and appeals authorized representation of the Member in, and for the purposes of, a current grievance and related appeals

2. The BHO shall establish and submit policies and procedures for the processing of a grievance and appeal authorized reporesentatvie appointment form, by which the Member names and authorizes a grievence and appeal authorized representative as part of its Grievance System policies and procedures to DHS for review and approval by the due date identified in Section 13.3.B, to include, but not be limited to, its authorized representative form.

3. Members shall be allowed, in person or by telephone, to verbally identify another person who may communicate with the BHO on the Member's behalf, for any matter that does not require a written request or written designation of an authorized representative under this RFP and contract.

E) Grievance Process

1. A grievance may be filed about any matter other than an adverse benefit determination, as defined above. Subjects for grievances include, but are not limited to:
    a. The quality of care of a provider;
    b. Rudeness of a provider or a provider's employee; or
    c. Failure to respect the Member's rights regardless of whether remedial action is requested.

2. Grievance includes a Member's right to dispute an extension of time proposed by the BHO to make an authorization decision.

3. A Member or a Member's authorized representative may file a grievance orally or in writing with the BHO at any time. The BHO shall accept any grievance filed on the Member's behalf from a Member's representative even without verbal or written consent of the Member. However, the BHO shall send the outcome of any grievance filed by a Member's representative without oral or written consent (i.e., AOR form) to the Member.

4. The BHO shall have in place written policies and procedures for processing grievances in a timely manner to include if a grievance is filed by a provider on behalf of the Member or Member's authorized representative and there is no documentation of a written form of authorization, such as an AOR form.

5. As part of the grievance system policies and procedures, the BHO shall have in effect mechanisms to: (a) ensure reasonable attempts were made to obtain a written form of authorization; and (b) consult with the requesting provider when appropriate. The BHO shall submit these policies and procedures as part of its Grievance System policies and procedures to DHS for review and approval by the due date identified in Section 13.3.B.

6. In addition to meeting all requirements detailed in Section 9.8, in fulfilling the grievance process requirements the BHO shall:
    a. Send a written acknowledgement of the grievance within five (5) business days of the Member's expression of dissatisfaction;
    b. Convey a disposition, in writing, of the grievance resolution as expeditiously as the Member's health condition requires and within thirty (30) calendar days of the initial expression of dissatisfaction; and
    c. Include clear instructions as to how to access DHS' grievance review process on the written disposition of the grievance.

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

8. In the event DHS requires the Member to seek redress through the BHO's grievance system before DHS makes a decision on

the Member's request for disenrollment, the BHO is required to complete its review of the grievance in time to permit the disenrollment to be effective no later than the first day of the second month following the month in which the Member requests disenrollment or the BHO refers the request to DHS.

9. The BHO may do the following related to a grievance extension:
    a. Upon request of the Member, the timeframe for processing can extend by up to fourteen (14) calendar days;
    b. Upon DHS request, extend the timeframe for processing a grievance by up to fourteen (14) calendar days if the BHO shows that there is need for additional information and that the delay is in the Member's best interest;
    c. If not at the request of the Member, make reasonable efforts to give the Member prompt oral notice of the delay;
    d. If not at the request of the Member, the BHO shall give the Member written notice (in the DHS established format and language, that at a minimum, meets applicable notification standards) within two (2) calendar days, of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision; and
    e. The BHO shall notify the Member of the resolution of a grievance in a format and language that meets applicable notification standards.

F) State Grievance Review

1. As part of its grievance system, the BHO shall inform Members of their rights to seek a grievance review from the State in the event the disposition of the grievance does not meet the satisfaction or expectations of the Member. The BHO shall provide its Members with the following information about the State grievance review process:
    a. BHO Members may request a State grievance review, within thirty (30) calendar days of the Member's receipt of the grievance disposition from the BHO. A State grievance review may be made by contacting DHS at or mailing a request to:

        Department of Human Services
        Med-QUEST Division
        Health Care Services Branch
        601 Kamokila Blvd., Suite 506A
        Kapolei, HI 96709-0190
        Telephone: 808-692-8094

    b. DHS shall review the grievance and contact the Member with a determination within ninety (90) calendar days from the day the request for a grievance review is received; and
    c. The grievance review determination made by DHS is final.

G) Appeals Process

1. The BHO has only one level of appeal for Members. An appeal may be filed when the BHO issues a notice of adverse benefit determination to a Member.

2. A Member, a Member's authorized representative, or a provider acting on behalf of the Member with the Member's authorization, may file an appeal within sixty (60) calendar days of the notice of adverse benefit determination, orally or in writing. An oral appeal may be submitted in order to establish the appeal submission date; however, this shall be followed by a written, signed appeal.

3. In addition to meeting the general requirements detailed in Section 9.8:
    a. Ensure that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals and confirmed in writing, unless the Member, provider or other authorized representative requests expedited resolutions;
    b. As part of the grievance system policies and procedures, the BHO shall have in effect mechanisms to ensure reasonable attempts were made to obtain a written confirmation of the appeal;
    c. Send an acknowledgement of the receipt of the appeal within five (5) business days from the date of the receipt of the written or oral appeal;

d. Provide the Member and his or her authorized representative a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments;
e. Provide the Member and/or his or her representative the opportunity, before and during the appeals process, to examine the Member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the BHO (or at the direction of the BHO) in connection with the appeal of the adverse benefit determination;
f. Include as parties to the appeal, the Member and his or her authorized representative, or the legal representative in the case of a deceased Member's estate; and
g. Provide the Member and his or her representative the Member's case file free of charge and sufficiency in advance of the resolution timeframe for standard and expedited appeal resolutions.

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

5. The BHO may extend the resolution time frame by up to fourteen (14) additional calendar days if the Member requests

the extension, or the BHO shows (to the satisfaction of DHS, upon its request for review) that there is need for additional information and how the delay shall be in the Member's best interest. For any extension not requested by a Member, the BHO shall give the Member written notice of the reason for the delay.

6. For any extension not requested by the Member, the BHO shall do the following:
    a. Give the Member written notice, within two (2) calendar days, of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with the decision;
    b. Make reasonable efforts to give the Member prompt oral notice of the delay, and
    c. Resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires.

7. The BHO shall provide written notice of the resolution of the appeals process in a format and language that, at a minimum meets applicable notification standards. The BHO shall include the following in the written notice of the resolution:
    a. The results of the appeal process and the date it was completed; and
    b. For appeals not resolved wholly in favor of the Member:
        1) The right to request a State administrative hearing with the Administrative Appeals Office (AAO), and

clear instructions about how to access this process;

2) The right to request and receive benefits while the hearing is pending, and how to make the request; and
3) A statement that the Member may be held liable for the cost of those benefits if the hearing decision is not in the Member's favor.

8. The BHO shall notify the Member, provider or other authorized representative in writing within thirty (30) calendar days of the resolution.

H) Expedited Appeal Process

1. The BHO shall establish and maintain an expedited review process for appeals. The Member, his or her provider or other authorized representative acting on behalf of the Member with the Member's written authorization may file an expedited appeal either orally or in writing. No additional follow-up shall be required. An expedited appeal is only appropriate when the BHO determines (based on a request from the Member) or the provider indicates (in making the request on the Member's behalf) that taking the time for a standard resolution could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

2. The BHO shall ensure that punitive action is not taken against a provider who requests an expedited resolution or who supports a Member's appeal.

3. The BHO shall inform Members of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments in the case of an expedited appeal resolution. The BHO shall inform Members of this sufficiently in advance of the resolution timeframe for appeals.

4. For expedited resolution of an appeal, the BHO shall resolve the appeal and provide written notice to the affected parties as expeditiously as the Member's health condition requires, but no more than seventy-two (72) hours from the time the BHO received the expedited appeal request. The BHO shall make reasonable efforts to also provide oral notice to the Member with the appeal determination.

5. The BHO shall include the following in the written notice of the resolution:
    a. The results of the appeal process and the date it was completed; and
    b. For appeals not resolved wholly in favor of the Member:
        1) The right to request a State administrative hearing as described in Section 9.8, and clear instructions about how to access this process;
        2) The right to request an expedited State administrative hearing;

3) The right to request to receive benefits while the hearing is pending, and how to make the request; and
4) A statement that the Member may be held liable for the cost of those benefits if the hearing decision upholds the BHO's adverse benefit determination.

6. The BHO may extend the expedited appeal resolution time frame by up to fourteen (14) additional calendar days if the Member requests the extension or the BHO needs additional information and demonstrates to DHS how the delay shall be in the Member's best interest. For any extension not requested by the Member or if the BHO denies a request for expedited resolution of an appeal, it shall:
    a. Transfer the appeal to the timeframe for standard resolution;
    b. Make reasonable efforts to give the Member prompt oral notice of the delay;
    c. Within two (2) calendar days give the Member written notice of the reason for the decision to extend the timeframe or deny a request for expedited resolution of an appeal. Follow-up within two (2) calendar days with written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with the decision;
    d. Inform the Member orally and in writing that they may file a grievance with the BHO for the delay of the

expedited process, if he or she disagrees with that decision; and

e. Resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires.

7. The BHO shall notify DHS within twenty-four (24) hours, regarding expedited appeals if an expedited appeal has been granted by the BHO or if an expedited appeal time frame has been requested by the Member or the provider. The BHO shall provide the reason it is requesting a fourteen additional (14) day extension to DHS. The BHO shall notify DHS within twenty-four (24) hours (or sooner if possible) from the time the expedited appeal is upheld. DHS shall provide information on the method of notification to DHS.

8. The BHO shall provide the Member a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. The BHO shall inform the Member of limited time available to present this information.

I) State Administrative Hearing for Regular Appeals

1. If the Member is not satisfied with the BHO's resolution of their appeal, he or she may request for an administrative hearing within thirty (30) calendar days of the receipt of the notice of disposition (denial). When the BHO denies the Member's appeal, the BHO shall also inform the Member, the Member's provider or other authorized representative, or the legal

representative of a deceased Member's estate that he or she may request for an administrative hearing by submitting a letter to the Administrative Appeals Office (AAO) within thirty (30) calendar days from the receipt of the BHO's denial of the Member's appeal.

2. The administrative hearing shall be in accordance with HAR Chapter 17-1703.1, and 42 CFR §§431.220 431.244, and based on the following issues:
    a. Member's claim for services is denied or is not acted upon with reasonable promptness;
    b. Member believes the BHO has taken an action erroneously;
    c. Member believes a skilled nursing facility or nursing facility has erroneously determined that he or she shall be transferred or discharged; or
    d. Member believes DHS has made an erroneous determination with regards to the preadmission and annual resident review requirement of Section 1919(e)(7) of the Social Security Act.

3. Hearing decisions shall be based exclusively on evidence introduced at the hearing. The record shall consist only of:
    a. The transcript or recording of testimony and exhibits, or an official report containing the substance of what happened at the hearing;
    b. All papers and requests filed in the proceeding; and
    c. The recommendation or decision of the hearing officer.

4. The BHO shall provide the following address to the Members:

State of Hawaii Department of Human Services
Administrative Appeals Office
PO Box 339
Honolulu, HI 96809-0339

5. DHS shall reach its decision within ninety (90) calendar days of the date the Member filed the request for an administrative hearing with the State. The disposition of the appeal at the State administrative hearing level shall be final.

J) Expedited State Administrative Hearings

1. The Member may file for an expedited State administrative hearing only when the Member requested for or the BHO has provided an expedited appeal and the action of the appeal was determined to be adverse to the Member (Action Denied). The Member may file for an expedited State administrative hearing process by submitting a letter to the Administrative Appeals Office (AAO) within thirty (30) calendar days from the receipt of the Member's appeal determination.

2. The BHO shall provide the following address to the Members:

State of Hawaii Department of Human Services
Administrative Appeals Office
PO Box 339
Honolulu, HI 96809-0339

3. An expedited State administrative hearing shall be heard and determined within seventy-two (72) hours after the date the Member filed the request for an expedited State administrative hearing with no opportunity for extension on behalf of the State. The BHO shall collaborate with DHS to ensure that the best results are provided for the Member and to ensure that the procedures comply with state and federal regulations.

4. In the event of an expedited State administrative hearing the BHO shall submit information that was used to make the determination, (e.g. medical records, written documents to and from the Member, provider notes, etc.). The BHO shall submit this information to DHS within twenty-four (24) hours of the decision denying the expedited appeal.

K) Continuation of Benefits During an Appeal or State Administrative Hearing

1. The BHO shall continue to provide the Member's benefits if the following conditions have been met:
    a. The Member files the request for an appeal within sixty (60) calendar days following the date of the adverse benefit determination notice;
    b. The Member timely files for continuation of benefits;
    c. The appeal or request for an administrative hearing is filed in a timely manner, meaning on or before the later of the following:

1) Within ten (10) calendar days of the BHO mailing the notice of adverse benefit determination; or
2) The intended effective date of the BHO's proposed adverse benefit determination.

d. The appeal or request for State administrative hearing involves the termination, suspension, or reduction of previously authorized services;
e. The services were ordered by an authorized provider; and
f. The original authorization period has not expired.

2. If the BHO continues or reinstates the Member's benefits while the appeal or administrative hearing is pending, the BHO shall continue all benefits until one of the following occurs:
   a. The Member withdraws the appeal or request for an administrative hearing;
   b. The Member does not request for an administrative hearing and continuation of benefits within ten (10) calendar days from when the BHO mails a notice of an adverse benefit determination; or
   c. An administrative hearing decision unfavorable to the Member is made.

3. If the final resolution of the appeal or administrative hearing is adverse to the Member, that is, upholds the BHO's adverse benefit determination, the BHO may, consistent with the DHS' policy on recoveries and as specified in the BHO's contract recover the cost of services furnished to the Member while the appeal and administrative hearing were pending, to the extent

that they were furnished solely because of the requirements of this Section.

4. If the BHO or the AAO reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the BHO shall authorize or provide these disputed services promptly, and as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours from the date it receives notice of the disposition if the services were not provided while the appeal or administrative hearing was pending and if the BHO or the AAO reverses a decision to deny, limit, or delay services.

5. If the BHO or the AAO reverses a decision to deny authorization of services, and the Member received the disputed services while the appeal or administrative hearing was pending, the BHO shall pay for those services, unless State policy and regulations provide for DHS to cover the cost of such services.

L) Notice of Adverse Benefit Determination

1. The BHO shall give the Member and the referring provider a written notice of an adverse benefit determination within the timeframes specified below. The notice to the Member or provider shall include the following information:
    a. The adverse benefit determination the BHO has made or intends to make;

b. The reason for the adverse benefit determination, including the right of the Member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Member's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits;
c. The Member's or provider's right to an appeal with the BHO;
d. The Member's or provider's right to request an appeal of the BHO's adverse benefit determination, including information on exhausting the BHO's one level of appeal and the right to request a State fair hearing after receiving notice the adverse benefit determination is upheld;
e. Procedures for filing an appeal with the BHO;
f. Allow Members to file appeals, grievances, and State fair hearing requests after receiving notice that an adverse benefit determination is upheld;
g. Member may represent himself or use legal counsel or an authorized representative;
h. The circumstances under which an appeal process can be expedited and how to request for it;
i. The Member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with DHS policy, under which the Member may be required to pay the costs of these services; and

j. The circumstances under which a hearing will be granted when action is based upon change in federal or state law, as applicable.

2. The notice of adverse benefit determination to the Member shall be written pursuant to the requirements in Section 9.8.L of this RFP.

3. The BHO shall mail the notice within the following time frames:
    a. For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) calendar days prior to the date the adverse benefit determination is to start except:
        1) By the date the adverse benefit determination is to start (date of action), for the following reasons:
            a) The BHO has factual information confirming the death of a Member;
            b) The BHO receives a clear written statement signed by the Member that he or she no longer wishes services or gives information that requires termination or reduction of services and indicates that he or she understands that this shall be the result of supplying that information;
            c) The Member has been admitted to an institution that makes him or her ineligible for further services;

d) The Member's address is unknown, and the post office returns BHO mail directed to the Member indicating no forwarding address;
e) The Member has been accepted for Medicaid services by another local jurisdiction;
f) The Member's provider prescribes a change in the level of behavioral health care;
g) There has been an adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989; or
h) In the case of adverse actions for nursing facility transfers, the safety or health of individuals in the facility would be endangered, the Member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the Member's urgent medical needs, or the Member has not resided in the nursing facility for thirty (30) calendar days;
i) The period of advanced notice is shortened to five (5) calendar days if there is alleged fraud by the Member and the facts have been verified, if possible, through secondary sources;

b. For denial of payment: at the time of any action affecting the claim;

c. For standard service authorization decisions that deny or limit services: as expeditiously as the Member's health condition requires, but not more than fourteen (14) calendar days for standard authorization decisions that deny or limit services following receipt of request for service, with a possible extension of up to fourteen (14) additional calendar days (total time frame allowed with extension is twenty-eight (28) calendar days from the date of the request for services) if: (1) the Member or provider requests an extension; or (2) the BHO justifies a need for additional information and how the extension is in the Member's best interest. If the BHO extends the time frame, it shall: (1) give the Member written notice of the reason for the decision to extend the time frame and inform the Member of the right to file a grievance if he or she disagrees with that decision to extend the time frame; and (2) issue and carry out its determination as expeditiously as the Member's health condition requires but no later than the date the extension expires;

d. For expedited authorization decisions: as expeditiously as the Member's health condition requires but no later than seventy-two (72) hours after receipt of the request for service. The BHO may extend the seventy-two (72) hour timeframe by up to an additional fourteen (14) calendar days if the Member requests an extension, or if the BHO justifies to DHS a need for additional information and how the extension is in the Member's best interest; and

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

4. If the BHO fails to adhere to notice and timing requirements, the Member is deemed to have exhausted the BHO's appeals process, and the Member may initial a State fair hearing.

9.9 Marketing and Advertising

A) General Information

1. Marketing is any communication from the BHO to any individual enrolled with a QI Health Plan who is not enrolled in the CCS program that can reasonably be interpreted as intended to influence the individual to enroll in the CCS program. Marketing materials are resources that are produced in any medium, by or on behalf of the BHO that can reasonably be interpreted as intended to market to potential CCS Members.

B) Allowable Activities

1. The BHO shall be permitted to perform the following marketing activities:
    a. Distributing general information through mass media (i.e., newspapers, magazines and other periodicals,

radio, television, the Internet, public transportation advertising, and other media outlets);

b. Distributing brochures and displaying posters at provider offices and clinics that inform patients that the clinic or provider is part of the BHO's provider network; and

c. Attending activities that benefit the entire community such as health fairs or other health education and promotion activities.

2. If the BHO performs an allowable activity, the BHO shall conduct these activities statewide.

3. All materials shall comply with the information requirements in 42 CFR § 438.10 and as detailed in Section 9.7.D of this RFP.

C) State Approval of Materials

1. All printed materials, advertisements, video presentations, and other information prepared by the BHO that pertain to or reference the programs or the BHO's program business shall be reviewed and approved by DHS before use and distribution by the BHO. In addition, the BHO shall submit to DHS any marketing materials it has received from a provider for review and prior approval. The BHO shall not advertise, distribute or provide any materials to its Members or to any potential Members of the CCS program that have not been approved by DHS.

2. The BHO shall not change any approved materials without the consent and approval of DHS.

SECTION 10 – Information Systems and Information Technology

10.1 DHS Responsibilities

A) Hawaii Prepaid Medicaid Management Information Systems (HPMMIS)

1. DHS operates the HPMMIS to effectively and efficiently administer the Medicaid managed care and fee-for-service programs. HPMMIS is an integrated Medicaid Management Information System that supports program administration. The major functional areas of HPMMIS include:
    a. Receiving daily eligibility files from KOLEA and processing enrollment of Members into, and disenrollment of Members from, the BHO based on established enrollment and disenrollment rules;
    b. Processing Member BHO choices submitted to DHS enrollment call center;
    c. Producing daily enrollment/disenrollment rosters, monthly enrollment rosters, and TPL rosters;
    d. Processing bi-monthly encounter submissions from the BHO and generating encounter error reports for BHO correction. Accepting and processing monthly BHO provider network submissions to assign Medicaid provider IDs for BHO use. Errors associated with these submissions are generated and returned to the BHO on a monthly basis for correction;
    e. Processing additional reports submitted by the BHO;

f. Monitoring the access and utilization of services provided to the Members by the BHO and the activities or movement of the Members within and between the BHO;
g. Monitoring the activities of the BHO through information and data received from the BHO and generating management reports;
h. Evaluating BHO quality and performance through a variety of metrics and analyses;
i. Calculating capitation rates and adjustments;
j. Determining the amount due to the BHO for the monthly capitated rate for enrolled Members;
k. Producing a monthly provider master registry file for the BHO to use for tracking the assignment of Medicaid provider IDs, provider types, and allowable categories of services by DHS; and monitoring provider approvals by DHS for the purpose of ensuring that providers render services in accordance with the approvals they have received from DHS, and in preparing and submitting encounter files to DHS;
l. Generating required CMS reports and submitting data to other entities as permitted and necessary; and
m. Generating management information reports.

2. Receiving/transmitting of data files between the BHO and HPMMIS is done via the DHS Secure File Transfer Protocol (SFTP) service. The SFTP service allows DHS and the BHO to securely transfer Member, provider, and encounter data via the internet.

3. In addition, DHS processes Hawaii's Medicaid fee-for-service payments utilizing HPMMIS through its fiscal agent.

10.2 BHO Responsibilities

A) General Requirements

1. The BHO shall have information management systems that enable it to meet DHS requirements, state and federal reporting requirements, all other contract requirements, and any other applicable state and federal laws, rules and regulations, including the Health Insurance Portability and Accountability Act (HIPAA). The BHO is responsible for adopting national standards and code sets, and up-to-date protocols and formats for encounter data submission, validation, and adjudication.

2. The BHO shall maintain a written manual of its claims adjudication protocol and submit to DHS for review and approval as requested; the BHO shall routinely review its claims processing protocols and update the protocols and manual as needed. The BHO shall notify DHS of updates and revisions to its claims processing protocols at least thirty (30) days prior to implementation of the updates or revisions.

3. The BHO shall have a system or systems that collect, analyze, integrate, and report data and achieve the objectives of 42 CFR § 438.242. The system or systems shall provide information on areas including, but not limited to,

utilization, claims, grievances and appeals, and disenrollment's for other than loss of Medicaid eligibility.

B) Specific Requirements

1. The BHO shall have a system or systems able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by DHS to meet the requirements of Section 1903(r)(1)(F) of the Social Security Act.

2. The BHO shall have a system or systems able to collect data on Member and provider characteristics as specified by DHS, and on all services furnished to Members through an encounter data system or other methods as may be specified by DHS.

3. The BHO shall have a system or systems that will ensure that data received from providers is accurate and complete by:
    a. Verifying the accuracy and timeliness of reported data, including data from network providers the BHO is compensating on the basis of capitation payments;
    b. Screening the data for completeness, logic, and consistency. As specified by DHS, the BHO shall align its screening process and reference tables with DHS to streamline encounter data processing; and
    c. Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for

DHS Medicaid quality improvement and care coordination efforts.

4. The BHO shall make all collected data available to DHS, and upon request, to CMS.

5. The BHO shall implement, by the compliance date identified in the CMS Interoperability and Patient Access final rule, a Fast Healthcare Interoperability Resources (FHIR)-based Application Programming Interface (API) to support Medicaid beneficiaries as specified in 42 CFR § 431.60 that permits third-party applications to retrieve, with the approval and at the direction of a current beneficiary or the beneficiary's personal representative, data specified below through the use of common technologies (e.g. via a smartphone) and without special effort from the beneficiary.

    a. The API shall conform to all technical, documentation, and data access standards and requirements specified or referenced within 42 CFR § 431.60(c)-(g).

    b. The information shall also be accessible to its current beneficiaries or the beneficiary's personal representative through the API, and include:
        1) All encounter data on the beneficiary, including encounter data from any network providers the BHO is compensating on the basis of capitation payments and adjudicated claims and encounter data from any subcontractors;

2) Encounters from providers compensated on the basis of capitation payments posted no later than one (1) business day after receiving the data from providers;
3) Data concerning claims data for payment decisions that may be appealed, were appealed, or are in the process of appeal, and provider remittances and beneficiary cost-sharing pertaining to such claims, no later than one (1) business day after a claim is processed;
4) Clinical data, including laboratory results, if the BHO maintains any such data, no later than one (1) business day after the data is received by the BHO; and
5) Information about covered outpatient drugs and updates to such information, including, where applicable, preferred drug list information, no later than one (1) business day after the effective date of any such information or updates to such information.

c. As feasible, the BHO shall develop this functionality to also include information on beneficiary care gap data available to the BHO, no later than one (1) business day after the effective date of any such information or updates to such information.

d. Data transmitted via the API shall also be made available in a DHS-specified format to DHS.

6. The BHO shall implement, by the compliance date identified in the CMS Interoperability and Patient Access final rule, and maintain a FHIR-based API that provides a complete and accurate directory of the BHO's provider directory information specified in 1902(a)(83) of the Social Security Act, as specified in 42 CFR § 431.70.

    a. The directory shall conform to all technical requirements specified in 42 CFR § 431.60(c), excluding the security protocols related to user authentication and authorization and any other protocols that restrict the availability of this information to particular persons or organizations; and the documentation requirements in 42 CFR § 431.60(d).

    b. The directory shall be updated no later than 30 calendar days after the BHO receives provider directory information or updates to provider directory information.

    c. The directory shall be accessible via a public-facing digital endpoint on the BHO's website.

    d. The directory shall include all information specified in 42 CFR § 438.10(h)(1) and (2).

7. The BHO shall ensure the following regarding Member encounter data:

a. Collection and maintenance of Member encounter data to identify the provider who delivers any item(s) or service(s) to Members, including any additional information required by DHS;
b. Submission of Member encounter data to DHS at a frequency, level of detail, and formats specified in Section 6.11 and in the HPMMIS Manual, based on program administration, oversight, and program integrity needs; and
c. Submission of all Member encounter data that DHS is required to report to CMS under 42 CFR § 438.818.

8. DHS shall review and validate the encounter data collected, maintained, and submitted to DHS by the BHO for completeness and accuracy of the representation of services provided to Members under the contract between DHS and the BHO. All encounter data requirements specified in Section 6.11 and the HPMMIS Manual are subject to verification and validation.

9. Per 42 CFR §438.62, the BHO's transition of care policy shall include an electronic data exchange process to ensure continued access to services during transitions between the BHO and QI Health Plans when a Member, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization. As specified in 42 CFR § 438.62(b)(1)(vi), the BHO shall implement, by the compliance date identified in the CMS Interoperability and Patient Access final rule, a process for

the electronic Payer-to-Payer Data Exchange of, at a minimum, the data classes and elements included in the United States Core Data for Interoperability (USCDI) content standard adopted at 45 CFR § 170.213, including the following requirements:

a. The BHO shall develop mechanisms to both send and receive data from QI Health Plans, including DHS;
b. Information received by the BHO shall be incorporated into the BHO's records about the current Member;
c. With the approval and at the direction of a current or former Member or the Member's personal representative, the BHO shall receive all such data for a current Member from any other payer that has provided coverage to the Member within the preceding 5 years, including non-Medicaid Plans and out-of-state Health Plans;
d. At any time, the Member is currently enrolled in the BHO, and up to 5 years after disenrollment, send all such data to any other payer that currently covers the Member or a payer the Member or the Member's personal representative specifically requests receive the data;
e. Send data received from another payor in the electronic form and format it was received;
f. The BHO shall develop this functionality in a manner that additionally facilitates data exchange with the CCS Plan for CCS beneficiaries;
g. As feasible, the BHO shall also develop this functionality in a manner that would facilitate data

exchange to support healthcare coordination in the future with non-Health Plans including, but not limited to, DOH for beneficiaries receiving direct services from various DOH programs; providers, care teams, and hospitals; and health homes, when implemented; and

h. To support enhanced functionality, the BHO is encouraged to develop this functionality to enable closed-loop, bi-directional referrals of services from the BHO to the provider, and between providers in the community.

10. The BHO shall comply with provisions of Section 4004 of the Cures Act (42 U.S.C. 300jj-52) and not charge beneficiaries for access to the Patient Access API specified in Section 10.2.B.5, or the Provider Directory API specified in Section 10.2.B.6.

11. The BHO shall support any additional requirements implemented by DHS that will be needed for DHS to comply with the CMS Interoperability and Patient Access final rule that requires DHS to exchange certain data with CMS daily on beneficiaries who are dually eligible for Medicaid and Medicare.

12. In addition to the required health information exchange functionality specified in Section 10.2.B.9, the BHO shall participate in and support the state-designated health information exchange entity to the extent feasible.

C) Expected Functionality

1. The BHO shall have information systems and supports that, at a minimum, facilitate and integrate the following essential BHO health coordination functions:
    a. predictive analytics to support identification of Members who are likely to benefit from special program services including but not limited to SHCN, EHCN, CIS, LTSS, and SDOH supports;
    b. administration of and collection of data on various Member health status screeners and assessments and data to support quality reporting;
    c. documentation and sharing of Member's assessment, health action plan(s) in a concise, understandable, and printable or electronic format;
    d. coordination and oversight of the data elements to support the delivery of optimal health services;
    e. provision of essential and actionable health information on Members and patient panels to providers and service coordinators in the community to facilitate care, and to DHS as requested;
    f. support the expansion of telehealth to enhance care and service delivery;
    g. collection and analysis of data on the health and service utilization of the beneficiary population, including but not limited to the adoption of interoperable data exchange protocols with State public health registries, such as the immunization registry;

h. collection, analysis, and reporting of provider-level data to support a variety of quality, value-based purchasing, and other efforts;
i. collection, analysis, and reporting of Member attribution information, where relevant, to contextualize differences in health outcomes; and
j. collection, analysis, and reporting, at the member-level, of encounter data, and additional data that extend beyond encounter submissions to support contextualization and evaluation of various DHS programs and services.

2. The BHO shall adhere to all reporting requirements, including those that extend beyond the required information systems functionality described herein.

3. The BHO shall have a system or systems capable of adapting to DHS formats and sharing information electronically with DHS, service providers in the community, and with QI Health Plans, that are readily accessible yet secured to enable the efficient execution of the aforementioned functions.

D) Method of Data Exchange with DHS

1. The DHS SFTP service is the primary but not the only mechanism for file transfers between DHS and trading partners, including the BHO. Technical specifications and instructions are provided in the HPMMIS Manual available on the Med-QUEST web site. The SFTP service allows DHS and

the BHO to securely transfer electronic Member, provider, and encounter data.

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

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

F) Audits of BHO Information Technology

1. The BHO shall institute processes to ensure the validity and completeness of the data submitted to DHS. DHS or its contractors may conduct general data validity and completeness audits using industry standard sampling techniques.

2. DHS may additionally request information from the BHO on its health systems, including but not limited to, system configuration, data verification and validation processes, and processes used to prepare and submit encounters and data in other reports to DHS.

3. DHS reserves the right to have access to the BHO's system at any time.

G) Disaster Planning and Recovery Operations

1. The BHO shall have in place disaster planning and recovery operations that is consistent with the IT Disaster Recovery Plan on Ready.gov and comply with all applicable federal and state laws relating to security and recovery of confidential information and electronic data.

2. The BHO shall submit documentation of its disaster planning and recovery operations for DHS review in accordance with Section 13.3.B.

H) Information Systems and Information Technology Compliance

1. The BHO is expected to meet all requirements specified in Section 10.2.B prior to the start of the contract, or as applicable, by the compliance date identified in the CMS Interoperability and Patient Access final rule.

2. The BHO is not expected to have met the minimum functionality expectations in Section 10.2.C fully prior to the execution of the contract, but is required to provide DHS with a description of what functionality requirements it has met, and an anticipated timeline of when it will meet full compliance with all expected functionality, during Readiness Review (Section 13.3.B). The BHO is expected to have fully met the minimum functionality expectations of Section 10.2.C by Year 2 of the contract. DHS may exempt specific functionality requirements on a case-by-case basis.

SECTION 11 – BHO Personnel

11.1 General Requirements

A) The BHO shall have in place the organizational, management, and administrative arrangements, procedures and systems capable of fulfilling all contractual requirements of this RFP.

B) The BHO shall also have in place the organizational, management, and administrative arrangements, procedures and systems, pursuant to 42 CFR § 438.608.

C) For purposes of this contract, the BHO shall not knowingly have an employment or contractual relationship or affiliation of the types addressed in 42 CFR § 438.610, involving any individual, affiliate or entity that:

1. is debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, pursuant to 42 CFR § 438.610(a)(1);
2. is excluded from participation in any Federal health care program under Section 1128 or 1128A of the Social Security Act, pursuant to 42 CFR §438.610(b);
3. has been debarred, suspended or otherwise lawfully prohibited from participating in non-procurement activities under HRS § 103D-702;

4. has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, Title XX Services Programs or Title XXI Program in the last 10 years; or
5. has been excluded through Federal databases including, but not limited to, List of Excluded Individuals/Entities (LEIE), System for Award Management (SAM), or any such databases.

D) The BHO shall not have a contract for the administration, management, or provision of medical services (or the establishment of policies or provision of operational support for such services), either directly or indirectly, with an individual convicted of crimes described in Section 1128(b)(8)(B) of the Social Security Act.

E) The BHO is responsible for operating its BHO in the State of Hawaii. The BHO shall be solely responsible for any additional charges associated with on-site audits or other oversight activities that result when required systems and operations are located outside of the State of Hawaii.

11.2 Staffing Requirements

A) Staffing Table

1. The following table (CCS Staffing Table) contains a list of mandated CCS staff and requirements regarding each staff position.

Table 11.2.A-1 CCS Staffing Table

	Mandated CCS Staff	Requirements			
	Position	**FTE or # of Positions**	**HI**	**Resume**	**Change Notification**
1	**After-Hours Staff**	Adequate to meet Contract requirements	✓		
2	BHO Staff (not contracted): **BHO Psychiatrist**	0.5	✓	✓	✓
3	BHO Staff (not contracted): **BHO Case Management Coordinator**	1.0	✓	✓	✓
4	BHO Staff (not contracted): **BHO Registered Nurse**	1.0	✓	✓	✓
5	**Case Management Staff**	Adequate to meet Contract requirements	✓		
6	**CIS Coordinator**	1.0	✓	✓	✓
7	**Compliance Officer**	1.0	✓	✓	✓
8	**Executive Director**	1.0	✓	✓	✓
9	**Financial Officer**	Adequate to meet Contract requirements	✓		
10	**Grievance Coordinator**	0.5	✓	✓	✓
11	**Information System Staff**	Adequate to meet Contract requirements			
12	**Medical Director**	0.5	✓	✓	✓
13	**Member Relations Staff**	Adequate to meet	✓		

	Mandated CCS Staff	Requirements			
		Contract requirements			
14	**Pharmacist**	0.5	✓	✓	✓
15	**Provider Relations Staff**	Adequate to meet Contract requirements	✓		
16	**QA/UR Coordinator**	0.5	✓	✓	✓
17	**Support Service Staff**	Adequate to meet Contract requirements	✓		

B) Full-Time Equivalent (FTE) Requirement

1. Some positions have an FTE requirement. An FTE is a measure of full-time work. Full-time work is employment for at least thirty-five (35) hours per week. For a position with an FTE requirement, the FTE indicates the minimum amount of full-time work that shall be dedicated to, and performed for, that particular position by one person, in order to meet its staffing requirement for purposes of this RFP.

2. Except as otherwise noted, a specific FTE or number of positions, is not required. For each position having an FTE requirement, the BHO shall submit to DHS, the FTE that each individual serving in said position, is assigned to perform work only toward that position as it relates to the CCS program. This information shall be included in the Staffing Plan (discussed below), and in staffing change notifications (discussed below) submitted to DHS.

3. The BHO shall ensure that adequate staff is available and assigned to appropriate areas to fulfill the required functions specified in this contract. The BHO shall increase staffing in specific areas if determined by DHS that contractual requirements are not being met.

C) State of Hawaii – Location of Residence and Work

1. Positions with a checkmark in the "HI" column, shall be filled by individuals residing and working in the State of Hawaii. The BHO shall submit to DHS, whether each individual serving in any such position, resides and works in the State of Hawaii. This information shall be included in the Staffing Plan (discussed below), and in staffing change notifications (discussed below) submitted to DHS.

D) Resumes

1. For positions with a checkmark in the "Resume" column, the BHO shall submit to DHS, a current resume of each individual serving in any such position. Resumes shall be submitted to DHS as part of the Staffing Plan (discussed below), and with staffing change notifications (discussed below).

E) Professional References

1. Upon request, the BHO shall submit to DHS three (3) professional references for an individual. Each professional reference shall include the first name, last name, job title, company, phone number and email address. Such references shall be from the current (if any) and most recent previous employers.

F) Staffing Change Notification

1. For positions with a checkmark in the "Change Notification" column, the BHO shall notify DHS in writing, within seven (7) days of learning of a change in the status of such positions. The submission to DHS of a completed Staffing Change Notification Form with all required attachments, will serve as written notification to DHS. If a position remains vacant at the time the written notification is submitted to DHS, the BHO shall provide the name, position title, and contact information of the interim employee within the written notification. As soon as the vacancy is filled, the BHO shall provide written notification to DHS of such staffing change, including the name of the individual filling the vacancy and other related information. Upon request by DHS, the BHO shall provide a written plan for filling the vacant position, including expected timelines.

2. The Staffing Change Notification Form, the Staffing Change Notification Form Instructions, and the Staffing Change

Notification Form Sample, are included as part of this RFP as Appendix K.

G) Job Descriptions

1. Upon request, the BHO shall submit a job description for positions listed in the CCS Staffing Table, to DHS for review. The job description shall include the function, duties, and responsibilities of the position. The job description shall also include the minimum education, experience, and other position qualifications required.

H) Staffing Plan and Training Plan

1. Overview

    a. The BHO shall ensure that all staff have the necessary qualifications (i.e., education, skills, experience, and licenses) to fulfill position requirements and duties. The BHO shall conduct initial and ongoing training of its staff to ensure the staff is knowledgeable, capable, and prepared to perform work to quality standards, and fulfill the obligations of this contract.

    b. A complete and up-to-date Staffing Plan, and a Training Plan, shall be submitted to DHS for Readiness Review (see Section 13.3.B).

2. Staffing Plan

a. The Staffing Plan shall provide the BHO's staffing for the CCS line of business, and all other staffing information necessary to demonstrate compliance with this Section and Section 12 of this RFP. It shall include a table that matches each required CCS RFP position to the corresponding BHO position that meets the CCS RFP staffing requirement. The table shall provide: the names, titles, and contact information of all individuals serving in each required position with a checkmark in the "Change Notification" column; the FTE each individual will serve in the position held (if applicable); whether each individual resides and works in the State of Hawaii (if applicable); and a total FTE for each mandated staff category (for example, "6.0 FTE total" for the mandated "Support Service Staff" category).

b. All resumes (if applicable) shall be submitted as part of the Staffing Plan. However, the resumes may be provided as attachments to the Staffing Plan table described above.

3. Training Plan

a. The Training Plan shall include a description of the BHO's systems and procedures to ensure employees are appropriately trained and informed to perform job duties, and the processes in place

that will assure rapid responsiveness to effect change for contract compliance.

11.3 Position Descriptions

A) The following position descriptions provide basic and minimum requirements. The BHO shall ensure that all CCS staff are appropriately and adequately qualified, experienced, and able to execute and meet the administrative and service requirements of this RFP. DHS reserves the right to amend required CCS staff and position descriptions, in the best interests of the CCS program and Members.

1. **After-Hours Staff:**
   The After-Hours Staff shall be responsible to respond to crisis calls in-person if crises cannot be resolved via telephone support. This requirement is an expansion of the same service provided during normal operating hours. If the BHO does not have in place BHO staff to meet the requirement, the BHO shall develop an alternative plan on how crisis support will be provided. Such alternative plan shall be submitted to, and approved by, DHS.

2. **BHO Psychiatrist** (BHO Staff (not contracted))**:**
   The BHO Psychiatrist shall be separate from the Medical Director, reside in the State of Hawaii, and be employed at least 0.5 FTE.

3. **BHO Case Management Coordinator** (BHO Staff (not contracted))**:**

The BHO Case Management Coordinator shall be responsible for supervising the Case Management Staff and ensuring services are provided. The BHO Case Management Coordinator shall be employed at 1.0 FTE and reside in the State of Hawaii.

4. **BHO Registered Nurse** (BHO Staff (not contracted))**:**
   The BHO Registered Nurse shall be separate from the QA/UR Coordinator, licensed in the State of Hawaii, and employed at 1.0 FTE. Also, the BHO Registered Nurse shall be responsible for clinical duties including, but not limited to, the following:
   a. Medication administration and education;
   b. Providing education and clinical care for medical conditions (hypertension, diabetic care, dressing changes, etc.); and
   c. Assisting psychiatrist (calling in prescriptions, etc.).

5. **Case Management Staff:**
   The Case Management Staff shall ensure timely access to medically necessary services and assist Members in understanding and following individual treatment plans.

6. **CIS Coordinator:**
   The CIS Coordinator shall ensure that eligible Members are provided the CIS benefits and assistance needed to secure and maintain permanent housing, be employed at 1.0 FTE, and reside in the State of Hawaii.

7. **Compliance Officer:**

   The Compliance Officer shall reside in the State of Hawaii, be employed at 1.0 FTE, and be responsible for all compliance and detection activities related to fraud, waste, and abuse.

8. **Executive Director:**

   The Executive Director shall serve as the BHO's key contact, be employed at 1.0 FTE, and reside in the State of Hawaii.

9. **Financial Officer:**

   The Financial Officer shall reside in the State of Hawaii, and be responsible for all accounting and finance operations, including all audits related to Fraud, Waste and Abuse, and value-based payment arrangements.

10. **Grievance Coordinator:**

    The Grievance Coordinator shall reside in the State of Hawaii, be employed at least 0.5 FTE, and investigate Member complaints.

11. **Information System Staff:**

    The Information System Staff shall ensure the timely and accurate submission of encounter data and other required information and reports, including ad hoc reports as requested by DHS.

12. **Medical Director:**

    The Medical Director shall be employed or contracted at least 0.5 FTE. The Medical Director shall reside and be licensed to

practice medicine with a specialty in psychiatry, in the State of Hawaii. The Medical Director shall oversee the quality of behavioral healthcare furnished by the BHO and ensure care is provided by qualified personnel. The Medical Director shall address any potential quality of care problems and direct the BHO's quality programs. The Medical Director shall not be employed by any community case management provider. The Medical Director shall work closely with the MQD Medical Director when applicable, and participate in any committees when requested by DHS.

13. Member Relations Staff:

The Member Relations Staff shall reside in the State of Hawaii, and be responsible for responding to, and answering questions regarding, Member complaints. The Member Relations Staff shall also address Member needs and assist in coordinating services.

14. Pharmacist:

The Pharmacist shall be employed at least 0.5 FTE, reside in the State of Hawaii, and address pharmacy needs of Members.

15. Provider Relations Staff:

The Provider Relations Staff shall reside in the State of Hawaii, and be responsible for responding to, and answering questions regarding, provider complaints. The Provider Relations Staff shall also ensure that Members have access

to behavioral health providers and monitor subcontractor services.

16. **QA/UR Coordinator:**

    The QA/UR Coordinator shall be employed at least 0.5 FTE, be a licensed R.N. in the State of Hawaii, and reside in the State of Hawaii.

17. **Support Service Staff:**

    The Support Service Staff shall ensure timely and accurate processing of reports and coverage of the toll-free telephone hotline.

SECTION 12 – Program Integrity

12.1 Fraud, Waste and Abuse

A) Administrative Requirements

1. Pursuant to 42 CFR Part 455 (Program Integrity: Medicaid) and 42 CFR § 438 Subpart H (Additional Program Integrity Safeguards), the BHO and Subcontractors, to the extent that the Subcontractor can be delegated responsibilities, shall have a program integrity program, including a mandatory compliance plan designed to guard against Fraud, Waste, and Abuse (FWA). The BHO's FWA activities shall comply with the program integrity requirements outlined in 42 CFR § 438.608. This program shall include internal controls, policies, procedures, and standards of conduct for the prevention, detection, reporting, and corrective action for known or suspected cases of FWA in the administration and delivery of services under this Contract.

2. The BHO shall have a Compliance Officer, who is responsible for the compliance program required under 42 CFR § 438.608. This includes compliance with sufficient staffing in accordance with Section 11, and resources to identify and investigate unusual incidents and develop and implement Corrective Action Plans to assist the BHO in preventing and detecting potential FWA activities.

3. The BHO shall include a Compliance Committee at the senior management level. The committee shall be responsible for overseeing the organization's compliance program and its compliance with the requirements under the Contract.

4. To facilitate cooperation with the State, the BHO shall establish and maintain a special investigative unit (SIU), either in-house or by contract with another entity, to investigate possible acts of FWA for all services provided under the Contract, including those services provided by Subcontractors.

5. The BHO Compliance Officer, BHO SIU and applicable Subcontractors shall work with DHS, the Medicaid Fraud Control Unit (MFCU), the Office of the Inspector General (OIG), the Centers for Medicare and Medicaid Services (CMS), and any other law enforcement agencies to administer effective FWA practices and participate in any subsequent legal actions.

6. The BHO shall take part in coordination activities within the State to maximize resources for FWA issues.

7. BHO cooperation shall include access to the BHO’s place of business during normal business hours and provision of requested information, including financial records, medical records, claims, and internal reports of actions taken, such as investigative, corrective, and legal actions.

8. The BHO shall also provide access to BHO employees and consultants for interviews, at no charge to DHS, including but not limited to, those with expertise in the administration of the program and/or medical or pharmaceutical matters, or those who are in any matter related to an investigation.

9. The BHO shall include Compliance Officer or designee and one secondary contact person for program integrity and investigation related material requests including but not limited to records, documents, data, media, or other information. Requests will be sent to the designated BHO contact person(s) in writing by e-mail, fax, or mail, and will provide the specifics of the information being requested.

10. The BHO shall respond to the appropriate DHS staff member within the timeframe designated in the request. If the BHO is unable to provide all of the requested information within the designated timeframe, the BHO may request an extension in writing (e-mail) to the DHS requestor no less than two (2) business days prior to the due date.

11. The BHO's response shall include data for all data fields as requested by DHS. The data shall be provided in the order and format requested. If any data field is left blank, an explanation shall accompany the response. The BHO shall not add or delete any additional data fields in its response. The BHO Compliance Officer and designated staff shall attend FWA training sessions as scheduled by the MFCU or DHS.

12. The MFCU or DHS will convene and facilitate monthly meetings regarding program integrity and FWA. The BHO shall participate in meetings with state Program Integrity, Investigations or Fraud Control personnel, the Department's Recovery Audit Contractor (RAC) and with other BHO compliance staff. Using a pre-defined template provided by DHS, the BHO shall prepare a written update on cases, audits, recoveries and trends; the BHO shall submit the completed template to the DHS program integrity staff three (3) business days prior to the monthly meeting. The BHO representatives shall participate in discussions and share BHO activities and findings with all meeting attendees.

13. The BHO shall be compliant with the following requirements as directed by DHS:
    a. Within fifteen (15) business days of receipt of information from DHS, on a questionable billing pattern or provider with questionable claims patterns, the BHO shall complete and submit an analysis of the provider's billing history related to the claims pattern. The analysis shall include, but is not limited to, the review time period, number of claims reviewed, number of claims with the specific claim pattern identified by DHS or the BHO, total dollars for reviewed claims and dollars identified for the specific claim pattern or allegation. The completed analysis shall be submitted to the Program Integrity representative designated by DHS; and

b. If DHS terminates a provider's participation in the Medicaid or CCS program, a written notice of the termination will be provided by DHS to the BHO. The BHO is required to terminate the provider from its respective provider network in compliance with the terms provided in the DHS written notice.

14. In addition to reporting requirements related to prompt and timely information on suspected FWA described in Section 12, the BHO shall provide compiled reports on FWA activities to DHS as described in Section 6.8.A.8. Information on FWA activities may be requested in a number of ways, and across multiple reports, including but not limited to: Suspensions, Terminations and Program Integrity Education Report; Fraud, Waste, and Abuse Report; and Overpayments Report, as described in Section 6.8.

B) Compliance Plan

1. The BHO shall have a written FWA compliance plan that shall include program goals and objectives, program scope, assignments, policies and procedures, and methodology in compliance with 42 CFR § 438.608.

2. At a minimum, the BHO's compliance plan shall:
   a. Designate a Compliance Officer who is accountable to the BHO's senior management and is responsible for ensuring policies to establish effective lines of communication between the Compliance Officer and

the BHO's staff, and between the Compliance Officer and DHS staff are followed;

b. Establish a Compliance Committee that meets quarterly and reviews FWA compliance issues;
c. Establish an organizational structure and personnel roles and responsibilities for preliminary investigation(s) of provider FWA.
d. Require the reporting of suspected and/or confirmed FWA be done as required in Section 6.8;
e. Submit timely BHO disclosures in accordance with Section 6.8;
f. Ensure notification to DHS requesting permission before initiating any form of adverse action, including but not limited to notifying a provider of the outcome of an investigation and/or recovering any overpayments identified;
g. Ensure that all of its officers, directors, managers and employees know and understand the provisions of the BHO's FWA compliance plan;
h. Have processes in place to monitor all providers and their officers/directors/agents/managing employees as described in Sections 8.1.A and 8.2;
i. Ensure and describe effective training and education for the Compliance Officer and the organization's employees, senior and mid-level management, and Subcontractors;
j. Ensure that providers and Members are educated about FWA identification and reporting, and include information in the provider and Member material;

k. Ensure the enforcement of standards through well-publicized disciplinary guidelines;
l. Ensure provision of internal monitoring and auditing of reported FWA violations, including specific methodologies, and provisions for prompt response to potential offenses, and for the development of Corrective Action initiatives relating to the BHO's FWA efforts;
m. Possess written policies, procedures and standards of conduct that articulate the organization's commitment to comply with all federal and state standards related to Medicaid Health Plans;
n. Ensure that no individual who reports BHO violations or suspected FWA is retaliated against;
o. Include a monitoring program that is designed to prevent and detect potential or suspected FWA. This monitoring program shall include but not be limited to:
    1) Monitoring the billings of its providers to ensure Members receive services for which the BHO is billed;
    2) Requiring the investigation of all reports of suspected fraud and over billings (upcoding, unbundling, billing for services furnished by others, and other overbilling practices);
    3) Reviewing providers for over-utilization or under-utilization;
    4) Verifying with Members the delivery of services as claimed; and

5) Reviewing and developing mechanisms to track consumer complaints on providers;

a) Ensure that all suspected instances of internal and external FWA relating to the provision of, and payment for, Medicaid services including, but not limited to, BHO employees/management, providers, subcontractors, vendors, are reported to DHS. Additionally, any final resolution reached by the BHO shall include a written statement that provides notice to the provider that the resolution in no way binds the State of Hawaii or the federal government nor precludes the State of Hawaii or the federal government from taking further action for the circumstances that brought rise to the matter; and

b) Ensure that the BHO shall cooperate fully in any investigation by federal and state oversight agencies and federal and state law enforcement agencies and any subsequent legal action that may result from such an investigation.

3. The BHO shall submit its compliance plan for DHS review in accordance with Section 13.3.B.

4. The BHO shall submit a written compliance plan to DHS for approval each year. The plan shall be submitted 90 days prior to the start of the State Fiscal Year. If the BHO has not made any changes to its plan from the previous year, it may notify DHS that:

a. No changes have been made to the previously approved compliance plan; and
b. the plan will remain in place for the upcoming State Fiscal Year. The notification shall be signed and certified by an officer or director of the BHO that is responsible for carrying out the compliance plan.

5. Upon receipt of a written request from DHS, the BHO shall submit the complete compliance plan to DHS within two (2) business days.

6. The BHO's failure to fully implement, enforce and monitor its compliance plan may subject the BHO to all available remedies set forth in Section 14.21, in addition to any other legal remedy.

C) Investigating Suspected Fraud, Waste and Abuse

1. All suspected FWA committed by a Member should be reported to the appropriate entity. The BHO shall report eligibility fraud affecting medical services of the Hawaii Medicaid program to the Investigations Office (INVO) of DHS. The reporting shall be done either through written notification or a telephone call to the INVO Hotline.

2. The BHO shall report Member fraud for circumstances such as fraudulently obtaining controlled substances, other medical services, or collusion between provider and Member

to obtain services, to DHS after a preliminary investigation is complete.

3. If the BHO receives a complaint of suspected Medicaid FWA from any source or identifies any questionable practices, either by Members or Providers, it shall conduct a preliminary investigation to determine whether there is sufficient basis to warrant a further investigation by DHS and/or the MFCU. If the findings of a preliminary investigation give the BHO reason to believe that an incident of FWA has occurred in the Medicaid program, the BHO shall promptly refer any potential FWA that it identifies to DHS. BHOs are required to report all incidences of suspected FWA to DHS within fourteen (14) days of making such a determination. It is possible the BHO may need to report the suspected activity immediately, such as when patient safety is at risk, evidence is being destroyed, or there is ongoing significant monetary loss. Criminal intent to commit fraud is not determined by either DHS or the BHO. Based on all the evidence gathered, the BHO only determines that an identified activity has the potential to be fraudulent and is likely not the result of an unintentional error.

4. The BHO shall use the report form provided by DHS to report or refer suspected cases of Medicaid FWA. At a minimum, this form shall require the following information for each case:
    a. Subject (Name and ID number);
    b. Source of complaint;

c. Type of provider;
d. BHO contact;
e. Contact information for BHO staff with practical knowledge of the workings of the relevant programs;
f. Date reported to DHS;
g. Description of suspected intentional misconduct, with specific details:
    1) Category of service;
    2) Factual explanation of the allegation. (The BHO should provide as much detail as possible concerning the names, positions and contact information of all relevant persons; a complete description of the alleged scheme as it is understood by the HP, including, when possible, one or more examples of specific claims that are believed to be fraudulent; the manner in which the HP came to learn of the conduct; and the actions taken by the HP to investigate the allegations.);
    3) Date(s) of conduct. (When exact dates are unknown, the HP should provide its best estimate.);
    4) Specific statutes, rules, regulations, or policies violated includes all applicable Federal/Medicaid violations as well as BHO policy violations;
    5) Amount paid to the provider during the past three (3) years or during the period of the alleged misconduct, whichever is greater;

6) Dollar amount of claims exposed to suspected FWA when available;
7) Legal and administrative disposition of the case; and
8) Copies of any and all communications between the BHO and the provider concerning the conduct at issue (including, provider enrollment documentation, and any education given to the provider as a result of past problems; as well as advisory bulletins, policy updates, or any other general communication to the provider community regarding questionable behavior. Letters, emails, faxes, memos, and phone logs are all sources of communication).

5. In addition to the information required on the form, this report shall include any and all evidence obtained in the preliminary investigation including but not limited to, copies of claims and medical records reviewed, summary of interviews conducted, and copies of audit results or review board determinations.

6. The required form and additional information shall be submitted to DHS within the timeframes set forth in this Section.

7. When it is determined that an investigation has the potential to be fraudulent, the BHO shall not contact the provider who is the subject of the investigation about any matters related to the investigation, enter in an attempt to negotiate any

settlement or agreement, or accept any item of monetary value or otherwise offered by the provider who is the subject of the investigation in connection with the incident.

D) Prompt Reporting of Overpayments to Providers and Recoveries

1. The BHO shall recover or report all overpayments. "Overpayment" as used in this Section is defined in 42 CFR § 438.2. All overpayments identified by the BHO shall be reported to DHS in accordance with Section 6.8. The overpayment shall be reported in the reporting period in which the overpayment is identified. It is understood the BHO may not be able to complete recovery of overpayment until after the reporting period. The BHO shall report to DHS the full overpayment identified.

2. The BHO shall track claims and providers being audited and submit a written report to DHS Program Integrity detailing the auditing activities on a quarterly basis.

3. During the eighteen (18) month period after date of service, DHS Program Integrity and other entities will not initiate a separate review of claims being audited by the BHO.

4. The BHO may retain funds recovered due to audit activities it initiates during the initial eighteen (18) months from the date of service. After 18 months, DHS Program Integrity or

other entities have full right to audit and pursue overpayments directly from providers. DHS or their representatives will notify the BHO of recoveries or direct the BHO to make recoveries. In all cases, encounters should be adjusted and submitted to DHS within one hundred-twenty (120) days of adjudication or adjustment.

5. The BHO may negotiate and retain a lesser repayment amount with the provider; however, the full overpayment amount will be used when by the BHO when submitting replacement encounter data; and by DHS when setting capitation rates for the BHO.

6. The BHO shall have in place a process for providers to report to the BHO when it has received an overpayment, and a process for the provider to return the overpayment to the BHO within 60 calendar days after the date on which the overpayment was identified. The BHO shall require the provider to notify the BHO in writing of the reason for the overpayment. DHS, or its contractor, may recover any overpayments made to the BHO, and the method of recovery shall be determined by DHS.

7. The BHO shall also report quarterly to DHS on all recoveries as described in Section 6.8. This report shall specify overpayments identified as FWA. The BHO shall check the reporting of overpayments recoveries for accuracy and shall provide such accuracy reports to DHS upon request. The BHO shall certify that the report contains all overpayments

and those overpayments are reflected in encounter data submitted to DHS and list these overpayments as itemized recoveries in reports submitted to DHS, as described in Sections 6.2.F and 6.4.

8. The BHO is prohibited from recovering overpayments that are being investigated by the DHS, are the subject of pending federal or state litigation or investigation or are being audited by the Hawaii Recovery Audit Contractor (RAC) or other state contracted auditor. Once the BHO receives notice from DHS or other state or federal agency of such action, the BHO shall cease any ongoing recovery efforts and coordinate with the notifying agency.

9. If DHS determines there is a credible allegation of Fraud against a provider, then payments to the provider shall be suspended absent a good cause exception. DHS will be responsible for the determination of a credible allegation of fraud and any good cause exception.

10. The BHO shall have in place policies and controls to prevent payments to providers under payment suspension.

11. DHS will notify the BHO in writing if payments to a provider are to be suspended and the effective date of the payment suspension. The BHO shall suspend payments to the provider within one (1) business day of DHS notification.

12. DHS will notify the BHO in writing if the payment suspension may be discontinued. The BHO shall respond to the notice from DHS within three (3) business days and inform DHS of action taken.

13. The BHO shall also report all of the following information to DHS after it suspends payment to the provider or discontinues the suspension dates the BHO suspended payments or discontinued the payment suspension, outcome of any appeals, and amount of adjudicated Medicaid payments held.

14. If the BHO fails to suspend payments to a provider after being notified in accordance with this Section, any payments made to the provider during the effective suspension may be recovered from the BHO, and liquidated damages or sanctions may be imposed in accordance with Sections 14.21.E and 14.21.F.

15. BHO Recoveries of Overpayments to Providers. The BHO shall be in compliance with 42 CFR § 438.608(d) as follows:
    a. The treatment of recoveries made by the BHO of overpayments to providers due to FWA shall specify:
        1) The retention policies for the treatment of recoveries of overpayments due to FWA:
        2) The process, timeframes, and documentation required for reporting the recovery for all overpayments;

3) The process, timeframes, and documentation required for payment of recoveries of overpayments to DHS in situations where the BHO is not permitted to retain some or all of the recoveries of overpayments; m

b. The BHO shall have a mechanism for a network provider to report to the BHO when it has received an overpayment, to return the overpayment to the BHO within sixty (60) days after the date on which the overpayment was identified, and to notify the BHO in writing of the reason for the overpayment; and

c. The BHO shall report to DHS within sixty (60) days when it has identified capitation payments or other payments in excess of amounts specified in the Contract.

E) Employee Education About False Claims Recovery

1. The BHO shall establish written policies and procedures for its employees (including management, Subcontractors, providers, and agents) that provide detailed information about the False Claims Act and any other federal and state laws described in Section 1902(a)(68) of the Act, including whistleblower protections, administrative remedies for false claims, any state laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting FWA in federal health care programs. The BHO shall include in any employee handbook

a description of the laws and the rights of employees to be protected as whistleblowers.

F) Adult Abuse Reporting Requirements

1. The BHO shall report all cases of suspected dependent adult abuse to the Adult Protective and Community Services Branch of the Social Services Division of DHS as required by state and federal statutes.

2. The BHO shall ensure that its network providers report all cases of suspected dependent adult abuse to the Adult Protective and Community Services Branch of DHS as required by state and federal statutes.

12.2 Verification of Services (VOS) and Electronic Visit Verification (EVV)

A) Verification of Services (VOS)

1. Verification of Services (VOS) billed by providers and actually received by beneficiaries is required by 42 CFR § 455.20. The VOS shall include a summary of the claim(s) or explanation of benefits for the month prior to mailing.

2. The BHO shall include in each VOS a cover letter explaining the document, providing a telephone number for the Member to call if they did not receive the services. All written communication shall comply with Section 9.7.

3. Whether the method of verification is by explanation of benefits or a summary of the claim(s), the verification shall include the service furnished, name of the provider furnishing the service, date on which service was furnished and amount of payment made to the provider for the service. The BHO shall encourage Members to respond to the VOS by calling the BHO if the billing information is not correct.

4. The BHO shall send by mail VOS each month to at least twenty-five percent (25%) of their Members who received services. The BHO shall randomly select Members who received inpatient, outpatient, and prescription drugs at least forty-five (45) days after the claim(s) was submitted.

5. If a Member responds that the service was not received or provided, the BHO shall report this finding to their FWA staff. Once received by the FWA staff, steps should be initiated by the BHO to investigate accuracy of information provided by the Member. The BHO shall report information on their VOS program as part of their FWA program as specified in Section 6.8.

B) Electronic Visit Verification (EVV)

1. The 21st Century Cures Act (Section 12006(a)(1)(A)), passed by Congress in December 2016, requires states to implement Electronic Visit Verification (EVV). This new law requires states to have an EVV system to electronically

capture point of service information for personal care services (PCS) and home health care services (HHCS).

2. At a minimum, an EVV system shall be able to electronically capture these six (6) data points:
    a. Type of service performed;
    b. Individual receiving the services;
    c. Date of service;
    d. Location of service delivery at beginning and end;
    e. Individual providing the service; and
    f. Time the service begins and ends.

3. DHS agrees with the many benefits of EVV, which include improved service quality and reduction in FWA activities. DHS may in the future require EVV systems to be in place for some CCS services delivered to Members in the community. Additional requirements may include reporting all CCS EVV visit data to the statewide EVV data aggregator.

12.3 Non-compliance of Program Integrity

1. The BHO's failure to comply with the requirements of this Section may subject the BHO to all available remedies set forth in Section 14.21, in addition to any other legal remedy.

SECTION 13 – Readiness Review and Contract Implementation Activities

13.1 Overview

A) DHS is committed to ensuring the BHO is prepared and able to serve as a good administrator of the Medicaid managed care program. DHS and the BHO will engage in detailed Readiness Review and contract implementation activities beginning immediately after the contract award through the Date of Commencement of Services to Members, or a different period as determined by DHS. The readiness review may be conducted in phases at the discretion of DHS. The readiness review shall include all areas identified in 42 CFR § 438.66 and others to be identified by DHS.

13.2 DHS Responsibilities

A) Prior to the Date of Implementation of Services to Members as described in Section 1.5, the DHS or its agent shall conduct a readiness review of the BHO in accordance with 42 CFR § 438.66 in order to provide assurances that the BHO is able and prepared to perform all administrative functions required by this contract and to provide high quality service to Members.

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

C) If the BHO is unable to demonstrate its ability to meet the requirements of the contract, as determined by DHS, within the time frames specified by DHS, DHS may postpone availability for enrollment or terminate the contract.

D) A BHO's failure to pass the readiness review thirty (30) calendar days prior to the beginning of service delivery may result in the assessment of financial penalties against the BHO, delayed operations and/or immediate contract termination.

13.3 BHO Responsibilities

A) Overview and Scope of Readiness Review

1. The BHO shall comply with all readiness review activities at the BHO's or the subcontractor's facilities as required by DHS. As requested by DHS, the BHO shall require participation of its subcontractors in the readiness review activities. The scope of the desk review and on-site readiness review activities conducted by DHS will include, but will not be limited to, review and/or verification of the BHO's progress on the following:
    a. Submission of all required review documents;
    b. A walk-thru of the BHO's operations/administration;
    c. Operational readiness of subcontractors, including system readiness and demonstrations;
    d. The BHO Information Systems readiness and demonstrations (refer to Sections 10.2.C and 10.2.H);

e. Interviews with BHO staff and (if requested) subcontractor staff;
f. Statewide provider network composition and access;
g. Staffing Plan, Training Plan, and hiring;
h. Transition of care plan (including plans for coordination, cooperation and transition with community programs);
i. Readiness of call centers;
j. Member education and outreach;
k. Provider education and outreach;
l. Language and written material requirements (including Translation Contractor agreement);
m. Policies and procedures required under the terms of the contract, including grievance and appeals;
n. Case Management system;
o. Quality Assessment and Performance Improvement (QAPI) program standards;
p. Utilization Management Program (UMP); and
q. Submission of updates on implementation activities.

B) Readiness Review

1. The BHO shall submit all required review documents identified in the table below by the required due date. DHS reserves the right to request additional documents for review and approval during readiness review. DHS will provide due dates for additional documents at the time of the request. Please see table 13.3.B-1 below:

Table 13.3.B-1: Readiness Review

Submission Requirement	RFP Section Reference	Due Date
Model for each provider contract	**Section 8.3.A.4** Provider Contracts	10 calendar days after contract effective date
Detailed plan for service delivery system	**Section 4** (4.1 – 4.12) Covered Benefits and Services	30 calendar days after contract effective date
Behavioral Health Adverse Events policy and procedure	**Section 4.13.H** Adverse Events Policy and Reporting	
Transition of Care policies and procedures	**Section 4.14** Transition of Care	
Member & Provider Call Center policies and procedures	**Section 4.15** Member & Provider Toll-Free Call Center	
Provider availability policy and procedure	**Section 8.1.C** Availability of Providers	
Provider Credentialing, Recredentialing and Other Certifications policies and procedures	**Section 8.2** Provider Credentialing, Recredentialing and Other Certifications	
Member Handbook	**Section 9.7.C** Member Education and Member Handbook	
Geographic Information Systems (GIS) Mapping	**Section 13.4** Geographic Information Systems (GIS) Mapping	
Quality Assurance and Performance Improvement (QAPI) Plan	**Section 5.1.D** QAPI Plan – Submission Requirements	60 calendar days after contract effective date
Prior authorization/pre-certification policies and procedures	**Section 5.8** Authorization of Services	
Medical Records Standards	**Section 5.9.A** Medical Records Standards	
Mental Health and Substance Use Disorder Parity Compliance	**Section 6.7.A.1** Mental Health and Substance Use Disorder Parity Report	

Submission Requirement	RFP Section Reference	Due Date
Grievance and Appeals System policies and procedures	**Section 9.8** Member Grievance and Appeals System	60 calendar days after contract effective date
Staffing and Training plans	**Section 11.2.H** Staffing and Training Plan	
Fraud, Waste and Abuse Compliance plan	**Section 12.1.B** Fraud, Waste and Abuse Compliance Plan	
Subcontractor Agreements	**Section 14.4** Subcontracts Agreements	
Documentation describing disaster planning and recovery operations	**Section 10.2.G** Disaster Planning and Recovery Operations	90 calendar days after contract effective date

13.4 Geographic Information Systems (GIS) Mapping

A) The BHO shall submit, thirty (30) calendar days after the date of the Contract Effective Date identified in Section 1.5, GIS mapping (or one generated by a similar program) that includes all providers who have signed a provider agreement.

13.5 BHO Provider Network

A) The BHO shall meet provider network requirements outlined in Section 8 no later than sixty (60) calendar days after the Contract Effective Date described in Section 1.5.

SECTION 14 – Special Terms and Conditions

14.1 Overview

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

1. Contract for Health and Human Services: Competitive Purchase of Service (AG Form 103F1 (10/08)) (see Appendix E), including General Conditions for Health & Human Services Contracts (AG Form 103F (10/08) (see Appendix E), Business Associate Agreement (BAA) (see Appendix J), any Special Conditions, attachments, and addenda;
2. this RFP, Appendices, attachments, and addenda, which shall be incorporated by reference; and
3. the BHO's technical proposal submitted in response to this RFP form, which shall be incorporated by reference.

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

14.2 Conflict between Contract Documents, Statutes, and Rules

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

1. Contract Documents: In the event of a conflict among the Contract documents, the controlling order of precedence shall be as follows:
    a. Contract for Health and Human Services: Competitive Purchase of Service (AG Form 103F1), including all general conditions, special conditions, attachments, and addenda;
    b. The RFP, including all attachments and addenda, as amended; and
    c. Applicant's proposal. In the event of a conflict between the General Conditions and the Special Conditions, the Special Conditions shall control;
2. Contract and Statutes: In the event of a conflict between the language of the Contract, and applicable statutes, the statute shall prevail;
3. Contract and Procurement Rules/Directives: In the event of a conflict between the Contract and the Procurement Rules or a Procurement Directive, the Procurement Rules or any Procurement Directive in effect on the date this Contract became effective shall control and are hereby incorporated by reference; and
4. The sections of the rules and regulations cited in this RFP may change as the rules and regulations are amended for MQD. No changes shall be made to this RFP due to changes in the section numbers.

14.3 Licensing and Accreditation

A) General Condition 1.2.2, Licensing and Accreditation, is amended to read as follows:

1. At the time of submission of the Offeror's proposal, the Offeror shall be properly licensed as a BHO in the State of Hawaii as described in chapters 431, 432, or 432D, HRS, and any other licenses and accreditations required under applicable federal, state, and county laws, ordinances, codes, rules, and regulations to provide the services under the Contract. The Offeror shall comply with all applicable requirements set forth in the above-mentioned statutes and shall include with its proposal proof of licensure and a certificate of good standing from the DCCA Insurance Division dated within 30 days of the date of the proposal (see Section 15.3.J). In the event of any conflict between the requirements of the contract and the requirements of any these licensure statutes, the statute shall prevail, and the Offeror shall not be deemed to be in default of compliance with any mandatory statutory requirement.

14.4 Subcontractor Agreements

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

1. The BHO shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the DHS, notwithstanding any relationship(s) that the BHO may have with any subcontractor.

2. The BHO may negotiate and enter into contracts or agreements with subcontractors to the benefit of the BHO and DHS. All

such agreements shall be in writing. No subcontract that the BHO enters into with respect to the performance under the Contract shall in any way relieve the BHO of any responsibility for any performance required of it by the Contract.

3. The BHO shall submit to DHS for review and prior approval, all subcontractor agreements related to the provision of covered benefits and services and Member services activities to Members (e.g., call center) and provider services activities and payments to providers. The BHO shall submit these subcontractor agreements in accordance with Section 13.3.B. In addition, DHS reserves the right to inspect all subcontractor agreements at any time during the Contract period.

4. The BHO shall notify DHS in writing at least ninety (90) days prior to adding or deleting subcontractor agreements or making any change to any subcontractor agreements which may materially affect the BHO's ability to fulfill the terms of the Contract.

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

B) Additionally, no assignment by the BHO of the BHO's right to compensation under the Contract shall be effective unless and until the assignment is approved by the Comptroller of the State of Hawaii, as provided in Section 40-58, HRS.

C) All subcontractor agreements shall include all provisions that comply with 42 CFR §438.230 and the following:

1. Describe the activities, including reporting responsibilities, to be performed by the subcontractor and require that the subcontractor meet all established criteria prescribed and provide services in a manner consistent with the minimum standards specified in the BHO's Contract with the DHS;
2. Require that the subcontractor fulfill the requirements of 42 CFR §438.6 that are appropriate to the service delegated under the subcontract;
3. Provide information regarding Member rights and processes regarding the Member Grievance System found in Section 9.8, if applicable;
4. Include a provision that allows the BHO to do the following:
    a. Evaluate the subcontractor's ability to perform the activities to be delegated;
    b. Monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule (the frequency shall be stated in the agreement) established by DHS and consistent with industry standards or state laws and regulations;

c. Identify the subcontractor's deficiencies or areas for improvement;
d. Take corrective action or impose other sanctions including, but not limited to, revoking delegation, if the subcontractor's performance is inadequate;
e. Take corrective action if the subcontractor fails to comply with the timely access requirements;

5. Require that the subcontractor submits to the BHO proof from the Internal Revenue Service (IRS) that all federal taxes have been paid and a tax clearance certificate from the Director of the DOTAX, State of Hawaii, showing that all delinquent taxes, if any, levied or accrued under state and federal law against the subcontractor have been paid;
6. Include a provision that the BHO shall designate itself as the sole point of recovery for any subcontractor;
7. Include a provision that neither DHS nor the BHO Members shall bear any liability of the BHO's failure or refusal to pay valid claims of subcontractors;
8. Require that subcontractors have in place and follow written policies and procedures for processing requests for initial and continuing authorizations of services;
9. Require that the subcontractor track and report complaints against itself to the BHO;
10. Require that the subcontractor fully adhere to the privacy, confidentiality and other related requirements stated in the RFP and in applicable federal and state law;
11. Require that the subcontractor follow all audit requirements as outlined in Section 14.18. The actual requirements shall be detailed in the agreement;

12. Require that the medical records be retained in compliance with Section 14.5. The actual requirements shall be detailed in the agreement;
13. Require that the subcontractor comply with all requirements related to confidentiality of information as outlined in Section 14.17. The actual requirements found in this Section shall be detailed in the agreement;
14. Require that the subcontractor notify the BHO and the MQD of all breaches of confidential information relating to Medicaid applicants and recipients, as BHO Members. The notice to DHS shall be within two (2) business days of discovery of the breach and a written report of the investigation and resultant mitigation of the breach shall be provided to DHS within thirty (30) calendar days of the discovery of the breach;
15. Fulfill the requirements of 42 CFR § 434.6 that are appropriate to the service delegated under the subcontract.
16. Provide that Members will not be billed for non-covered services, any amount greater than would be owed if the entity provided the services directly;
17. Require Requires that the BHO or the subcontractor provide for revocation of the delegation of activities or obligations or specify other remedies in instances where DHS or the BHO determines that the subcontractor has not performed satisfactorily;

18. Require that the subcontractor allow DHS and federal government full access to audit, evaluate, and inspect any books, records, contracts, documents, computer or other

electronic system that pertain to any aspect of services and activities performed, or determination of amounts payable under the BHO's contract with DHS;

19. Require that the subcontractor make available its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Medicaid Members for the purposes of an audit, evaluation, or inspection by the state or federal government;
20. Require the subcontractor agree that the right to audit by DHS, CMS, the DHHS Inspector General, the Comptroller General or their designees, will exist through ten (10) years from the final date of the contract period or from the date of complete of any audit, whichever is later;
21. Require that the subcontractor comply with all applicable Medicaid laws, regulations, including applicable sub regulatory guidance and contract provisions;
22. Submit data in standard claims submission formats on all services provided, and be subject to accuracy, completeness, timeliness, and other requirements described in Section 6.11.C;
23. Require that if DHS, CMS, or the DHHS Inspector General determine that there is a reasonable possibility of fraud or similar risk, DHS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the subcontractor at any time; and
24. Require that physical access, reasonable accommodations, and accessible equipment for Members with physical or mental disabilities are provided.

14.5 Retention of Medical Records

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

1. The BHO and its providers shall retain all medical records, in accordance with 42 CFR §438.3(h), for a minimum of ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later. For minors, the BHO shall retain all medical records during the period of minority plus a minimum of ten (10) years after the age of majority;
2. The BHO shall include in its subcontracts and provider agreements record retention requirements that are at least equivalent to those stated in this Section; and
3. During the period that records are retained under this Section, the BHO and any subcontractor or provider shall allow the state and federal government full access to inspect and audit any records or documents, and inspect the premises physical facilities, and equipment where Medicaid-related activities or work is conducted, to the extent allowed by law.

B) The BHO and the BHO's subcontractors retain, as applicable, Member grievance and appeal records in 42 CFR § 438.416, base data in 42 CFR 438.5(c), MLR reports in 42 CFR § 438.8(k), and the data, information, and documentation specified in 42 CFR §§ 438.604, 438.606, 438.608, and 438.610 for a period of no less than ten (10) years.

14.6 Responsibility for Taxes

A) In addition to the requirements of General Condition 3.4.4, PROVIDER's Responsibilities, subject to its corporate structure, licensure status, or other statutory exemptions, the BHO may be liable for, or exempt from, other federal, state, and/or local taxes including, but not limited to, the insurance premium tax (chapter 431, Article 7, Part II, HRS). The BHO is responsible for determining whether it is subject to, or exempt from, any such federal, state, or local taxes. DHS makes no representations whatsoever as to the liability or exemption from liability of the BHO to any tax imposed by any governmental entity.

14.7 Full Disclosure

A) Business Relationships

1. The BHO warrants that it has fully disclosed all business relationships, joint ventures, subsidiaries, holding companies, or any other related entity in its proposal and that any new relationships shall be brought to the attention of DHS as soon as such a relationship is consummated. The terms and conditions of CMS require full disclosure on the part of the BHO and its providers.
2. The BHO shall not knowingly have a director, officer, partner, or person with more than five (5) percent of the BHO's equity, or have an employment, consulting, or other agreement with such a person for the provision of items and services that are significant and material to the entity's contractual obligation with DHS, who has been debarred,

suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. The BHO shall not, without prior approval of DHS, lend money or extend credit to any related party. The BHO shall fully disclose such proposed transactions and submit a formal written request for review and approval.

3. The BHO cannot be controlled by a sanctioned individual under Section 128(b)(8) of the Social Security Act.

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

B) Litigation

1. The BHO shall disclose any pending litigation both in and out of Hawaii to which they are a party, including the disclosure of any outstanding judgment.

C) Effect of Prohibited Relationships

1. If DHS learns that the BHO has a prohibited relationship with an individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in nonprocurement activities under regulations issued under

Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or if the BHO has relationship with an individual who is an affiliate of such an individual, DHS may continue an existing agreement with the BHO unless the Secretary of DHHS directs otherwise.

2. If DHS learns that a BHO has a prohibited relationship with an individual or entity that is excluded from participation in any Federal health care program under Section 1128 or 1128A of the Social Security Act, DHS may continue an existing agreement with the BHO unless the Secretary of DHHS directs otherwise.

3. If DHS learns that the BHO has a prohibited relationship with an individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or if the BHO has relationship with an individual who is an affiliate of such an individual, DHS may not renew or extend the existing agreement with the BHO unless the Secretary of DHHS provides to DHS and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliation.

4. If DHS learns that the BHO has a prohibited relationship with an individual or entity that is excluded from participation in any Federal health care program under Section 1128 or 1128A of the Social Security Act, DHS may not renew or extend the existing

agreement with the BHO unless the Secretary provides to DHS and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliation.

14.8 Conflict of Interest

A) The following is added to the end of General Condition 1.7, Conflicts of Interest:

1. No official or employee of the State of Hawaii or the federal government who exercises any function or responsibilities in the review or approval of the undertaking or carrying out of the programs shall, prior to the completion of the project, voluntarily acquire any personal interest, direct or indirect, in the Contract. All officials or employees of the State of Hawaii shall be bound by Chapter 84, HRS, Standards of Conduct; and
2. The BHO shall not contract with the State of Hawaii unless the conflict of interest safeguards described in 42 CFR §438.58 and in Section 27 of the Office of Federal Procurement Policy Act (41 U.S.C § 423) are in place and complies with the requirement described in Section 1902 (a)(4)(c) of the Social Security Act, applicable to contracting officers, employees, or independent contractors.

14.9 Employment of State Personnel

A) The BHO shall not knowingly engage any persons who are or have been employed within the past twelve (12) months by the State of Hawaii to assist or represent the BHO for consideration in

matters which he/she participated as an employee or on matters involving official action by the state agency or subdivision, thereof, where the employee had served.

14.10 Fiscal Integrity

A) Warranty of Fiscal Integrity

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

B) Performance Bond

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

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

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

4. Upon termination of the Contract, for any reason, including expiration of the Contract term, the BHO shall ensure that the performance bond is in place until such time that all of the terms of the Contract have been satisfied. The performance bond shall be liable for, and DHS shall have the authority to, retain funds for additional costs including, but not limited to:
    a. Any costs for a special plan change period necessitated by the termination of the Contract;
    b. Any costs for services provided prior to the date of termination that are paid by MQD;
    c. Any additional costs incurred by DHS due to the termination; and
    d. Any sanctions or penalties owed to DHS.

14.11 Term of the Contract

A) This is a multi-term contract solicitation that has been deemed to be in the best interest of DHS by the Director of DHS in accordance with HAR § 3-149-302(c). The Contract is for the initial term from the Date of Implementation of Services to Members as specified in Section 1.5 to June 30, 2024. Unless terminated, the Contract may be extended without the necessity of re-bidding, for not more than two (2) additional twelve (12) month periods or parts thereof, only upon mutual agreement of the parties in writing. The BHO shall not contract with the State of Hawaii unless safeguards at least equal to Federal safeguards (41 USC § 423) are in place.

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

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

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

14.12 Liability Insurance Requirements

A) Liability Insurance Requirements Generally

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

2. Prior to or upon execution of the Contract and any supplemental contracts, the BHO shall provide to DHS certificate(s) of insurance, including any referenced endorsements, dated within thirty (30) days of the effective date of the Contract necessary to satisfy DHS that the insurance provisions of this Contract have been complied with. Upon request by DHS, BHO shall furnish a copy of the policy(ies) and/or updated Certificate of Liability Insurance including referenced endorsement(s) necessary for DHS to verify the coverages required by this Section.

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

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

Table 14.12.A-1: Liability Insurance Requirements

Coverage	Limits
Commercial General Liability	Per occurrence, not claims made • $1 million per occurrence • $2 million in the aggregate
Automobile	May be combined single limit: • Bodily Injury: $1 million per person, $1 million per accident • Property Damage: $1 million per accident
Workers Compensation / Employers Liability (E.L.)	• Workers Comp: Statutory Limits • E.L. each accident: $1,000,000 • E.L. disease: $1,000,000 per employee, $1,000,000 policy limit • E.L. $1 million aggregate
Professional Liability, if applicable	May be claims made: • $1 million per claim • $2 million annual aggregate

5. Each insurance policy required by this Contract shall contain the following clauses, which shall also be reflected on the certificate of Insurance:
    a. "The State of Hawaii is an additional insured with respect to operations performed for the State of Hawaii"; and
    b. "Any insurance maintained by the State of Hawaii shall apply in excess of, and not contribute with, insurance provided by this policy."

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

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

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

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

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

B) Waiver of Subrogation

1. BHO shall agree by entering into a contract with DHS to provide a Waiver of Subrogation for the Commercial General Liability, Automobile Liability, and Workers Compensation policies. When required by the insurer or should a policy condition not permit the BHO to enter into a pre-loss agreement to waive subrogation without an endorsement, the BHO shall agree to notify the insurer and request the policy be endorsed with a Waiver of Subrogation in favor of DHS. This Waiver of Subrogation requirement shall not apply to any policy, which includes a condition specifically prohibiting such an endorsement, or voids coverage should BHO enter into such an agreement on a pre-loss basis.

14.13 Modification of Contract

A) The following is added as General Condition 4.1.4:

1. All modifications of the Contract may be negotiated and accompanying capitated rates established. Such modifications shall result in a supplemental agreement document produced by DHS and delivered to the BHO. If the parties are in agreement, the supplemental agreement document shall be signed by the Director of DHS and an authorized representative of the BHO. If the parties are unable to reach an agreement within thirty (30) calendar days of the BHO's receipt of the supplemental agreement document, the provisions of such Contract change will be deemed to have been accepted on the thirty-first (31st)

calendar day after the BHO received the supplemental agreement document, even if the Contract change has not been signed by the BHO, unless within the thirty (30) calendar days after the BHO received the supplemental agreement document, the BHO notifies DHS in writing that it refuses to sign the amendment. If the BHO provides such notification, DHS will initiate termination proceedings.

14.14 Conformance with Federal Regulations

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

14.15 Conformance with State Regulations

A) Should any part of the scope of work under this contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the BHO shall do no work on that part after the effective date of the loss of program authority. DHS shall adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If the BHO works on a program or activity no longer authorized by law after the date the legal

authority for the work ends, the BHO will not be paid for that work. If DHS paid the BHO in advance to work on a no-longer-authorized program or activity and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to DHS. However, if the BHO worked on a program or activity prior to the date legal authority ended for that program or activity, and DHS included the cost of performing that work in its payments to the BHO, the BHO may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

14.16 Termination of Contract

A) General Termination Bases

1. The Contract may terminate or may be terminated by DHS for any or all of the following reasons in addition to the General Conditions in Appendix E.
    a. Termination for Default.
    b. Termination for Expiration or Modification of the Programs by CMS.
    c. Termination for Bankruptcy or Insolvency.

B) Termination for Default

1. The failure of the BHO to comply with any term, condition, or provision of the Contract or applicable requirements in Sections 1932, 1903(m) and 1905(t) of the Social Security

Act shall constitute default by the BHO. In the event of default, DHS shall notify the BHO by certified or registered mail, with return receipt requested, as well as regular mail, of the specific act or omission of the BHO, which constitutes default.

2. The BHO shall have fifteen (15) days from the date of receipt of such notification to cure such default. Regular mail is deemed received two days after mailing. In the event of default, and during the above-specified grace period, performance under the Contract shall continue as though the default had never occurred. In the event the default is not cured within fifteen (15) days, DHS may, at its sole option, terminate the Contract for default. Such termination shall be accomplished by written notice of termination forwarded to the BHO by certified or registered mail and shall be effective as of the date specified in the notice. If it is determined, after notice of termination for default, that the BHO's failure was due to causes beyond the control of and without error or negligence of the BHO, the termination shall be deemed a termination for convenience under General Condition 4.3 in Appendix E.

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

C) Termination for Expiration of Modification of the Programs by CMS

1. DHS may terminate performance of work under the Contract in whole or in part whenever, for any reason, CMS terminates or modifies the programs. In the event that CMS elects to terminate its agreement with DHS, DHS shall so notify the BHO by certified or registered mail, return receipt requested, as well as regular mail. Regular mail is deemed received two (2) days after mailing. The termination shall be effective as of the date specified in the notice.

D) Termination for Bankruptcy or Insolvency

1. In the event that the BHO shall cease conducting business in the normal course, become insolvent, make a general assignment for the benefit of creditors, suffer or permit the appointment of a receiver for its business or its assets or shall avail itself of, or become subject to, any proceeding under the Federal Bankruptcy Act or any other statute of any state relating to insolvency or the protection of the rights or creditors, DHS may, at its option, terminate the Contract. In the event DHS elects to terminate the Contract under this provision it shall do so by sending notice of termination to the BHO by registered or certified mail, return receipt requested, as well as regular mail. Regular mail is deemed received two days after mailing.

The termination shall be effective as of the date specified in the notice.

2. In the event of insolvency of the BHO, the BHO shall cover continuation of services to Members for the duration of period for which payment has been made, as well as for inpatient admissions up until discharge. Members shall not be liable for the debts of the BHO. In addition, in the event of insolvency of the BHO, Members may not be held liable for the covered services provided to the Member for which DHS does not pay the BHO.

E) Procedure for Terminations

1. In the event DHS decides to terminate the Contract, it shall provide the BHO with a pre-termination hearing. DHS shall:
    a. Give the BHO written notice of its intent to terminate, the reason(s) for termination, and the time and place of the pre-termination hearing; and
    b. Give the BHO's Members written notice of the intent to terminate the Contract, notify Members of the hearing, and allow them to disenroll immediately without cause.

2. Following the termination hearing, DHS shall provide written notice to the BHO of the termination decision affirming or reversing the proposed termination. If DHS decides to terminate the Contract, the notice shall include

the effective date of termination. In addition, if the Contract is to be terminated, DHS shall notify the BHO's Members in writing of their options for receiving Medicaid services following the effective date of termination.

3. In the event of any termination, the BHO shall:
    a. Stop work under the Contract on the date and to the extent specified in the notice of termination;
    b. Complete the performance of such part of the work as shall not have been terminated by the notice of the termination;
    c. Notify the Members of the termination and arrange for the orderly transition to the new BHO, including timely provision of any and all records to DHS that are necessary to transition the BHO’s Members to the new BHO;
    d. Promptly supply all information necessary for the reimbursement of any outstanding claims;
    e. Place no further orders or enter into subcontracts for materials, services, or facilities, except as may be necessary for completion of the work under the portion of the Contract that is not terminated;
    f. Terminate all orders and subcontracts to the extent that they relate to the performance of work terminated by the notice of termination;
    g. Assign to DHS in the manner and to the extent directed by the MQD Administrator the right, title, and interest of the BHO under the orders or subcontracts so terminated, in which case DHS shall

have the right, in its discretion, to settle or pay any or all claims arising out of the termination of such orders and subcontracts;

h. With the approval of the MQD Administrator, settle all outstanding liabilities and all claims arising out of such termination of orders and subcontracts, the cost of which would be reimbursable, in whole or in part, in accordance with the provisions of the Contract;

i. Take such action as may be necessary, or as the MQD Administrator may direct, for the protection and preservation of any and all property or information related to the contract which is in the possession of the BHO and in which DHS has or may acquire an interest;

j. Within thirty (30) business days from the effective date of the termination, deliver to DHS copies of all current data files, program documentation, and other documentation and procedures used in the performance of the Contract at no cost to DHS. The BHO agrees that DHS or its designee shall have a non-exclusive, royalty-free right to the use of any such documentation; and

k. Submit 100% of encounter data no later than 15 months following the end of the Contract term.

4. The BHO shall create written procedures for the orderly termination of services to any Members receiving the required services under the Contract, and for the transition to services supplied by another BHO upon termination of

the Contract, regardless of the circumstances of such termination. These procedures shall include, at the minimum, timely notice to the BHO's Members of the termination of the Contract, and appropriate counseling. The BHO shall submit these procedures to DHS for review and approval in accordance with Section 13.3.B.

F) Termination Claims

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

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

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

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

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

14.17 Confidentiality of Information

A) In addition to the requirements of General Condition 8, the BHO understands that the use and disclosure of information concerning applicants, beneficiaries or Members is restricted to purposes directly connected with the administration of the Hawaii Medicaid program, and agrees to guard the confidentiality of an applicant's, beneficiary's or Member's information as required by law. The BHO shall not disclose confidential information to any individual or entity except in compliance with the following:
   1. 42 CFR Part 431, Subpart F;
   2. The Administrative Simplification provisions of HIPAA and the regulations promulgated thereunder, including but not

limited to the Security and Privacy requirements set forth in 45 CFR Parts 160 and 164;

3. HRS § 346-10; and
4. All other applicable federal and state statutes and administrative rules, including but not limited to:
    a. HRS § 325-101, relating to persons with HIV/AIDS;
    b. HRS § 334-5, relating to persons receiving mental health services;
    c. HRS Chapter 577A, relating to emergency and family planning services for minor females;
    d. 42 CFR Part 2 relating to persons receiving substance abuse services;
    e. HRS Chapter 487J, relating to social security numbers and HRS Chapter 487N, relating to personal information; and
    f. Session Laws of Hawaii, Act 252, relating to insurance.

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

C) Any other party shall be granted access to confidential information only after complying with the requirements of state and federal laws, including but not limited to HIPAA, and regulations pertaining to such access. The BHO is responsible for knowing

and understanding the confidentiality laws listed above as well as any other applicable laws. The BHO, if it reports services to its Members, shall comply with all applicable confidentiality laws. Nothing herein shall prohibit the disclosure of information in summary, statistical or other form that does not identify particular individuals, provided that de-identification of protected health information is performed in compliance with the HIPAA Privacy Rule.

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

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

F) The BHO is a business associate of DHS as defined in 45 CFR §160.103, and agrees to the terms of the Business Associate Agreement (BAA) found in Appendix J.

14.18 Audit Requirements

A) Overview

1. The state and federal standards for audits of DHS designees, contractors and programs conducted under contract are applicable to this sub-section and are incorporated by reference into the Contract.

2. DHS, the HHS, the Secretary, CMS, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any records, inspect the premises, physical facilities, and equipment of the BHO and its subcontractors, subcontractor's contractors, or providers where Medicaid-related activities or work is conducted.

3. There shall be no restrictions on the right of the state or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services and reasonableness of their costs.

4. The right to audit shall exist for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later.

B) Accounting Records Requirements

1. The BHO shall, in accordance with generally accepted accounting practices, maintain fiscal records and supporting documents and related files, papers and reports that adequately reflect all direct and indirect expenditures and management and fiscal practices related to the BHO's performance of services under the Contract.

2. The BHO's accounting procedures and practices shall conform to generally accepted accounting principles and the costs properly applicable to the contract shall be readily ascertainable from the records. The BHO shall submit audited financial reports specific to this Contract to DHS annually. The audit shall be conducted in accordance w/ generally accepted accounting principles and generally accepted auditing standards.

C) Inclusion of Audit Requirements in Subcontracts

1. The provisions of this Section and its associated subsections shall be incorporated in every subcontract/provider agreement.

14.19 Ongoing Inspection of Work Performed

A) DHS, the State Auditor of Hawaii, the Secretary, the U.S. Department of Health and Human Services (HHS), CMS, the General Accounting Office (GAO), the Comptroller General of the

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

14.20 Disputes

A) The parties shall first attempt to resolve all disputes arising under this Contract by informal resolution. Where informal resolution cannot be reached, the BHO shall submit a written request for dispute resolution (by certified mail, return receipt requested) to the Director of DHS or the Director's duly authorized representative. The BHO shall be afforded the opportunity to be heard and to present evidence in support of its position in the dispute. The Director of DHS or the Director's authorized representative shall issue a written decision within ninety (90) days of the BHO's written request. The decision of the Director of DHS or the Director's authorized representative shall be final and binding and may only be set aside by a State court of

competent jurisdiction where the decision was fraudulent, capricious, arbitrary, or grossly erroneous as to imply bad faith.

B) Pending any subsequent legal proceedings regarding the final decision, including all appeals, the BHO shall proceed diligently in the performance of the Contract in accordance with the Director's final decision.

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

D) This dispute resolution Section does not apply to the appeals of sanctions imposed under Section 14.21.F.

14.21 Remedies for Non-Performance of Contract

A) Understanding and Expectations

1. The BHO shall comply with all terms, conditions, requirements, performance standards and applicable state and federal laws as set forth in this Contract or any amendments thereto including any rules, policies, or procedures incorporated pursuant to this Contract.

2. DHS reserves the right to impose any and all remedies available under the terms of the Contract, at law or equity, in the event DHS determines, in its sole discretion, that the

BHO or a Subcontractor has violated any provision of the Contract, or if the BHO or a Subcontractor does not comply with any other applicable state or federal law or regulation, compliance with which is mandated expressly or implicitly by this Contract.

3. Risk Categories: DHS may conduct performance reviews at its discretion at any time that relate to any Contractor responsibility for timely and responsive performance of Contract requirements. Based on such performance reviews or as determined through other means, upon the discovery of a BHO's or Subcontractor's violation or non-performance of the terms, conditions, or requirements of this Contract, or any other non-compliance by the BHO, the Department shall assign the violation or non-performance into one of the following categories of risk:
    a. Category 1: Action(s) or inaction(s) that seriously jeopardize the health, safety, and welfare of Members(s); reduces Members' access to care; and/or jeopardize the integrity or viability of Hawaii's Medicaid managed care program;
    b. Category 2: Action(s) or inaction(s) that jeopardize the integrity or viability of Hawaii's Medicaid managed care program, but do(es) not necessarily jeopardize Member(s') health, safety, and welfare or reduce access to care; or
    c. Category 3: Action(s) or inaction(s) that diminish the efficient operation and effective oversight and

administration of Hawaii’s Medicaid managed care program.

4. Remedial Considerations If any of the BHO's responsibilities do not conform to Contract requirements, DHS may pursue contractual remedies for correcting violations or non-performance with any provision of this Contract. At any time and at its sole discretion, DHS may impose or pursue one or more remedies for each violation or item of non-performance. DHS may impose additional remedies if the BHO fails to comply with the originally imposed action. DHS will consider some or all of the following factors in determining the need to impose remedies against the BHO as set forth below:
    a. Risk category;
    b. The nature, severity, and duration of the violation, breach, or non-performance;
    c. The type of harm suffered (e.g., impact on the quality of care, access to care, Program Integrity);
    d. Whether the violation, breach or non-performance (or one that is substantially similar) has previously occurred;
    e. The timeliness in which the BHO self-reports a violation, breach or non-performance;
    f. The BHO’s history of compliance;
    g. The good faith exercised by the BHO in attempting to stay in compliance (including self-reporting by the BHO); and

h. Any other factor DHS deems relevant based on the nature of the violation, breach, or non-performance.

B) Notice of Concern and Opportunity to Cure

1. Should DHS determine that the BHO or a Subcontractor is in violation or non-performance of any requirement of the Contract, DHS shall issue a "Notice of Concern" prior to the imposition of remedies against the BHO as set forth in Section 14.21.C through Section 14.21.F.

2. DHS will provide the BHO with the written Notice of Concern detailing the nature of the violation or non-performance, the assigned Risk Category, any action DHS seeks to impose against the BHO, and, if applicable, the method and timeframes by which the BHO may dispute the claim of violation or non-performance and the imposed actions.

3. The BHO shall within ten (10) business days (or another date approved by DHS) of receipt of the written Notice of Concern, provide DHS a written response that:
   a. Explains the reasons for the deficiency, the BHO's plan to remediate the violation or non-performance, and the date and time by which the violation or non-performance will be cured; or
   b. If the BHO disagrees with the findings of DHS, its reasons for disagreeing with those findings.

4. If the BHO fails to timely contact DHS regarding the Notice of Concern, DHS shall proceed to additional remedies contained in this Contract.

5. The BHO shall confirm in writing the date that the violation or non-performance was resolved and the actions the BHO took to remediate the deficiency(ies).

6. The BHO's proposed cure is subject to the approval of DHS.

C) Corrective Action Plan

1. Should DHS determine that the BHO is non- compliant with any material provision of this Contract, DHS shall issue a Written Deficiency Notice to the BHO specifying the deficiency (violation or non-performance) and assigned Risk Category and requesting a Corrective Action Plan be filed by the BHO within ten (10) business days following the date of the Notice. DHS reserves the right to require a more accelerated timeframe if the deficiency warrants a more immediate response.

2. The Corrective Action Plan shall provide the following information at a minimum:
    a. The names of the individuals who are responsible for implementing the Corrective Action Plan;
    b. A description of the deficiency(ies) and the cause of the deficiency(ies) that resulted in need for Corrective Action;

c. A detailed approach for addressing the existing deficiency(ies) and prevention of the repeated and/or similar deficiency(ies) in the future; and
d. The timeline for implementation, establishment of major milestones and correspondence dates to DHS, and notification of completion of Corrective Actions.

3. The Corrective Action Plan shall be submitted by the deadline set forth in DHS's request for a Corrective Action Plan.

4. The Corrective Action Plan shall be subject to approval by DHS, which may accept the Corrective Action Plan as submitted, may accept the Corrective Action Plan with specified modifications, or may reject the Corrective Action Plan in full within ten (10) business days of receipt.

5. DHS may extend or decrease the timeframe for Corrective Action depending on the nature of the specific deficiency.

6. The BHO shall update the Corrective Action Plan on an ongoing basis and report progress to DHS on a frequency to be determined by DHS.

7. Notwithstanding the submission and acceptance of a Corrective Action Plan, the BHO remains responsible for achieving all written performance criteria.

8. The Department's acceptance of a Corrective Action Plan under this Section will not:
    a. Excuse the BHO's prior substandard performance;
    b. Relieve the BHO of its responsibility to comply with
    c. performance standards; or
    d. Prohibit DHS from assessing additional remedies or pursuing other appropriate remedies for continued substandard performance.

D) Administrative Actions

1. At its discretion and based on the Risk Category, DHS may impose one or more of the following remedies for each item of material non-compliance and will determine the scope and severity of the remedy on a case-by case basis:
    a. Conduct accelerated monitoring of the BHO. Accelerated monitoring includes more frequent or more extensive monitoring by DHS or its agent;
    b. Require additional, more detailed, financial and/or programmatic reports to be submitted by the BHO; or
    c. Require additional and/or more detailed financial and/or programmatic audits or other reviews of the BHO.

E) Liquidated Damages

1. In the event the BHO fails to meet the terms, conditions or requirements of the Contract and said failure results in

damages that can be measured in actual cost, DHS will assess the actual damages warranted by said failure.

2. The BHO acknowledges that its failure to complete the tasks, activities and responsibilities set forth in Appendix L, Liquidated Damages will cause DHS substantial damages of types and in amounts which are difficult or impossible to ascertain exactly. DHS and the BHO further acknowledge and agree that the specified liquidated damages in Appendix L, Liquidated Damages, are the result of a good faith effort by the parties to estimate the actual harm caused by the BHO's failure to meet requirements under the Contract.

3. DHS and the BHO further acknowledge and agree that the liquidated damages referenced in Appendix L, Liquidated Damages, are not intended to be in the nature of a penalty, but are intended to be reasonable estimates of the Department's projected financial loss, approximate costs of obtaining alternative medical benefits for its Members and damage resulting from: the BHO's non-performance, including financial loss as a result of project delays, of the activities and responsibilities described in Appendix L, Liquidated Damages; or the BHO's failure to timely submit the deliverables described therein. As applicable, the damages shall include, without limitation, the difference in the capitated rates paid to the BHO and the rates paid to a replacement BHO.

4. The BHO acknowledges, affirms, ratifies, and agrees that the damage provisions set forth herein meet the criteria for enforceable damages that are reasonable, appropriate, and necessary. Liquidated damages shall be in addition to any other remedies that DHS may have. Accordingly, DHS reserves the right to seek all other reasonable and appropriate remedies available at law and in equity.

5. If the BHO commits any of the violations or fails to meet the requirements set forth in Appendix L Liquidated Damages, the BHO shall submit a written Corrective Action Plan to DHS as set forth in Section 14.21.C. In addition, the BHO may be subject to Administrative Actions as described in Section 14.21.D.

6. The BHO shall agree to or provide evidence acceptable to DHS to challenge the reimbursement to DHS for actual damages or the amounts set forth as liquidated damages within thirty (30) days.

7. DHS will notify the BHO in writing of the proposed damage assessment. At the Department's sole discretion, DHS may require the BHO to remit the actual or liquidated damages within thirty (30) days following the notice of assessment or resolution of any dispute or DHS may be deduct from any fees, capitation payments or other payments to the BHO until such damages are paid in full.

8. Notwithstanding the above, the BHO shall not be relieved of liability to DHS for any damages sustained by DHS due to the BHO's violation or breach of the Contract.

F) Sanctions

1. DHS may impose sanctions for breach of Contract requirements if DHS determines that a BHO acts or fails to act as follows:
    a. Fails substantially to provide medically necessary services that the BHO is required to provide, under law or under its contract with DHS, to a Member covered under the contract;
    b. Imposes on Members' premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program;
    c. Acts to discriminate among Members on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a Member, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services;
    d. Misrepresents or falsifies information that it furnishes to CMS or to DHS;
    e. Misrepresents or falsifies information that it furnishes to a Member, potential Member, or health care provider;

f. Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 CFR §§ 422.208 and 422.210;
g. Has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by DHS or that contain false or materially misleading information; or
h. Has violated any of the other requirements of Sections 1903(m) or 1932 of the Social Security Act, or any implementing regulations.

2. Sanctions shall be determined by DHS and may include:
   a. Imposing civil monetary penalties (as described below);
   b. Suspending enrollment of new Members with the BHO;
   c. Suspending payment;
   d. Notifying and allowing Members to change plans without cause;
   e. Appointment of temporary management (as described in Section 14.21.G); or
   f. Terminating the Contract (as described in Section 14.16).

3. DHS shall give the BHO timely written notice that explains the basis and nature of the sanction as outlined in 42 CFR Part 438, Subpart I. The BHO may follow DHS appeal procedures to contest the penalties or sanctions.

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

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

Table 14.21.B-1: Sanction Penalties

Number	Activity	Penalty
1	Misrepresentation of actions or falsification of information furnished to the CMS or DHS.	A maximum of one hundred thousand dollars ($100,000) for each determination.
2	Acts to discriminate among Members on the basis of their health status or need for healthcare services.	A maximum of one hundred thousand dollars ($100,000) for each determination.
3	Failure to implement requirements stated in the BHO's proposal, the RFP or the contract, or other material failures in the BHO's duties, including but not limited to failing to meet readiness review or performance standards.	A maximum of fifty thousand dollars ($50,000) for each determination.
4	Substantial failure to provide medically necessary services that are required under law or under contract, to an enrolled Member.	A maximum of twenty-five thousand dollars ($25,000) for each determination.
5	Imposition upon Members' premiums and charges that are in excess of the premiums or charges permitted under the program.	A maximum of twenty-five thousand dollars ($25,000) or double the amount of the excess charges (whichever is greater). DHS shall deduct

Number	Activity	Penalty
		from the penalty the amount of overcharge and return it to the affected Member(s).
6	Misrepresentation or false statements to Members, potential Members or providers.	A maximum of twenty-five thousand dollars ($25,000) for each determination.
7	Violation of any of the other applicable requirements of Sections 1903(m), 1905(t)(3) or 1932 of the Social Security Act and any implementing regulations.	A maximum of twenty-five thousand dollars ($25,000) for each determination.
8	Failure to comply with the requirements for physician incentive plans, as set forth in 42 CFR §§422.208 and 422.210.	A maximum of twenty-five thousand dollars ($25,000) for each determination.
9	Not enrolling a Member because of a discriminatory practice.	A maximum of fifteen thousand dollars ($15,000) for each Member DHS determines was not enrolled because of a discriminatory practice.
10	Failure to resolve Member appeals and grievances within the time frames specified in Section 9.8.	A maximum of ten thousand dollars ($10,000) for each determination of failure.
11	Failure to comply with the claims processing standard required in Section 7.2.A.	A maximum of five thousand dollars ($5,000) for each determination of failure.
12	Failure to conduct an assessment or develop a service plan within the timeframe required in Section 4.	A maximum of five thousand dollars ($5,000) for each determination of failure.

Number	Activity	Penalty
13	Failure to comply with staffing requirements as outlined in Section 11.	A maximum of five thousand dollars ($5,000) for each determination of failure.
14	Failure to provide accurate information, data, reports and medical records, including behavioral health and substance abuse records to DHS under the Contract.	Two hundred dollars ($200) per day until all required information, data, reports and medical records are received.
15	Failure to report confidentiality breaches relating to Medicaid applicants and recipients to DHS by the specific deadlines provided in Section 14.17.	One hundred dollars ($100) per day per applicant/recipient. A maximum of twenty-five thousand dollars ($25,000) until the reports are received.

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

G) Special Rules for Temporary Management

1. The sanction of temporary management may be imposed by DHS, as allowed or required by 42 CFR §438.706, if it finds that:
    a. There is continued egregious behavior by the BHO, including, but not limited to, behavior that is described in 42 CFR § 438.700, or that is contrary to any requirements of Sections 1903(m) and 1932 of the Social Security Act;
    b. There is substantial risk to the Member's health; or

c. The sanction is necessary to ensure the health of the BHO's Members while improvements are made to remedy violations under 42 CFR §438.700 or until there is an orderly termination or reorganization of the BHO.

2. DHS that the BHO has repeatedly failed to meet the substantive requirements in Sections 1903(m) and 1932 of the Social Security Act. DHS may not delay imposition of temporary management to provide a hearing before imposing this sanction.

3. DHS may not terminate temporary management until it determines that the BHO can ensure that the sanctioned behavior will not recur.

4. In the event DHS imposes the sanction of temporary management, Members shall be allowed to disenroll from the BHO without cause.

14.22 Compliance with Laws

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

A) Wages, Hours and Working Conditions of Employees Providing Services

1. Pursuant to HRS § 103-55, services to be performed by the BHO and its subcontractors or providers shall be performed

by employees paid at wages or salaries not less than the wages paid to public officers and employees for similar work. Additionally, the BHO shall comply with all applicable federal and state laws relative to workers compensation, unemployment compensation, payment of wages, prepaid healthcare, and safety standards.

2. Failure to comply with these requirements during the Contract period shall result in cancellation of the Contract unless such noncompliance is corrected within a reasonable period as determined by DHS. Final payment under the Contract shall not be made unless

3. DHS has determined that the noncompliance has been corrected.

4. The BHO shall complete and submit the Wage Certification provided in Appendix C.

B) Compliance with other Federal and State Laws

1. The BHO shall agree to conform to the following federal and state laws as affect the delivery of services under the Contract including, but not limited to:
    a. Titles VI, VII, XIX, and XXI of the Social Security Act;
    b. Title VI of the Civil Rights Act of 1964;
    c. Title IX of the Education Amendments of 1972 (regarding education programs and activities);
    d. The Age Discrimination Act of 1975;
    e. The Rehabilitation Act of 1973;

f. The Americans with Disability Act of 1990 as amended;
g. The Patient Protection and Affordable Care Act of 2010, including Section 1557;
h. Chapter 489, HRS (Discrimination in Public Accommodations);
i. Education Amendments of 1972 (regarding education programs and activities);
j. Copeland Anti-Kickback Act;
k. Davis-Bacon Act;
l. Debarment and Suspension;
m. All applicable standards, orders or regulations issued under Section 306 of the Clean Air Act, as amended (42 USC § 1857 (h)), Section 508 of the Clean Water Act (33 USC § 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR Chapter I Subchapter A) and the Federal Water Pollution Control Act, as amended (33 U.S.C. Section 1251, et seq.);
n. The Byrd Anti-Lobbying Amendment (31 USC § 1352); and
o. E.O. 11246, "Equal Employment Opportunity," as amended by E.O. 11375 "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor".

2. The BHO shall comply with any and all applicable Federal and state laws that pertain to Member rights and ensure that its employees and contracted providers observe and protect those rights.

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

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

14.23 Miscellaneous Special Conditions

A) Use of Funds

1. The BHO shall not use any public funds for purposes of entertainment or perquisites and shall comply with any and all conditions applicable to the public funds to be paid under the Contract, including those provisions of appropriate acts of the Hawaii State Legislature or by administrative rules adopted pursuant to law.

B) Prohibition of Gratuities

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

C) Publicity

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

D) Force Majeure

1. If the BHO is prevented from performing any of its obligations hereunder in whole or in part as a result of major epidemic, act of God, war, civil disturbance, court order or any other cause beyond its control, the BHO shall make a good faith effort to perform such obligations through its then-existing facilities and personnel; and such non-

performance shall not be grounds for termination for default.

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

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

E) Attorney's Fees

1. In addition to costs of litigation provided for under General Condition 5.2, in the event that DHS shall prevail in any legal action arising out of the performance or non-performance of the Contract, or in any legal action challenging a final decision under Section 14.20, the BHO shall pay, in addition to any damages, all of DHS' expenses of such action including reasonable attorney's fees and costs. The term "legal action" shall be deemed to include administrative proceedings of all kinds, as well as all actions at law or in equity.

F) Time is of the Essence

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

G) BHO request for waiver of contract requirements

1. The BHO may request a waiver of operational contract requirements from DHS that are described in the RFP.

2. The BHO may submit this request in a format provided by DHS.

3. DHS shall only approve the BHO's request for waiver of a contract requirement that does not adversely affect the outcome of services that its Members receive, is consistent with state law and policy, and is allowable under federal and state authority.

4. DHS reserves the right to revoke these waivers at any time upon written notice to the BHO.

5. Whenever possible, DHS shall provide reasonable advance notice of any such revocation to allow the BHO to make any necessary operational changes.

14.24 Transition Plan for Mergers

A) The BHO shall not assign or transfer any right or interest in this Contract to any successor entity or other entity that results from a merger of the BHO and another entity, without the prior written consent of DHS. The BHO shall include in such request for approval a detailed transition plan for DHS to review. The purpose of the transition plan review is to:

1. Ensure services to Members are not interrupted or diminished;
2. Evaluate the new entity's staffing plan;
3. Evaluate the new entity's plan to support the BHO's provider network;
4. Ensure that the new entity can pass a readiness review; and
5. Ensure that DHS is not adversely affected by the assignment or transfer of this Contract.

SECTION 15 – Technical Proposal

15.1 Overview

A) The Offeror shall submit all responses in PDF format and comply with all content and format requirements for the technical proposal. The proposal shall be on standard 8 ½" by 11" format, one and a half (1½) spaced with text no smaller than 11-point Calibri font. For graphics and diagrams, text shall be no smaller than 10-point Calibri font. The pages shall have at least one-inch margins. All proposal pages shall be numbered and identified with the Offeror's name.

B) The Offeror shall answer all questions as part of the narrative in the order that they appear below:

1. Proposal Letter
2. Transmittal letter
3. Financial Status
4. Executive Summary
5. Offeror background and experience
    a. Background of the Offeror
    b. Offeror experience
    c. Offeror references
6. Organization and staffing
    a. Organization charts
    b. Personnel required information
    c. FTE Projection
7. Provider Network
    a. Provider Listing

b. Map of Behavior Providers and Hospitals

8. Case Management
9. Approach to Care Delivery and Coordination
10. Outreach and education programs
11. Transition of Care
12. Member and Provider Toll-Free Call Center
13. Other Documentation (Appendix C)
    a. The Proposal Application Identification form (Form SPO-H-200);
    b. The State of Hawaii DHS Proposal Letter;
    c. The Certification for Contracts, Grants, Loans and Cooperative Agreements form;
    d. The Disclosure Statement (CMS required) form;
    e. Disclosure Statement;
    f. The Disclosure Statement (Ownership) form;
    g. The Organization Structure and Financial Planning form;
    h. The Financial Planning form;
    i. The Controlling Interest form;
    j. The Background Check Information form;
    k. The Operational Certification Submission form;
    l. The Grievance System form;
    m. Insurance requirements certification form;
    n. The Wage Certification form;
    o. The Standards of Conduct Declaration form; and
    p. The State and Federal Tax Clearance certificates from the prime Offeror and, upon request from subcontractors, as assurance that all federal and state tax liabilities have been paid and that there are no

significant outstanding balances owed (a statement shall be included if certificates are not available at time of submission of proposal that the certificates will be submitted in compliance with Section 1.5.

C) The section reference number shall be restated above the response if there is reference to a section of this RFP in Section 15.2 below. The questions related to any attachment shall include the heading of the referenced attachment. Attachments may be placed, in the order in which they are requested, behind the narrative responses for that sub-section.

D) The following sections describe the required content and format for the mandatory and technical proposals. These sections are designed to ensure submission of information essential to understanding and evaluating the proposal.

15.2 Mandatory Requirements

A) Proposal Letter

1. The proposal letter (refer to Appendix C) shall be signed by an individual authorized to legally bind an Offeror and be affixed with a corporate seal, if applicable. Please provide a Corporate Resolution or a certificate of authority to sign on behalf of the company.

B) Transmittal Letter

1. The transmittal letter shall be on official business letterhead and shall be signed by an individual authorized to legally bind the Offeror. It shall include the following:
    a. A statement indicating that the Offeror is a corporation or other legal entity. All subcontractors shall be identified, and a statement included indicating the percentage of work to be performed by the prime Offeror and each subcontractor, as measured by percentage of total contract price. If subcontractors will not be used for this contract, a statement to this effect shall be included;
    b. A statement that the Offeror has an established provider network to serve CCS beneficiaries in the State of Hawaii or will have a provider network to serve CCS beneficiaries in the State of Hawaii before the Commencement of Services;
    c. A statement that the Offeror is registered to do business in Hawaii and has obtained a State of Hawaii General Excise Tax License, if applicable, and that this will be submitted to DHS with the signed contracts (following the Contract Award date and prior to the Contract Effective Date identified in Section 1.5);
    d. The Offeror's Hawaii Excise tax number (if applicable);
    e. A statement that the Offeror's Hawaii Compliance Express information is current and provide a copy of the "Certificate of Vendor Compliance" conducted no

later than seven (7) calendar days prior to proposal submission;

f. A statement to acknowledge and identify all amendments and addenda to this RFP issued by the issuing office. If no amendments or addenda have been received, a statement to that effect should be included;

g. A statement of affirmative action that the Offeror does not discriminate in its employment practices with regard to race, color, creed, ancestry, age, marital status, arrest and court records, sex, including gender identity or expression, sexual orientation, religion, national origin or mental or physical handicap, except as provided by law;

h. A statement that neither cost nor pricing is included in this letter or the technical proposal;

i. If the use of subcontractor(s) is proposed, a statement from each subcontractor shall be appended to the transmittal letter signed by an individual authorized to legally bind the subcontractor and stating the general scope of work to be performed by the subcontractor(s).

j. A statement that no attempt has been made or will be made by the Offeror to induce any other party to submit or refrain from submitting a proposal;

k. A statement that the person signing this proposal certifies that he/she is the person in the Offeror's organization responsible for, or authorized to make, the offer firm and binding, and that he/she has not

participated and will not participate in any action contrary to the above conditions;

l. A statement that the Offeror has read, understands, and agrees to all provisions of this RFP;

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

n. A statement that the person signing this proposal certifies that he/she is the person in the Offeror's organization responsible for, or authorized to make, the offer firm and binding, and that he/she has not participated and shall not participate in any action contrary to the above conditions.

2. The proposals are government records subject to public inspection, unless protected by law, but may include information that the Offeror feels is confidential or proprietary. If any page is marked "Confidential" or "Proprietary" in the Offeror's proposal, an explanation to DHS of how substantial competitive harm would occur if the information is released. If the DHS determines that it is Confidential or Proprietary, then the information will be excluded from disclosure to the public, refer to Section 1.10.

C) Financial Status

1. The financial status of an Offeror and related entities shall be reviewed in order to determine the financial solvency of the

organization. If an Offeror does not have adequate resources and fails to meet the financial requirements, the proposal shall not be scored and shall be returned to the Offeror.

2. Audited Financial Statements.

   Audited Financial Statements for the applicable legal entity and any subcontractor that is providing at a minimum of twenty (20%) of the work shall be provided for each of the last two years, including at a minimum:

   a. Balance Sheets;
   b. Statements of Income;
   c. Federal Income Tax returns; and
   d. Cash on hand.

3. If an Offeror seeks confidentiality on a part of a submission, each page of the section of that submission which is sought to be protected shall be marked as "Proprietary" and an explanation of how substantial competitive harm would occur if that information was released upon request. If the explanation is sufficient, then, to the extent permitted by the exemptions in HRS § 92F-13, 45 CFR Part 5, Office of Information Practices, or by a court order, the affected section may be deemed confidential. Blanket labeling of the entire document as "Proprietary," however, is inappropriate Blanket labeling of the entire document as "proprietary," shall result in none of the document being considered proprietary.

15.3 Technical Proposal

A) Executive Summary

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

B) Company Background and Experience

1. The company background and experience section shall include for the Offeror and each subcontractor (if any): the background of the company, its size and resources (gross revenues, number of employees, type of businesses), and details of company experience relevant to the operation of managed care plans (type of plan, number of Members, etc.). The required information is set forth in detail below.

2. For each subcontractor (if any), the Offeror shall include within this Section of the proposal, a break-down of responsibilities and functions that describe and clearly illustrate the percentage of work (scope of services required under this RFP) to be performed by the subcontractor, in comparison to the percentage of work to be performed by the Offeror

3. Background of the Offeror.

A description of the history of the Offeror to include but not limited to the following:

a. The legal name of the Offeror, including any names that the Offeror has used or is using to do business under; Federal and State Tax Identification Numbers.
b. Address, telephone number and email address of the Offeror's headquarter office;
c. Date company was established;
d. Date company began operations;
e. Provide a general description of the primary business of your organization and its Member base;
f. Provide a brief history and current company ownership including the ultimate parent organization and major shareholders/principals. An out-of-state Offeror shall become duly qualified to do business in the State of Hawaii before a contract can be executed;
g. Ownership of the company (names and percent ownership), including the officers of the corporation;
h. The home office location and all other offices (by city and state, not outside the United States);
i. The location of an office from which any contract would be administered;
j. The name, address and telephone number of the Offeror's point of contact for a contract resulting from this RFP;
k. The number of employees both in Hawaii and nationally, if applicable;

l. The size and resources, including the gross revenues both in Hawaii and nationally, if applicable;
m. The areas of specialization;
n. Description of any allegations made against the Offeror and each of its subcontractors, both in and out of the State of Hawaii in the past five (5) years. If applicable, please provide an explanation of the circumstances surrounding the allegations; and
o. Disclosure of any past and pending, (within five (5) years), litigation both in and out of the State of Hawaii for which the Offeror and each of its subcontractor, including the disclosure of any outstanding judgment, and if applicable, please explain the circumstances surrounding the litigation or outstanding judgment.

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

5. Offeror Experience.
The details of Offeror's experience including subcontractor experience, relevant to the proposal shall include but not limited to the following:
a. Length and quality of previous experience in providing the required behavioral health services to a Medicaid population or low-income group;
b. Length and quality of previous experience with managed care, including experience in working with

behavioral health agencies and behavioral health agencies as subcontractors;

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

d. Existing volume of current non-Medicaid Members receiving SMI services broken down by age and sex; and

e. Any instances of sanctions, corrective oversight, findings of fraud or abuse, or dissatisfaction with performance on the part of the Offeror, or their subcontractors or agents. (Describe the event, findings, agency bringing the action, outcome, and any other relevant facts that relate to the matter listed.)

6. Offeror References.

The Offeror shall provide no more than three (3) organizations for which the Offeror is currently providing services, or has previously provided services, and shall notify each organization named, that the DHS might contact it. The following information shall be provided for each organization:

a. Name of the organization;

b. Name, title, phone number, and e-mail address of a key contact at the organization, who is familiar with the services provided by the Offeror;

c. Name, title, address, phone number, and e-mail address of the contract manager; and

d. Number of Members served under the contract with the Offeror, the duration of the contract, and the type of services provided (e.g., behavioral health, TANF, ABD, etc.).

C) Organization and Staffing

1. The organization and staffing section of the proposal shall include: the Offeror's organizational chart showing company structure and personnel; the individual's name and contact information, FTE projection, state residence and work location, resume, and job description for each position listed below; and the FTE projection for each general area of work listed below.

2. The information should provide the DHS with a clear understanding of the Offeror's organizational structure, the functions of key personnel, and demonstrate compliance with the requirements of Section 11.

3. Organization Charts.

   The organization charts shall show the following:

   a. Relationships of the Offeror to related entities;
   b. Organizational structure, lines of authority, functions and staffing of the Offeror or proposed entity;
   c. Current (include names of individuals) or proposed personnel, with indication of the major areas of responsibility and relative placement within the organization; and

d. Geographic location of key personnel.

4. Required Personnel Information (for specified positions only).

   For each position listed below, the Offeror shall include the individual's name and contact information, FTE projection, state residence and work location, resume, and job description, in its proposal. [Note: The list below does not contain all the required positions included in Section 11. Should Offeror become the BHO, all required information in Section 11, shall be submitted to DHS as the BHO's Staffing Plan for Readiness Review]:

   a. Medical Director
   b. BHO Psychiatrist
   c. BHO Case Management Coordinator
   d. BHO Registered Nurse
   e. Executive Director
   f. Compliance Officer
   g. Pharmacist
   h. QA/UR Coordinator
   i. Grievance Coordinator

5. FTE Projections (for general areas of work).

   The Offeror shall include in its proposal, FTE projections for the following general areas of work. The projections should provide the DHS with a clear indication of the total amount, division, and focus of labor resources that the Offeror proposes to provide toward these general areas of work in executing the CCS program. The Offeror shall also

include a brief explanation for the FTE projections provided:

a. Member Services
b. Provider Services, including monitoring of subcontractor services
c. Case Management Services - contracted and BHO CM (not contracted)
d. Information Systems
e. Fraud, Waste, and Abuse Investigation
f. Administrative Support

D) Provider Network

1. Provider Listing.

   a. The Offeror shall have a provider network that complies with the requirements in Section 8. The Offeror shall identify its providers on each island by specialty. The Offeror shall provide the full range of behavioral health services to Members included in their proposal statewide. All providers required in Section 8 shall be included in the proposal.

   b. The provider network shall be based on either existing contracted providers or the Offeror may provide its network based on providers' intent to contract with the Offeror. The provider letter of intent (LOI) format provided in Appendix F shall be used to identify providers that are willing to contract with the Offeror.

A copy of each LOI shall be submitted in the proposal. Within one month of notice of award, the Offeror shall submit its preliminary network to the DHS. Failure to meet the requirements of the contract will result in a delay in implementation of the plan.

c. The Offeror shall include provider types as follows:
    1) Physicians, including specialists;
    2) Hospitals;
    3) Pharmacies; and
    4) Behavioral health providers.

d. The Offeror shall provide its provider listing (to include providers who have signed a LOI) for each island using the format in Appendix G. For each provider type, the offeror shall list the following information in Excel format:
    1) Provider type;
    2) Specialty (i.e., psychiatrist, psychologist, psychiatric nurse practitioner, social workers, substance abuse counselors, etc.);
    3) Island/County (for Oahu, include the city);
    4) List the provider name (last name, first name, M.I.) as well as any group affiliations;
    5) Provider street address (location where service is provided);
    6) City;
    7) Zip code;
    8) Telephone number(s);

9) Indication as to whether the provider is accepting new BHO Members (Y/N);
10) Indication as to whether the provider has a limit on the number of Members they will accept (Y/N);
11) The cultural and linguistic capabilities of providers available; and
12) Indication of provider's offices/facilities, exam rooms, and equipment have accommodations for people with physical disabilities.

e. Separate the providers by provider type noted below:
1) Behavioral healthcare specialist services such as psychiatrists, psychologists, social workers, certified substance abuse counselors, and advance practice nurses trained in psychology;
2) Case management;
3) Inpatient behavioral health hospital services;
4) Outpatient behavioral health hospital services;
5) Mental health rehabilitation services;
6) Day treatment programs;
7) Psychosocial rehabilitation (PSR)/Clubhouse;
8) Pharmacies;
9) Laboratory Services;
10) Crisis services: mobile crisis response and crisis residential services;
11) Interpretation services;
12) CIS;
13) Representative payee;

14) Supported employment; and
15) Peer Specialist

f. Each provider should be listed only once.

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

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

i. Finally, the Offeror shall describe its proposed approach to use of telehealth services to increase access and availability of services. In addition,

describe telehealth solutions for practices in rural and neighbor islands to build integrated care through non-local workforce and expand provider capacity. The response shall include information about its experience in contracting for telehealth services and specifically how it will use lessons learned to inform its contracting for telehealth services in Hawaii.

2. Mapping of Behavioral Health Providers and Hospitals

   a. The Offeror shall include in its proposal a Geographic Information Systems (GIS), or a similar program, mapping of each island indicating the locations of all of its behavioral health providers to include acute psychiatric hospitals. The Offeror shall include all providers that have signed a LOI and contracted providers.

E) Case Management

1. The Offeror shall explain how its case management system complies with Section 4.12, including but not limited to:
   a. How persons (Members, family members, community providers and providers) may access the case management system;
   b. How the Offeror intends to perform assessments to include SDOH and develop ITP using the stepped care approach and person-centered practices for Members;

c. A description and inclusion of the Offeror's assessment that includes SDOH that was used to gather information on the Member, when referred by a health plan, provider, DOH-CAMHD, DOH-AMHD, DOH-DDD, or others;
d. How the Offeror will interface with the Member's PCP, the HCS and other service providers;
e. How the Offeror will coordinate with the QI health plan HCS, other state divisions and Hawaii CARES;
f. How the Offeror will perform concurrent reviews during acute psychiatric hospitalization and perform safe and appropriate discharge planning;
g. How the Offeror will prioritize cases for case management (i.e., how it will address the various levels of complexity and intensity of Members' behavioral health care needs);
h. How the Offeror intends to implement the different levels of CM services described in Section 4.12.C;
i. How the Offeror intends to assure that case load ratios described in Section 4.12.C are met;
j. A description of how the Offeror will review cases suspected of not meeting SMI criteria;
k. A description of the components of an ITP and implementation using the stepped care approach and person-centered practices;
l. A description of how the Offeror will monitor CM services to report encounters, progress, discharge planning and outcomes;

m. A description of CM staffing including a job description of the CM and the type of initial and/or on-going training and education that it will provide to its case managers;
n. A description of how the Offeror will monitor Member progress and continued need for enrollment in the BHO; and
o. A description of how the Offeror will coordinate enrollment and disenrollment process which includes transition out of the CCS program.

F) Approach to Care Delivery and Coordination

1. The Offeror shall describe how it will ensure and monitor that the full continuum of care for behavioral health services will be available for CCS Members, including describing how they will be working with both their behavioral and physical health providers, regional enhanced referral networks, and health plan HCS system to optimize their overall health. The Offeror shall also describe how Members will be able to move up or down the continuum using the stepped care approach and person-centered practices.

G) Outreach and Education Programs

1. The Offeror shall describe how they intend to perform all of the requirements described in Section 4.13, "Other Services to be provided" (i.e., the Offeror's efforts to contact persons who are homeless, homebound, and

physically disabled, and the Offeror's ability to provide cultural and linguistic services to meet the needs of the Members). This Section should include information on the following:

a. Member Education;
b. Provider Education and Outreach;
c. Cultural/Interpretation Services;
d. Accessible Transportation Services;
e. Outreach to Members;
f. Appointment Follow-Up;
g. Hotline;
h. Adverse Events Policy/Reporting; and
i. Assistance with Certification of Physical or Mental Impairment.

H) Transition of Care

1. The Offeror shall describe how Members will be transitioned as described in Section 4.14, and what safeguards will be put into place to ensure that there is no disruption of services and to avoid an abrupt change in treatment plan or service providers, especially for the Members in high risk populations; i.e., the physically disabled, homeless, delinquent populations and other persons who have a SMI/SPMI diagnosis with special needs. The proposal shall include the transition procedures for:
   a. Referral and coordination for Members who have received behavioral health services from their QI health plan provider, and/or DOH-CAMHD, DOH-

AMHD, DOH-DDD, Hawaii CARES, the Hawaii State Hospital and prison system;

b. Inclusion of certain QI health plan providers into the behavioral health network to support and coordinate behavioral health services to high-risk Members;
c. How the Offeror will resolve differences in treatment plans/approaches with the current PCP and health plan HCS;
d. How the Offeror intends to establish and maintain community linkages with other service providers, i.e., QI health plan HCS, DOH-CAMHD, DOH-AMHD, DOH-DDD, DOH-ADAD, Hawaii CARES, and other community-based providers.

I) Member and Provider Toll-Free Call Center

1. Describe the Offeror's operation of the Member and Provider toll-free call center including:
    a. How the Offeror will monitor and assure full staffing during operational hours;
    b. Examples of training and informational resources provided to call center staff, including the process for remedial training for staff failing to meet call center standards. The response shall address how the call center staff information is provided, updated, and monitored to ensure accuracy of information provided to all callers;
    c. Approach to using back-up staff to support increased call volumes, how the Offeror assures such staff are

trained and have the correct materials specific to CCS and location of these staff; and

d. Process for routing calls including hotline calls (Section 4.13.F), crisis calls, and after-hours calls, to appropriate persons, including case managers, and the process for escalation and tracking.

J) Other Documentation

1. The Offeror shall attach, in the following order:
    a. The Proposal Application Identification Form (SPO-H-200);
    b. The State of Hawaii DHS Proposal Letter;
    c. The Certification for Contracts, Grants, Loans and Cooperative Agreements Form;
    d. Disclosure Statement (CMS required);
    e. Disclosure Statement (Related Party Transactions and Attestation);
    f. Disclosure Statement (Ownership);
    g. Financial Reporting Guide Forms (Organization Structure and Financial Planning);
    h. Controlling Interest Form;
    i. Background Check Information;
    j. Operational Certification Submission Form;
    k. Grievance System Form;
    l. Insurance Requirements Certification Form;
    m. Wage Certification Form;
    n. Provider's Standards of Conduct Declaration;

o. The State and Federal Tax Clearance certificates from the prime Offeror and, upon request from subcontractors, as assurance that all federal and state tax liabilities have been paid and that there are no significant outstanding balances owed (a statement shall be included if certificates are not available at time of submission of proposal that the certificates will be submitted in compliance with Section 1.11);

p. Proof that the Health Plan or BHO is actively registered in good standing with the Department of Commerce and Consumer Affairs (DCCA) in the State of Hawaii. A letter from the Insurance Division notifying the Offeror of its license shall be acceptable "proof" for the DHS; and

q. Certificate of Compliance from the State of Hawaii, Department of Commerce and Consumer Affairs, Insurance Division that validates financial solvency.

SECTION 16 – Evaluation and Selection

16.1 Overview

A) DHS shall conduct a comprehensive, fair and impartial evaluation of proposals received in response to this RFP. DHS shall be the sole judge in the selection of the BHO. The evaluation of the proposals shall be conducted as follows:

1. Review of the proposals to ensure that all mandatory requirements detailed in Section 15;
2. Review and evaluation of the technical proposals that meet all mandatory requirements to determine whether the Offeror meets the minimum technical criteria and requirements detailed in Section 15; and
3. Award of the Contract to the selected Offeror.

B) DHS reserves the right to waive minor irregularities in proposals provided such action is in the best interest of the State. DHS will determine what is considered a minor irregularity. Where DHS may waive minor irregularities, such waiver shall in no way modify the RFP requirements or excuse the Offeror from full compliance with the RFP specifications and other Contract requirements if the Offeror is awarded the contract.

16.2 Evaluation Process

A) DHS shall establish an Evaluation Committee (Committee) that shall review and evaluate each Offeror's proposal and make award

recommendations. The Committee shall consist of members who are familiar with the programs and the minimum standards or criteria for the particular area. Additionally, DHS may, at its discretion, designate additional representatives to assist in the evaluation process. DHS reserves the right to alter the composition of the Committee or designate other staff or vendors to assist in the evaluation process. The Committee shall review and evaluate all qualified responses to the RFP. The Committee will be responsible for the entire evaluation process and scoring will be determined by consensus.

16.3 Mandatory Proposal Evaluation

A) Each proposal shall be evaluated to determine whether the requirements as specified in this RFP have been met. The proposal shall first be evaluated against the following:
   1. The Offeror successfully met all of the requirements set for in Section 1.16;
   2. All information required in Section 15.2, has been submitted; and
   3. The proposal contains the required information in the proper order.

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

16.4 Technical Proposal Evaluation

A) DHS shall conduct a comprehensive, fair, and impartial evaluation of all Offeror proposals. DHS may reject any proposal that is incomplete, in which there are significant inconsistencies or inaccuracies, or did not follow DHS' procedures in submitting the proposal including submitting it on the due date. DHS will determine whether there is a sufficient basis to reject a proposal for reasons stated in this RFP or any applicable state and federal law or regulations. Each Offeror is responsible for submitting all relevant, factual and correct information with their proposal to enable the Committee to afford each Offeror the maximum score based on the available data submitted by the Offeror.

B) The Offeror's responses to the technical proposal will be evaluated in how responses address program requirements for Oahu and the Neighbor Islands.

16.5 Evaluation Categories and Criteria

A) The Evaluation Categories and points are described in the table below:

Table 16.5.A-1: Evaluation Categories and Point Allocation

Evaluation Categories	RFP Section	Maximum Points Possible
Mandatory Proposal		
1. Proposal Letter	15.2.A	Pass/Fail

2. Transmittal Letter	15.2.B	Pass/Fail
3. Financial Status	15.2.C	Pass/Fail
Technical Proposal		
1. Executive Summary	15.3.A	50
2. Company Background and Experience	15.3.B	50
3. Organization and Staffing	15.3.C	125
4. Provider Network	15.3.D	100
5. Case Management	15.3.E	200
6. Approach to Care Delivery and Coordination	15.3.F	200
7. Outreach and Education Programs	15.3.G	125
8. Transition of Care	15.3.H	150
Total Possible Points		**1000**

16.6 Scoring

A) The Evaluation Committee will score Offeror proposals using the following rating methodology:

Table 16.6.A-1: Technical Proposal Rating

Rating Score	Description
5	**Excellent.** The proposal addresses the criterion in an excellent and highly comprehensive manner. No deficiencies noted. The proposal goes beyond the requirements listed in the RFP to provide added value. In addition, the response may cover areas not originally addressed within the RFP and/or include additional information and recommendations that would prove both valuable and beneficial to DHS. The response includes a full, clear, and detailed explanation of how requirement(s) are met. No errors in technical writing.
4	**Very Good.** The proposal addresses the criterion very well, in a highly comprehensive manner. No deficiencies noted. The response meets the requirements. Demonstrates knowledge and understanding of the subject matter. The proposal describes how the requirements will be minimally met.
3	**Good.** The proposal addresses all aspects of the question well. The response meets the requirements. Demonstrates knowledge and understanding of the subject matter. The proposal contains no major deficiencies and only minor deficiencies that are easily correctible.
2	**Fair.** The proposal broadly addresses all aspects of the question, but there are significant weaknesses. The proposal has one major deficiency and/or multiple minor deficiencies that do not appear to be easily correctable.
1	**Poor.** Aspects of the question are inadequately addressed. Offeror's response has multiple major deficiencies that do not appear to be correctable.
0	The proposal fails to address aspects of the question or cannot be assessed due to missing or incomplete information. Offeror has not demonstrated sufficient knowledge of the subject matter or has failed to explain how requirement(s) is met.

B) The Offeror shall receive at minimum a rating score of three (3) for each Evaluation Category or the proposal will not be considered technically acceptable and shall be rejected. Offerors shall receive a minimum score of seven hundred fifty (750) points,

seventy-five percent (75%) of the total available points to be considered responsive to the RFP. Proposals not meeting the conditions stated in this paragraph shall not be awarded a contract.

C) The rating score (0-5) shall represent the corresponding conversion factor used to calculate the points awarded for each Evaluation Category listed in Section 16.5, as follows:

Table 16.6.C-1 Rating Score Conversion

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

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

E) Scoring will be based on the entire content of the proposal and the information as communicated to the Committee. The information contained in any part of the proposal may be evaluated by DHS with respect to any other scored section of the

proposal. Lack of clarity and inconsistency in the proposal will impede effective communication of the content and may result in a lower score.

16.7 Selection of Offeror

A) Upon completion of the Technical Proposal evaluations, DHS shall sum the scores from the evaluation to determine the Offeror that shall be awarded the contract from the State. One (1) Offeror will be selected.

16.8 Contract Award

A) Upon selection of the Offeror that will be awarded the contract, DHS shall initiate the contracting process. The Offeror shall be notified in writing that the RFP proposal has been accepted and that DHS intends to award the contract to the Offeror. This letter shall serve as notification that the Offeror should begin to develop its programs, materials, policies and procedures for the programs.

B) The contract shall be awarded no later than the Contract Award date identified in Section 1.5. If an awarded Offeror requests to withdraw its proposal, it shall be requested in writing to DHS before the close of business (4:30 p.m. H.S.T.) on the Contract Award date identified in Section 1.5. After that date, DHS expects to enter into a contract with the Offeror.

C) This RFP, the Offeror's technical proposal, and any other materials submitted by the Offeror shall become part of the contract,

excluding any terms inconsistent with the RFP, as determined by DHS.

APPENDICES

Appendix A: Written Questions Format
Appendix B: Notice of Intent to Propose
Appendix C: Proposal Forms
Appendix D: CCS Referral Form (DHS 1157) and Instructions
Appendix E: 103 F Forms
Appendix F: Provider Letter of Intent
Appendix G: Provider Listing
Appendix H: Risk Sharing Mechanisms
Appendix I: Financial Responsibility Guideline
Appendix J: Business Associate Agreement
Appendix K: Staffing Change Notification Form, Instructions, and Sample
Appendix L: Remedies for Non-Performance of CCS Contract
Appendix M: Report Inventory
Appendix N: Provider Contract Requirements

Appendix A

Written Questions Format
Community Care Services (CCS) Program RFP

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

CCS RFP Notice of Intent to Propose

RFP Number and Title: RFP-MQD-2021-010
Offeror Name: _____
Name and Title of the Authorized Individual: _____

Signature and Date: _____

List up to five (5) Offeror contact person(s) who can upload, revise or edit the Mandatory and Technical proposals in the DHS proposal designated electronic submission site. DHS will provide the submission site address to these five (5) staff no later than ten (10) calendar days before the proposal due date as described in Section 1.5.

	First Name, Last Name	Title	E-mail Address	Contact Phone Number
1				
2				
3				
4				
5				

Appendix C – Proposal Forms (14 documents)

(01) Proposal Application Identification Form (SPO-H 200)
(02) State of Hawaii DHS Proposal Letter
(03) Certification for Contracts, Grants, Loans and Cooperative Agreements Form
(04) Disclosure Statement (CMS Required)
(05) Disclosure Statement (Related Party Transactions and Attestation)
(06) Disclosure Statement (Ownership)
(07) Financial Reporting Guide Forms (Organization Structure and Financial Planning)
(08) Controlling Interest Form
(09) Background Check Information
(10) Operational Certification Submission Form
(11) Grievance System Form
(12) Insurance Requirements Certification Form
(13) Wage Certification Form
(14) Provider's Standards of Conduct Declaration

STATE OF HAWAII

STATE PROCUREMENT OFFICE

PROPOSAL APPLICATION IDENTIFICATION FORM

STATE AGENCY ISSUING RFP: _____

RFP NUMBER: _____

RFP TITLE: _____

Check one:

☐ Initial Proposal Application

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

1. APPLICANT INFORMATION

Legal Name:

Doing Business As:

Street Address:

Mailing Address:

Contact person for matters involving this application:
Name:

Title:

Phone Number:

Fax Number:

e-mail:

2. BUSINESS INFORMATION

Type of Business Entity *(check one)*:

☐ Non-Profit Corporation ☐ Limited Liability Company ☐ Sole Proprietorship

☐ For-Profit Corporation ☐ Partnership

If applicable, state of incorporation and date incorporated:

State: Date:

3. PROPOSAL INFORMATION

Geographic area(s):

Target group(s):

4. **FUNDING REQUEST**

FY _____ _____ FY _____ _____

FY _____ _____ FY _____ _____

FY _____ _____ FY _____ _____

Grand Total _____

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

_____ _____

Authorized Representative Signature *Date Signed*

_____

Name and Title

STATE OF HAWAII

Department of Human Services

PROPOSAL LETTER

We propose to furnish and deliver any and all of the deliverables and services named in the attached Request for Proposal for the Community Care Services Program. The administrative rates offered herein shall apply for the period of time stated in said RFP.

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

It is understood and agreed that we have read the State's specifications described in the RFP and that this proposal is made in accordance with the provisions of such specifications. By signing this proposal, we guarantee and certify that all items included in this proposal meet or exceed any and all such State specifications.

We agree, if awarded the contract, to deliver goods or services which meet or exceed the specifications.

_____ _____

Authorized Applicant's Signature/Corporate Seal Date

CERTIFICATION FOR CONTRACTS, GRANTS, LOANS AND COOPERATIVE AGREEMENTS

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

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

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

Applicant: _____

Signature: _____

Title: _____

Date: _____

DISCLOSURE STATEMENT (CMS REQUIRED)

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

a) Disclosures in accordance with 42 CFR 455 Subpart B
§ 455.104
Disclosure by Medicaid providers and fiscal agents: Information on ownership and control.
(a) Who must provide disclosures. The Medicaid agency must obtain disclosures from disclosing entities, fiscal agents, and managed care entities.
(b) What disclosures must be provided. The Medicaid agency must require that disclosing entities, fiscal agents, and managed care entities provide the following disclosures:
(1) (i) The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.
(ii) Date of birth and Social Security Number (in the case of an individual).
(iii) Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest.
(2) Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.
(3) The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.
(4) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).
(c) When the disclosures must be provided.
(1) Disclosures from providers or disclosing entities. Disclosure from any provider or disclosing entity is due at any of the following times:
(i) Upon the provider or disclosing entity submitting the provider application.
(ii) Upon the provider or disclosing entity executing the provider agreement.
(iii) Upon request of the Medicaid agency during the re-validation of enrollment process under § 455.414.
(iv) Within 35 days after any change in ownership of the disclosing entity.
(2) Disclosures from fiscal agents. Disclosures from fiscal agents are due at any of the following times:
(i) Upon the fiscal agent submitting the proposal in accordance with the State's procurement process.
(ii) Upon the fiscal agent executing the contract with the State.
(iii) Upon renewal or extension of the contract.
(iv) Within 35 days after any change in ownership of the fiscal agent.
(3) Disclosures from managed care entities. Disclosures from managed care entities (MCOs, PIHPs, PAHPs, and HIOs), except PCCMs are due at any of the following times:
(i) Upon the managed care entity submitting the proposal in accordance with the State's procurement process.
(ii) Upon the managed care entity executing the contract with the State.
(iii) Upon renewal or extension of the contract.

(iv) Within 35 days after any change in ownership of the managed care entity.
(d) To whom must the disclosures be provided. All disclosures must be provided to the Medicaid agency.
(e) Consequences for failure to provide required disclosures. Federal financial participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by this section.

§ 455.105
Disclosure by providers: Information related to business transactions.
(a) Provider agreements. A Medicaid agency must enter into an agreement with each provider under which the provider agrees to furnish to it or to the Secretary on request, information related to business transactions in accordance with paragraph (b) of this section.
(b) Information that must be submitted. A provider must submit, within 35 days of the date on a request by the Secretary or the Medicaid agency, full and complete information about—
(1) The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and
(2) Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.
(c) Denial of Federal financial participation (FFP). (1) FFP is not available in expenditures for services furnished by providers who fail to comply with a request made by the Secretary or the Medicaid agency under paragraph (b) of this section or under § 420.205 of this chapter (Medicare requirements for disclosure).
(2) FFP will be denied in expenditures for services furnished during the period beginning on the day following the date the information was due to the Secretary or the Medicaid agency and ending on the day before the date on which the information was supplied.

§ 455.106
Disclosure by providers: Information on persons convicted of crimes.
(a) Information that must be disclosed. Before the Medicaid agency enters into or renews a provider agreement, or at any time upon written request by the Medicaid agency, the provider must disclose to the Medicaid agency the identity of any person who:
(1) Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and
(2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs.
(b) Notification to Inspector General. (1) The Medicaid agency must notify the Inspector General of the Department of any disclosures made under paragraph (a) of this section within 20 working days from the date it receives the information.
(2) The agency must also promptly notify the Inspector General of the Department of any action it takes on the provider's application for participation in the program.
(c) Denial or termination of provider participation. (1) The Medicaid agency may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the title XX Services Program.
(2) The Medicaid agency may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under paragraph (a) of this section.

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

1) Names and addresses of the Board of Directors of the disclosing entity.

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

3) Names and addresses of creditors whose loans or mortgages are secured by a five (5) percent or more interest in the assets of the disclosing entity.

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

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

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

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

§ 455.101
Definitions.
Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Disclosing entity means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Other disclosing entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:
(a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);

(b) Any Medicare intermediary or carrier; and
(c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

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

Health insuring organization (HIO) has the meaning specified in § 438.2.

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

Managed care entity (MCE) means managed care organizations (MCOs), PIHPs, PAHPs, PCCMs, and HIOs.

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

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

Person with an ownership or control interest means a person or corporation that—
(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
(e) Is an officer or director of a disclosing entity that is organized as a corporation; or
(f) Is a partner in a disclosing entity that is organized as a partnership.

Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of a provider's total operating expenses.

Subcontractor means—
(a) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
(b) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreeement.

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

Termination means—
(1) For a—
(i) Medicaid or CHIP provider, a State Medicaid program or CHIP has taken an action to revoke the provider's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired; and
(ii) Medicare provider, supplier or eligible professional, the Medicare program has revoked the provider or supplier's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired.
(2) (i) In all three programs, there is no expectation on the part of the provider or supplier or the State or Medicare program that the revocation is temporary.
(ii) The provider, supplier, or eligible professional will be required to reenroll with the applicable program if they wish billing privileges to be reinstated.
(3) The requirement for termination applies in cases where providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause which may include, but is not limited to—
(i) Fraud;
(ii) Integrity; or
(iii) Quality.

Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

DISCLOSURE STATEMENT

Instructions

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

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

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

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

Description of Transaction(s)	Name of Related Party and Relationship	Dollar Amount for Reporting Period

Justification

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

Description of Transaction(s)	Name of Related Party and Relationship	Dollar Amount for Reporting Period

Justification

DISCLOSURE STATEMENT

BHO NAME/NO. _____

DISCLOSURE STATEMENT FOR THE YEAR ENDED _____

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

Date Signed	Chief Executive Officer (Name and Title Typewritten)
Notarized	Signature

DISCLOSURE STATEMENT
OWNERSHIP

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

For the period beginning: _____ and ending _____ Type

of BHO:

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

Type of Entity:

- ☐ Sole Proprietorship
- ☐ Partnership
- ☐ Corporation
- ☐ Governmental

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

455.104 Information on Ownership arid Control

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

Name	Address	Percent of Ownership Control

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

Name	Address	Percent of Ownership Control

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

Name	Address	Percent of Ownership Control

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

Name	Address	Percent of Ownership Control

455.105 Information Related to Business Transactions

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

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

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

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

455.106 Information on Persons Convicted of Crime

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

Name	Address	Title

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

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

Name/Title	Address

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

Name/Title	Address

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

Name	Address	Amount of Debt	Description of Security

Financial Reporting Guide Forms
Organization Structure and Financial Planning Form

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

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

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

Service Component	License/Requirement	Renewal Date

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

   Yes _____ No _____ If yes, please explain:

3) Civil Rights Compliance Data

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

   Yes _____ No _____ If yes, please explain:

4) Handicapped Assurance

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

   Yes _____ If yes, briefly describe how such assurances are provided.
   No _____ If no, briefly describe how your organization is taking affirmative steps to provide assurance.

5) Prior Convictions

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

6) Federal Government Suspension/Exclusion

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

Yes _____ No _____ If yes, please explain:

Financial Planning Form

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

2) Does the offeror prepare an annual financial statement?

   Yes _____ No _____ If yes, please explain:

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

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

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

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

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

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

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

   b. By whom are they conducted? _____

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

d. Are management letters on internal controls issued by the accounting firm?
Yes _____ No _____

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

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

e. Do you have any uncorrected audit exceptions?
Yes _____ No _____

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

5) Does the offeror have an accounting manual?
Yes _____ No _____

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

6) Does the offeror have a formal basis to allocate indirect costs reflected in your financial statement?
Yes _____ No _____

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

7) What types of liability insurance does the offeror have?
a. With what company(s)? _____

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

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

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

Briefly describe each item and indicate probable amount.

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

If yes, when? _____

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

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

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

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

If yes, provide the following information:

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

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

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

Yes _____ No _____

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

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

b. How often are IBNRs projected? _____

_____

c. Identify all major data sources most often used.

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

Yes _____ No _____ If so, how?

e. Are detailed written procedures maintained? Yes _____

No _____

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

Yes _____ No _____

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

Yes _____ No _____

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

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

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

Yes _____ No _____ If yes, enter name: ____

_____

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

a. Medicare reimbursement Yes _____ No ____

_____

b. Other third-party recoveries Yes _____ No ____

_____

If no, explain why.

Controlling Interest Form

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

Name	Address	Owner or Controller	Has Controlling Interest? Yes	No

Background Check Information

The Offeror must provide fingerprint criminal background check results for all the key personnel (i.e. Chief Executive Officer, Medical Director, Financial Officer, Consultants, Accountants, Attorneys, etc.) to DHS.

Operational Certification Submission Form

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

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

_____

Signature Date

Grievance System Form

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

I hereby certify that _____
Offeror Name

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

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

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

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

Authorized Signature	Date
Printed Name	Title

INSURANCE REQUIREMENTS CERTIFICATION

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

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

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

(Check and complete one)

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

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

_____

_____

_____

_____

_____

_____

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

_____

Name of Offeror

_____ _____

Authorized Representative Signature Date

_____

Print Name and Title

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

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

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

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

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

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

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) (1)

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

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

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

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

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

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

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

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

CERTIFICATE HOLDER

(14)

CANCELLATION

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

AUTHORIZED REPRESENTATIVE

(15)

Wage Certification

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

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

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

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

Offeror: _____

Signature: _____

Title: _____

Date: _____

CONTRACT NO. _____

PROVIDER'S
STANDARDS OF CONDUCT DECLARATION

For the purposes of this declaration:

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

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

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

On behalf of:

_____
(Name o]PROVIDER)

PROVIDER, the undersigned does declare as follows:

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

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

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

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

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

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

CONTRACT NO. _____

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

PROVIDER _____

By _____
(Signature)

Print Name _____

Print Title _____

_____

Date _____

AG Fonn 103F9 (10/08)

REFERRAL FOR SERIOUS MENTAL ILLNESS (SMI) COMMUNITY CARE SERVICES (CCS) PROGRAM

CLIENT NAME _____ ☐ MALE ☐ FEMALE
Last First M.I.

HOME ADDRESS _____ PHONE NO. _____

_____ CASE NO. _____

MAILING ADDRESS _____ CLIENT ID NO. _____

_____ SOCIAL SECURITY NUMBER _____

DATE OF BIRTH _____ AGE _____ COUNTY ☐ OAHU ☐ HAWAII ☐ MAUI ☐ KAUAI

HEALTH PLAN: ☐ UNITED HEALTHCARE ☐ OHANA ☐ ALOHA CARE ☐ HMSA ☐ KAISER FOUNDATION

PRIMARY DIAGNOSIS _____ DSMIV CODE _____

SECONDARY DIAGNOSIS _____ DSMIV CODE _____

CURRENT MEDICAL CONDITIONS (Indicate, if none) _____

_____

DATE OF REFERRAL: _____ NAME OF PCP: _____ PCP NOTIFIED: Y / N

HOSPITALIZATIONS	**CURRENTLY AT:** ☐ **Castle** ☐ **Queen's** ☐ **Other:** _____ *(list)* **Admitted on** _____/_____/_____			
Past Hospitalizations- Facility	Location	Date Admitted	Date Discharged	Diagnosis
MEDICATIONS	Strength	Dosage	Start Date	End Date
OUTPATIENT THERAPISTS	Diagnosis		Start Date	End Date

Section below to be completed by MQD/CSO Evaluation Panel

Date of Evaluation _____ Date of Enrollment/Disenrollment of CCS Services_____

Approved for CCS Referral: ☐ Yes ☐ No ☐ Additional Information Needed

Re-Evaluation Required: ☐ Yes ☐ No If Yes, date to be re-evaluated: ____/____/____

Reason for denial/comments _____

_____

_____

Signature: _____

FOR ADULTS ONLY

Client Name: _____ Client I.D. No.: _____

I. MENTAL STATES

A. General:

1. Appearance: Within Normal Limits [ ] Other [ ] _____
2. Dress: Appropriate [ ] Bizarre [ ] Clean [ ] Dirty [ ]
3. Grooming: Neat [ ] Disheveled [ ] Needs improvement [ ]

B. Behavior:

1. Eye Contact: Good [ ] Fair [ ] Poor [ ]
2. Posture: Good [ ] Slumped [ ] Rigid [ ] Other [ ] _____
3. Body Movements: None [ ] Involuntary [ ] Akathisia [ ] Other [ ] _____

C. Speech: Clear [ ] Mumbled [ ] Rapid [ ] Whispers [ ] Monotone [ ]
Slurred [ ] Slow [ ] Loud [ ] Constant [ ] Mute [ ]
Other [ ] _____

D. Mood: Anxious [ ] Fearful [ ] Friendly [ ] Euphoric [ ] Calm [ ]
Aggressive [ ] Hostile [ ] Depressed [ ]
Other [ ] _____

E. Affect: Full range [ ] Flat [ ] Constricted [ ] Inappropriate [ ]
Other [ ] _____

F. Thought:

1. Process or Form: Loose associations [ ] Poverty of content [ ] Flight of ideas [ ]
   Neologism [ ] Perseveration [ ] Blocking [ ]
2. Content: Delusions [ ] Thought broadcasting [ ]
   Thought insertion [ ] Thought withdrawal [ ] Other [ ] _____

G. Perception – Hallucinations:

Auditory [ ] Tactile [ ] Somatic [ ] Other [ ] _____

H. Reality Orientation:

1. Mark all areas which the recipient can name:
   Time: Day [ ] Month [ ] Year [ ]
   Place: (can describe location) Yes [ ] No [ ]
   Person: Self [ ] Family or friend [ ]
2. Memory: Recent intact? Yes [ ] Remote intact: Yes [ ]
   No [ ] No [ ]

I. Insight: Aware of illness [ ] Denies illness [ ] Other [ ] _____

J. Judgment: Good [ ] Fair [ ] Poor [ ]

FOR ADULTS ONLY

Client Name: _____ Client I.D. No.: _____

II. FUNCTIONAL SCALES: *(Check and specify any problem(s) in the following areas)*

[ ] Medical/Physical

_____

_____

[ ] Family/Living

_____

_____

[ ] Interpersonal Relations

_____

_____

[ ] Role Performance

_____

_____

[ ] Socio-Legal

_____

_____

[ ] Self-Care/Basic Needs

_____

_____

III. **SUPPORTING DOCUMENTATION:** Please supply additional comprehensive information and assessments (if available) which would be of assistance in the evaluation of the criteria for eligibility.

Signed: _____ Date: _____

Reporting Psychiatrist/Psychologist *(Print Name)*: _____

Reporting Psychiatrist/Psychologist Phone No.: _____

Signed: _____ Date: _____

Medical Director or Attending Physician for in-patients *(Print Name)*: _____

INSTRUCTIONS
DHS 1157 (Rev. 04/14)

REFERRAL FOR SERIOUS MENTAL ILLNESS (SMI) COMMUNITY CARE SERVICES (CCS) PROGRAM

PURPOSE:

The DHS 1157, Referral for Serious Mental Illness (SMI) to the Community Care Services (CCS) Program, shall be initiated by the health plan or hospital when there is reason to believe that an applicant/beneficiary of medical assistance may meet the definition of SMI and would meet the criteria to receive services from CCS.

GENERAL INSTRUCTIONS:

The applicant/beneficiary's provider, with review and concurrence by the health plan medical director or attending physician, shall complete this form to refer an applicant/beneficiary for consideration for the CCS program and submit it along with pertinent medical records to the Med- QUEST Division/Clinical Standards Office (MQD/CSO). The MQD/CSO evaluation panel will complete the Section to be completed by MQD/CSO Evaluation Panel and make a determination for CCS referral based on the information provided in the Referral for SMI CCS packet.

SPECIFIC INSTRUCTIONS:

The DHS 1157 should be completed by the applicant/beneficiary's provider, with review and concurrence by the health plan medical director or attending physician.

The DHS 1157 page 1, the Mental States page 2, and the Functional Scales page 3, should be signed by the applicant/beneficiary's treating psychiatrist or psychologist. If the applicant/beneficiary does not have a treating psychiatrist or psychologist, then the treating medical provider for the applicant/beneficiary may sign where indicated on the form. Signature also required indicating review and concurrence by the health plan medical director or behavioral health specialist

Page 1:
Section A: To Be Completed By the Health Plan Medical Director or Attending Physician

1. Furnish the following identifying data: the applicant/beneficiary's name, gender, home address, mailing address, date of birth, age, phone number, DHS case No., client ID No., Social Security number, county and health plan.
2. Indicate the primary and secondary diagnosis along with any current medical conditions and DSMIV code. Qualifying diagnosis need to be present for over 12 months or expected to continue for 12 months.
3. Complete date of referral, name of primary care provider (PCP) and identify whether or not the PCP was informed of the referral.
4. Applicant/beneficiary is to initial acknowledgement of the statement to comply with the CCS program directions and understand that current provider(s) may change.
5. Applicant/beneficiary signature is required for the process to move forward.
6. Hospitalizations:
   Identify if the applicant/beneficiary is currently hospitalized and indicate the location. List all other hospitalizations by facility, location, date admitted, date discharged and diagnosis. Attach an extra sheet if more space is needed.

7. Medications:
List the routine psychiatric medications, as well as frequently used prn psychiatric medications identifying the medication strength, dosage, start date and end date

Outpatient therapists:
Provide a list of current and past mental health therapists, diagnosis, start and end dates of treatment. Attach an extra sheet if more space is needed.

Section B: To Be Completed By MQD/CSO Evaluation Panel

MQD medical director or behavioral health consultants will complete and sign this section indicating:

1. The date the Referral for CCS is evaluated;
2. If approved for CCS referral, the date of enrollment is indicated in this section and will be five business days after the date the CCS referral is approved.
3. Whether the applicant/beneficiary is approved for CCS referral or if additional information is needed;
4. Whether re-evaluation is required, if yes, date to be re-evaluated;
5. Reason for denial and any other comments.

Page 2

Section C: To Be Completed By the Health Plan Medical Director or Attending Physician

I. MENTAL STATES - Self-explanatory.

Page 3

II. FUNCTIONAL SCALES - Self-explanatory.

Section D: To Be Completed By the Health Plan Medical Director or Attending Physician

III. SUPPORTING DOCUMENTATION – Provide additional comprehensive information and assessments to assist in the evaluation of the criteria for CCS eligibility.

ELIGIBILITY CRITERIA

The beneficiary is eligible for CCS referral if A through E can be answered "Yes."

The applicant/beneficiary:

1. Is 18 years of age or older and is Medicaid eligible.
2. Is NOT successfully engaged in existing case management services, including AMHD Case management services.
3. Have been diagnosed as having one of the qualifying diagnoses (see attached).
4. Demonstrates the presence of the qualifying diagnosis for the last 12 months or is expected to demonstrate the qualifying diagnosis for the next 12 months.
5. Meets at least one of the criteria below that demonstrates instability and/or functional impairment:
   a. Clinical records demonstrate that the beneficiary is currently unstable under

current treatment and plan of care (e.g. multiple hospitalizations in the last year and currently unstable, substantial history of crises and currently unstable, consistently noncompliant with meds and follow-up, unengaged with providers, significant and consistent isolation, at risk for hospitalization, resource deficit causing instability).

b. The applicant/beneficiary's GAF scores, supported by submitted clinical records, currently is and have been consistently less than 50 over the past 6 months.

c. The applicant/beneficiary is under Adult Protective Services (APS) or requires intervention by housing or law enforcement officials. Supporting documentation exists in the medical record, such as a letter from APS or housing official.

If the referral to CCS does not provide sufficient information under A through E to make a determination, the referral will be sent back for more information, or the health plan or hospital will be contacted to provide additional information.

Upon Referral to CCS by the MQD, the applicant/beneficiary will be assessed by CCS. If the applicant/beneficiary does not meet or no longer meets the criteria for CCS admission, based on the initial evaluation, CCS will complete the DHS 1157 to indicate the reason for applicant/beneficiary not being recommended for either continued services or disenrollment from CCS. MQD will return the beneficiary referral back to the referring health plan or if applicant/beneficiary is still hospitalized, to the hospital.

Provisional Referral to CCS is made for individuals whose qualifying condition or duration of illness is uncertain because of co-existing substance abuse or medical condition. The criteria above should still be met. CCS will be made aware of the provisional status of the referral and the applicant/beneficiary must be re-evaluated by MQD using the DHS 1157 and reassessment completed by CCS at the timeframe indicated on the initial DHS 1157.

FILING INSTRUCTIONS:

In order for MQD CSO to perform an evaluation and determination, the supporting documentation must be adequate and complete. The following requirements must be included as part of the SMI CCS packet:

1. DHS 1157 'Referral for Serious Mental Illness (SMI) CCS Program page 1, page 2 "Mental States" and page 3 "Functional Scales";
2. Clinical notes within the past year outlining current plan of care and treatment;
3. Hospital admission and discharge notes within the past year, if applicable;
4. Psychiatric and/or psychosocial assessment within the past year; and
5. Global Assessment of Functioning (GAF) scores within the last six months, and highest within the last year, supported by clinical documentation.

The DHS 1157 form and supporting documentation may be faxed or mailed to the applicant's health plan for referral to the CCS Program with the exception of those providers who are allowed to fax directly to MQD at 808-692-8131

CONTRACT NO. _____

GENERAL CONDITIONS FOR HEALTH & HUMAN SERVICES CONTRACTS
TABLE OF CONTENTS

GENERAL CONDITIONS
FOR HEALTH & HUMAN SERVICES CONTRACTS

1. Representations and Conditions Precedent

1.1 Contract Subject to the Availability of State and Federal Funds.

1.1.1 State Funds. This Contract is, at all times, subject to the appropriation and allotment of state funds, and may be terminated without liability to either the PROVIDER or the STATE in the event that state funds are not appropriated or available.

1.1.2 Federal Funds. To the extent that this Contract is funded partly or wholly by federal funds, this Contract is subject to the availability of such federal funds. The portion of this Contract that is to be funded federally shall be deemed severable, and such federally funded portion may be terminated without liability to either the PROVIDER or the STATE in the event that federal funds are not available. In any case, this Contract shall not be construed to obligate the STATE to expend state funds to cover any shortfall created by the unavailability of anticipated federal funds.

1.2 Representations of the PROVIDER. As a necessary condition to the formation of this Contract, the PROVIDER makes the representations contained in this paragraph, and the STATE relies upon such representations as a material inducement to entering into this Contract.

1.2.1 Compliance with Laws. As of the date of this Contract, the PROVIDER complies with all federal, state, and county laws, ordinances, codes, rules, and regulations, as the same may be amended from time to time, that in any way affect the PROVIDER's performance of this Contract.

1.2.2 Licensing and Accreditation. As of the date of this Contract, the PROVIDER holds all licenses and accreditations required under applicable federal, state, and county laws, ordinances, codes, rules, and regulations to provide the Required Services under this Contract.

1.3 Compliance with Laws. The PROVIDER shall comply with all federal, state, and county laws, ordinances, codes, rules, and regulations, as the same may be amended from time to time, that in any way affect the PROVIDER's performance of this Contract, including but not limited to the laws specifically enumerated in this paragraph:

1.3.1 Smoking Policy. The PROVIDER shall implement and maintain a written smoking policy as required by Chapter 328K, Hawaii Revised Statutes (HRS), or its successor provision.

1.3.2 Drug Free Workplace. The PROVIDER shall implement and maintain a drug free workplace as required by the Drug Free Workplace Act of 1988.

1.3.3 Persons with Disabilities. The PROVIDER shall implement and maintain all practices, policies, and procedures required by federal, state, or county law, including but not limited to the Americans with Disabilities Act (42 U.S.C. §12101, et seq.), and the Rehabilitation Act (29 U.S.C.§701, et seq.).

1.3.4 Nondiscrimination. No person performing work under this Contract, including any subcontractor, employee, or agent of the PROVIDER, shall engage in any discrimination that is prohibited by any applicable federal, state, or county law.

1.4 Insurance Requirements. The PROVIDER shall obtain from a company authorized by law to issue such insurance in the State of Hawai‘i commercial general liability insurance ("liability insurance") in an amount of at least TWO MILLION AND NO/100 DOLLARS ($2,000,000.00) coverage for bodily injury and property damage resulting from the PROVIDER's performance under this Contract. The PROVIDER shall maintain in effect this liability insurance until the STATE certifies that the PROVIDER's work under the Contract has been completed satisfactorily.

The liability insurance shall be primary and shall cover the insured for all work to be performed under the Contract, including changes, and all work performed incidental thereto or directly or indirectly connected therewith.

A certificate of the liability insurance shall be given to the STATE by the PROVIDER. The certificate shall provide that the STATE and its officers and employees are Additional Insureds. The certificate shall provide that the coverages being certified will not be cancelled or materially changed without giving the STATE at least 30 days prior written notice by registered mail.

Should the "liability insurance" coverages be cancelled before the PROVIDER's work under the Contract is certified by the STATE to have been completed satisfactorily, the PROVIDER shall immediately procure replacement insurance that complies in all respects with the requirements of this section.

Nothing in the insurance requirements of this Contract shall be construed as limiting the extent of PROVIDER's responsibility for payment of damages resulting from its operations under this Contract, including the PROVIDER's separate and independent duty to defend, indemnify, and hold the STATE and its officers and employees harmless pursuant to other provisions of this Contract.

1.5 Notice to Clients. Provided that the term of this Contract is at least one year in duration, within 180 days after the effective date of this Contract, the PROVIDER shall create written procedures for the orderly termination of services to any clients receiving the Required Services under this Contract, and for the transition to services supplied by another provider upon termination of this Contract, regardless of the circumstances of such termination. These procedures shall include, at

the minimum, timely notice to such clients of the termination of this Contract, and appropriate counseling.

1.6 Reporting Requirements. The PROVIDER shall submit a Final Project Report to the STATE containing the information specified in this Contract if applicable, or otherwise satisfactory to the STATE, documenting the PROVIDER's overall efforts toward meeting the requirements of this Contract, and listing expenditures actually incurred in the performance of this Contract. The PROVIDER shall return any unexpended funds to the STATE.

1.7 Conflicts of Interest. In addition to the Certification provided in the Standards of Conduct Declaration to this Contract, the PROVIDER represents that neither the PROVIDER nor any employee or agent of the PROVIDER, presently has any interest, and promises that no such interest, direct or indirect, shall be acquired, that would or might conflict in any manner or degree with the PROVIDER's performance under this Contract.

2. Documents and Files

2.1 Confidentiality of Material.

2.1.1 Proprietary or Confidential Information. All material given to or made available to the PROVIDER by virtue of this Contract that is identified as proprietary or confidential information shall be safeguarded by the PROVIDER and shall not be disclosed to any individual or organization without the prior written approval of the STATE.

2.1.2 Uniform Information Practices Act. All information, data, or other material provided by the PROVIDER to the STATE shall be subject to the Uniform Information Practices Act, chapter 92F, HRS, and any other applicable law concerning information practices or confidentiality.

2.2 Ownership Rights and Copyright. The STATE shall have complete ownership of all material, both finished and unfinished that is developed, prepared, assembled, or conceived by the PROVIDER pursuant to this Contract, and all such material shall be considered "works made for hire." All such material shall be delivered to the STATE upon expiration or termination of this Contract. The STATE, in its sole discretion, shall have the exclusive right to copyright any product, concept, or material developed, prepared, assembled, or conceived by the PROVIDER pursuant to this Contract.

2.3 Records Retention. The PROVIDER and any subcontractors shall maintain the books and records that relate to the Contract, and any cost or pricing data for three (3) years from the date of final payment under the Contract. In the event that any litigation, claim, investigation, audit, or other action involving the records retained under this provision arises, then such records shall be retained for three (3) years from the date of final payment, or the date of the resolution of the action, whichever occurs later. During the period that records are retained under this section, the

PROVIDER and any subcontractors shall allow the STATE free and unrestricted access to such records.

3. Relationship between Parties

3.1 Coordination of Services by the STATE. The STATE shall coordinate the services to be provided by the PROVIDER in order to complete the performance required in the Contract. The PROVIDER shall maintain communications with the STATE at all stages of the PROVIDER's work, and submit to the STATE for resolution any questions which may arise as to the performance of this Contract.

3.2 Subcontracts and Assignments. The PROVIDER may assign or subcontract any of the PROVIDER's duties, obligations, or interests under this Contract, but only if (i) the PROVIDER obtains the prior written consent of the STATE and (ii) the PROVIDER's assignee or subcontractor submits to the STATE a tax clearance certificate from the Director of Taxation, State of Hawai'i, and the Internal Revenue Service showing that all delinquent taxes, if any, levied or accrued under state law against the PROVIDER's assignee or subcontractor have been paid. Additionally, no assignment by the PROVIDER of the PROVIDER's right to compensation under this Contract shall be effective unless and until the assignment is approved by the Comptroller of the State of Hawai'i, as provided in section 40-58, HRS.

3.3 Change of Name. When the PROVIDER asks to change the name in which it holds this Contract, the STATE, shall, upon receipt of a document acceptable or satisfactory to the STATE indicating such change of name such as an amendment to the PROVIDER's articles of incorporation, enter into an amendment to this Contract with the PROVIDER to effect the change of name. Such amendment to this Contract changing the PROVIDER's name shall specifically indicate that no other terms and conditions of this Contract are thereby changed, unless the change of name amendment is incorporated with a modification or amendment to the Contract under paragraph 4.1 of these General Conditions.

3.4 Independent Contractor Status and Responsibilities, Including Tax Responsibilities.

3.4.1 Independent Contractor. In the performance of services required under this Contract, the PROVIDER is an "independent contractor," with the authority and responsibility to control and direct the performance and details of the work and services required under this Contract; however, the STATE shall have a general right to inspect work in progress to determine whether, in the STATE's opinion, the services are being performed by the PROVIDER in compliance with this Contract.

3.4.2 Contracts with Other Individuals and Entities. Unless otherwise provided by special condition, the STATE shall be free to contract with other individuals and entities to provide services similar to those performed by the Provider under this Contract, and the

PROVIDER shall be free to contract to provide services to other individuals or entities while under contract with the STATE.

3.4.3 PROVIDER's Employees and Agents. The PROVIDER and the PROVIDER's employees and agents are not by reason of this Contract, agents or employees of the State for any purpose. The PROVIDER and the PROVIDER's employees and agents shall not be entitled to claim or receive from the STATE any vacation, sick leave, retirement, workers' compensation, unemployment insurance, or other benefits provided to state employees. Unless specifically authorized in writing by the STATE, the PROVIDER and the PROVIDER's employees and agents are not authorized to speak on behalf and no statement or admission made by the PROVIDER or the PROVIDER's employees or agents shall be attributed to the STATE, unless specifically adopted by the STATE in writing.

3.4.4 PROVIDER's Responsibilites. The PROVIDER shall be responsible for the accuracy, completeness, and adequacy of the PROVIDER's performance under this Contract.

Furthermore, the PROVIDER intentionally, voluntarily, and knowingly assumes the sole and entire liability to the PROVIDER's employees and agents, and to any individual not a party to this Contract, for all loss, damage, or injury caused by the PROVIDER, or the PROVIDER's employees or agents in the course of their employment.

The PROVIDER shall be responsible for payment of all applicable federal, state, and county taxes and fees which may become due and owing by the PROVIDER by reason of this Contract, including but not limited to (i) income taxes, (ii) employment related fees, assessments, and taxes, and (iii) general excise taxes. The PROVIDER also is responsible for obtaining all licenses, permits, and certificates that may be required in order to perform this Contract.

The PROVIDER shall obtain a general excise tax license from the Department of Taxation, State of Hawai‘i, in accordance with section 237-9, HRS, and shall comply with all requirements thereof. The PROVIDER shall obtain a tax clearance certificate from the Director of Taxation, State of Hawai‘i, and the Internal Revenue Service showing that all delinquent taxes, if any, levied or accrued under state law against the PROVIDER have been paid and submit the same to the STATE prior to commencing any performance under this Contract. The PROVIDER shall also be solely responsible for meeting all requirements necessary to obtain the tax clearance certificate required for final payment under section 103-53, HRS, and these General Conditions.

The PROVIDER is responsible for securing all employee-related insurance coverage for the PROVIDER and the PROVIDER's employees and agents that is or may be required by law, and for payment of all premiums, costs, and other liabilities associated with securing the insurance coverage.

3.5 Personnel Requirements.

3.5.1 Personnel. The PROVIDER shall secure, at the PROVIDER's own expense, all personnel required to perform this Contract, unless otherwise provided in this Contract.

3.5.2 Requirements. The PROVIDER shall ensure that the PROVIDER's employees or agents are experienced and fully qualified to engage in the activities and perform the services required under this Contract, and that all applicable licensing and operating requirements imposed or required under federal, state, or county law, and all applicable accreditation and other standards of quality generally accepted in the field of the activities of such employees and agents are complied with and satisfied.

4. Modification and Termination of Contract

4.1 Modification of Contract.

4.1.1 In Writing. Any modification, alteration, amendment, change, or extension of any term, provision, or condition of this Contract permitted by this Contract shall be made by written amendment to this Contract, signed by the PROVIDER and the STATE.

4.1.2 No Oral Modification. No oral modification, alteration, amendment, change, or extension of any term, provision or condition of this Contract shall be permitted.

4.1.3 Tax Clearance. The STATE may, at its discretion, require the PROVIDER to submit to the STATE, prior to the STATE's approval of any modification, alteration, amendment, change, or extension of any term, provision, or condition of this Contract, a tax clearance from the Director of Taxation, State of Hawai‘i, and the Internal Revenue Service showing that all delinquent taxes, if any, levied or accrued under state and federal law against the PROVIDER have been paid.

4.2 Termination in General. This Contract may be terminated in whole or in part because of a reduction of funds available to pay the PROVIDER, or when, in its sole discretion, the STATE determines (i) that there has been a change in the conditions upon which the need for the Required Services was based, or (ii) that the PROVIDER has failed to provide the Required Services adequately or satisfactorily, or (iii) that other good cause for the whole or partial termination of this Contract exists. Termination under this section shall be made by a written notice sent to the PROVIDER ten (10) working days prior to the termination date that includes a brief statement of the reason for the termination. If the Contract is terminated under this paragraph, the PROVIDER shall cooperate with the STATE to effect an orderly transition of services to clients.

4.3 Termination for Necessity or Convenience. If the STATE determines, in its sole discretion, that it is necessary or convenient, this Contract may be terminated in whole or in part at the option of the STATE upon ten (10) working days' written notice to the PROVIDER. If the STATE elects to terminate under this paragraph, the PROVIDER shall be entitled to reasonable payment as determined by the STATE for satisfactory services rendered under this Contract up to the time of termination. If the STATE elects to terminate under this section, the PROVIDER shall cooperate with the STATE to effect an orderly transition of services to clients.

4.4 Termination by PROVIDER. The PROVIDER may withdraw from this Contract after obtaining the written consent of the STATE. The STATE, upon the PROVIDER's withdrawal, shall determine whether payment is due to the PROVIDER, and the amount that is due. If the STATE consents to a termination under this paragraph, the PROVIDER shall cooperate with the STATE to effect an orderly transition of services to clients.

4.5 STATE's Right of Offset. The STATE may offset against any monies or other obligations that STATE owes to the PROVIDER under this Contract, any amounts owed to the State of Hawai'i by the PROVIDER under this Contract, or any other contract, or pursuant to any law or other obligation owed to the State of Hawai'i by the PROVIDER, including but not limited to the payment of any taxes or levies of any kind or nature. The STATE shall notify the PROVIDER in writing of any exercise of its right of offset and the nature and amount of such offset. For purposes of this paragraph, amounts owed to the State of Hawai'i shall not include debts or obligations which have been liquidated by contract with the PROVIDER, and that are covered by an installment payment or other settlement plan approved by the State of Hawai'i, provided, however, that the PROVIDER shall be entitled to such exclusion only to the extent that the PROVIDER is current, and in compliance with, and not delinquent on, any payments, obligations, or duties owed to the State of Hawai'i under such payment or other settlement plan.

5. Indemnification

5.1 Indemnification and Defense. The PROVIDER shall defend, indemnify, and hold harmless the State of Hawai'i, the contracting agency, and their officers, employees, and agents from and against any and all liability, loss, damage, cost, expense, including all attorneys' fees, claims, suits, and demands arising out of or in connection with the acts or omissions of the PROVIDER or the PROVIDER's employees, officers, agents, or subcontractors under this Contract. The provisions of this paragraph shall remain in full force and effect notwithstanding the expiration or early termination of this Contract.

5.2 Cost of Litigation. In case the STATE shall, without any fault on its part, be made a party to any litigation commenced by or against the PROVIDER in connection with this Contract, the PROVIDER shall pay any cost and expense incurred by or imposed on the STATE, including attorneys' fees.

6. Publicity

6.1 Acknowledgment of State Support. The PROVIDER shall, in all news releases, public statements, announcements, broadcasts, posters, programs, computer postings, and other printed, published, or electronically disseminated materials relating to the PROVIDER's performance under this Contract, acknowledge the support by the State of Hawai'i and the purchasing agency.

6.2 PROVIDER's Publicity Not Related to Contract. The PROVIDER shall not refer to the STATE, or any office, agency, or officer thereof, or any state employee, or to the services or goods, or both provided under this Contract, in any of the PROVIDER's publicity not related to the PROVIDER's performance under this Contract, including but not limited to commercial advertisements, recruiting materials, and solicitations for charitable donations.

7. Miscellaneous Provisions

7.1 Nondiscrimination. No person performing work under this Contract, including any subcontractor, employee, or agent of the PROVIDER, shall engage in any discrimination that is prohibited by any applicable federal, state, or county law.

7.2 Paragraph Headings. The paragraph headings appearing in this Contract have been inserted for the purpose of convenience and ready reference. They shall not be used to define, limit, or extend the scope or intent of the sections to which they pertain.

7.3 Antitrust Claims. The STATE and the PROVIDER recognize that in actual economic practice, overcharges resulting from antitrust violations are in fact usually borne by the purchaser. Therefore, the PROVIDER hereby assigns to the STATE any and all claims for overcharges as to goods and materials purchased in connection with this Contract, except as to overcharges which result from violations commencing after the price is established under this Contract and which are not passed on to the STATE under an escalation clause.

7.4 Governing Law. The validity of this Contract and any of its terms or provisions, as well as the rights and duties of the parties to this Contract, shall be governed by the laws of the State of Hawai'i. Any action at law or in equity to enforce or interpret the provisions of this Contract shall be brought in a state court of competent jurisdiction in Honolulu, Hawai'i.

7.5 Conflict between General Conditions and Procurement Rules. In the event of a conflict between the General Conditions and the Procurement Rules or a Procurement Directive, the Procurement Rules or any Procurement Directive in effect on the date this Contract became effective shall control and are hereby incorporated by reference.

7.6 Entire Contract. This Contract sets forth all of the contracts, conditions, understandings, promises, warranties, and representations between the STATE and the PROVIDER relative to this Contract. This Contract supersedes all prior agreements, conditions, understandings,

promises, warranties, and representations, which shall have no further force or effect. There are no contracts, conditions, understandings, promises, warranties, or representations, oral or written, express or implied, between the STATE and the PROVIDER other than as set forth or as referred to herein.

7.7 Severability. In the event that any provision of this Contract is declared invalid or unenforceable by a court, such invalidity or unenforceability shall not affect the validity or enforceability of the remaining terms of this Contract.

7.8 Waiver. The failure of the STATE to insist upon the strict compliance with any term, provision, or condition of this Contract shall not constitute or be deemed to constitute a waiver or relinquishment of the STATE's right to enforce the same in accordance with this Contract. The fact that the STATE specifically refers to one provision of the Procurement Rules or one section of the Hawai'i Revised Statutes, and does not include other provisions or statutory sections in this Contract shall not constitute a waiver or relinquishment of the STATE's rights or the PROVIDER's obligations under the Procurement Rules or statutes.

7.9 Execution in Counterparts. This Contract may be executed in several counterparts, each of which shall be regarded as an original and all of which shall constitute one instrument.

8. Confidentiality of Personal Information

8.1 Definitions.

8.1.1 Personal Information. "Personal Information" means an individual's first name or first initial and last name in combination with any one or more of the following data elements, when either name or data elements are not encrypted:

1) Social Security number;

2) Driver's license number or Hawaii identification card number; or

3) Account number, credit or debit card number, access code, or password that would permit access to an individual's financial information.

Personal information does not include publicly available information that is lawfully made available to the general public from federal, state, or local government records.

8.1.2 Technological Safeguards. "Technological safeguards" means the technology and the policy and procedures for use of the technology to protect and control access to personal information.

8.2 Confidentiality of Material.

8.2.1 Safeguarding of Material. All material given to or made available to the PROVIDER by the STATE by virtue of this Contract which is identified as personal information, shall be safeguarded by the PROVIDER and shall not be disclosed without the prior written approval of the STATE.

8.2.2 Retention, Use, or Disclosure. PROVIDER agrees not to retain, use, or disclose personal information for any purpose other than as permitted or required by this Contract.

8.2.3 Implementation of Technological Safeguards. PROVIDER agrees to implement appropriate "technological safeguards" that are acceptable to the STATE to reduce the risk of unauthorized access to personal information.

8.2.4 Reporting of Security Breaches. PROVIDER shall report to the STATE in a prompt and complete manner any security breaches involving personal information.

8.2.5 Mitigation of Harmful Effect. PROVIDER agrees to mitigate, to the extent practicable, any harmful effect that is known to PROVIDER because of a use or disclosure of personal information by PROVIDER in violation of the requirements of this paragraph.

8.2.6 Log of Disclosures. PROVIDER shall complete and retain a log of all disclosures made of personal information received from the STATE, or personal information created or received by PROVIDER on behalf of the STATE.

8.3 Security Awareness Training and Confidentiality Agreements.

8.3.1 Certification of Completed Training. PROVIDER certifies that all of its employees who will have access to the personal information have completed training on security awareness topics related to protecting personal information.

8.3.2 Certification of Confidentiality Agreements. PROVIDER certifies that confidentiality agreements have been signed by all of its employees who will have access to the personal information acknowledging that:

1) The personal information collected, used, or maintained by the PROVIDER will be treated as confidential;

2) Access to the personal information will be allowed only as necessary to perform the Contract; and

3) Use of the personal information will be restricted to uses consistent with the services subject to this Contract.

8.4 Termination for Cause. In addition to any other remedies provided for by this Contract, if the STATE learns of a material breach by PROVIDER of this paragraph by PROVIDER, the STATE may at its sole discretion:

1) Provide an opportunity for the PROVIDER to cure the breach or end the violation; or

2) Immediately terminate this Contract.

In either instance, the PROVIDER and the STATE shall follow chapter 487N, HRS, with respect to notification of a security breach of personal information.

8.5 Records Retention.

8.5.1 Destruction of Personal Information. Upon any termination of this Contract, PROVIDER shall, pursuant to chapter 487R, HRS, destroy all copies (paper or electronic form) of personal information received from the STATE.

8.5.2 Maintenance of Files, Books, Records. The PROVIDER and any subcontractors shall maintain the files, books, and records, that relate to the Contract, including any personal information created or received by the PROVIDER on behalf of the STATE, and any cost or pricing data, for three (3) years after the date of final payment under the Contract. The personal information shall continue to be confidential and shall not be disclosed without the prior written approval of the STATE. After the three (3) year retention period has ended, the files, books, and records that contain personal information shall be destroyed pursuant to chapter 487R, HRS.

CONTRACT NO. _____

STATE OF HAWAI'I
CONTRACT FOR HEALTH AND HUMAN SERVICES:
COMPETITIVE PURCHASE OF SERVICES

This Contract, executed on the respective dates indicated below, is effective as of _____, 20 _____ between the _____

_____,
(Name of the state department, agency board or commission)

_____

State of Hawai'i ("STATE"), by its _____
(Title of person signing for the STATE)

whose address is: _____

_____

_____

and _____,
(Name of PROVIDER)

("PROVIDER"), a _____,
(Legal form of PROVIDER i.e., Corporation, Limited Liability Company, etc.)

under the laws of the State of _____ whose business street address and taxpayer identification numbers are as follows:

Business street address:

_____

_____

_____

Mailing address if different than business street address:

_____

_____

_____

Federal employer identification number: _____

Hawai'i general excise tax number: _____

RECITALS

A. This Contract is for a competitive purchase of services (a "Competitive POS"), as defined in section 103F-402, Hawaii Revised Statutes ("HRS"), and chapter 3-143, Hawai'i Administrative Rules.

B. The STATE needs the health and human services described in this Contract and its attachments ("Required Services") and the PROVIDER agrees to provide the Required Services.

C. Money is available to fund this Contract pursuant to:

(1) _____,
(Identify state sources)

in the amount of _____, or
(state funding)

(2) _____,
(Identify federal sources)

in the amount of _____, or both.
(federal funding)

D. The STATE is authorized to enter into this Contract pursuant to:

_____
(Legal authority for Contracts)

E. The undersigned representative of the PROVIDER represents, and the STATE relies upon such representation, that he or she has authority to sign this Contract by virtue of (check any or all that apply):

☐ corporate resolutions of the PROVIDER or other authorizing documents such as partnership resolutions;

☐ corporate by-laws of the PROVIDER, or other similar operating documents of the PROVIDER, such as a partnership contract or limited liability company operating contract;

☐ the PROVIDER is a sole proprietor and as such does not require any authorizing documents to sign this Contract;

☐ other evidence of authority to sign:

_____

F. The PROVIDER has provided a "Certificate of Insurance" to the STATE that shows to the satisfaction of the STATE that the PROVIDER has obtained liability insurance

which complies with paragraph 1.4 of the General Conditions of this Contract and with any relevant special condition of this Contract.

G. The PROVIDER produced, and the STATE inspected, a tax clearance certificate as required by section 103-53, HRS.

NOW, THEREFORE, in consideration of the promises contained in this Contract, the STATE and the PROVIDER agree as follows:

1. Scope of Services. The PROVIDER shall, in a proper and satisfactory manner as determined by the STATE, provide the Required Services set forth in Attachment "1" to this Contract, which is hereby made a part of this Contract, and the Request for Proposals ("RFP"), and the PROVIDER's Proposal, which are incorporated in this Contract by reference. In the event that there is a conflict among the terms of this Contract, and either the Proposal or the RFP, or both, then the terms of this Contract shall control.

2. Time of Performance. The PROVIDER shall provide the Required Services from _____, 20 _____, to _____, 20 _____, as set forth in Attachment "2" to this Contract, which is hereby made a part of this Contract.

3. Certificate of Exemption from Civil Service. The Certificate of Exemption from Civil Service is attached and made a part of this Contract.

4. Standards of Conduct Declaration. The Standards of Conduct Declaration of the PROVIDER is attached and made a part of this Contract.

5. General and Special Conditions. The General Conditions for Health and Human Services Contracts ("General Conditions") and any Special Conditions are attached hereto and made a part of this Contract. In the event of a conflict between the General Conditions and the Special Conditions, the Special Conditions shall control.

6. Notices. Any written notice required to be given by any party under this Contract shall be (a) delivered personally, or (b) sent by United States first class mail, postage prepaid.

Notice required to be given to the STATE shall be sent to:

_____

_____.

Notice to the PROVIDER shall be sent to the mailing address as indicated on page 1. A notice shall be deemed to have been received three (3) days after mailing or at the time of actual receipt, whichever is earlier. The PROVIDER is responsible for notifying the STATE in writing of any change of address.

IN VIEW OF THE ABOVE, the parties execute this Contract by their signatures below.

STATE

By _____
(Signature)

Print Name _____

Print Title _____

_____

Date _____

FUNDING AGENCY (to be signed by head of funding agency if other than the Contracting Agency)

By _____
(Signature)

Print Name _____

Print Title _____

_____

Date _____

CONTRACT NO. _____

CORPORATE SEAL
(if available)

PROVIDER

By _____
(Signature)

Print Name _____

Print Title _____

_____

Date _____

APPROVED AS TO FORM:

_____
Deputy Attorney General

APPENDIX F

Provider Letter of Intent

SAMPLE LETTER OF INTENT (LOI) TO ENTER INTO CONTRACT NEGOTIATIONS WITH [the offeror] FOR PROVISION OF BEHAVIORAL HEALTH SERVICES TO CCS MEMBERS

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

[Offeror's name] is proposing to participate in the CCS program. The provider signing below is willing to enter into contract negotiations with [offeror's name], for the provision of behavioral health services to CCS members enrolled with [offeror's name] as indicated below.

This provider intends to sign a contract with [offeror's name] if [offeror's name] is awarded the CCS contract **and** an acceptable agreement can be reached between the provider and [offeror's name].

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

Do not return completed LOI to the DHS. Completed LOI needs to be returned to [offeror's name and address.]

1. **PROVIDER'S SIGNATURE** _____
2. **DATE** _____
3. **PRINTED NAME OF SIGNER** _____
4. **TITLE OF SIGNER** _____
5. **PRINTED NAME OF PROVIDER** (IF DIFFERENT FROM SIGNER) _____

6. **OFFEROR REPRESENTATIVE'S SIGNATURE** _____
7. **DATE** _____
8. **PRINTED NAME OF SIGNER** _____

9. **TITLE OF SIGNER** _____

ADDITIONAL PROVIDER AND SERVICES INFORMATION FOR LOI BETWEEN PROVIDERS AND OFFERORS FOR PROVISION OF SERVICES TO CCS MEMBERS

1. MQD PROVIDER IDENTIFICATION NUMBER, if any _____

2. PROVIDER'S PRINTED NAME _____

3. ADDRESS (where services will be provided) _____
If services will be provided in more than one location, attach separate sheet with addresses. _____

_____

4. ZIP CODE _____
5. COUNTY _____
6. TELEPHONE _____
7. FAX _____

___Check here if additional service site information is attached.

8. PROVIDER TYPE (e.g., behavioral health provider, case management agency, inpatient behavioral health hospital, outpatient behavioral health hospital, mental health rehabilitation, psychosocial rehabilitation, pharmacy, laboratory, crisis service, etc.) _____

9. SERVICE(S) TO BE PROVIDED TO CCS MEMBERS _____

_____

_____

_____

10. AREAS OF PROVIDER SPECIALTY, IF ANY _____

11. LANGUAGES SPOKEN BY THE PROVIDER (OTHER THAN ENGLISH) _____

12. NAME OF HOSPITAL(S) WHERE PHYSICIAN HAS ADMITTING PRIVILEGES _____

_____

_____

Provider Listing

for Section 15.3.D.1

Provider Type (examples listed below)	**Island/County (for Oahu include the city)**	**Provider Name (Last name, First name, Middle Initial)**	**Address**	**City**	**Zip Code**	**Accepting new CCS members (Y/N)?**	**Any limit on CCS members (Y/N)?**
Behavioral Health Specialist	Honolulu, Oahu	Last Name, First Name, MI					
Case Management	Kapolei, Oahu	Last Name, First Name, MI					
Inpatient behavioral health hospital	Maui County	Last Name, First Name, MI					
Hospital	Kauai	Hospital Name					
Crisis Services: mobile crisis response	Hawaii- East	Agency Name					

RISK SHARING MECHANISMS

To be determined.

Financial Responsibility Guideline for QI and CCS health plans

IP Facility:

- If only billing BH rev codes, then CCS pays all.
- If only billing medical rev codes with primary dx of BH, then CCS pays all.
- If only billing medical rev codes with primary dx is medical, QI pays all.
- If only billing medical rev codes with primary admitting dx of BH, but primary dx is medical, then QI pays all (i.e., metastatic cancer discovery).
- If both BH and medical rev codes, but discharge dx is BH, then CCS pays. (overflow from Kekela)
- If both BH and medical rev codes, then BH rev codes, then CCS should pay. QI pays for all other rev codes. Bill is split by day proportional.
- Sample Scenarios in which CCS would be payor.
    - Admitted for psychiatric care but requires infectious disease treatment/clearance for scabies or MRSA on medical floor. CCS is payor.
- Sample Scenarios in which QI plan would be payor
    - Admitted for obstetrical care and has concurrent psychiatric care.
    - Admitted for psychiatric care but required surgical intervention. Surgery and follow up treatment QI payor.

OP Facility:

- Based on ordering MD's specialty, either CCS or QI.

Professional:

- Based on specialty, either CCS or QI.

Supportive Housing Services (SHS):

- For eligible CCS members, CCS pays all SHS.

APPENDIX J
BUSINESS ASSOCIATE AGREEMENT

The State of Hawaii Department of Human Services (STATE) has determined that it is a Covered Entity or a Health Care Component of a Covered Entity under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA), as amended, and its implementing regulations at 45 CFR parts 160 and 164 (the HIPAA Rules).

The CONTRACTOR/PROVIDER (BUSINESS ASSOCIATE), under the CONTRACT will provide to STATE certain services described in the CONTRACT to which this Exhibit I is attached, and may have access to Protected Health Information (PHI) (as defined below) in fulfilling its responsibilities under the CONTRACT. To the extent BUSINESS ASSOCIATE needs to create, receive, maintain or transmit PHI to perform services under the CONTRACT, it will be acting as a Business Associate[1] of STATE and will be subject to the HIPAA Rules and the terms of this Business Associate Agreement (this Agreement).

In consideration of STATE's and BUSINESS ASSOCIATE's (collectively referred to as "the Parties") continuing obligations under the CONTRACT, and the provisions below, the Parties agree as follows:

1. DEFINITIONS.

Except for terms otherwise defined herein, and unless the context indicates otherwise, any capitalized terms used in this Agreement and the terms "person," "use," and "disclosure" shall have the same meaning as defined by the HIPAA Rules. An amendment to the HIPAA Rules that modifies any defined term, or which alters the regulatory citation for the definition, shall only be incorporated into this Agreement by written ratification of the Parties.

Breach[2] means the acquisition, access, use, or disclosure of PHI in a manner not permitted under the HIPAA Privacy Rule or as provided for by this Agreement, which compromises the security or privacy of the PHI.

An acquisition, access, use, or disclosure of PHI in a manner not permitted by the Privacy Rule is presumed to be a breach unless the BUSINESS ASSOCIATE demonstrates to the STATE's satisfaction that there is a low probability that the PHI has been compromised based on a risk assessment that identifies at least the following: (i) the nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification; (ii) the unauthorized person who used the PHI or to whom the disclosure was made; (iii) whether the PHI was actually acquired or viewed; and (iv) the extent to which the risk to the PHI has been mitigated.

[1] Business Associate is defined at 45 CFR §160.103
[2] Breach: 45 CFR §164.402.

Breach excludes:

A. Any unintentional acquisition, access or use of PHI by a Workforce member or person acting under the authority of the BUSINESS ASSOCIATE if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under the Privacy Rule.

B. Any inadvertent disclosure by a person who is authorized to access PHI at the BUSINESS ASSOCIATE to another person authorized to access PHI at the same BUSINESS ASSOCIATE, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under the Privacy Rule.

C. A disclosure of PHI where the BUSINESS ASSOCIATE has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

Designated Record Set means records, including but not limited to PHI maintained, collected, used, or disseminated by or for the STATE relating to (i) medical and billing records about Individuals maintained by or for a covered Health Care Provider, (ii) enrollment, Payment, claims adjudication, and case or medical management records systems maintained by or for a Health Plan, or (iii) that are used in whole or in part by the STATE to make decisions about Individuals.[3]

Electronic Protected Health Information (EPHI) means PHI that is transmitted by Electronic Media or maintained in Electronic Media.[4]

HIPAA Rules shall mean the Privacy, Security, Breach Notification, and Enforcement Rules in 45 CFR Parts 160 and 164.

Individual shall have the same meaning as defined in 45 CFR §160.103, and shall include a person who qualifies as a personal representative as provided by 45 CFR §164.502(g).

Privacy Rule means the HIPAA Standards for Privacy of Individually Identifiable Health Information found at 45 CFR part 160, and part 164, subparts A and E.

Protected Health Information (PHI) means any oral, paper or electronic information, data, documentation, and materials, including, but not limited to, demographic, medical, genetic, and financial information that is created or received by a Health Care Provider, Health Plan, Employer, or Health Care Clearinghouse, and relates to the past, present, or future physical or mental health or condition of an Individual; the provision of health care to an Individual; or the past, present, or future payment for the provision of health care to an Individual; and that identifies the Individual or with respect to which there is a reasonable basis to believe the information can be used to identify the Individual. For purposes of this Agreement, the term

[3] Designated Record Set: 45 CFR §164.501.
[4] Electronic Protected Health Information: 45 CFR §160.103

Protected Health Information is limited to the information created, maintained, received, or transmitted by BUSINESS ASSOCIATE on behalf of or from the STATE under the CONTRACT. Protected Health Information includes without limitation EPHI, and excludes education records under 20 U.S.C. §1232(g), employment records held by the STATE as an employer, and records regarding an Individual who has been deceased for more than 50 years.[5]

Security Incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system under 45 CFR §164.304.

Security Rule means the HIPAA Security Standards for the Protection of Electronic Protected Health Information found at 45 CFR part 160, and part 164, subpart C.

Unsecured Protected Health Information means protected health information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5.[6]

2. BUSINESS ASSOCIATE'S OBLIGATIONS.

BUSINESS ASSOCIATE agrees to:

a. Not use or disclose PHI other than as permitted or required by this Agreement or as Required by Law. In no event may BUSINESS ASSOCIATE use or further disclose PHI in a manner that would violate the Privacy Rule if done by the STATE, except as expressly provided in this Agreement and as required by 45 CFR §§ 164.502(a)(3), 164.502(a)(4) and 164.504(e)(2(ii)(A).

b. Implement appropriate safeguards, and comply, where applicable, with the Security Rule to ensure the confidentiality, integrity, and availability of all EPHI the BUSINESS ASSOCIATE creates, receives, maintains, or transmits on behalf of the STATE; protect against any reasonably anticipated threats or hazards to the security or integrity of such information; prevent uses or disclosures of such information other than as provided for by this Agreement or as Required by Law; and ensure compliance with the HIPAA Rules by BUSINESS ASSOCIATE's Workforce.[7] These safeguards include, but are not limited to:

    (i) Administrative Safeguards. BUSINESS ASSOCIATE shall implement policies and procedures to prevent, detect, contain, and correct security violations, and reasonably preserve and protect the confidentiality, integrity

[5] Protected Health Information: 45 CFR §160.103
[6] 45 CFR §164.402.
[7] 45 CFR §164.306(a)

and availability of EPHI, and enforce those policies and procedures, including sanctions for anyone not found in compliance;

(ii) Physical Safeguards. BUSINESS ASSOCIATE shall implement appropriate physical safeguards to protect PHI, including, but not limited to, facility access, facility security, workstation use, workstation security, device and media controls, and disposal;[8]

(iii) Technical Safeguards. BUSINESS ASSOCIATE shall implement appropriate technical safeguards to protect PHI, including, but not limited to, access controls, authentication, and transmission security;[9] and

(iv) Security Awareness and Training. BUSINESS ASSOCIATE shall provide training to relevant workforce members, including management, on how to prevent the improper access, use, or disclosure of PHI; and update and repeat training on a regular basis.[10]

c. In accordance with 45 CFR §164.316, document the required policies and procedures and keep them current, and cooperate in good faith in response to any reasonable requests from STATE to discuss, review, inspect, and/or audit BUSINESS ASSOCIATE's safeguards. BUSINESS ASSOCIATE shall retain the documentation required for six (6) years from the date of its creation or the date when it last was in effect, whichever is later.[11]

d. Comply with the provisions found in 45 CFR §164.308 (a)(1) (ii)(A) and (B), requiring BUSINESS ASSOCIATE to conduct an accurate and thorough *risk analysis*, and to periodically update the risk analysis (no less than once every 3 years); and to implement *risk management* measures to reduce the risk and vulnerabilities to a reasonable and appropriate level to comply with 45 CFR §164.306(a).

e. As applicable only to the PHI BUSINESS ASSOCIATE receives from STATE, BUSINESS ASSOCIATE shall ensure that any subcontractor of BUSINESS ASSOCIATE that creates, receives, maintains, or transmits PHI on behalf of BUSINESS ASSOCIATE agrees in writing to the same restrictions, conditions, and requirements that apply to BUSINESS ASSOCIATE through this Agreement with respect to such PHI.[12]

f. Notify the STATE following discovery of any use or disclosure of PHI not permitted by this Agreement of which it becomes aware, or any Breach of Unsecured PHI.[13]

[8] 45 CFR §164.310
[9] 45 CFR §§ 164.310, 164.312
[10] 45 CFR §164.308(a)(5)
[11] 45 CFR §§164.306 – 164.316; 164.504(e)(2)(ii)(B)
[12] 45 CFR §§164.308(b), 164.314(a)(2), 164.502(e), 164.504(e)(2)(ii)(D)
[13] 45 CFR §§164.314(a)(2), 164.410(a), 164.504(e)(2)(ii)(C)

(i) BUSINESS ASSOCIATE shall immediately notify the STATE's HIPAA Privacy or Security Officer verbally.

(ii) BUSINESS ASSOCIATE shall subsequently notify the STATE's HIPAA Privacy or Security Officer in writing, without unreasonable delay, and in no case later than two (2) business days following discovery of the impermissible use or disclosure of PHI, or Breach of Unsecured PHI.

(iii) A Breach of Unsecured PHI shall be treated as discovered by the BUSINESS ASSOCIATE as of the first day on which such breach is known to the BUSINESS ASSOCIATE or, by exercising reasonable diligence, would have been known to the BUSINESS ASSOCIATE. BUSINESS ASSOCIATE shall be deemed to have knowledge of a Breach if the Breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the Breach, who is an employee, officer, or other agent of the BUSINESS ASSOCIATE.[14]

g. Take prompt corrective action to mitigate, to the extent practicable, any harmful effect that is known to BUSINESS ASSOCIATE of a Security Incident or a misuse or unauthorized disclosure of PHI by BUSINESS ASSOCIATE in violation of this Agreement, and any other action pertaining to such unauthorized disclosure required by applicable Federal and State laws and regulations. BUSINESS ASSOCIATE shall reasonably cooperate with the STATE's efforts to seek appropriate injunctive relief or otherwise prevent or curtail potential or actual Breaches, or to recover its PHI, including complying with a reasonable corrective action plan.[15]

h. Investigate such Breach and provide a written report of the investigation and resultant mitigation to STATE's HIPAA Privacy and/or Security Officer within thirty (30) calendar days of the discovery of the Breach.

i. Provide the following information with respect to a Breach of Unsecured PHI, to the extent possible, as the information becomes available, to the STATE's HIPAA Privacy or Security Officer:

(i) The identification of each Individual whose Unsecured PHI has been, or is reasonably believed by BUSINESS ASSOCIATE to have been accessed, acquired, used, or disclosed during the breach; and

(ii) Any other available information that the STATE is required to include in notification to the Individual under the HIPAA Rules, including, but not limited to the following:[16]

[14] 45 CFR §164.410(a)(2)
[15] 45 CFR §§164.308(a)(6)(ii); 164.530(f)
[16] 45 CFR §§164.404(c)(1), 164.408, 164.410(c)(1) and (2)

A. Contact information for Individuals who were or who may have been impacted by the HIPAA Breach (e.g., first and last name, mailing address, street address, phone number, and email address);

B. A brief description of the circumstances of the Breach, including the date of the Breach and date of discovery, if known;

C. A description of the types of Unsecured PHI involved in the Breach (such as whether the full name, social security number, date of birth, address, account number, diagnosis, disability and/or billing codes, or similar information was involved);

D. A brief description of what the BUSINESS ASSOCIATE has done or is doing to investigate the Breach, mitigate harm to the Individual(s) impacted by the Breach, and protect against future Breaches; and

E. Contact information for BUSINESS ASSOCIATE's liaison responsible for investigating the Breach and communicating information relating to the Breach to the STATE.

j. Promptly report to STATE's HIPAA Privacy and/or Security Officer any Security Incident of which BUSINESS ASSOCIATE becomes aware with respect to EPHI that is in the custody of BUSINESS ASSOCIATE, including breaches of Unsecured PHI as required by 45 CFR §164.410, by contacting the STATE's HIPAA Privacy and/or Security Officer.[17]

k. Implement reasonable and appropriate measures, including training, to ensure compliance with the requirements of this Agreement by Workforce members who assist in the performance of functions or activities on behalf of the STATE under this Agreement and use or disclose PHI, and discipline such Workforce members who intentionally violate any provisions of these special conditions, which may include termination of employment.[18]

l. Make its internal policies, procedures, books, and records relating to the use and disclosure of PHI received from or created or received by BUSINESS ASSOCIATE on behalf of the STATE available to the Secretary of Health and Human Services or to STATE if necessary or required to assess BUSINESS ASSOCIATE's or the STATE's compliance with the HIPAA Rules. BUSINESS ASSOCIATE shall promptly notify STATE of communications with the U.S. Department of Health and Human Services (HHS) regarding PHI provided by or created by STATE and shall provide STATE with copies of any information BUSINESS ASSOCIATE has made available to HHS under this paragraph.[19]

[17] 45 CFR §§164.314(a)(2), 164,410
[18] 45 CFR §§164.308(a), 164.530(b) and (e)
[19] 45 CFR §164.504(e)(2)(ii)(I)

m. Upon notice from STATE, accommodate any restriction to the use or disclosure of PHI and any request for confidential communications to which STATE has agreed in accordance with the Privacy Rule.[20]

n. Make available PHI held by BUSINESS ASSOCIATE, which the STATE has determined to be part of its Designated Record Set, to the STATE as necessary to satisfy the STATE's obligations to provide an Individual with access to their PHI under 45 CFR §164.524, in the time and manner designated by the STATE.[21]

o. Make available PHI held by BUSINESS ASSOCIATE, which the STATE has determined to be part of its Designated Record Set, for amendment, and incorporate any amendments to PHI that the STATE directs or agrees to in accordance with 45 CFR §164.526, upon request of the STATE or an Individual, subject to State law and BUSINESS ASSOCIATE policies regarding amending vital records.

p. Document disclosures of PHI made by BUSINESS ASSOCIATE, which are required to be accounted for under 45 CFR §164.528(a)(1), and make this information available as necessary to satisfy the STATE's obligation to provide an accounting of disclosures to an Individual within two (2) business days notice by the STATE of a request by an Individual of a request for an accounting of disclosures of PHI. If an Individual directly requests an accounting of disclosures of PHI from BUSINESS ASSOCIATE, BUSINESS ASSOCIATE shall notify STATE's HIPAA Privacy and/or Security Officer of the request within two (2) business days, and STATE shall either direct BUSINESS ASSOCIATE to provide the information directly to the Individual, or it shall direct that the information required for the accounting be forwarded to STATE for compilation and distribution to the Individual.[22]

q. Comply with any other requirements of the HIPAA Rules not expressly specified in this Agreement, as and to the extent that such requirements apply to Business Associates under the HIPAA Rules.

3. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE.

BUSINESS ASSOCIATE may, except as otherwise limited in this Agreement:

a. General Use and Disclosure: Create, receive, maintain or transmit PHI only for the purposes listed in the CONTRACT and this Agreement, provided that the use or disclosure would not violate the HIPAA Rules if done by the STATE or violate the Minimum Necessary requirements applicable to the STATE.[23]

b. Limited Use of PHI for BUSINESS ASSOCIATE's Benefit. Use PHI received by the BUSINESS ASSOCIATE in its capacity as the STATE's BUSINESS ASSOCIATE, if

[20] 45 CFR §164.522
[21] 45 CFR §§164.504(e)(2)(ii)(E), 164.524
[22] 45 CFR §§164.504(e)(2)(ii)(G) and (H), 164.528; HAR ch. 2-71, subch. 2.
[23] 45 CFR §§164.502(a) and (b), 164.504(e)(2)(i)

necessary, for the proper management and administration of the BUSINESS ASSOCIATE or to carry out the legal responsibilities of the BUSINESS ASSOCIATE. BUSINESS ASSOCIATE's proper management and administration does not include the use or disclosure of PHI by BUSINESS ASSOCIATE for Marketing purposes or for sale of PHI. [24]

c. Limited Disclosure of PHI for BUSINESS ASSOCIATE's Benefit. Disclose PHI for BUSINESS ASSOCIATE's proper management and administration or to carry out its legal responsibilities only if the disclosure is Required by Law, or BUSINESS ASSOCIATE obtains reasonable assurances from the person to whom PHI is disclosed that it will remain confidential and used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person, and the person notifies BUSINESS ASSOCIATE of any instances of which it is aware in which the confidentiality of PHI has been breached. [25]

d. Minimum Necessary. BUSINESS ASSOCIATE shall only request, use, and disclose the minimum amount of PHI necessary to accomplish the purpose of the request, use, or disclosure.[26]

e. Data Aggregation. Use PHI to provide Data Aggregation services relating to the STATE's Health Care Operations as permitted by 45 CFR §164.504(e)(2)(i)(B).

f. Disclosures by Whistleblowers: Disclose PHI to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR §164.502(j)(1).

4. STATE'S OBLIGATIONS.

a. STATE shall not request BUSINESS ASSOCIATE to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by STATE.

b. STATE shall not provide BUSINESS ASSOCIATE with more PHI than is minimally necessary for BUSINESS ASSOCIATE to provide the services under the CONTRACT and STATE shall provide any PHI needed by BUSINESS ASSOCIATE to perform under the CONTRACT only in accordance with the HIPAA Rules.

5. TERM AND TERMINATION.

a. This Agreement shall be effective as of the date of the CONTRACT or CONTRACT amendment to which this Agreement is attached, and shall terminate on the date the STATE terminates this Agreement or when all PHI is destroyed or returned to STATE.

b. In addition to any other remedies provided for by this Agreement or the CONTRACT, upon the STATE's knowledge of a material Breach by BUSINESS ASSOCIATE of this

[24] 45 CFR §§164.502(a)(5)(ii), 164.504(e)(2)(i)(A), 164.504(e)(4)(i), 164.508(a)(3) and (a)(4)
[25] 45 CFR §164.504(e)(4)(ii)
[26] 45 CFR §164.502(b)

Agreement, the BUSINESS ASSOCIATE authorizes the STATE to do any one or more of the following, upon written notice to BUSINESS ASSOCIATE describing the violation and the action it intends to take:

(i) Exercise any of its rights to reports, access and inspection under this Agreement or the CONTRACT;

(ii) Require BUSINESS ASSOCIATE to submit a plan of monitoring and reporting, as STATE may determine necessary to maintain compliance with this Agreement;

(iii) Provide BUSINESS ASSOCIATE with a reasonable period of time to cure the Breach, given the nature and impact of the Breach; or

(iv) Immediately terminate this Agreement if BUSINESS ASSOCIATE has breached a material term of this Agreement and sufficient mitigation is not possible.[27]

c. Effect of Termination.[28]

(i) Upon any termination of this Agreement, until notified otherwise by the STATE, BUSINESS ASSOCIATE shall extend all protections, limitations, requirements and other provisions of this Agreement to all PHI received from or on behalf of STATE or created or received by BUSINESS ASSOCIATE on behalf of the STATE, and all EPHI created, received, maintained or transmitted by BUSINESS ASSOCIATE on behalf of the STATE.

(ii) Except as otherwise provided in subsection 5(c)(iii) below, upon termination of this Agreement for any reason, BUSINESS ASSOCIATE shall, at the STATE's option, return or destroy all PHI received from the STATE, or created or received by the BUSINESS ASSOCIATE on behalf of the STATE, that the BUSINESS ASSOCIATE still maintains in any form, and BUSINESS ASSOCIATE shall retain no copies of the information. This provision shall also apply to PHI that is in the possession of subcontractors or agents of BUSINESS ASSOCIATE. BUSINESS ASSOCIATE shall notify the STATE in writing of any and all conditions that make return or destruction of such information not feasible and shall provide STATE with any requested information related to the STATE's determination as to whether the return or destruction of such information is feasible.

(iii) If the STATE determines that returning or destroying any or all PHI is not feasible or opts not to require the return or destruction of such information, the protections of this Agreement shall continue to apply to such PHI, and BUSINESS ASSOCIATE shall limit further uses and disclosures of PHI to those purposes that make the return or destruction infeasible, for so long as BUSINESS ASSOCIATE maintains such PHI. STATE hereby acknowledges and agrees that

[27] 45 CFR §164.504(e)(2)(iii)
[28] 45 CFR §164.504(e)(2)(ii)(J)

infeasibility includes BUSINESS ASSOCIATE's need to retain PHI for purposes of complying with its work product documentation standards.

6. MISCELLANEOUS.

a. Amendment. BUSINESS ASSOCIATE and the STATE agree to take such action as is necessary to amend this Agreement from time to time for compliance with the requirements of the HIPAA Rules and any other applicable law.

b. Interpretation. In the event that any terms of this Agreement are inconsistent with the terms of the CONTRACT, then the terms of this Agreement shall control. In the event of an inconsistency between the provisions of this Agreement and mandatory provisions of the HIPAA Rules, as amended, the HIPAA Rules shall control. Where provisions of this Agreement are different than those mandated in the HIPAA Rules, but are nonetheless permitted by the HIPAA Rules, the provisions of this Agreement shall control. Any ambiguity in this Agreement shall be resolved to permit STATE to comply with the HIPAA Rules. Notwithstanding the foregoing, nothing in this Agreement shall be interpreted to supersede any federal or State law or regulation related to confidentiality of health information or vital record information that is more stringent than the HIPAA Rules.

c. Indemnification. BUSINESS ASSOCIATE shall defend, indemnify, and hold harmless the STATE and STATE's officers, employees, agents, contractors and subcontractors to the extent required under the Contract for incidents that are caused by or arise out of a Breach or failure to comply with any provision of this Agreement or the HIPAA Rules by BSUSINESS Associates or any of BUSINESS ASSOCIATE's officers, employees, agents, contractors or subcontractors.

d. Costs Related to Breach. BUSINESS ASSOCIATE shall be responsible for any and all costs incurred by the STATE as a result of any Breach of PHI by BUSINESS ASSOCIATE, its officers, directors, employees, contractors, or agents, or by a third party to which the BUSINESS ASSOCIATE disclosed PHI under this Agreement, including but not limited to notification of individuals or their representatives of a Breach of Unsecured PHI,[29] and the cost of mitigating any harmful effect of the Breach.[30]

e. Response to Subpoenas. In the event BUSINESS ASSOCIATE receives a subpoena or similar notice or request from any judicial, administrative, or other party which would require the production of PHI received from, or created for, the STATE, BUSINESS ASSOCIATE shall promptly forward a copy of such subpoena, notice or request to the STATE to afford the STATE the opportunity to timely respond to the demand for its PHI as the STATE determines appropriate according to its State and federal obligations.

[29] 45 CFR Part 164, Subpart D
[30] 45 CFR §164.530(f)

f. Survival. The respective rights and obligations of STATE and BUSINESS ASSOCIATE under sections 5.c., Effect of Termination, 6.c., Indemnification, and 6.d., Costs Related to Breach, shall survive the termination of this Agreement.

g. Notices: Whenever written notice is required by one party to the other under this Agreement, it should be mailed, faxed, or e-mailed to the appropriate address noted below. If notice is sent by e-mail, then a confirming written notice should be sent by mail or fax within two (2) business days after the date of the e-mail. The sender of any written notice required under this Agreement is responsible for confirming receipt by the recipient.

STATE:	**BUSINESS ASSOCIATE:**
DHS Information Security / HIPAA Compliance Manager P.O. Box 700190 Kapolei, Hawaii 96709-0190 Fax: (808) 692-8173 Email: LYong@dhs.hawaii.gov	_____ _____ _____ Fax: (_____) _____ Email: _____

IN WITNESS WHEREOF, the Parties have executed this Agreement effective as of the date and year first written above.

BUSINESS ASSOCIATE

Dated: _____ By _____

Representative

DEPARTMENT OF HUMAN SERVICES, STATE OF HAWAII

Dated: _____ By _____

Director

STAFFING CHANGE NOTIFICATION FORM

Use this form (Notification Form) to notify Med-QUEST Division (MQD) of staffing changes, for which written notification to MQD is a requirement under the Request for Proposal (RFP). The submission to MQD of this Notification Form, will serve as written notification to MQD. Complete a Notification Form for each position affected for which written notification is required. (See sample Notification Form provided.) If this Notification Form is not adequate to describe, or is not applicable to, the staffing change to be reported, please notify MQD using written correspondence that explains the staffing change in detail.

1. Date Notification Form is submitted to MQD:

2. Date Health Plan has knowledge of the subject staffing change:
(For example: the date of the employee's resignation letter; the date of the decision to terminate an employee; the date an applicant accepts the offer of employment; or the date an employee receives the promotion to a new position.)

3. ☐ QI ☐ CCS ☐ Other

4. Health Plan Position Title and **FTE**:

5. RFP Position Title and **Required FTE** (as listed in the RFP):

6. Name of person *exiting* the above position:

7. Name & contact information of person *entering* the above position and **FTE** this person will serve in the position & program:

(If there is no *entering* person at this time, please provide information for the *Interim Contact Employee* below in item #10.)

Name:
FTE:
Phone:
Email:

8.

- **Does the *entering* person reside in the State of Hawaii?** ☐ Yes ☐ No
- **Does the *entering* person work in the State of Hawaii?** ☐ Yes ☐ No
- ****Submit to MQD, a current RESUME of the *entering* person, along with this Notification Form.** (This resume submission may not apply to the above position. Please refer to the RFP.)

9. Describe the staffing change:

(For example: "Jane Doe is retiring and will no longer be the ***QI Member Services Director*** as of 11/1/20. Effective 11/1/20, Bob Sox will be the ***QI Member Services Director***. Bob Sox accepted the promotion to the ***QI Member Services Director*** (Officer, Medicaid Member Services) position, from his position as the *QI Member Grievance Coordinator*. A separate Notification Form will be submitted for the *QI Member Grievance Coordinator* position that Bob Sox will be vacating.") (Complete separate Notification Forms for each position affected that requires a written notification.)

10. *Interim Contact Employee* (if applicable):

Name:
Position Title:
Phone:
Email:

11. Name, position title, and contact information of the person who completed this Notification Form:

STAFFING CHANGE NOTIFICATION FORM (10/20)

INSTRUCTIONS

PURPOSE:

The purpose of this form (Notification Form) is to notify Med-QUEST Division (MQD) of staffing changes, for which written notification to MQD is a requirement under the Request for Proposal (RFP). The submission to MQD of this Notification Form, will serve as written notification to MQD. Complete a Notification Form for each position affected for which written notification is required. (See SAMPLE Notification Form provided.) If this Notification Form is not adequate to describe, or is not applicable to, the staffing change to be reported, please notify MQD using written correspondence that explains the staffing change in detail.

FORM INSTRUCTIONS:

1. Date Notification Form is submitted to MQD

Enter the date that this Notification Form is submitted to MQD.

2. Date Health Plan has knowledge of the subject staffing change

Enter the date that the Health Plan is informed of, or decides upon, the staffing change being reported. Health Plans must notify MQD in writing within seven (7) days of learning of a change in the status of particular positions.

3. ☐ QI ☐ CCS ☐ Other

Check the box next to the program to which the staffing change being reported applies. Only one box shall be checked. If "Other" is checked, provide the name of the applicable program in the space provided.

4. Health Plan Position Title and **FTE**

If more than one position is affected by the staffing change, select one to be the "subject position" for this Notification Form, and complete separate Notification Forms for each position affected that requires written notification. Enter the official name of the subject position given by the Health Plan. Also, enter the full-time equivalent (FTE) assignment from the Health Plan for the subject position. The FTE indicates the extent to which an individual serving in the subject position is required by the Health Plan to dedicate work to that position as it relates to the program specified above (QI, CCS, or Other). For example, a 1.0 FTE assignment by a Health Plan regarding QI, indicates that its employee serving in the subject position is specifically designated and assigned to perform only the work of the position as it relates to QI, in an amount equal to a full-time schedule. Likewise, a 0.6 FTE assignment by a Health Plan regarding QI, of a full-time employee indicates that the full-time employee serving in the subject position, may perform other work not pertaining to the QI program or QI position, in an amount equal to 40% of a full-time schedule.

5. RFP Position Title and **Required FTE** (as listed in the RFP)

Enter the name of the position listed in the RFP (as it is listed in the RFP) to which the subject position of this Notification Form corresponds. Also, enter the FTE requirement (if any) for this position as stated in the RFP.

6. Name of person *exiting* the above position

Enter the name of the person leaving the subject position.

7. Name & contact information of person *entering* the above position and **FTE** this person will serve in the position & program

Enter the name, phone number, and email address of the person hired or promoted to officially fill the subject position. Also, enter the FTE this person is required by the Health Plan to dedicate toward this position and program. If no one has yet been hired or promoted to fill the subject position, provide information for the *Interim Contact Employee* in item #10.)

8.

- **Does the *entering* person reside in the State of Hawaii?** ☐ Yes ☐ No
- **Does the *entering* person work in the State of Hawaii?** ☐ Yes ☐ No

Check one box for each question. For some positions, the RFP requires that the employee reside and work in the State of Hawaii.

- ****Submit to MQD, a current RESUME of the *entering* person, along with this Notification Form**

Submit to MQD along with this Notification Form, an updated resume of the person officially hired or promoted to fill the subject position. Most positions for which a staffing change notification is required, also require the submission of a resume. If a resume for the person officially hired or promoted to fill the subject position has already been submitted to MQD within the past year, and there are no updates for the resume, then state so below in the space provided for "Describe the staffing change", and re-submission of the same resume is not necessary.

9. Describe the staffing change

In the space provided, briefly describe the staffing change.

For example: "Jane Doe is retiring and will no longer be the ***QI Member Services Director*** as of 11/1/20. Effective 11/1/20, Bob Sox will be the ***QI Member Services Director***. Bob Sox accepted the promotion to the ***QI Member Services Director*** (Officer, Medicaid Member Services) position, from his position as the *QI Member Grievance Coordinator*. A separate Notification Form will be submitted for the *QI Member Grievance Coordinator* position that Bob Sox will be vacating."

(Note: Complete separate Notification Forms for each position affected that requires a written notification.)

10. *Interim Contact Employee* (if applicable)

Complete this section only if the subject position has not been officially filled. Enter the name, position title, phone number, and email address of the person designated as the Interim Contact for the subject position while the subject position remains vacant.

11. Name, position title, and contact information of the person who completed this Notification Form

Enter the name, position title, phone number, and email address of the person who filled-out this form.

SAMPLESTAFFING CHANGE NOTIFICATION FORM**SAMPLE**

Use this form (Notification Form) to notify Med-QUEST Division (MQD) of staffing changes, for which written notification to MQD is a requirement under the Request for Proposal (RFP). The submission to MQD of this Notification Form, will serve as written notification to MQD. Complete a Notification Form for each position affected for which written notification is required. (See sample Notification Form provided.) If this Notification Form is not adequate to describe, or is not applicable to, the staffing change to be reported, please notify MQD using written correspondence that explains the staffing change in detail.

1. Date Notification Form is submitted to MQD: 10/18/20

2. Date Health Plan has knowledge of the subject staffing change: 10/14/20

(For example: the date of the employee's resignation letter; the date of the decision to terminate an employee; the date an applicant accepts the offer of employment; or the date an employee receives the promotion to a new position.)

3. ☒ QI ☐ CCS ☐ Other

4. Health Plan Position Title and **FTE**: Officer, Medicaid Member Services (1.0 FTE)

5. RFP Position Title and **Required FTE** (as listed in the RFP): Member Services Director (1.0 FTE)

6. Name of person *exiting* the above position: Jane Doe

7. Name & contact information of person *entering* the above position and **FTE** this person will serve in the position & program:

(If there is no *entering* person at this time, please provide information for the *Interim Contact Employee* below in item #10.)

Name: Bob Sox
FTE: 1.0 FTE
Phone: 808-123-4567
Email: B.sox@healthplan.org

8.

- **Does the *entering* person reside in the State of Hawaii?** ☒ Yes ☐ No
- **Does the *entering* person work in the State of Hawaii?** ☒ Yes ☐ No
- ****Submit to MQD, a current RESUME of the *entering* person, along with this Notification Form.** (This resume submission may not apply to the above position. Please refer to the RFP.)

9. Describe the staffing change:

Jane Doe is retiring and will no longer be the ***QI Member Services Director*** as of 11/1/20. Effective 11/1/20, Bob Sox will be the ***QI Member Services Director***. Bob Sox accepted the promotion to the ***QI Member Services Director*** (Officer, Medicaid Member Services) position, from his position as the *QI Member Grievance Coordinator*. A separate Notification Form will be submitted for the *QI Member Grievance Coordinator* position that Bob Sox will be vacating. (Complete separate Notification Forms for each position affected that requires a written notification.)

10. *Interim Contact Employee* (if applicable):

Name: N/A
Position Title: N/A
Phone: N/A
Email: N/A

11. Name, position title, and contact information of the person who completed this Notification Form:

Charles Brown QI Compliance Officer 808-222-5555 C.brown@healthplan.org

APPENDIX L. REMEDIES FOR NON-PERFORMANCE OF CCS CONTRACT
This Appendix includes Contract non-performance for which DHS may assess Liquidated Damages.

No.	Non-performance of Contract	Liquidated Damages
	Readiness Reviews and Implementation Activities	
1.	Failure to meet readiness review requirements as set forth in Section 13, Readiness Review and Contract Implementation Activities, within timelines as set by the DHS, including non-submission of deliverables or submitting deliverables late, with inaccuracies or incomplete.	Up to $2,500.00 per day for each day of non-compliance or $5,000.00 per deliverable for non-submission, late, inaccurate, or incomplete deliverables.
2.	Failure to be operational by the agreed upon operational start date of the Contract, based on DHS determination as to when the Health Plan is considered to be fully operational.	Up to $5,000.00 per day for each day beyond the start date of the Contract that the Health Plan is not operational until the day that the Health Plan is fully operational as determined by DHS.
	Administration and Management	
3.	Failure to comply with licensure requirements, as set forth in Section 14.3, Licensing and Accreditation.	Up to $5,000.00 per day that Health Plan is not licensed or qualified as required by applicable state or local law.
4.	Violation of a subcontracting requirement as set forth in Section 14.4**,** Subcontractor Agreements, and other sections of the Contract as applicable.	Up to $5,000.00 per violation.

No.	Non-performance of Contract	Liquidated Damages
5.	Failure to comply with the Health Plan staffing requirements, as set forth in Section 11.0, Health Plan Personnel.	Up to $1,000.00 per day for each separate failure to comply, for the first thirty (30) days non-compliance. At its discretion, DHS may double this amount for each day after thirty (30) days for each specific instance that the Health Plan remains non-compliant.
6.	Failure to have appropriate staff member(s) attend meetings as requested and designated by DHS.	Up to $250.00 per appropriate staff person per meeting as requested by DHS.
7.	Failure of the Health Plan to respond to a Notice of Concern within three (3) business days of receipt or to provide a sufficient response as set forth in Section 14.20.D, Notice of Concern and Opportunity to Cure.	Up to $500.00 per day for each day until the response is received and $1,000.00 for failure to respond sufficiently to Notice of Concern.
8.	Failure of the Health Plan to submit a Corrective Action Plan within ten (10) business days following the date of the Written Deficiency Notice as set forth in Section 14.21.E, Corrective Action Plan.	Up to $1000.00 per day for each day until the Corrective Action Plan is received.
9.	Failure to timely implement and comply with an accepted Corrective Action Plan as set forth in Section 14.20.E, Corrective Action Plan.	Up to $500.00 per day for each day the Health Plan fails to comply with an accepted Corrective Action Plan as determined by DHS.
10.	For requests not otherwise specifically addressed in this Contract, failure to respond or to submit a complete or accurate written response to a Department's written request within the designated timeframe.	Up to $500.00 per day penalty until the response is received, complete or accurate, whichever is applicable.

No.	Non-performance of Contract	Liquidated Damages
11.	Failure to provide notice of any known or suspected conflicts of interest or criminal conviction disclosures, as set forth in Section 14.8, Conflict of Interest.	Up to $1,000.00 per day that disclosure is late.
	Financial Requirements and Reimbursement	
12.	Failure to submit accurate and complete information or respond to a Department request regarding Medical Loss Ratio Calculation within the requested timeframe and as defined in the Contract.	Up to $500.00 per day until the information or response is received
13.	Failure to seek, collect and/or report third party information, as set forth in Section 7.3, Third Party Liability.	Up to $5,000.00 per day.
	Information Systems	
18.	Failure of the Health Plan's MIS to meet all requirements in Section 10, Information Systems and Information Technology, at any given time during operations.	Up to $2,500.00 per day of non-compliance.

No.	Non-performance of Contract	Liquidated Damages
19.	Failure of the Health Plan to provide notice to the Department, as set forth in Section 10, Information Systems and Information Technology, at least 30 days prior to implementation of any significant system changes that may impact data integrity, including such changes as new Claims processing software, and new Claims processing vendors..	Up to $2,500.00 per day of non-compliance.
	Encounter Data	
20.	Failure to submit accurate, complete, and timely encounter data to MQD in accordance with the requirements and specifications defined by the State and included in the HPMMIS Health Plan Manual ("Health Plan Manual").	Timeliness: $1,000.00 per day late. Accuracy: Per Encounter File error fee of $500.00
21.	Failure of the Health Plan to submit encounter data in the required form or format (as required by the HPMMIS Health Plan Manual and the Hawaii Companion Guide) for one calendar month.	$10,000 per file.
22.	Failure of the Health Plan to submit the required attestation as required in Section 6.5. B, Health Plan Certification	Up to $5,000.00 per file and an additional penalty of $1,000.00 per each late day beyond the thirty (30) days of notification.
23.	Encounter records are not resubmitted within thirty (30) days of the date the record is returned, as set forth in the Contract.	Per Encounter File error fee of $1,000.00.

No.	Non-performance of Contract	Liquidated Damages
	Quality and Health Outcomes	
24.	Failure to submit quality measures including audited HEDIS and CAHPS results within required timeframes, as set forth in Section 5, Quality, Utilization Management, and Administrative Requirements.	Up to $1,000.00 per day for every day reports are late.
25.	Failure to timely submit appropriate PIPs to DHS as set forth in Section 6, Quality, Utilization Management, and Administrative Requirements.	Up to $1,000.00 per day beyond the due date for which an appropriate PIP is received.
	Utilization Management	
26.	Imposing arbitrary utilization guidelines, prior authorization restrictions, or other quantitative coverage limits on an Member as prohibited under the Contract or not in accordance with an approved policy.	Up to $5,000.00 per occurrence per Member.
	Member Services	
27.	Failure to obtain approval of Member materials, as set forth in the Contract.	$500.00 per day for each day that the Department determines the Health Plan has provided Member materials that have not been approved by the Department.
28.	Failure to comply with timeframes for providing Member materials to Members as set forth the Contract.	$250.00 per occurrence per Member.

No.	Non-performance of Contract	Liquidated Damages
29.	Engaging in prohibited marketing activities or discriminatory practices or failure to market statewide, as set forth in the Contract.	Up to $5,000.00 per occurrence.
30.	Failure of the Health Plan to issue written notice to Members upon PCP's notice of termination in the Health Plan's plan, as set forth in the Contract.	Up to $1,000.00 per occurrence.
	Complaints, Grievances and Appeals	
31.	Failure to resolve at least 50% of Member and provider complaints within required timeframes from the date the complaint, grievance or appeal is received.	Up to $250.00 per reporting period.
32.	Failure to maintain a Grievance or Appeal System as set forth in Section 9.5, Member Grievance and Appeals System.	Up to $500.00 per day the Health Plan is in default.
33.	Failure to resolve Member appeals and grievances within required timeframes as set forth in Section 9.5, Member Grievance and Appeals System.	Up to $5,000.00 per violation.
34.	Failure to provide a timely and content-compliant Notice of Adverse Benefit Determination in accordance with Section 9.5, Member Grievance and Appeals System.	Up to $500.00 per day the Health Plan is in default.

No.	Non-performance of Contract	Liquidated Damages
35.	Failure to comply with all orders and final decisions relating to claim disputes, grievances, appeals and/or State Fair Hearing as issued or as directed by DHS and as set forth in Section 9.5, Member Grievance and Appeals System.	Up to $5,000.00 per occurrence.
36.	Failure to comply with Transition of Care requirements as set forth in the Contract.	$100.00 per day, per Member and the value of the services the Health Plan failed to cover during the applicable transition of care period, as determined by DHS.
	Provider Services and Network	
37.	Failure to comply with requirements and timeframes to process credentialing as set forth in the Contract.	Up to $1,000.00 per incident.
38.	Failure to maintain provider agreements as set forth in the Contract.	Up to $1,000.00 per provider agreement found to be non-compliant.
	Covered Services	
39.	Failure to timely provide a covered service as required under this contract when determined by the Department that such failure results in actual harm to an Member or places an Member at risk of imminent harm.	Up to $5,000.00 per day for each incidence of non-compliance.
	Program Integrity	
40.	Failure to fully implement, enforce and monitor the Health Plan's compliance plan as set forth in Section 12.1.A.4, Administrative Requirements.	Up to $500.00 per day for each day of non-compliance.

No.	Non-performance of Contract	Liquidated Damages
41.	Failure to establish and maintain a special Investigative unit as described in Section 12.1.A.4, Administrative Requirements.	Up to $500.00 per day for each day of non-compliance.
42.	Failure to comply with other Fraud, Waste and Abuse provisions set forth in Section 12, Program Integrity.	Up to $500.00 per day for each day of non-compliance.
43.	Failure to respond to informational or reporting requests whether recurring or a onetime request from DHS, the OIG, the OAG, the MFCU or any other agent or contractor of DHS within the timeframe requested.	Up to $500 a day penalty until the information is received.
	Data, Reporting Requirements and Deliverables	
44.	Failure to provide a required report or deliverable set forth in Appendix K, (Reporting Inventory), in the required timeframe; for which submission is incomplete or incorrect; or failure to resolve identified reporting or deliverable errors within five (5) business days or other required timelines upon notification by DHS.	$250 per day until the violation is remedied.
	Confidentiality and Protected Health Information	

No.	Non-performance of Contract	Liquidated Damages
45.	Failure to ensure Member confidentiality in accordance with 45 CFR 160 and 45 CFR 164; and an incident of non-compliance will be assessed as per Member and/or per HIPAA regulatory violation, as set forth in Section 14.16, Confidentiality of Information.	Up to $2,500.00 for each breach.
46.	Failure to ensure that all Hawaii Medicaid data containing protected health information (PHI), as defined by HIPAA, is secured as set forth in Section 14.16, Confidentiality of Information.	Up to $500.00 per Member per occurrence, and if DHS deems credit monitoring and/or identity theft safeguards are needed to protect those Members whose PHI was placed at risk by the Health Plan's failure to comply with the terms of this Contract, the BHO shall be liable for all costs associated with the provision of such monitoring and/or safeguard services.
47.	Failure to seek express written approval from DHS prior to the use or disclosure of Member data or Hawaii Medicaid confidential information as set forth in Section 14.15, Confidentiality of Information.	Up to $1,000.00 per Member or per occurrence.
48.	Failure to timely report violations in the access, use and disclosure of PHI or timely report a security incident or timely make a notification of breach or notification of provisional breach.	$500.00 per Member per occurrence, not to exceed $10,000,000.00.

Report #	Name	Report Category	Submission Frequency	Due Dates
1	Disclosure of Information on Annual Business Transactions	Administration, Finances, and Program Integrity	Annually	31-Oct
2	Encounter Data/Financial Summary Reconciliation	Administration, Finances, and Program Integrity	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
3	Fraud, Waste, and Abuse	Administration, Finances, and Program Integrity	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
4	Medicaid Contract	Administration, Finances, and Program Integrity	Annually	31-Dec
5	Medical Loss Ratio	Administration, Finances, and Program Integrity	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
6	Overpayments	Administration, Finances, and Program Integrity	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
7	Prescription Drug Rebates	Administration, Finances, and Program Integrity	Monthly	The 15th of each month
8	BHO Financial	Administration, Finances, and Program Integrity	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
9	BHO Financial – Annual	Administration, Finances, and Program Integrity	Annually	31-Oct
10	Community Integration Services	Covered Benefits and Services	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
11	Behavioral Health Services Report	Covered Benefits and Services	Monthly	Last day of the month following the reporting month
12	Behavioral Health Services Report	Covered Benefits and Services	Annually	31-Jan
13	Case Management Services Report	Covered Benefits and Services	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
14	Call Center Report & Remote Monitoring	Member Services	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
15	Member Grievance and Appeals	Member Services	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
16	Provider or Enrollee Satisfaction Survey	Member Services	Annually	31-Dec
17	Provider Grievance and Claims	Provider Network/ Services	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
18	Provider Network Adequacy Verification	Provider Network/ Services	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
19	Suspensions, Terminations, and Program Integrity Education	Provider Network/ Services	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan

20	Timely Access	Provider Network/ Services	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
21	Value Driven Health Care	Provider Network/ Services	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
22	Accreditation Status	Quality	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
23	Performance Improvement Projects	Quality	Annually	1-Jul
24	QAPI Progress Report and Annual Plan Update	Quality	Annually	1-Jul
25	QAPI Quarterly Progress and Work Plan Update	Quality	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
26	Quality and Performance Measurement Report	Quality	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
27	Adverse Events	Utilization Management	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
28	Drug Utilization Review	Utilization Management	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
29	Mental Health and Substance Use Disorder Parity	Utilization Management	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
30	Over-Utilization and Under-Utilization of Services	Utilization Management	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
31	Prior Authorizations - Medical & Pharmacy	Utilization Management	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan
32	Provider Preventable Conditions	Utilization Management	Quarterly	30-Apr, 31-Jul, 31-Oct, 31-Jan

Provider Contract Requirements

Community Care Services (CCS)

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

1. Specify covered populations and specifically cite the Community Care Services (CCS) program;
2. Specify covered services;
3. Specify rates of payment and applicable VBP arrangements;
4. Prohibit the provider from seeking payment from the Member for any covered services provided to the Member within the terms of the contract and require the provider to look solely to the BHO for compensation for services rendered, with the exception of cost sharing pursuant to the Hawaii Medicaid State Plan;
5. Prohibit the provider from imposing a no-show fee for CCS program Members who were scheduled to receive a CCS covered service;
6. Require the provider to cooperate with the BHO's quality improvement activities;
7. Require that providers meet all applicable state and federal regulations, including but not limited to all applicable HAR sections, and Medicaid requirements for licensing, certification and recertification;
8. Require the provider to cooperate with the BHO's utilization review and management activities;

9. Not prohibit a provider from discussing treatment or non-treatment options with Members that may not reflect the BHO's position or may not be covered by the BHO;
10. Not prohibit, or otherwise restrict, a provider from acting within the lawful scope of practice, from advising or advocating on behalf of a Member for the Member's health status, medical care, or treatment or non-treatment options, including any alternative treatments that might be self-administered;
11. Not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice from advocating on behalf of the Member to obtain necessary healthcare services in any grievance system or utilization review process, or individual authorization process;
12. Require providers to meet appointment waiting time standards pursuant to the terms of the RFP as described in Section 8.1.C;
13. Provide for continuity of treatment in the event a provider's participation terminates during the course of a Member's treatment by that provider except in the case of adverse reasons on the part of the provider;
14. Require that providers maintain the confidentiality of Member's information and records as required by law, including but not limited to privacy and security regulations adopted under HIPAA;
15. Keep any records necessary to disclose the extent of services the provider furnishes the Members;
16. Specify that CMS, the State Medicaid Fraud Control Unit, and DHS or its respective designee shall have the right to inspect, evaluate, and audit any pertinent books, financial records, medical records, lab results, documents, papers, and records of any provider involving financial transactions related to this contract and for the

monitoring of quality of care being rendered without the specific consent of the Member or the provider;

17. Require that provider comply with disclosure requirements identified in accordance with 42 CFR Part 455, Subpart B;
18. Require providers that are compensated by capitation payments to submit complete and accurate encounter data on a monthly basis and make available all medical records to support encounter data without the specific consent of the Member upon request from the BHO, DHS or its designee for the purpose of validating encounters;
19. Require provider to certify claim/encounter submissions to the plan as accurate and complete;
20. Require the provider to provide medical records or access to medical records to the BHO and DHS or its designee, upon request. Refusal to provide medical records, access to medical records or inability to produce the medical records to support the claim/encounter shall result in recovery of payment;
21. Include the definition and standards for medical necessity, pursuant to the definition in Section 3 of this RFP;
22. Specify acceptable billing and coding requirements;
23. Require that providers comply with the BHO's cultural competency requirements;
24. Require that the provider submit to the BHO any marketing materials developed and distributed by the provider related to the CCS program;
25. Require that the provider maintain the confidentiality of Members' information and records as required by the RFP and by federal and state law, including but not limited to:

a. The Administration Simplification (AS) provisions of HIPAA, Public Law 104-191 and the regulations promulgated thereunder, including but not limited to 45 CFR Parts 160, 162, and 164, if the provider is a covered entity under HIPAA;
b. 42 CFR Part 431 Subpart F;
c. Chapter 17-1702, HAR;
d. Section 346-10, HRS;
e. 42 CFR Part 2;
f. Section 334-5, HRS; and
g. Chapter 577A, HRS;

26. Require that providers comply with 42 CFR Part 434 and 42 CFR Section 438.6, if applicable;
27. Require that providers not employ or subcontract with individuals or entities whose owner, those with controlling interest, or managing employees are on any state or federal exclusion lists;
28. Prohibit providers from making referrals for designated health services to healthcare entities with which the provider or a Member of the provider's family has a financial relationship as defined in Section 3;
29. Require providers of transitioning Members to cooperate in all respects with the Members' prior providers to assure the best health outcomes for Members;
30. Require the provider to comply with corrective action plans initiated by the BHO or DHS;
31. Specify the provider's responsibilities regarding third party liability;
32. Require the provider to comply with the BHO's compliance plan including all fraud and abuse requirements and activities;

33. Require that providers accept Members for treatment, unless the provider applies to the BHO for a waiver of this requirement;
34. Require that the provider provide services without regard to race, color, creed, ancestry, sex, including gender identity or expression, sexual orientation, religion, health status, income status, or physical or mental disability;
35. Require that providers offer hours of operation that are no less than the hours of operation offered to commercial members or, if the provider has no commercial members, that the hours of operation are comparable to hours offered to recipients under Medicaid fee-for-service;
36. Require that providers offer access to interpretation services for Members that have a Limited English Proficiency (LEP) at no cost to the Member, and to document the offer and provision of interpreter services to the same extent as the BHO under the Contract;
37. Require that providers offer access to auxiliary aids and services at no cost for Members living with disabilities, and to document the offer and provision of auxiliary aids to the same extent as the BHO under the Contract;
38. Include a statement that DHS and the CCS Members shall bear no liability for the BHO's failure or refusal to pay valid claims of subcontractors or providers for covered services;
39. Include a statement that the provider shall accept BHO payment in full and cannot charge the patient for any cost of a BHO covered service whether or not the service was reimbursed by the BHO;
40. Include a statement that DHS and the CCS Members shall bear no liability for services provided to a Member for which DHS does not pay the BHO;

41. Include a statement that DHS and the CCS Members shall bear no liability for services provided to a Member for which the plan or DHS does not pay the individual or healthcare provider that furnishes the services under a contractual, referral, or other arrangement to the extent that the payments are in excess of the amount that the Member would owe if the BHO provided the services directly;
42. Require the provider to secure and maintain all necessary liability insurance and malpractice coverage as is necessary to protect CCS Members and the BHO;
43. Require the provider to secure and maintain automobile insurance when transporting Members, if applicable;
44. Require that the provider use the definition for emergency medical condition included in Section 3;
45. Require that the provider provides copies of medical records to requesting Members and allows them to be amended as specified in 45 CFR Part 164, HIPAA, or any other applicable federal or state law;
46. Require that the provider provide record access to any authorized DHS personnel or personnel contracted by DHS without Member authorization so long as the access to the records is required to perform the duties of the contract with DHS and to administer the CCS programs;
47. Require that the provider complies with BHO standards that provide DHS or its designee(s) prompt access to Members' medical records whether electronic or paper;
48. Require that the provider coordinate with the BHO in transferring medical records (or copies) when a Member changes providers;

49. Require that the provider comply with the advance directives requirements for hospitals, nursing facilities, providers of home and health care, hospices, and HMOs specified in 42 CFR Part 489, subpart I, and 42 CFR Section 417.436(d);
50. Require all Medicaid related records, be retained in accordance with 42 CFR Section 438.3(u) for a minimum of ten (10) years after the last date of entry in the records. For minors, records must be preserved and maintained during the period of minority plus a minimum of ten (10) years after the minor reaches the age of majority;
51. Require that the provider complies with all credentialing and re-credentialing activities;
52. Require that the provider refund any payment received from a resident or family member (in excess of share of cost) on behalf of the Member for the prior coverage period;
53. Require that the provider submit annual cost reports to DHS, if applicable;
54. Require that the provider comply with all requirements regarding when they may bill a Member or assess charges as described in Section 7.2.A;
55. Require that the provider is licensed in good standing in the State of Hawaii; and
56. Require provider to report capitation payments or other overpayments in excess of amounts specified in the contract within sixty (60) calendar days when identified.