



THIS NUMBER MUST APPEAR
ON ALL DOCUMENTS

Bill To:
State of Idaho

Send invoices to the address listed below or as indicated in the comments or instructions field
Boise, ID 83720-0075

State of Idaho

Contract Purchase Order

Contract Purchase Order
CPO02571

DELIVER

TO: Idaho Dept of Health & Welfare
450 W State Street
Boise, ID 83702
Ballardj@idhw.idaho.gov

Date: Mon Apr 29, 2013
F.O.B.: Destination
Terms:

VENDOR: UNITED BEHAVIORAL HEALTH
444 Brickell Avenue
Suite 1010
Miami, FL 33131
Attn: Director of Marketing
Vendor Nbr:
Emailed To: UnitedBH@uhc.com
Phone: 305-372-3550
Fax: 305-358-2521
eCommerce ID: P00000061700

Start of Service Thu Apr 25, 2013
Date
Thu Mar 24, 2016
End of Service
Date:

Solicitation#: RFQ09945
DOC#: PREQ21519

1 Header Attachments

Buyer: MARY JEPSEN 208-332-1607

Item No	Description	Quantity UOM	Unit Price	Extension
001	Behavioral Health Coverage for Prevention , screening, diagnostic, treatment and support services and the coordination of such services for qualified Members enrolled in Idaho Medicaid through a statewide network of licensed and/or certified, qualified behavioral health providers, per RFP02482 Services for Dual Eligible s - \$107.19 Total PMPM Cost Services for Non-Duals - \$39.59 Total PMPM Cost (958-56) (nt)	1 LOT	\$300,321,549.90	\$300,321,549.90
	Subtotal:			\$300,321,549.90
	Total:			\$300,321,549.90
Administrative Fee	SicommNet, Inc. will invoice Vendor separately for the 1.25% Administrative Fee applicable to this award, in accordance with the Solicitation Instructions to Vendors and Standard Terms and Conditions.			
	CONTRACT PURCHASE ORDER (CPO) AWARD This Contract is for a Behavioral Health Plan for the Idaho Department of Health and Welfare. This			

Contract shall be for the period noted above (and 2 optional renewals of 2 years each, subject to mutual agreement between the parties).

Vendor Contact:..... Andrew Sekel
 Phone:..... 415-547-6033
 Facsimile:..... 415-547-5999
 E-mail:..... andrew.sekel@optum.com

INVOICES MUST BE SENT TO Idaho Department of Health and Welfare

Agency Contact:..... Pat Martelle
 Phone:..... 208-364-1813
 Facsimile:..... 208-332-7292
 E-Mail Address:..... martelleP@dhw.idaho.gov

General
 Comments:

THIS CONTRACT, (including any files attached), CONSTITUTES THE STATE OF IDAHO'S ACCEPTANCE OF YOUR SIGNED BID, QUOTATION, OR OFFER (including any electronic bid submission), WHICH SUBMISSION IS INCORPORATED HEREIN BY REFERENCE AS THOUGH SET FORTH IN FULL.

The dollar amount listed in the contract pricing is an estimate and cannot be guaranteed. The actual dollar amount of the contract may be more or less depending on the actual orders, requirements, or tasks given to the Contractor by the State or may be dependent upon the specific terms of the Contract.

In the event of any inconsistency, unless otherwise provided herein, such inconsistency shall be resolved by giving precedence in the following order:

1. This Contract Purchase Order document.
2. The state of Idaho's original solicitation document

Instructions:		
Freight / Handling Included in Price		
		Signed By: MARY JEPSEN
Select an action.		and Execute Action
		Back to Quick Search
		mary.jepsen@adm.idaho.gov

STATE OF IDAHO
Department of Health and Welfare Contract

CONTRACT NO. RC070800
CONTRACTOR'S FEDERAL I.D. NO. 94264909700
RFP NO. RRFP1103 / RFP02482
CONTRACT PURCHASE ORDER NO.

CONTRACT NAME: UNITED BEHAVIORAL HEALTH

This Contract is entered into by the State of Idaho, Department of Health and Welfare, hereinafter referred to as the **DEPARTMENT**, and **UNITED BEHAVIORAL HEALTH**, hereinafter referred to as the **CONTRACTOR**. This contract is anticipated to be effective as of **03/25/2013** and expire on **03/24/2016**. As outlined in Paragraph II of the Contract Terms and Conditions, this Contract will not be effective until signed by all parties.

WITNESSETH: The **DEPARTMENT** enters into this Contract pursuant to authority granted to it in Title 56, Chapter 10, Idaho Code. The **CONTRACTOR** agrees to undertake performance of this Contract under the terms and conditions set forth herein.

The Contractor agrees to provide, and the Department agrees to accept the services detailed in the Scope of Work and generally described as follows:

Managed care of behavioral health services.

The following Attachments are hereby incorporated and made a part of this Agreement:

Special Terms and Conditions
State of Idaho Terms and Conditions (by reference)
Riders
Scope of Work
Cost/Billing Procedure
Reports
Department's RFP No RRFP1103 / RFP02482 and all Attachments (1-27) (by reference)
Vendor's Response to Department's RFP No RRFP1103 / RFP02482 (by reference)

TOTAL CONTRACT AMOUNT: \$300,321,549.90

SUB OBJECT: 704100-MEDICAID
PROGRAM COST ACCOUNT (PCA) 42830 - MEDICAID PREPAID HEALTH PLANS

CONTRACT MONITOR: Paige Grooms

CONTRACT MANAGER: Patricia Martelle

SPECIAL TERMS AND CONDITIONS

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

V. CUSTOMER SERVICE.

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

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

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

VIII. COMPLIANCE WITH CERTAIN LAWS.

- A. HIPAA The Contractor acknowledges that it may have an obligation, independent of this contract, to comply with the Health Insurance Portability and Accountability Act (HIPAA), Sections 262 and 264 of Public Law 104-191, 42 USC Section 1320d, and federal regulations at 45 CFR Parts 160, 162 and 164. If applicable, Contractor shall comply with all amendments to the law and federal regulations made during the term of the Contract.
- B. Lobbying
 - 1. The Contractor certifies that none of the compensation under the Contract has been paid or will be paid by or on behalf of the Contractor to any person for influencing or attempting to influence an officer or employee of any governmental agency, a member, officer or employee of Congress or the Idaho Legislature in connection with the awarding, continuation, renewal, amendment, or modification of any contract, grant, loan, or cooperative agreement
 - 2. If any funds, other than funds provided by the Contract, have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any governmental agency, a member, officer or employee of Congress or the State Legislature in connection with the Contract, the Contractor shall complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions, and submit a copy of such form to the IDHW.

3. The Contractor shall require that the language of this certification be included in any subcontract, at all tiers, (including grants, subgrants, loans, and cooperative agreements) entered into as a result of the Contract, and that all sub-recipients shall certify and disclose as provided herein.
4. The Contractor acknowledges that a false certification may be cause for rejection or termination of the Contract, subject Contractor to a civil penalty, under 31 U.S.C. § 1352, of not less than \$10,000.00 and not more than \$100,000.00 for each such false statement, and that Contractor's execution of the Contract is a material representation of fact upon which the IDHW relied in entering the Contract.

C. Qualification The Contractor certifies to the best of its knowledge and belief that it and its principals:

1. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from performing the terms of the Contract by a government entity (federal, state or local);
2. Have not, within a three (3) year period preceding the Contract, been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or contract under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
3. Are not presently indicted for or otherwise criminally or civilly charged by a government entity (federal, state or local) with commission of any of the offenses enumerated in paragraph 2 of this certification; and
4. Have not within a three (3) year period preceding the Contract had one or more public transactions (federal, state, or local) terminated for cause or default.
5. The Contractor acknowledges that a false statement of this certification may be cause for rejection or termination of the Contract and subject Contractor, under 18 U.S.C. § 1001, to a fine of up to \$10,000.00 or imprisonment for up to 5 years, or both.

D. Faith-Based Organization If the Contractor is a faith-based organization, the contractor and all approved subcontractors shall:

1. Segregate contract funds in a separate account.
2. Serve all members without regard to religion, religious belief, refusal to hold a religious belief, or refusal to actively participate in a religious practice.
3. Ensure that IDHW-referred clients' participation in religious activities, including worship, scripture study, prayer or proselytization, is only on a voluntary basis.
4. Notify members of the religious nature of the organization, their right to be served without religious discrimination, their right not to take part in religious activities, their right to request an alternative provider and the process for doing so.
5. Ensure that contract funds are not expended on inherently religious activities.
6. Comply with applicable terms of 42 CFR Parts 54, 54a, and 45 CFR Parts 260 and 1050.

- E. Tribe If the Contractor is a Tribe, the Contractor and IDHW recognize that services performed pursuant to this Contract by the Contractor and all approved subcontractors within reservation boundaries are subject to applicable laws, ordinances and regulations of the Tribe. Nothing in this Contract should be construed as a waiver of sovereign immunity.

IX. CONFLICT OF INTEREST.

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

X. REMEDIES.

- A. Remedial Action Notwithstanding any conflicting provision in the State of Idaho Standard Contract Terms and Conditions, and in addition to any remedies available to the State under law or equity, the State may at its sole discretion require one (1) or more of the following remedial actions, taking into account the nature of the deficiency, if any, of the services or products that do not conform to Contract requirements: (1) require the Contractor to take corrective action to ensure that performance conforms to Contract requirements; (2) reduce payment to reflect the reduced value of services received; (3) require the Contractor to subcontract all or part of the service at no additional cost to the State; (4) withhold payment or require payment of actual damages caused by the deficiency; (5) withhold payment or require payment of an overpayment or duplicate payment; (6) withhold payment or require payment of liquidated damages, as more particularly set forth below; (7) secure products or services and deduct the costs of products or services from payments to the Contractor; or (8) terminate the Contract pursuant to section 2 of the State of Idaho Standard Contract Terms and Conditions. No remedy conferred by any of the specific provisions of the Contract is intended to be exclusive of any other remedy, and each and every remedy shall be cumulative and shall be in addition to every other remedy given hereunder, now or hereafter existing at law or in equity or by statute or otherwise. The election of any one or more remedies by either party shall not constitute a waiver of the right to pursue other available remedies.
- B. Liquidated Damages. The IDHW and Contractor agree that it will be extremely impractical and difficult to determine the actual damages that the IDHW will sustain in the event the Contractor fails to perform under the Contract. The State may, in its discretion, assess liquidated damages as more particularly set forth below.

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

the effective date of the contract. Due to the foregoing, the IDHW may, in its discretion, assess the liquidated damages as more particularly described below.

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

BB	Member Protections/Liability for Payment	Critical	100%
CC	Provider Manual	Essential	95%
DD	Community Partnerships	Critical	100%
FF	Outcomes, Quality Assessment and Performance Improvement Program	Essential	95%
GG	Compliance and Monitoring (Utilization Management)	Essential	95%
II	Data Tracking and Utilization Information System	Critical	100%
KK	Disaster Recovery Plan	Critical	100%
LL	Reports/Records/Documentation	Critical	100%
MM	Contract Transition Plan	Essential	95%

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

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

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

1. Performance Indicators

- a) The IDHW reserves the right to monitor the performance of any aspect of the Contract, not just those elements identified in the Performance Indicators below. Each Performance Indicator has been assigned a classification of either "Critical" which must be performed at a level of 100%; "Essential" which must be performed at a level of 95%; and "Important" which must be performed at a level of 90%. The thresholds have been determined by the relationship of the Performance Criteria to the Idaho Behavioral Health Plan critical, essential and important standards.
- b) The chart of Performance Indicators below outlines areas that are subject to liquidated damages. Criteria are subject to change based on updated legal or policy mandates. The IDHW shall give the Contractor written notification ten (10) business days prior to any new criteria being added to the chart or any criteria existing in the chart being changed. Such ten (10) day period shall commence upon the date of mailing or electronic transmission of the notice. The IDHW shall

maintain a current chart of Performance Indicators and shall provide a copy of the current chart to the Contractor upon written request.

2. Objective Performance Criteria

- a) The chart of Performance Indicators above outlines areas that are subject to liquidated damages. Criteria are subject to change based on updated legal or policy mandates. The IDHW shall give the Contractor written notification ten (10) business days prior to any new criteria being added to the chart or any criteria existing in the chart being changes. Such ten (10) day period shall commence upon the date of mailing or electronic transmission of the notice.
- b) If the Contractor considers any new criteria or changes to existing criteria to be a material change to the contract, it must notify the IDHW in writing within the ten (10) business day period set forth above. The Contractor's notice shall include an explanation identifying why it considers the new criteria or changes to be a material change to the contract. For the purpose of Performance Indicator criteria additions and changes, material changes shall be changes that affect the time, scope or cost of the contract. If the Contractor timely provided notification to the IDHW that the new criteria or changes to the Performance Indicator criteria are material, the parties will then negotiate in good faith to add the new criteria or to change existing criteria via written amendment to the contract.
- c) If the Contractor does not prove notification to the IDHW that new or revised criteria are material within the (10) business days from receipt of written notification from the IDHW, the new criteria or changed criteria will become part of the contract without further action by the parties. The Contractor must comply with new criteria or changes to existing criteria within thirty (30) business days of them becoming part of the contract, whether by written amendment or by failure of the Contractor to provide notice of materiality.
- d) The table of Performance Indicators above is a summary chart of criteria for the performance of the Contractor subject to performance monitoring. Details for each performance indicator are provided in RFP sections identified in the aforementioned summary chart. Each criterion has been assigned a "threshold." Monitoring will determine if the Contractor is operating above or below the established threshold. If the finding is that the Contractor is operating below the established threshold, liquidated damages may be imposed. Liquidated damages will be based on the average amount of time the IDHW must invest to monitor the performance of the Contractor. The average amount of time required is then multiplied by the cost, to the IDHW, for the staff involved. As the Contractor's results continue to fall below the established thresholds, the number of people involved in monitoring performance is increased and the amount of liquidated damages is increased accordingly as illustrated in the table below.
- e) If the Contractor falls below the threshold for the first follow up monitoring, then level one (see table below) liquidated damages will be assessed as more particularly described below. The second (follow up) monitoring that does not meet established thresholds will result in assessment of level two (2) liquidated damages. Level three (3) liquidated damages will be assessed for failure to meet performance criteria for a third (3rd) time and for subsequent failures. Rates imposed upon the Contractor will be calculated using the then current employee and consultant costs established in the records of the State.

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

- f) The IDHW shall document and discuss liquidated damages with the Contractor prior to the issuance of notice of the imposition of liquidated damages. The Contractor will be notified in writing and the appropriate deduction will be made in the next monthly payment following the expiration of any applicable appeal deadline or other applicable cure or notice periods and in accordance with the contract requirements and limitations. If the next monthly payment is insufficient to fully recover liquidated damages, the IDHW may, in its discretion require full payment by the Contractor of the then outstanding liquidated damages or may continue recovering liquidated damages from future payments to the Contractor.
- g) Contractor's submission and the State's payment of an invoice reduced as set forth above shall not limit the remedies afforded to the State under law and pursuant to the Contract.

3. Monitoring Process

- a) The purpose of performance monitoring is to:
- (1) Determine the degree to which state funded programs and activities are accomplishing their goals and objectives;
 - (2) Provide measurements of program results and effectiveness;
 - (3) Evaluate efficiency in the allocation of resources; and
 - (4) Assess compliance with the contract, laws, and regulations.
- Failure to meet the thresholds established for performance monitors constitutes breach of the contract and will initiate remedial action.
- b) The IDHW will engage in ongoing contract monitoring, and this may include performance monitoring of the Contractor, This may include review of documentation as well as onsite monitoring at any operational facilities and business offices that handle any component of the Contract requirements for the Idaho Behavioral Health Plan.
- c) During any form of performance monitoring, the Contractor or any subcontractor or network provider will provide to IDHW any Member's medical records, behavioral health records, logbooks, staffing charts, time reports, claims data, administrative documents, complaints, grievances, and any other requested documents and data as requested when at the sole discretion of the IDHW it is determined to be required to assess the performance of the Contractor, a subcontractor or a network provider. Self-monitoring and reporting to the IDHW is required. Such information must be provided to the IDHW in the Compliance Report.
- d) If monitoring activities are conducted at a network provider location they will be conducted in a manner so as not to disrupt the provision of treatment to Members.
- e) Any monitoring performed, may or may not be scheduled in advance, and may last for several days.

- f) The performance level of the Contractor or a subcontractor or a network provider may affect the frequency of the monitors.
- g) The IDHW reserves the right to monitor any aspect of the contract, not just those elements identified in the Performance Indicators.
- h) Additionally, if the IDHW receives continual unresolved Member or provider network complaints regarding behavioral health service issues, the IDHW will initiate a focused monitoring of that area, utilizing at least one of the performance criteria listed in this document. The IDHW will then follow the reporting, cure period, and appeal process listed below.
- i) Areas in which performance deficiencies have been found may be followed continually, or subsequently re-examined as designated by the IDHW.
- j) All monitoring is designed and will be performed in accordance with the following standards:
 - (1) Idaho Statutes
 - (2) Idaho Administrative Code
 - (3) Department of Health and Welfare Policies and Procedures
 - (4) SAMHSA guidelines
 - (5) Code of Federal Regulations
 - (6) National Accreditation Standards
 - (7) The RFP and current Idaho Behavioral Health Plan contract
- k) General requirements applicable to all Members will typically be assessed via a randomly selected data review of approximately ten percent (10%) sample of Member files at a provider location. Other requirements, relevant to a segment of the Member population, may be reviewed using a higher percentage, up to one hundred percent (100%) of the records of a sub-population. Areas in which performance deficiencies have been found may be re-examined in the subsequent quarter or follow up period, as designated by the IDHW, in order to gauge progress towards satisfactory performance.

4. Monitoring Report and Appeal

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

5. Breach Cure Period

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

- C. Termination for Convenience The IDHW or the Contractor may cancel the Contract at any time, with or without cause, upon one-hundred eighty (180) calendar days written notice to the other party specifying the date of termination.
- D. Effect of Termination Upon termination by the IDHW, Contractor shall: (a) promptly discontinue all work, unless the termination notice directs otherwise; (b) promptly return to the IDHW any property provided by the IDHW pursuant to the Contract; and, (c) deliver or otherwise make available to the IDHW all data, reports, estimates, summaries and such other information and materials as may have been accumulated by Contractor in performing the Contract, whether completed or in process. Upon termination by the IDHW, the IDHW may take over the services and may award another party a contract to complete the services contemplated by the Contract. Upon termination for cause, the IDHW shall be entitled to reimbursement from Contractor for losses incurred as a result of the Contractor's breach.
- E. Survival of Terms Any termination, cancellation, or expiration of the Contract notwithstanding, provisions which are intended to survive and continue shall survive and continue, including, but not limited to, the provisions of these Special Terms and Conditions, Sections IV (Records and Data), VII (Federal and State Audit Exceptions), VIII (Compliance with Certain Laws), and the State of Idaho General Terms and Conditions, Sections 9 (Contract Relationship) and 12 (Save Harmless).

XII. MISCELLANEOUS.

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

IN WITNESS WHEREOF, the parties have executed this agreement.

CONTRACTOR:

UNITED BEHAVIORAL HEALTH
Name of Organization

ANDREW SEKEL
Name of Signature Authority (printed)

CEO
Title

[Signature]
Signature

APRIL 22, 2013
Date

Mailing Address:

425 MARKET ST, 14TH FLOOR
SAN FRANCISCO CA 94105

415-547-6033
Telephone No.

Contract Number: RC070800

STATE OF IDAHO:

Department of Health and Welfare
Name of Organization

Richard M. Armstrong, Department of Health and Welfare
Name of Signature Authority (printed)

Director
Title

[Signature]
Signature

4/24/13
Date

Mailing Address:

P.O. Box 83720
Boise, ID 83720-0036

Telephone No.

Mary Jepsen
Division of Purchasing
Name of Signature Authority

Purchasing Officer
Title

[Signature]
Signature

4/25/13
Date

Mailing Address:

650 W. State St. Rm B-15
Boise, ID 83702

208-332-1611
Telephone No.

Cost/Billing Procedure

Cost:

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

The number of per eligible participants per month listed below is the Department's best estimate and may vary from actual number of eligible participants that may be served. Estimated quantity is for evaluation purposes and is not to be considered a guarantee of actual number of services to be experienced under the contract. For payment purposes, the most current eligible participant count is based on the number of eligible participants as of the first day of each month.

The PMPM proposed cost, which includes administrative costs, is effective for the first three (3) years of the contract. The IDHW will conduct actuarial analyses after the first three (3) years of the contract. The IDHW shall have the option to renew the contract for two (2) additional two (2) year periods.

COST MATRIX

Item	Unit - Per Eligible Member Per Month (PMPM)	PMPM Services Cost	PMPM Administrative Costs <i>(Must not exceed 15% of fixed claims allowance fee)</i>	Total PMPM Cost
Idaho Behavioral Health Plan: Dual eligibles	22,175	\$98.84	\$8.35	\$107.19
				Monthly Total PMPM Cost
Monthly Total	22,175 X Total PMPM Cost ▶			\$2,376,938.25
				Six (6) Month Total: Idaho Behavioral Health Plan: dual eligibles
Six (6) Month Total	Monthly Total PMPM Cost X 6 ▶			\$14,261,629.50
Item	Unit - Per Eligible Member Per Month (PMPM)	PMPM Services Cost	Administrative Costs <i>(Must not exceed 15% of fixed claims allowance fee)</i>	Total PMPM Cost
Idaho Behavioral Health Plan: non-duals	200,710	\$34.58	\$5.01	\$39.59
				Monthly Total PMPM Cost
Monthly Total	200,710 X Total PMPM Cost ▶			\$7,946,108.90

		Three (3) Year Total: Idaho Behavioral Health Plan: non-duals
Three (3) Year Total	Monthly Total PMPM Cost X 36 ▶	\$286,059,920.40
Administrative costs may not exceed 15% of the PMPM cost.		

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

Incentives for Stabilization and Reduction of Behavioral Health Inpatient Costs

The Contractor shall provide an array of outpatient services designed to prevent or limit the need for inpatient services. An initial withhold from the capitation rate for the non-dual population of 5% will be used as an incentive. Six (6) months after the first year the contractor has begun administering services, the IDHW will calculate the previous year expenditures and the prior year fee-for-service expenditures. The amounts are calculated on a PMPM basis.

If Medicaid does not experience an increase in BH inpatient expenditures above its' historical inflationary factor of 5%, the total amount of the withheld amount will be paid to the Contractor. However, should Medicaid experience an increase in inpatient costs in an amount greater than its' historical inflationary factor of 5%, the amount of the increase above the 5% (inflation) will be applied to the amount withheld from the PMPM on a dollar to dollar basis, up to the total of the withheld amount. The difference is then paid to the Contractor.

Additionally, should the IDHW experience a 5% or greater reduction in inpatient costs, 50% of the savings realized will be paid to the contractor. The calculations will occur on an annual basis throughout the life of the contract. The incentive payment for reduction of inpatient costs is capped at 5% of the net PMPM (the proposed PMPM less the 5% withhold). The net PMPM must be certified by the IDHW's actuary as a sound rate.

Billing Procedure:

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

Inquiries, invoices, and deliverables shall be submitted to:

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

Reports

The IDHW shall retrieve reports from the Contractor via SFTP by 10.00 a.m. Mountain Time on the tenth (10th) business day of the month following the month or quarter when services were provided. All reports based on Member utilization or Member input shall be sorted by duals and non-duals. Complete reports with data and all documentation that supports all summarized reports below shall be provided by the Contractor at the request of the IDHW.

Report Description:

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

Report Format:

Excel Spreadsheet

Report Due Date:

Monthly, after capitation processing and reconciling.

Report Description:

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

Report Format:

Excel Spreadsheet

Report Due Date:

Monthly

Report Description:

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

Report Format:

Excel Spreadsheet

Report Due Date:

Monthly

Report Description:

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

Report Format:

Excel Spreadsheet

Report Due Date:

Monthly

Report Description:

Access Availability Report. If a provider loss results in a network deficiency, the Contractor shall submit to the IDHW a report listing each deficiency, along with time frames and action steps for correcting each deficiency within thirty (30) days. This report shall include documentation that each Member affected is transitioned to appropriate alternative service providers in accordance with the network notification requirements. The Contractor shall summarize the number of network providers in each county and region and the percentage of Members who have a behavioral health provider within: thirty (30) miles of their residence for Ada, Canyon, Twin Falls, Nez Perce, Kootenai, Bannock, and Bonneville counties; and forty five (45) miles of their residence for all other counties in Idaho.

Report Format:

Excel Spreadsheet

Report Due Date:

Monthly

Report Description:

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

Report Format:

Excel Spreadsheet

Report Due Date:

Monthly

Report Description:

Complaint and Critical Incident Resolution Tracking Report. The Contractor shall submit a complaint and critical incident resolution tracking report that includes the complaint and critical incident type, number of complaints and critical incidents received, how complaints and critical incidents were received (by phone, written communication), Members, staff and network providers involved in the reporting, investigation and resolution of the complaint or critical incident, dates received, date of resolution, a description of the resolution, and number and status of complaints and critical incidents awaiting resolution. The report shall include all current complaints and critical incidents whether they are resolved or not. This report shall cover the most recent twelve (12) month period and be sorted by Member and provider, as well as by complaint or critical incident categories

Report Format:

Excel Spreadsheet

Report Due Date:

Monthly

Report Description:

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

Report Format:

Excel Spreadsheet

Report Due Date:

Monthly

Report Description:

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

Report Format:

Excel Spreadsheet

Report Due Date:

Quarterly

Report Description:

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

Report Format:

Excel Spreadsheet

Report Due Date:

Quarterly

Report Description:

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

Report Format:

Excel Spreadsheet

Report Due Date:

Monthly

Report Description:

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

Report Format:

Excel Spreadsheet

Report Due Date:

Monthly

Report Description:

Member Access to Care Inquiries. The Contractor shall submit a report summarizing the number of inquiries received from Members each month and the reasons for the calls, categorize the inquiries as telephonic, written, face-to-face, or use of other electronic mediums. This report is separate from, and should include non-duplicative data from, the Customer Service Reports.

Report Format:

Excel Spreadsheet

Report Due Date:

Monthly

Report Description:

Timeliness of Services Report. The Contractor shall submit a detailed report that includes the following: Days taken for authorization decision to be formally documented; Existing Members: waiting time (number of calendar days) for an appointment for non-urgent behavioral health services; New Members who are initiating behavioral health services and who do not require urgent care: waiting time (number of calendar days) for an appointment for behavioral health services; Existing Members: waiting time (number of hours) for urgent behavioral health services for treatment of specific problems requiring immediate attention; New Members: waiting time (number of hours) for urgent behavioral health services for treatment of specific problems requiring immediate attention; Number of referrals made to the emergency IDHW of the Member's local hospital; Time taken for the Contractor to find a provider, in or out of network, who will agree to treat a Member if the Member cannot find a provider on their own: number of calendar days for non-urgent cases and number of hours for urgent cases.

Report Format:

Excel Spreadsheet

Report Due Date:

Monthly

Report Description:

Provider Enrollment Report. The Contractor shall submit a report that details the number, names, service locations, addresses, zip codes, county and Identification numbers of all enrolled providers, by provider type. Each section shall include identification of: Providers lost and gained; Prescribers lost and gained; Prescriber sufficiency analysis; The name and address of each provider; Contracted capacity, populations served; and An analysis of the effect on network sufficiency and progress in accordance with efforts to increase service capacity in areas requiring further development, including barriers encountered and actions planned to eliminate the barriers.

Report Format:

Excel Spreadsheet

Report Due Date:

Quarterly

Report Description:

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

Report Format:

Excel Spreadsheet

Report Due Date:

Quarterly

Report Description:

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

Report Format:

Excel Spreadsheet

Report Due Date:

Annually

Report Description:

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

Report Format:

Excel Spreadsheet

Report Due Date:

Monthly

Report Description:

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

Report Format:

Excel Spreadsheet

Report Due Date:

Monthly

Report Description:

Level of Care Report. The Contractor shall submit a report of Members' changes in levels of care. The report shall detail the following: The number of Members who discontinue their behavioral health services which shall include the Member names, Member ID numbers, ages, and reasons for dropping out of services; The number of Members who received inpatient behavioral health services and their names, Member ID numbers, and ages and the names and ID numbers of the hospitals; and The number of Members at each level of care.

Report Format:

Excel Spreadsheet

Report Due Date:

Quarterly and an annual summary

Report Description:

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

Engagement of Alcohol and Other Drug Dependence Treatment.

Report Format:

Excel Spreadsheet

Report Due Date:

Annually

Report Description:

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

Report Format:

Excel Spreadsheet

Report Due Date:

Quarterly

Report Description:

Implementation Project Status Report. In conjunction with establishing and attending project status meetings, the Contractor shall provide written status reports during the implementation process. The report shall include: Updated Work Plan and responsibility matrix; Tasks that are behind schedule; Dependent tasks for tasks behind schedule; Items requiring the State Project Manager's attention; Anticipated staffing changes; Outstanding issues, current status and plans for resolution; Any issues that can affect schedules for project completion; and Identification, time frames, critical path effects, resource requirements, and materials for unplanned items.

Report Format:

Excel Spreadsheet

Report Due Date:

Bi-weekly

Report Description:

Contract Transition Status Report. Ninety (90) days prior to the end of the contract, the Contractor shall establish and attend bi-weekly project status meetings with the IDHW and provide bi-weekly (alternative weeks from meetings) written status reports during the transition process. This report shall include: Updated transition implementation plan and responsibility matrix; Tasks that are behind schedule; Dependent tasks for tasks behind schedule; Items requiring the State Project Manager's attention; Anticipated staffing changes; Outstanding issues, current status and plans for resolution; Any information set forth in this contract and necessary for the transition process; Identification of any issues that can affect schedules for project completion; and Identification, time frames, critical path effects, resource requirements, and materials for unplanned items.

Report Format:

Excel Spreadsheet

Report Due Date:

Bi-weekly when transition period has been identified

Report Description:

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

Report Format:

Excel Spreadsheet

Report Due Date:

Annually

Report Description:

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

Report Format:

Excel Spreadsheet

Report Due Date:

Monthly

Report Description:

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

Report Format:

Excel Spreadsheet

Report Due Date:

Monthly

Report Description:

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

Report Format:

Excel Spreadsheet

Report Due Date:

Annually

Report Description:

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

Report Format:

Excel Spreadsheet

Report Due Date:

Quarterly

Report Description:

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

Report Format:

Excel Spreadsheet

Report Due Date:

Quarterly

Report Description:

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

Report Format:

Excel Spreadsheet

Report Due Date:

Quarterly

Report Description:

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

Report Format:

Excel Spreadsheet

Report Due Date:

Bi-Annually: mid-July and mid-January

Report Description:

Compliance Report. The Contractor shall report monthly on its own performance by providing a report of its compliance to the specific criteria of each performance indicator. The operational definition of each criterion shall be negotiated with the Contractor.

Report Format:

Excel Spreadsheet

Report Due Date:

Monthly

Scope of Work

I. General Requirements

- A. Idaho Department of Health and Welfare (IDHW) Responsibilities: The IDHW will:
1. Provide an IDHW Contract Manager for ongoing contract administration and contract performance monitoring.
 2. Designate an IDHW Contract Manager who shall have overall responsibility for the management of all aspects of this contract and the IDHW Contract Manager shall be a member of the implementation team. This person shall oversee the Contractor's progress, facilitate issue resolution, coordinate the review of deliverables, and manage the delivery of IDHW resources to the project, consulting with the Contractor as needed. The IDHW Contract Manager may designate other IDHW staff to assume designated portions of the IDHW Contract Manager's responsibility. The IDHW Contract Manager shall be the central point of communications and any deliverables to the IDHW shall be delivered to the IDHW Contract Manager and any communication or approval from the IDHW shall be communicated to the Contractor through the IDHW Contract Manager. Should disagreements arise between Contractor staff and the IDHW's Project Team, those disagreements shall be escalated for resolution through each organization's respective reporting structure. Should those disputes remain unresolved after that process, the IDHW's Contract Manager has the authority to escalate through the Division of Medicaid's leadership to the IDHW's Director who retains ultimate authority to decide the outstanding issue or question.
 3. Review any required informational materials regarding the Idaho Behavioral Health Plan program prior to release, including, but not limited to brochures, provider and Member templates for correspondence. The IDHW will review draft documents, identify revisions, and return written comments to the Contractor within agreed upon timeframes.
 4. Prior to the provision of services under the contract, the IDHW's Division of Medicaid will notify all current eligible Members, and mental health and substance use disorder providers enrolled under the IDHW's current network of the following:
 - a. Creation of the Idaho Behavioral Health Plan
 - b. An explanation of how the new managed care plan works; and
 - c. The Contractor's information: toll-free number, mailing address, and website.
 5. Enroll all Medicaid beneficiaries, except for excluded populations identified by the IDHW, into the Idaho Behavioral Health Plan upon eligibility determination. As used in this RFP, a Medicaid enrollee means a Medicaid Member who is enrolled in the Idaho Medicaid Management Information System (MMIS).
 6. Determine the on-going eligibility of a person for Medicaid funded services.
 7. Be responsible for all enrollment and disenrollment into the PAHP. The IDHW automatically enrolls Medicaid beneficiaries on a mandatory basis into the PAHP, for which it has requested a waiver of the requirement of choice of plans. There are no potential enrollees in this program because the IDHW automatically enrolls beneficiaries into the single PAHP. 42 CFR § 438.10(a)
- B. Contractor's Responsibilities: The Contractor shall:
1. Administer behavioral health coverage for all Medicaid eligible Members. The

Contractor may not dis-enroll any Medicaid eligible Members.

2. Notify all Members, at the time of enrollment, of the Member's rights to change providers.
3. Provide all Members, at the time of enrollment, all information required per 42 CFR § 438.10(f)(6).
4. Notify all Members, at least annually, of their rights provided under 42 CFR § 438.10(f)(6), 42 CFR § 438.10 (g) and 42 CFR § 438.10 (h) and written notice of any changes in the information specified in these provisions.
5. Ensure services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished consistent with requirements at 42 CFR § 438.210(a)(3)(i) as amended.
6. Not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the Member. 42 CFR § 438.210(a)(3)(ii).
7. Comply with provisions of 42 CFR 438.210(a) (1)(2) and (4).
8. Defend, indemnify and hold harmless Members, the IDHW or its agents, employees or contractors against any and all claims, costs, damages, or expenses (including attorney's fees) of any type or nature arising from the failure, inability, or refusal of the Contractor to pay the behavioral health provider for covered services or supplies.
9. Designate a primary contact for the IDHW Contract Manager who will cooperate fully with respect to the direction and performance of the contract.
10. Participate in a contract implementation meeting, either in person or by phone. The IDHW will facilitate the implementation meeting to review contract requirements and timelines. The Contractor shall attend this meeting and all meetings throughout the contract at its own expense.
11. Comply with all provisions of state and federal laws, rules, regulations, policies, and guidelines as indicated, amended or modified that govern performance of the services. This includes, but is not limited to:
 - a. 42 CFR § 438.8(b) – requirements that apply to PAHP contracts
 - b. 42 CFR § 438.224 – HIPAA Protected Health Information
 - c. The IDHW's HIPAA Business Associated Agreement – Appendix E
 - d. Idaho statutes and administrative rules which can be accessed at http://www.idaho.gov/laws_rules/
12. Report to the IDHW's Contract Manager any facts regarding irregular activities or practices that may conflict with federal or state rules and regulations discovered during the performance of activities under the contract. Such information may also need to be reported to the Medicaid Fraud Control Unit and the Medicaid Program Integrity Unit as appropriate.
13. Maintain oversight, and be responsible for any functions and responsibilities it delegates to any subcontracted provider.
14. Not subcontract with or employ individuals who have been excluded from the federal

government or by the State's Medicaid program for fraud or abuse. The Contractor is prohibited from subcontracting with providers who have been terminated by other states in accordance with 42 CFR § 455.416. The Contractor shall be responsible for checking the lists, on a monthly basis, of behavioral health providers currently excluded by the state and the federal government per the provisions of 42.CFR § 455.436. One of the federal lists is available at: <http://exclusions.oig.hhs.gov>. The state list is available at: <http://healthandwelfare.idaho.gov/portals/0/providers/medicaid/ProviderExclusionList.pdf>

15. Comply with the following: The Contractor is prohibited from (1) being an owner, in full or in part, of any organization participating as a behavioral health provider in the Medicaid program, or (2) having an equity interest in or being involved in the management of any behavioral health provider organization or entity. This also applies to family members of owners and managers, as well as to any administrative or management services subcontractors of the Contractor on this project.
16. Ensure that all behavioral health services provided under this contract are provided by, or under the supervision of, at least a licensed master behavioral health clinician in the practice of his or her profession.
17. Act as the State's agent to collect Third Party Liability for all enrolled Medicaid recipients. The Contractor's capitated payments have been computed based on claim experience that is net of these collections.
18. Ensure that any compensation, to individuals or entities that are subcontracted by the Contractor to conduct utilization management activities under this contract, is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any Member per 42 CFR § 438.210(e).
19. Not prohibit, or otherwise restrict a health care professional, acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient for the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered. 42 CFR § 438.102(a)(1)(i)
20. Not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient, for any information the enrollee needs in order to decide among all relevant treatment options. 42 CFR § 438.102(a)(1)(ii)
21. Not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient, for the risks, benefits, and consequences of treatment or non-treatment. 42 CFR § 438.102(a)(1)(iii)
22. Not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient, for the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. 42 CFR § 438.102(a)(1)(iv)
23. Not provide, reimburse, or provide coverage for a counseling or referral service if Contractor objects to the service on moral or religious grounds. 42 CFR § 438.102(a)(2)
24. Notify the IDHW, in writing, when changes in key personnel of this contract occur, as well as other management and supervisory level staff. The Contractor shall provide the IDHW with resumes of the aforementioned individuals for review.

25. Notify the IDHW when there is a significant change in the Contractor's operations that would affect their ability to meet the required capacity and services. Operational changes may result in an amendment of the requirements, subcontracting to assure services are not disrupted for Members, or imposing the remedies identified in Appendix D – Special Terms and Conditions. A significant change includes, but is not limited to, changes in the Contractor's:
 - a. Services
 - b. Benefits
 - c. Geographic service area
 - d. Payments
 - e. Enrollment of a new population requiring services
26. Endorse and promote all therapeutic initiatives of the Idaho Medicaid Pharmacy and Therapeutics Committee and the Medicaid Pharmacy Program, including preferred drug list compliance, therapeutic guideline implementation and prior authorization criteria. The Contractor shall assist the IDHW with education to providers to drive implementation and compliance with pharmacy programs and shall not actively promote any programs or initiatives that conflict with those of the IDHW.
27. If a network provider elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds per the provisions of 42 CFR § 438.102(a)(2), it shall furnish information about the services the provider does not cover, per the requirements at 42 CFR § 438.102(b)(1) as follows:
 - a. To the IDHW;
 - b. With its application to be a network provider;
 - c. Whenever it adopts the policy during the term of the contract;
 - d. It shall be consistent with the provisions of 42 CFR § 438.10; and
 - e. It shall be provided to Members within ninety (90) calendar days after adopting the policy with respect to any particular service.
28. The Contractor shall coordinate with the IDHW's contracted transportation broker and support IDHW requirements for Medicaid reimbursed transportation services by providing sufficient information when it is needed to justify use of transportation. The IDHW's contracted transportation broker administers, coordinates, and manages all non-emergency medical transportation (NEMT). For information on Idaho's NEMT services, go to the following website:
<http://www.healthandwelfare.idaho.gov/Medical/Medicaid/MedicalCare/MedicalTransportation/tabid/704/Default.aspx>
29. Develop and maintain an updated Policies and Procedures Manual for the services identified in this RFP. The Policies and Procedures Manual shall be available in electronic and hard copy upon request to the IDHW at no additional cost.
30. Participate in the IDHW's appeal and Fair Hearing processes when required by the IDHW.

II. Administration and Operations

- A. The Contractor shall implement, administer and maintain the Idaho Behavioral Health Plan, an outpatient PAHP as defined in 42 CFR 438.2, and related services for all eligible Medicaid Members, an outpatient prepaid ambulatory health plan (PAHP), as defined in 42 CFR § 438.2., that provides behavioral health coverage for all Medicaid eligible children and adults. The following populations are excluded:
1. Those populations that are covered for premiums only;
 2. Undocumented aliens;
 3. Members who reside in State hospitals or institutions, except for discharge planning; and
 4. Members enrolled in the Medicare-Medicaid Coordinated Plan (MMCP).
- B. The Contractor shall provide a behavioral health benefit package for children and adults that is based on cost effective, evidence-based standards of practice within the behavioral health community. Attachment 12 - Continuum of Care, provides a detailed description of Medicaid-reimbursed services and services that statewide behavioral health stakeholders have identified as necessary components of a robust continuum of care. The package for children and adults must include community based behavioral health services as well as rehabilitative services.
- C. The Contractor shall:
1. Develop a robust continuum of care based on State Plan services;
 2. Pay providers in compliance with the prompt pay standards as follows:
 - a. Pay ninety percent (90%) of clean claims within thirty (30) days.
 - b. Pay ninety nine percent (99%) of clean claims within ninety (90) days.
 3. Develop and operate a complaint and grievance system which includes but is not limited to providing the IDHW with a Complaint and Grievance Resolution and Tracking Report;
 4. Educate Members and providers regarding all aspects of the Idaho Behavioral Health Plan;
 5. Hire, train, and maintain sufficient qualified staff to implement, administer, and manage the Idaho Behavioral Health Plan and all services related to the contract. Sufficiency shall be determined by comparison of baseline accessibility to changes in accessibility, Member complaints and quality assurance processes.
 6. Ensure that written material is in an easily understood language and format. Written material shall be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. The Contractor shall also ensure Members are aware of this availability. 42 CFR § 438.10:
 7. Ensure continuity of care between all providers of behavioral health services, PCPs, and other health care specialists and other services as needed (school/courts);
 8. Ensure verification of program eligibility for Members and providers;
 9. Process claims and prior authorize services when required;
 10. Promote the well-being of the population served through preventive and population-based behavioral health interventions;

11. Provide general information and orientation regarding all aspects of the program and operations. The Contractor shall have in place a comprehensive program to provide all Members, not just those who access services, with appropriate information, such as information about behavioral health treatment services, available providers, and education related to recovery, resilience and best practices, as well as Member rights. In developing these materials, obtain input from consumers, secondary Member and/or family Members and other stakeholders who can contribute to both the content and presentation of the information so that the information is provided in a manner and format that may be easily understood per 42 CFR § 438.10(b)(1);
12. Identify any new service offeror proposes to develop under the capitated rate as cost-effective services per 42 CFR § 438.6(e) as determined by the IDHW. Later in the contract period, if the opportunity for 1915(b)(3) services becomes available, the Contractor should identify any impacts the services they proposed would have on the capitation rates set for the contract;
13. Implement new special services and programs when identified by the Contractor's cost-benefit analysis as approved by the IDHW and CMS (as necessary); and
14. Provide day to day business operations for the state of Idaho to ensure ongoing communication and interaction with IDHW staff to implement and maintain the services outlined in the RFP. Response should include, but not be limited to, meeting with IDHW staff on an ongoing basis, providing ongoing support and interaction with network providers, and working with stakeholders. The IDHW will not provide work space for the Contractor's staff.

III. Work Plan and Service Implementation

- A. The Contractor shall provide and utilize a Work Plan for service implementation of the Idaho Behavioral Health Plan.
- B. The Contractor shall immediately begin to collaborate with the IDHW after the contract is fully executed to work toward a timely implementation period. The implementation period shall be complete within six (6) months of the contract execution date. The preferred implementation date of services is July 1, 2013.
- C. The Contractor shall establish an implementation team that shall ensure the plan for implementation of services progresses according to the required timelines. The Contractor shall meet with the IDHW within the first five (5) business days of the contract execution date to establish the following deliverables and to establish priorities.
 1. The Contractor is responsible for any costs they may incur for all meetings during the implementation process.
- D. The Contractor shall:
 1. Define the project management team, the communication paths and reporting standards between the IDHW and the Contractor staff;
 2. Establish a written comprehensive Work Plan, including the schedule for key activities and milestones which is a part of the Contractor's overall Work Plan;
 3. Define expectations for content and format of contract deliverables.
- E. The Contractor shall develop and maintain a comprehensive written Work Plan which shall include timelines. The Work Plan is due within ten (10) business days of the execution date of the contract and shall include time frames for critical milestones for implementation. The

Work Plan shall clearly include all tasks necessary to meet the requirements of the RFP and shall include timeframes for critical milestones for implementation. It shall clearly specify the Contractor's understanding of information to be provided by the IDHW. The Work Plan shall include the following Contractor tasks and plans:

1. Schedules and timetables for implementation;
 2. A detailed description of the implementation methods;
 3. Communication Plan that includes a plan to communicate with Members, providers and stakeholders, including Member service and provider service call centers and Member and provider handbooks;
 4. Website Development Plan;
 5. Network Development Plan, including analysis and plans to effect a smooth transition;
 6. Service Transition Plan;
 7. A Staffing Plan identifying hiring expectations and staff associated with each task of the implementation period and the work of the contract itself; the Contractor should describe how they would make use of the following positions: Contract Manager, Chief Financial Officer, Chief Medical Officer, Outcomes or Quality Improvement Director, Member and Family Affairs Director, Account Manager, Project Manager, Business Analysis Lead, Systems Analysis Lead, Systems Manager, Data Conversion Manager, Testing Lead, Training Lead, Documentation Lead;
 8. Training Plan for Contractor staff, IDHW staff, Members, providers, and stakeholders;
 9. Facilities, Fiscal Requirements and Cost Avoidance Plans;
 10. Quality Management Plan;
 11. Utilization Management Plan, including outlier management and plans for care coordination;
 12. Complaints, Grievances and Appeals Plan;
 13. Customer Service System Plan;
 14. Overall Project Plan, including reports and interface plans, claims processing and information management integration, hardware and equipment acquisition and installation, operating system and software installation, systems testing, etc.;
 15. Business Continuity, Disaster Recovery, and Risk Management Plan;
 16. Contract Compliance Plan; and
 17. Operational Readiness Plan.
- F. In addition to those items specifically enumerated above, the Contractor shall develop and execute plans that ensure completion of all necessary tasks, explicit or implicit, assigned to the Contractor by this RFP. Such plans shall be made available to the IDHW when completed and whenever updated.
- G. The Contractor shall utilize their Contract Manager, or a designee to be responsible for successful completion of Contractor's responsibilities and overseeing and monitoring the

Contractor's staff on a day-to-day basis as they undertake project activities. The Contract Manager, or designee, shall also work closely with the IDHW Contract Manager and assist in coordinating IDHW resources. The Contractor's Contract Manager, or designee, shall maintain the Work Plan.

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

- J. The Contractor shall:
1. Ensure the health and safety of Idahoans is not put at risk during the transition in administration from the fee-for-service reimbursement model to the managed care model of service delivery;
 2. Ensure major components of the current network delivery system are not adversely affected by transition to managed care;
 3. Honor existing Member-therapist relationships to the greatest extent possible;
 4. Effect transfers in care as seamlessly as possible to Members;
 5. Allow a transfer process with sufficient time for Members to receive notifications, make choices when choices are available, and ask questions of the Contractor regarding the transfer process and the Member's Idaho Behavioral Health Plan benefits;
 6. Ensure the provider network:
 - a. Is sufficiently informed of the Contractor's administrative requirements for participation in the network and for delivery of benefits to Members provided under the Idaho Behavioral Health Plan;
 - b. Is able to deliver services according to the Contractor's standards and all state and federal requirements;
 - c. Is scheduled according to the Contractor's established timelines for "go live" activation.

IV. Behavioral Health Services

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

Infant Toddler Mental Health.

2. Utilize and implement evidence-based practices in service delivery and describe how you will demonstrate fidelity to the tested model used for each evidence-based practice, when available, in order to assure the effectiveness of the service provided. Such fidelity should be applied except when adjustment is specifically described and justified for good cause, such as administering the practice in rural areas or to account for cultural differences. Information on sources for five (5) of the adult evidence-based practices, including fidelity checklists, and evidence-based practices applicable for children, is available on the SAMHSA website at <http://www.nrepp.samhsa.gov>.
 3. Provide culturally competent community-based services, including evidence-based, best practices, trauma-informed care and alternative services for Members of all ages. See Attachment 18 - Trauma-informed Care for more a detailed description of trauma-informed care.
 4. Provide Members with timely access to a comprehensive array of specialized behavioral health services delivered by culturally-competent, qualified service providers.
 5. Ensure that services reflective of continuous quality improvement are provided to Members, and families as appropriate.
 6. Provide all necessary services through a cost-effective system.
 7. Achieve a coordinated system of delivering medically necessary covered behavioral health services to Members.
 8. Maximize community resources in an effort to maintain the least restrictive level of care.
 9. Ensure provision for a second opinion from a qualified behavioral health care professional within the network, or arrange for a second opinion outside the network, at no cost to the Member per 42 CFR § 438.206(b)(3) and must occur within seven (7) calendar days from the date it is requested.
 10. Cover those services out-of-network for the Member for as long as the Contractor is unable to provide them by a network provider in the event that the network is unable to provide necessary services covered under the contract for a particular member, per 42 CFR § 438.206(b)(4).
 11. Coordinate with out-of-network providers with respect to payment and ensure that cost to the Member is no greater than it would be if the services were furnished within the network.
 12. Track and report Members' movement from one (1) level of care to another on a quarterly basis.
- E. The Contractor shall manage potential influences on the administration of behavioral health services under the PAHP, including the following:
1. Each region features a different mix of professional expertise and community volunteerism, and the array of services might be achieved through different types of venues or may have a different configuration from one region to another;
 2. Services will be available in all areas of the state, but the prevalence of any service may vary among regions as appropriate to reflect the needs of a region's targeted population;
 3. Working with regional behavioral health advisory boards to develop local access

standards using their own demographics, geography, and availability of services within pocketed areas of a particular region;

4. The Contractor may need to establish arrangements across regions to help make a service available that is not available in a certain region;
5. While initially it may only be possible that the Contractor provides services in areas where there are already services, the expectation is that the Contractor will engage in long term planning with regional behavioral health advisory boards to develop a full continuum of services across all areas of the state.

V. Member Enrollment/Disenrollment

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

VI. Coverage and Payment for Post-Stabilization Services

- A. The Contractor shall provide post-stabilization services as defined in 42 CFR § 438.114(a) and (b), and ensure the services are covered and paid for in accordance with the following provisions:
 1. Be financially responsible for medically necessary post-stabilization services that are pre-approved by an Idaho Behavioral Health Plan provider or other Idaho Behavioral Health Plan representative that the Contractor has authorized to make pre-approval decisions;
 2. Be financially responsible for medically necessary post-stabilization services obtained within or outside the network that are not pre-approved, but administered to maintain the Member's stabilized condition within one (1) hour of a request to the Contractor for

pre-approval of further post-stabilization covered services.

- B. The Contractor shall be financially responsible for medically necessary post-stabilization services obtained within or outside the network that are not pre-approved, but administered to maintain, improve or resolve the Member's stabilized condition if the Contractor:
 - 1. Does not respond to a request for pre-approval within one (1) hour;
 - 2. Cannot be contacted; or
 - 3. And the treating physician cannot reach an agreement concerning the Member's care and the Contractor's physician is not available for consultation. In this situation, the Contractor shall give the treating physician the opportunity to consult with the Contractor's physician and the treating physician may continue with care of the Member until the Contractor's physician is reached.
- C. The Contractor's financial responsibility for medically necessary post-stabilization covered services it has not pre-approved ends when:
 - 1. A network physician assumes responsibility for the Member's care through transfer; and
 - 2. The Contractor's representative and the treating physician reach an agreement concerning the enrollee's care.

VII. Access to Care

- A. The Contractor shall ensure services are provided through a well-organized service delivery system. The service delivery system shall include mechanisms for ensuring access to high quality, general and specialized care, from a comprehensive provider network. Mechanisms for access shall include opportunities for face-to-face inquiries, a twenty four (24) hour per day toll free telephone line, and electronic communication mediums.
- B. The Contractor shall ensure access to medically necessary covered behavioral health services for Members, and families as appropriate, including engaging Members with serious mental illness, serious and persistent mental illness and/or co-occurring substance use disorder who may not seek help on their own.
- C. The Contractor shall:
 - 1. Ensure access to care for all Members in need of covered behavioral health services through the provision of the following:
 - a. Varied geographic location of providers;
 - b. Providers located within thirty (30) miles or within thirty (30) minutes of travel within Ada, Canyon, Twin Falls, Nez Perce, Kootenai, Bannock and Bonneville counties and within forty five (45) miles or within forty five (45) minutes in all other counties. Where this standard is not achievable, the Contractor shall develop plans for moving toward achieving this standard; such planning is subject to IDHW oversight. Use of telehealth technology is encouraged;
 - c. Use of local providers whenever possible to minimize need for travel and promote local cultural competency;
 - d. Appropriate Member to provider ratio for all services in every region of the state, consistent with industry standards;
 - e. Ensure sufficient numbers of prescribers/psychiatrists are available in the state;
 - f. Make use of licensed psychologists to extend network capacity.

2. Ensure services to Members are uninterrupted.
 3. Adhere to professional standards for determining staffing patterns in all settings.
 4. Ensure minimum hours of provider operation are sufficient in each time zone in Idaho to meet the needs of the population served in each location, which includes crisis coverage twenty-four (24) hours a day, seven (7) days a week, 365 days per year. Sufficiency shall be determined by comparison of baseline access to changes in access, Member complaints, and quality assurance processes.
 5. Provide hours of operation and service coverage in every region at sufficient locations to meet the needs of the population in each region, which may include additional morning, evening or weekend hours, to accommodate Members who are unable to attend appointments during standard business hours.
 6. Ensure network providers offer flexibility of appointment times to Members whenever possible.
 7. Provide community-based access to increase accessibility and improve outcomes to ensure behavioral health services are provided in multiple community-based venues, based on a determination that the services:
 - a. Are medically necessary;
 - b. Are appropriate to the Member's needs and are not duplicative of other services the Member is receiving, and
 - c. Do not put the provider's safety at undue risk when provided in alternative treatment sites. Alternative treatment sites may include, but are not limited to,
 - i. Schools;
 - ii. Federally Qualified Health Centers;
 - iii. Homeless shelters;
 - iv. Assisted living facilities; and
 - v. Members' homes.
- D. The Contractor shall.
1. Provide evening and weekend support services for Members and families that include access to clinical staff, not just an answering service or referral service staff.
 2. Provide access to a twenty four (24) hour, seven (7) days per week, 365 days per year, toll-free line dedicated to Members that meets the following minimum standards
 - a. The toll-free number shall be approved by the IDHW;
 - b. The Member line shall be answered by a live voice at all times;
 - c. All phone calls, voice mail and email shall be responded to on the same or next business day.
 3. Identify Members who unexpectedly miss appointments or discontinue treatment. Appropriate and timely steps shall be taken to contact Members to determine if there is a problem that can be resolved and to promote continuation of services. The Contractor shall recognize that different strategies and levels of effort are appropriate for different

populations (e.g. age groups, diagnosis, severity of illness, culture, language, etc.) and conduct outreach efforts that are appropriate for different populations, using numerous attempts and multiple methods that could include mail, telephone, e-mail, text messaging, home visits, or other efforts that are reasonably calculated to ensure verifiable contact.

- E. The Contractor should establish clear and specific criteria for discharging Members from treatment and criteria should be included in Member materials and information. Ensure criteria for discharge, established with Member input, is agreed upon by Member and Provider and should be noted in the Member's health care record and modified, by agreement, as necessary.
- F. The Contractor shall meet industry standards for access in the following categories, including timeframes and types of professionals. Placing Members on waiting lists for initial routine service requests is not acceptable.
 - 1. Capacity for crisis response and service authorization;
 - 2. Life-threatening crisis intake and intervention services;
 - 3. Non-life-threatening crisis intake and intervention services;
 - 4. Urgent care, including urgent medication management;
 - 5. Access to board certified physicians to provide clinical consultation for network providers, including a psychiatrist. Describe any special accommodation for children.
 - 6. Access to board certified physicians to provide clinical consultation for PCPs, including a psychiatrist. Describe any special accommodations for children.
 - 7. Routine appointments; and
 - 8. Outpatient follow-up appointments after discharge from an inpatient psychiatric hospitalization or residential facility. Refer to Post-Stabilization Services for related requirements.
- G. The Contractor shall:
 - 1. Ensure the Member line is answered by a live voice at all times;
 - 2. Assist and triage callers who may be in crisis by effectuating an immediate transfer to at least a licensed masters level care manager. The call shall be answered within thirty (30) seconds and only transferred via a warm line to at least a licensed masters level care manager;
 - 3. Respond to Members with limited English proficiency through the use of bilingual/multicultural staff or language assistance services. Bilingual/multi-cultural staff, at a minimum, shall speak English and Spanish and any other language spoken by at least 5% of the eligible population. The Contractor shall notify Members that oral interpretation is available for any language and written information is available in English and Spanish, and inform the Members how to access such services 42 CFR § 438.10(c)(5);
 - 4. Ensure every reasonable effort is made to overcome any barrier that Members may have to receiving services, including any language or other communication barrier;
 - 5. Ensure network providers have staff available to communicate with the Member in his or her spoken language, and/or access to a phone-based translation service so that someone is readily available to communicate orally with the Member in his or her spoken

language;

6. Have available, at all times, a Telecommunications Device for the Deaf (TDD) and/or relay systems;
7. Interact with callers in a courteous, respectful, polite, culturally responsive, and engaging manner;
8. Respect the caller's privacy during all communications and calls;
9. Adhere to all regulatory confidentiality requirements, ensure call tracking and record keeping is established and utilized for tracking and monitoring phone lines, including tracing calls when appropriate, to ensure the safety of the Member or others;
10. Ensure calls received on the Member line are reported monthly to the IDHW per the requirements of the contract.

VIII. Cultural Competency

- A. The Contractor shall provide culturally competent behavioral health services to its Members, consistent with standards described at 42 CFR § 438.206(c)(2).
 1. The Cultural Competency Plan shall outline clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services with specific focus on Native Americans' and Hispanics' needs, and includes a positive statement that the Contractor shall have sufficient staff with cultural competency to implement and oversee compliance with the Cultural Competency Plan.
- B. The Contractor shall:
 1. Identify Members whose cultural norms and practices may affect their access to health care and its plan to outreach these Members;
 2. Recruit and retain qualified, diverse and culturally competent clinical staff within your provider network and include a positive statement that the Contractor will offer single case agreements to culturally competent staff outside of its network, if required to meet a Member's needs;
 3. Work with Native American and Hispanic providers to promote the development of these culturally specialized networks of providers;
 4. Monitor whether or not language services are being provided to all Members, upon request, and how it will address gaps or inadequacies found.

IX. Customer Service System

- A. The Contractor shall provide a customer service system that includes implementation of a Customer Service System Plan. The Customer Services System Plan must include services that meet the requirements at 42 CFR § 438.10(f)(6).
- B. The Contractor's Customer Service System Plan shall include a Call Center and Help Desk, policies on customer service, and identify how staff will be trained to meet the customer service requirements.
- C. The Contractor shall:
 1. Ensure that a toll-free number dedicated to customer service inquiries is established and publicized throughout Idaho and ensure multiple lines are available to accommodate

Members, providers, IDHW staff and others that may be calling. The IDHW shall own the rights to the toll-free call center number at the conclusion of the contract;

2. Maintain sufficient equipment and staff to meet the customer service requirements;
 3. Ensure no calls, e-mails or correspondence go unanswered (e-mails and other written correspondence shall be answered within two (2) business days);
 4. If an automated Interactive Voice Response (IVR) system is used, the system shall be programmed to answer all calls within three (3) telephone rings;
 5. The average daily hold time after initial automated response is two (2) minutes or less;
 6. Provide periodic live monitoring of service calls for quality management purposes;
 7. Ensure call tracking and record keeping is established and utilized for tracking and monitoring phone lines;
 8. Ensure customer service inquiries are reported monthly to the IDHW per the requirements of the contract. All customer service communications, written or verbal, shall be reflected in the report.
- D. Should the Contractor choose to use an IVR the Contractor shall:
1. Provide an up-front message in the phone system to inform users when the system is down or experiencing difficulties, including an indication when the system is expected to be operational;
 2. Roll incoming calls to the Call Center staff during those instances when the system is unavailable during the hours the Call Center is staffed;
 3. For IVR users who are seeking data, verify that the person using IVR is an authorized user, and allow access to data by Member ID number, social security number, or Member name and date of birth;
 4. Assign and provide the user a unique identifier for each inquiry;
 5. Provide appropriate safeguards to protect the confidentiality of all information, in compliance with federal, State and IDHW confidentiality laws, including HIPAA;
 6. Provide toll-free telephone number(s);
 7. Integrate with the Call Center and Help Desk to provide IVR users with an option for customer service representative support when requested during the hours the Call Center is staffed;
 8. Provide sufficient in-bound access lines to ensure IVR users:
 - a. Are connected with the IVR system within three (3) telephone rings at least ninety-nine percent (99%) of the time;
 - b. When transferred are connected with the IVR system within ten (10) seconds, ninety-nine percent (99%) of the time;
 - c. Receive a busy signal less than five percent (5%) of the time they call;
 - d. Are not dropped in excess of zero-point-five percent (0.5%) of the total daily call volume; and

- e. Are successfully transferred to live assistance at the Call Center in less than one-hundred-twenty (120) seconds of request to transfer;
 - f. Call abandonment rates should not exceed 7%;
9. Ensure that the IVR is available for information and service requests twenty (24) hours a day, seven (7) days a week, 365 days per year except for IDHW approved scheduled downtime;
 10. Resolve all IVR system downtimes caused by the IVR hardware, software, or other components under the Contractor's control, within thirty (30) minutes of initial notification of system failure. If the system is not in service within that time frame, the Vendor shall provide a failover IVR system to ensure that system downtime is limited to a maximum of thirty (30) continuous minutes;
 11. Maintain and retain for twenty-four (24) months, electronic records of all IVR inquiries made, information requested, and information conveyed;
 12. Make updates to the IVR recorded responses within two (2) business days of receiving a request from the IDHW.
- E. The Contractor shall:
1. Manage the Call center and Help Desk function and ensure staff are trained to provide customer service response to inquiries;
 2. Utilize a language line translation system for callers whose primary language is not English;
 3. Have available, at all times, a Telecommunications Device for the Deaf (TDD) and/or relay systems;
 4. Interact with callers in a courteous, respectful, polite, culturally responsive, and engaging manner;
 5. Respect the caller's privacy during all communications and calls;
 6. Assist callers with issues and concerns regarding service referrals, authorizations, payments, training, or other relevant inquiries, regarding service provision, eligibility or payment; a separate provider services line is also permitted to address provider issues;
 7. Work with callers to provide referrals to obtain eligibility for other supportive services, such as, but not limited to, community organizations. For complex matters, callers should be referred to the Contractor's care management staff;
 8. Facilitate access to information on available service requirements and benefits;

X. Provider Network Development and Management Plan

- A. As part of the implementation process, the Contractor shall implement a Provider Network Development and Management Plan for transforming the current service delivery system into a comprehensive system.
- B. The Contractor's Network Development and Management Plan shall clearly identify a plan for transforming the current service delivery system into a comprehensive system that:
 1. Includes qualified service providers and community resources designed and contracted

to deliver behavioral health care that is strength-based, family-focused as appropriate, community based, and culturally competent.

2. Is of sufficient size and scope to offer Members a choice of providers for all covered behavioral health services.
 3. Ensures behavioral health services are uniformly available throughout the state incorporating recognized evidence-based practices, best practices, and culturally competent services that promote recovery and resiliency through nationally recognized integrated service models.
 4. Increases access to family and community-based services and reduces reliance on higher cost services.
 5. Includes the needs of all Members identified in the scope of the PAHP and includes the following:
 - a. A fully operational network of psychiatric crisis response providers available twenty four (24) hours per day, seven (7) days per week, 365 days per year, prior to completion of the Readiness Review.
 - b. Within nine (9) months after the date of the implementation of services the Contractor shall conduct a statewide needs assessment to identify and quantify gaps in the array of State Plan services and in the network provider types, describe the challenges presented by such gaps, and then design an innovative solution for addressing the unmet service needs that is not limited to the agency/clinical model of service delivery. This solution shall be submitted by the Contractor to the IDHW within twelve (12) months after the implementation of services.
 6. Ensures there are a sufficient number of accessible qualified interpreters. Sufficiency shall be defined as baseline accessibility compared to changes in accessibility, Member complaints and quality assurance processes.
- C. The Contractor shall provide and maintain a database that contains real-time information identifying, according to ZIP code and by provider type, office hours, contracted capacity and out-of-region or out-of-network service alternatives. The IDHW shall have access to this database.
- D. The Contractor shall solicit input from the members of the provider network regarding their satisfaction with participating in the Contractor's network

XI. Provider Network

- A. The Contractor shall implement and maintain a network of providers, including psychiatrists, to deliver behavioral health treatment, rehabilitation, and support services, while optimizing the use of natural and informal supports that meet the needs of Members. The Contractor's network of providers shall assure the health, safety, and appropriate treatment of Members.
- B. The Contractor shall design the network to deliver culturally and linguistically (including the Member's prevalent language(s) and sign language) appropriate services in home and community-based settings and assist Members to achieve their recovery goals or treatment plans.
- C. The Contractor shall enter into written subcontracts with qualified service providers to deliver covered behavioral health services to Members. See Attachment 5 – Network Provider Subcontracts for minimum requirements for the subcontracts.

- D. The Contractor shall require providers to:
 1. Obtain a unique national provider identifier (NPI).
 2. Operate within their license and scope of practice.
 3. Obtain and maintain all applicable insurance coverage, in accordance with the Terms and Conditions of the contract.

- E. The Contractor is not obligated to contract with any provider agency or individual practitioner unable to meet contractual standards (see exceptions for FQHCs in section S and Tribal providers in section T). The Contractor shall provide written notice to any individual, facility or agency that applies to be part of the Contractor's network but is not enrolled. The notice shall include the reason(s) the applicant was not accepted into the network. The Contractor shall provide written notice to each network provider the Contractor chooses to end a contract with and shall state the reason for ending the contract. 42 CFR § 438.12(a)(1) and (b) (1).

- F. The Contractor is not obligated to continue to contract with a provider agency or individual practitioner who does not provide services reflective of continuous quality improvement or who demonstrates utilization of services that are an outlier compared to providers with similarly acute populations and/or compared to the expectations of the Contractor and the IDHW.

- G. The Contractor's provider agency and individual practitioner selection policies and procedures cannot discriminate against particular provider agencies or individual practitioners that serve high-risk populations or specialize in conditions that require costly treatment.

- H. The Contractor may not discriminate for the participation, reimbursement, or indemnification of any provider agency or individual practitioner who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If the Contractor declines to include provider agencies or individual practitioners in its network, it shall give the affected provider agencies and individual practitioners written notice of the reason for its decision. 42 CFR § 438.12 (a)(1). This section may not be construed to:
 1. Require the Contractor to contract with provider agencies or individual practitioners beyond the number necessary to meet the needs of its enrollee.
 2. Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty.
 3. Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to Member. 42 CFR § 438.12(b)

- I. The Contractor shall develop and implement written policies and procedures for the selection and retention of providers per 42 CFR § 438.214(a) and ensure the network of providers is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Members in the service area per 42 CFR § 438.207(b). The Contractor shall provide the policies and procedures to the IDHW when requested. The policies and procedures may be reviewed during the Readiness Review process. These policies and procedures shall include, at a minimum, the following:
 1. A documented process for receiving requests for initial services and continuing authorization of services per 42 CFR § 438.214(b)(1);
 2. A documented process for credentialing and re-credentialing of providers who have signed contracts or participation agreements with the Contractor per 42 CFR

§438.214(b)(2);

3. The Contractor's provider selection policies and procedures, consistent with 42 CFR § 438.214(c), shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment;
 4. The Contractor may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act and per 42 CFR § 438.214(d);
 5. Requirement that criminal conviction information for anyone who has ownership or control interest in the provider, or is an agent or managing employee of the provider as per 42 CFR § 455.106 shall be disclosed; and
 6. Disclosure of owners, per 42 CFR § 455.104(b)(2), who own five percent (5%) or more in this provider entity (42 CFR § 455.104(a)(2)) shall be disclosed to the IDHW including the following:
 - a. All managing employees of the disclosing entity (provider) as defined in 42 CFR § 455.101;
 - b. Subcontractor in which a practitioner has direct or indirect ownership of five percent (5%) or more per 42 CFR § 455.104(b)(2);
 - c. List ownership of any subcontractor with whom this provider has had business transactions totaling more than \$25,000 during the previous twelve (12) month period per 42 CFR § 455.105;
 - d. List persons that are related to each other (spouses, parents, children, or siblings); and
 - e. Identification of persons with criminal offenses for criminal offenses related to the person's involvement in any program under Medicare, Medicaid, or Title XX. 42 CFR §455.100; 42 CFR §455.106.
- J. The Contractor shall not restrict or inhibit providers in any way from freely communicating with or advocating for a Member regarding behavioral health, medical needs, and treatment options, even if the Member needs services that are not covered or if an alternate treatment is self-administered. The Contractor may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an Member who is his or her patient:
1. For the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
 2. For any information the Member needs in order to decide among all relevant treatment options.
 3. For the risks, benefits, and consequences of treatment or non-treatment.
 4. For the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- K. The Contractor shall require providers to communicate information to assist a Member to select among relevant treatment options, including the risks, benefits, and consequences of treatment or non-treatment; the right to participate in decisions regarding his or her behavioral health care; and the right to refuse treatment and to express preferences about

future treatment decisions.

L. The Contractor shall:

1. Ensure the provider network is sufficient in size and composition to meet the needs of Members, per 42 CFR 438.206(b)(1), based on the following factors:
 - a. Growth trends in eligibility and enrollment
 - b. Best practice approaches.
 - c. Accessibility of services including:
 - i. The number of current qualified service providers in the network who are not accepting new referrals
 - ii. The geographic location of providers and Members considering distance, travel time, and available means of transportation.
 - iii. Availability of services with physical access for persons with disabilities.
 - iv. Cultural and linguistic needs, including the Member's prevalent language(s) and sign language.
2. Maintain a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract per 42 CFR § 438.206(b)(1). In establishing and maintaining the network, the entity shall consider the following:
 - a. The anticipated Medicaid enrollment.
 - b. The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the particular contract.
 - c. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services.
 - d. The numbers of network providers who are not accepting new Members.
 - e. 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. Ensure at least as much access to services as exists within Medicaid's fee-for-service program.
4. Establish the initial managed care provider network by drawing from the pool of the existing enrolled Medicaid behavioral health agencies that have either successfully achieved Medicaid credentialing or national accreditation in addition to any other qualified practitioners that may or may not have ever delivered services to Members. Network providers shall meet the standards set by the Contractor and IDAPA and be in compliance with all federal and state requirements, including not being on the federal and state exclusion lists.
5. Perform credentialing and re-credentialing of qualified service providers in order to ensure they meet the accreditation requirements set by the Contractor and compliance to IDAPA, state and federal statutes.
6. Implement and maintain written credentialing and re-credentialing policies consistent with

federal and state regulations for selection and retention of providers, credentialing and re-credentialing, and nondiscrimination. 42 CFR § 438.214;

7. Contract with providers of behavioral health services who are appropriately licensed and/or certified and meet the Contractor's criteria for network enrollment including completion of a Network Provider Subcontracts. See Attachment 5 – Network Provider Subcontracts.
8. Evaluate every prospective individual practitioner's ability to deliver behavioral health services in the continuum of care prior to contracting with any provider agency that employs such practitioners.
9. Identify the gaps in services and access, and implement solutions to resolve the issues.
10. Develop and recruit culturally informed Native American and Hispanic practitioners into the provider network to provide services.
11. Whenever possible, ensure Members have a choice of providers, to the extent possible, which offer the appropriate level of care. (42 CFR § 438.6(m)) Exceptions would involve highly specialized services which are usually available through only one (1) agency or provider in the geographic area. Members may change providers.
12. Honor existing Member/provider relationships as much as possible in the newly established network. If a change is necessary, the Contractor shall ensure a seamless transition of services or providers.
13. Pursuant to Early Periodic Screening, Diagnosis and Treatment (EPSDT) requirements, if a child under the age of twenty one (21) needs a specialized medically necessary service that is not available through the network, the Contractor shall arrange for the service to be provided outside the network by a qualified provider.
14. Maintain a list of current network providers that is available to Members, the Member's family/ caregiver and referring providers in hard copy and electronically. The list shall specify providers who are able to deliver services in languages other than English.
15. Conduct an Annual Network Inventory and provide a written report to the IDHW by a date determined by the IDHW. The first inventory due date will be relative to the implementation of services date of the Idaho Behavior Health Plan. The Contractor shall prepare the network inventory to quantify the number of qualified service providers, including the crisis response providers, available within the network as follows:
 - a. Each category of covered behavioral health services as identified by the IDHW.
 - b. Specialty behavioral health service providers, including providers with expertise to deliver services to persons with developmental disabilities, non-English speaking persons, and other specialties as identified by the IDHW.

XII. Notification Requirements for Changes to the Network

- A. The Contractor shall notify and obtain written approval from the IDHW before making any material changes in the size, scope, or configuration of its network, as described in the Contractor's Network Development and Management Plan. A material change includes any event that affects service delivery and includes a reduction in workforce at a qualified service provider level; any plan to not fill, or delay filling, staff vacancies; or termination of a subcontract, the crisis provider and other qualified providers. The Contractor shall notify the IDHW, in writing within one (1) business day of the Contractor's knowledge of an expected, unexpected, or anticipated material change to the network or a network deficiency that could

- affect service delivery, availability, or capacity within the provider network. The notice shall include:
1. Information describing how the change will affect service delivery, availability, or capacity of covered behavioral health services.
 2. A plan to minimize disruption to the behavioral health Member's care and service delivery.
 3. A plan for clinical team meetings with the behavioral health Member and his or her family/caregiver as appropriate to discuss available options and revise the treatment plan to address any changes in services or service providers.
 4. A plan to correct any network deficiency.
- B. Should a provider be terminated from the network for cause, the Contractor ensure this information is reported to the Medicaid Program Integrity Unit as well as the IDHW Contract Manager.
- C. The Contractor shall utilize performance and quality assurance data when determining to retain providers. Describe the criteria to be used for making the determination to terminate a network provider.
- D. The Contractor shall notify a network provider in writing when a determination is made to terminate a provider from the network and ensure prior written notice includes details pertaining to the decision to terminate. Submit a sample of a termination notice with your proposal.
- E. The Contractor shall ensure the IDHW is notified within two (2) business days if a provider fails to meet licensing criteria, or if the Contractor decides to terminate, suspend, limit, or materially change qualified service providers or subcontractors. The notice to the IDHW shall include:
1. The number of Members affected by the termination, limitation, suspension, or material change decision.
 2. A plan to ensure that there is minimal disruption to the behavioral health Member's care and service delivery.
 3. The Contractor shall require the behavioral health Member's original provider to be responsible for transitioning his or her Members until the behavioral health Member has attended the first appointment with the new provider.
 4. A plan for clinical team meetings with the behavioral health Member and his or her family/caregiver as appropriate to discuss available options and to revise the treatment plan to address any changes in services or service providers.
 5. A plan to communicate changes to affected Members, including provision of required notices per 42 CFR § 438.10(f)(4) and (5).
 6. A written transition plan for Members affected by these network changes.
- F. The Contractor shall track all Members transitioned due to a subcontract's suspension, limitation, termination, or material change to ensure service continuity. At a minimum, the Contractor shall track the following elements: name, date of birth, population type, current services the Member is receiving, services that the Member will be receiving, name of new provider, date of first appointment, and activities to re-engage persons who miss their first appointment with the new provider. The IDHW may require the Contractor to add other

elements based on the particular circumstances.

- G. The Contractor shall ensure the Contractor and its providers, where applicable, use common data elements to match existing required data fields specified by the IDHW.

XIII. Provider Training and Technical Assistance

- A. The Contractor shall develop and implement comprehensive provider training and support a training program for providers to gain and maintain appropriate knowledge, skills, and expertise and receive technical assistance to comply with the requirements resulting from this RFP. The trainings should be reported in the annual Provider Training Report. The Contractor shall incur all costs required to perform the training tasks, including facility, staffing, hardware and software cost, printing and distribution of all reports, forms, training materials, and correspondence.
- B. The Contractor shall:
 - 1. Stimulate the development of providers' capacity to treat co-occurring disorders, dual diagnoses, very young children, Native American Members, and Hispanic Members;
 - 2. Develop and implement training opportunities for qualified providers to occur, at minimum, once per quarter;
 - 3. Provide technical assistance to network providers;
 - 4. Include a cultural competency component in each training topic;
 - 5. Educate and require providers to use evidence-based practices, promising practices, and emerging best practices;
 - 6. Educate providers on billing and documentation requirements;
 - 7. Provide required orientation and training for all providers new to the Contractor's network.
 - 8. Develop and implement an annual training plan that addresses all training requirements;
 - 9. Involvement of Members and family members in the development and delivery of trainings.

XIV. Electronic Health Records (EHR)

- A. The Contractor shall work with network providers to develop and implement EHR systems that will meet provider needs for real time data access and evaluation in medical care. See Attachment 13 – Electronic Health Records.
- B. The Contractor shall ensure that behavioral health providers participating in the managed care program adopt and use electronic health record technology. Please refer to Attachment 3 - Definitions for a definition of electronic health record and Attachment 13 - Electronic Health Records for more details regarding these requirements.

XV. Management of Care

- A. The Contractor shall provide care management and case management functions to promote achievement of the goals of this RFP including, but not limited to:
 - 1. Ensuring a person-centered process of care management and case management

2. Providing a multidisciplinary team approach that ensures working with all parties involved in the children's and adults' systems of care to establish service eligibility;
3. Arranging for services in network including movement to higher or less restrictive levels of care;
4. Linking to services out-of-network as appropriate;
5. Coordinating the delivery of services including primary care services that function to rule out metabolic processes that may mimic behavioral health symptoms;
6. Monitoring and evaluating the Member's response to the behavioral health services as well as tracking such Members with complex medical needs use of medical services;
7. Advocating for Members who need multiple services to meet complex needs;
8. Promoting activities and referrals to services that facilitate a Member's independence;
9. Operating a screening process for Member's seeking inpatient behavioral health services in order to activate a hospital diversion mechanism;
10. Participating in hospital discharge planning processes in an effort to impact lengths of stay and to facilitate timely admissions to step-down services;
11. Coordinating the provision of behavioral healthcare services with Medicaid's Primary Care Case Management program and with Medicaid's Health Home program to ensure the best possible outcomes for coordinated physical and behavioral health services;
12. Ensure that in the coordination of care that occurs through the Primary Care Case Management and Health Homes program confidentiality, requirements in 45 CFR parts 160 and 164 are observed; and
13. Coordinating with other providers and programs that deliver behavioral health services outside of the Contractor's delivery system.

XVI. Intake and Assessment

- A. The Contractor shall design and manage an intake process distinctive from the assessment process and that makes use of standardized tools. Currently the IDHW doesn't require a standardized tool to be used for determining Members' mental health program eligibility. The IDHW currently requires providers of substance use disorder services to use the Global Appraisal of Individual Needs (GAIN1) instruments for assessing Members seeking substance use disorders. For information on GAIN go to <http://www.chestnut.org/LI/gain/index.html>. The IDHW currently relies on a standardized tool for helping determine whether or not a child Member is experiencing a Serious Emotional Disturbance—the Child and Adolescent Functional Assessment System/Pre-school and Early Childhood Functional Assessment Scale® (CAFAS/PECFAS). For information on the CAFAS/PECFAS go to <http://www.fasoutcomes.com/>.
- B. The Contractor shall implement an intake process that includes a triage process which will identify and distinguish crises, urgent services and routine treatment needs.
- C. The Contractor shall:
 1. Ensure the intake process allows the Member to receive needed services immediately, when indicated by the presenting problem, without the delay that would be caused by the assessment process.

2. Implement a process that results in an independent, standardized assessment of the Member's behavioral health care needs.
3. Ensure the assessment process meets the intent of Idaho Code § 56-263.
4. Identify and monitor episodic behavioral health needs and support intervention in a coordinated and minimally disruptive manner. Contractor's response should include screening strategies for common episodic behavioral health conditions such as affective disorders, eating disorders, adjustment disorders and coping disorders.
5. Identify and monitor persistent behavioral health needs and support intervention in a coordinated and minimally disruptive manner. Contractor's response should include screening strategies for proactively identifying and locating persons with persistent behavioral health conditions.

XVII. Treatment Planning/Self Determination and Choice

- A. The Contractor shall implement a person-centered treatment planning process that results in improved Member and family experiences of care, promotes effectiveness and enhances outcomes. See Attachment 3- Definitions.
- B. The Contractor shall:
 1. Ensure the development of a plan of care for each Member receiving behavioral health services;
 2. Ensure the plan of care is developed according to the Member's choices regarding his or her recovery (and in the case of dependent minors, the choices of the minor's guardian are also considered);
 3. Ensure the plan is derived from all available diagnostic information and all available historical and current treatment information;
 4. Ensure development of plans of care provides opportunities for the following to participate in the process:
 - a. All service providers affiliated with the Member;
 - b. The Member, and
 - c. All support persons the Member chooses (and in the case of dependent minors, the choices of the minor's guardian).
 5. Ensure the plan of care includes all the components recognized as industry standards for behavioral health treatment planning;
 6. Ensure an appropriate intermittent review and oversight process is utilized that is consistent with industry standards.

XVIII. Primary Care Interface: Primary Care Case Management Program (PCCM) and Health Homes

- A. The Contractor shall coordinate services with the IDHW's two (2) programs for coordination of Members' physical health needs PCCM program: Healthy Connections and a program recently developed at Medicaid: Health Homes. More information about the Healthy Connections program can be read at the following link: <http://www.healthandwelfare.idaho.gov/Medical/Medicaid/HealthyConnections/tabid/216/Default.aspx>

ult.aspx). Please see Attachment 20 –State Medicaid Director Letters for more information about the Health Home program.

B. The Contractor shall:

1. Ensure a Member's primary care provider (PCP) has the opportunity to participate in the process used to diagnose and plan treatment for the Member;
2. Ensure ongoing communication and collaboration with a Member's PCP throughout the time period that the Member receives services through the Idaho Behavioral Health Plan, including the sharing of all screenings, assessments and treatment plans;
3. Ensure coordination of use of medications;
4. Operate a PCP hotline, or equivalent service, for PCPs' real-time telephonic consultation with a licensed behavioral health professional at the master's level or higher for either of the following two (2) purposes:
 - a. Information to support the PCP in the provision of behavioral health interventions/services that the PCP and Member choose;
 - b. Information for the PCP to use for referring the Member to the Contractor's services.
5. Provide on-line access to standardized screening tools for PCPs to use for identifying behavioral health issues.

XIX. Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)

- A. The Contractor shall recognize FQHC's that provide behavioral health services as behavioral health providers and enroll them in the Contractor's network.
- B. The Contractor shall interface with FQHC patient-centered processes to help ensure services are delivered in the most effective manner to the Members.
- C. The Contractor shall ensure that reimbursement to FQHCs and RHCs for behavioral health services done in the FQHC facility or RHC facility will be made using Medicaid's reimbursement methodology, which is payment at an encounter rate, in an amount unique to each FQHC and RHC, as determined by the IDHW.
 1. FQHC services are defined in IDAPA 16.03.09.832
 2. RHC services are defined in IDAPA 16.03.09.820
- D. The Contractor shall ensure that one (1) behavioral health encounter rate will be paid for all covered behavioral health services provided on the same visit to an FQHC or an RHC. Medicaid encounter rates for FQHC and RHC behavioral health providers are listed in Attachment 11 – FQHC and RHC Encounters.
 1. Because it is not possible to accurately project what the annual FQHC or RHC encounter rate increases may be, the IDHW will reimburse the Contractor for the difference between the encounter rates effective at the Idaho Behavioral Health Plan implementation and the FQHC or RHC rate increases over and above the annual inflation rate that may occur after the plan implementation.
- E. If there are no FQHCs in the Contractor's network to choose from, then the Contractor shall pay for the access out-of-network.

XX. Indian Health Services (IHS) and other Tribal Facilities

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

XXI. Member Service Transitions

- A. The Contractor shall implement and monitor written policies and procedures regarding service transitions for all members.
- B. The Contractor shall demonstrate its awareness of the unique set of challenges faced by children between the ages of fourteen (14) and twenty one (21), referred to in this RFP as youth, and families when the youth transitions from the child to the adult behavioral health system. Such challenges may include application for adult Medicaid benefits, service and provider changes, lack of coordination even within a provider organization, and failure of providers to recognize the additional time, training and support necessary for youth with behavioral health disorders to achieve customary developmental milestones. Youth with serious behavioral health challenges are delayed in almost every area of psychosocial development. There may also be significant resistance to accepting the label of mental illness or a substance use disorder among youth as they approach adulthood, and accompanying resistance to engaging in treatment.
- C. The Contractor's Member Service Transition Plan shall include:
 1. How the Contractor will identify Members who need assistance and how the Members will be evaluated;
 2. At a minimum, how the Contractor will address the specialized needs of adult and youth members as noted below:
 - a. Adults:
 - i. Behavioral health Member transitions to/from another behavioral health practitioner or agency;
 - ii. Behavioral health Members whose behavioral health service provider becomes unable to continue service delivery for any reason;
 - iii. Behavioral health Member transitions to/from an assisted care facility or long term care placement for Members who continue to require behavioral health services;
 - iv. Behavioral health Member transitions from the correctional or community corrections system back to the community;
 - v. Behavioral health Member discharges from an inpatient, sub-acute, psychiatric residential treatment facility, or mental health Institute.
 - b. Youth:
 - i. Assistance with application for adult Medicaid benefits, including submitting applications in advance so that reapplication may be made, if necessary, without losing benefits, and assisting families, as needed, to transfer diagnoses used in the child behavioral health system to the appropriate adult diagnoses;

- ii. Provide person-centered, strengths-based programming for youth from ages fourteen (14) to twenty one (21), focusing on education, employment, social and problem-solving skills, symptom management, reaction to stigma, sexual and gender identity, living situation/housing, personal health care, transportation resources, substance use disorder prevention or relapse prevention, and cultural and spiritual resources;
- iii. Provide programming to facilitate Member transitions from the juvenile correctional or community corrections system or inpatient/residential treatment back to the community;
- iv. Assist the youth and family to create a personal Safety Net of community supports, including a reliable family-like or healthy peer connection;
- v. Assess internal business practices, communication channels, and administrative support necessary to ensure a smooth transition for youth Members to the adult behavioral health system; and
- vi. Provide training and a curriculum to educate staff about the unique needs of this population.

XXII. Early Periodic Screening, Diagnosis and Treatment (EPSDT)

- A. The Contractor shall provide EPSDT benefits for Members up to the last day of the month in which they reach twenty-one (21) years of age.
- B. The Contractor shall:
 - 1. Ensure Members and the network of behavioral health providers are sufficiently informed of EPSDT requirements;
 - 2. Ensure accurate quarterly reporting of EPSDT requests, EPSDT benefits provided, EPSDT benefits denied, and the outcomes of such authorization decisions.

XXIII. Complaint and Critical Incident Resolution and Tracking System

- A. The Contractor shall implement and maintain a Complaint and Critical Incident Resolution and Tracking System for all complaints and critical incidents received. For complaints, the Contractor shall have a system in place allowing providers, Members and authorized representatives of Members, the opportunity to express dissatisfaction with the general administration of the plan and services received. For critical incidents, the Contractor shall have a system in place allowing network providers and/or Contractor staff to document incidents of health and safety issues impacting a Member.
- B. The Contractor shall have policies and procedures for resolving and tracking general complaints and critical incidents.
 - 1. General Complaint Process. The following must be included in the Contractor's general complaint procedures:
 - a. Complaints may be lodged by a Member, Member's authorized representative, or a provider either orally or in writing.
 - b. A person designated to conduct a reasonable investigation or inquiry into the allegations made by or on behalf of the Member or provider and shall give due consideration and deliberation to all information and arguments submitted by or on behalf of the Member or provider.

- c. Designee shall respond in writing to each General Complaint, stating at a minimum:
 - i. A summary of the General Complaint, including a statement of the issues raised and pertinent facts determined by the investigation;
 - ii. A statement of the specific coverage or policy or procedure provisions that apply; and
 - iii. A decision or resolution of the General Complaint including a reasoned statement explaining the basis for the decision or resolution.
- 2. Critical Incident Process. The following must be included in the Contractor's critical incident procedures:
 - a. The Contractor and its network providers shall abide by Idaho State law including those laws regarding mandatory reporting.
 - b. Critical incidents shall be defined and reported in categories of health and safety incidents affecting a Member. Definitions shall be proposed by the Contractor and accepted by the IDHW.
 - c. Critical incidents shall be logged by a network provider, or the Contractor itself, when a critical incident is either observed or noted.
 - d. Designate a network provider or Contractor staff to conduct a reasonable investigation or inquiry into the critical incident logged, and give due consideration and deliberation to all information submitted by or on behalf of the Members.
 - e. Designee shall resolve each critical incident report by documenting at a minimum:
 - i. A summary of the critical incident including a statement of the issues raised and pertinent facts determined by the investigation,
 - ii. A statement of the specific coverage or policy or procedure provisions that apply; and
 - iii. A decision or resolution of the critical incident including a reasoned statement explaining the basis for the decision or resolution.
- C. The Contractor's Complaint and Critical Incident Resolution and Tracking System shall include components that allow the Contractor to analyze the complaint or critical incident and provide reports as requested by the IDHW.
- D. The Contractor shall:
 - 1. Have a methodology for reviewing and resolving complaints and critical incidents received, including timeliness for the process
 - 2. Ensure complaints and critical incidents are resolved within ten (10) business days.
 - 3. Ensure complainants are sent written notifications of complaint resolutions that have all of the required information.
 - 4. Address complaints and critical incidents that may need resolution at the IDHW level
 - 5. Have internal controls to monitor the operation of the complaint and critical incident resolution and tracking system.
 - 6. Track all complaints and critical incidents, whether they are resolved or in the process of

resolution, and report the information to the IDHW.

7. Analyze the complaints and critical incidents and utilize the information to improve business practices.
- E. The Contractor shall ensure that all documents pertaining to general complaints or critical incident investigations and resolutions will be preserved in an orderly and accessible manner.

XXIV. Member Grievances and Tracking System

- A. The Contractor shall have a system in place for Members and a Member's authorized representative to file a Grievance challenging the Contractor's actions related to services.
- B. The Contractor shall have policies and procedures for addressing and tracking Grievances.
1. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a licensed clinician or physician who has appropriate clinical expertise in the treatment requested for the Member.
- C. The Contractor's policies and procedures shall include:
1. Definitions:
 - a. Action means the denial or limited authorization of a requested service; termination, suspension, or reduction of a previously authorized service, the denial, in whole or in part, of a payment for service; or the failure to act upon a request for services in a timely manner.
 - b. Appeal means a clear expression by the Member, or the Member's authorized representative, following a decision by the Contractor, that the Member wants the opportunity to present their case to the IDHW.
 - c. Grievance means an expression of dissatisfaction challenging the Contractor's action.
 - d. Notice means a written statement of the action the Contractor has taken or intends to take, the reasons for the action, the Member's right to file a Grievance and request a fair hearing with the IDHW, and the procedures for exercising that right.
 2. Notice of Action:
 - a. The notice must be in writing and comply with the language and format requirements of 42 CFR §438.10(c) & (d), with Spanish as the prevalent non-English language.
 - b. The notice must be given to the requesting provider and to the Member.
 - c. The notice must explain the following:
 - i. The action the Contractor has taken or intends to take;
 - ii. The reasons for the action;
 - iii. The procedures for filing a Grievance with the Contractor;
 - iv. The Member's right to represent themselves or be represented by a person of their choosing; and
 - v. The future right to request a fair hearing with the IDHW if they are not satisfied with the Contractor's resolution of the Grievance.

3. Timing of Notice:
 - a. For standard service authorization decisions that deny or limit services, within the timeframe specified in 42 CFR § 438.210(d)(1);
 - b. For cases in which a provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the participant's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the participant's health condition requires and no later than three (3) business days after receipt of the request for service. The Member or provider may file an expedited appeal either orally or writing. No additional Member follow-up is required.
 - c. If the Contractor extends the timeframe for decision in accordance with 42 CFR § 438.210(d)(1), it must:
 - i. Give the Member written notice of the reason for the extension of time and inform the participant of the right to file a Grievance if they disagree, and
 - ii. Issue and carry out its decision no later than the date the extension expires.
 - d. For termination, suspension, or reduction of previously authorized covered services, within the timeframes specified in 42 CFR §§ 431.211, 431.213, and 431.214.
 - e. For service authorizations decisions not reached within the timeframes specified in 42 CFR § 438.210(d) (which constitutes a denial), on the date the timeframes expire.
4. Grievance Process:
 - a. A Member or Member's authorized representative may file a Grievance.
 - b. A Grievance may be filed either orally or in writing with the Contractor. If mistakenly filed with the IDHW, it will be immediately forwarded to the Contractor.
 - c. Allow a reasonable time period following its action for the Member or authorized representative to file a Grievance. The time period shall be no less than twenty (20) days and no more than (28) days from the date of the Contractor's action.
 - d. Give Members any reasonable assistance in completing forms and taking other procedural steps including, but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
 - e. Acknowledge receipt of each Grievance.
 - i. Ensure that individuals who make decisions on Grievances are individuals who were not involved in any previous review or decision of the action; and if deciding a Grievance of a denial based on medical necessity or involving clinical issues, are health care professionals who have the appropriate clinical expertise, as determined by the IDHW, in treating the Member's condition.
5. Grievance Decision and Notification.
 - a. Notice of Grievance decisions shall be provided to the affected parties, in writing, within thirty (30) days from the date the Contractor received the Grievance stating at a minimum:
 - i. A statement of the Grievance issue(s);
 - ii. A summary of the facts asserted by each party;
 - iii. The Contractor's decision supported by a well-reasoned statement that explains how the decision was reached;

- iv. The date of the decision; and
- v. For Grievances not resolved wholly in favor of the Member, the Contractor's decision notice shall also include the Member's right to request a State fair hearing, the timeframe and procedure to do so by stating the following: a) You, or your representative have the right to request a fair hearing with the Idaho Department of Health and Welfare if you are not satisfied with the resolution of your Grievance. You have twenty-eight (28) days from the date of this decision to file your appeal. You must explain why you disagree with this decision and include any other information you want the IDHW to know. Your appeal must be received by the IDHW or postmarked within twenty-eight (28) days. b) To appeal, notify the IDHW in writing or complete a "Fair hearing Request" form. "Fair Hearing Request" forms are available at any Health and Welfare local office or via e-mail at: MyBenefits@dhw.idaho.gov. Include a copy of this notice with your appeal. You can bring your appeal to any local Health and Welfare office, fax or mail it to: Administrative Procedures Section; Idaho Department of Health and Welfare; 450 W. State St., 10th Floor; P.O. Box 83720; Boise, ID 83720-0036; Fax: (208) 334-6558

6. Miscellaneous Requirements.

- a. Information about Grievance System. The Contractor shall provide the information specified in this section about the Grievance system to all providers and subcontractors at the time they enter into a contract.
- b. Recordkeeping and Reporting Requirements. The Contractor shall maintain records of Grievances and must review the information as part of the State quality assurance.
- c. Effect of Reversed Grievance Decisions.
 - i. If the Contractor or the State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the Grievance or appeal was pending, the Contractor shall authorize or provide the disputed services promptly.
 - ii. If the Contractor or the State Fair Hearing officer reverses a decision to deny authorization of services, and the participant received the disputed services while the Grievance or appeal was pending, the Contractor must pay for those services, in accordance with State policy and regulations.

D. The Contractor shall:

- 1. Have a methodology for reviewing and resolving Member Grievances, including timelines for the process.
- 2. Ensure internal controls to monitor the operation of a Member Grievance Tracking System.
- 3. Track all Member Grievances received, whether they are resolved or in the process of resolution, and report the information to the IDHW.
- 4. Analyze the Member Grievances and utilize the information to improve business requirements.

XXV. Electronic System and Data Security

- A. The Contractor shall implement and maintain an electronic system and data security plan that includes, but is not limited to all of the requirements outlined in Attachment 6 - Technical

Requirements: Electronic Systems, Data Security and Website Requirements. In addition to submitting the Electronic System and Data Security Plan with the proposal, the Contractor may be required to submit a revised Electronic System and Data Security Plan for review as outlined in Attachment 10 – Readiness Review.

- B. The Contractor shall comply with the requirements in Attachment 6 - Technical Requirements: Electronic Systems, Data Security and Website Requirements; provided, however, in the event a change in MMIS vendors is required, the State and Contractor will endeavor to work in good faith to minimize the operational and financial impact of such change.

XXVI. Website

- A. The Contractor shall provide and maintain an internet website for Idaho's Medicaid Members and the network providers to access information pertaining to the Idaho Behavioral Health Plan.
 - 1. Website content regarding the Idaho Behavioral Health Plan shall be submitted to the IDHW for review and approval prior to posting the information on the website. See Attachment 6 - Technical Requirements: Electronic Systems, Data Security and Website Requirements.
- B. The Contractor shall:
 - 1. Communicate policies, procedures and relevant information to providers through secure or public Web pages.
 - 2. Provide, in accordance with national standards, claims inquiry information to qualified service providers and subcontracts via the Contractor's Website.
- C. The Contractor shall agree to the requirements in Attachment 6 - Technical Requirements: Electronic Systems, Data Security Plan and Website Requirements.

XXVII. Member Information and Member Handbook

- A. The Contractor shall provide all Members, not just those who access services, with appropriate information about behavioral treatment services, available providers, and education related to recovery, resilience and best practices.
- B. The Contractor shall develop and maintain a Member Handbook for behavioral health coverage and benefits. Member Information and the Member Handbook shall be available in hard copy and through web site access at least twenty (20) calendar days prior to the start of services. The Member Handbook shall include, but not be limited to:
 - 1. Behavioral Health program eligibility process and guidelines;
 - 2. Benefit descriptions and limitations;
 - 3. Resource information including, but not limited to:
 - a. Provider directory by city;
 - b. Hospital information and resources;
 - c. Behavioral health information and resources; and
 - d. Crisis information and resources.
 - 4. Member's Rights, including the following:
 - a. Each Member is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.

- b. Each Member is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.
 - c. Each Member is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment.
 - d. Each Member is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
 - e. Each Member is guaranteed the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR 164.
 - f. Each Member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the Contractor and its providers or the IDHW treats the Member. 42 CFR § 438.100(c).
- C. The Contractor shall comply with any other applicable federal and state laws (such as Title VI of the Civil Rights Act of 1964, etc.) and any other federal and state laws that pertain to Members' rights, i.e., "Members Bill of Rights", and other laws regarding privacy and confidentiality. 42 CFR § 438.100(a)(2) and (d), 42 CFR § 438.6(f)(1).
- D. The Contractor shall obtain input from consumers, secondary Member and/or family Members and other stakeholders who can inform both the content and presentation of the information so that the information is provided in a manner and format that may be easily understood per 42 CFR § 438.10(b)(1).
- E. The Contractor shall:
1. Ensure that written material is in an easily understood language and format, and be provided in English and Spanish. Written material shall be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. The Contractor shall also ensure Members are aware of this availability. 42 CFR § 438.10(d)(1)(i) and (ii) and (2);
 2. Ensure written policies regarding the Member rights specified in this section;
 3. Comply with any applicable federal and state laws that pertain to Member rights and ensure that its staff and affiliated providers take those rights into account when furnishing services to Members;
 4. Ensure limitations are not imposed on Members' freedom to change between mental health or Substance Use Disorder providers;
 5. Ensure the requirements in Attachment 8 – Member Rights are incorporated in your business operations.

XXVIII. Member Protections/Liability for Payment

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

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

XXIX. Provider Manual

- A. The Contractor shall develop and maintain a Provider Manual for use by the Contractor's network of providers.
- B. The Contractor shall ensure providers have access to the Provider Manual and any updates either through the Contractor's website, or by providing paper copies to providers who do not have Internet access. The manual shall be updated as information changes and shall include, but not be limited to:
1. General Information:
 - a. Overview of Program
 - b. Directory
 - c. Remittance Advice Analysis
 2. References
 - a. Glossary
 - b. Billing Instructions
 - c. Resources
 3. Claims Instructions
 - a. Provider Guidelines
 - b. Service Definitions
 - c. Provider Qualifications
 - d. Provider Responsibilities
 - e. Authorization Process
 - f. Payment
- C. The Contractor shall give all qualified service providers and subcontractors access to the Medicaid Provider handbook and the Contractor's Provider Manual.

XXX. Community Partnerships

- A. The Contractor shall operate in cooperation with the IDHW functions of being the designated agency to serve as the state's Behavioral Health Authority and the designated "safety net" agency for the state.
- B. The Contractor shall facilitate the delivery of medically necessary services in fulfillment of court ordered treatment for Members stemming from Idaho's problem-solving courts (mental health court, drug court, veterans' court)
- C. The Contractor shall collaborate with and support the efforts of local advocacy organizations and state agencies including, but not limited to, current efforts underway to establish a sustainable community-based twenty four (24) hour suicide response system.
- D. The Contractor shall offer processes and services in support of the challenges faced by foster parents of children with SED, refugee relocation agencies, and various IDHW home visiting programs.
- E. The Contractor shall lead an ongoing collaboration with the practitioners and agencies that the Contractor enrolls in the provider network to deliver services under the Idaho Behavioral Health Plan and demonstrate how input from this group shall be incorporated into the Contractor's policies and procedures.
- F. The Contractor shall support the development of a consumers' organization that will serve in an advisory capacity to the Contractor that would represent the voice of Members and their families who use the services provided under the Idaho Behavioral Health Plan and demonstrate how input from this group shall be incorporated into the Contractor's policies and procedures.
- G. The Contractor shall collaborate with Idaho's Regional Mental Health Boards (ID Code § 39-3130, www.healthandwelfare.idaho.gov/Medical/MentalHealth/RegionalMentalHealthBoards/tabid/332/Default.aspx).
- H. The Contractor shall collaborate with the Substance Use Disorders Regional Advisory Committees (ID Code §39-303A) www.healthandwelfare.idaho.gov/Medical/SubstanceUseDisorders/RegionalAdvisoryCommittees/RACRegion4/tabid/198/Default.aspx. The Boards and Councils are scheduled for reorganization through statutory changes in the 2013 legislative session which is expected to combine the two (2) types in readiness for mental health services and substance use disorder services to become integrated into "behavioral health services."
- I. The Contractor shall interact and support the efforts of behavioral health advocacy groups in Idaho including but not limited to the Idaho State Planning Council on Mental Health, the Idaho chapter of National Association of Mental Illness (NAMI Idaho), and the Office of Consumer and Family Affairs.
- J. The Contractor shall interact and collaborate with the various Idaho chapters of national associations for behavioral health professionals, including but not limited to the National Association of Social Workers, American Psychological Association, American Psychiatric Association, American Counseling Association, American Association for Marriage and Family Therapists, United States Psychosocial Rehabilitation Association, the Idaho Association of Infant Mental Health, as well as the regulatory agencies, e.g., Idaho Bureau of Occupational Licensing, the Idaho Board of Nursing, the Idaho Board of Medicine, and the Idaho Board of Alcohol/Drug Counselor Certification.

XXXI. Community Reinvestment Services

- A. The Contractor shall have experience participating in Community Reinvestment activities in other states.
- B. The Contractor shall have a process to provide services through reinvestment and incorporate stakeholder input into this process.
- C. The Contractor shall incorporate a threshold in terms of Medical Loss Ratio (or other trigger mechanisms) to begin reinvesting in community services.
 1. Include the amount(s) to be reinvested.
 2. Indicate whether or not you will commit to reinvesting in community services in Idaho.

XXXII. Outcomes, Quality Assessment, and Performance Improvement Program

- A. For all covered services, the Contractor shall maintain a comprehensive outcomes, quality assessment, quality management, quality assurance, and performance improvement program and includes evaluation of the Contractor's operations.
- B. Quality Improvement Plan -- The Contractor shall
 1. Have, in effect, a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program.
 2. Ensure the assurance plan is approved by the IDHW.
 3. Maintain a sufficient number of qualified quality assurance personnel to comply with and implement all of the requirements of this contract in a timely manner, including:
 - a. Reviewing performance standards;
 - b. Measuring treatment outcomes;
 - c. Assuring timely access to care; and
 - d. Participating in an independent assessor's quality review activities.
 4. Provide a mechanism for the input and participation of Members, families, caretakers, and other stakeholders in the monitoring of service quality and determining strategies to improve outcomes.
 5. Ensure the scope of the outcomes, quality assessment and performance improvement program include all requirements in this section but is not limited to these requirements. These requirements include:
 - a. Processes to assess, measure, and improve the quality of care provided to Members in accordance with:
 - i. All quality assurance requirements identified in this contract;
 - ii. The IDHW's Division of Medicaid;
 - iii. All IDHW and federal regulatory requirements; and
 - iv. All other applicable documents incorporated by reference.
 6. Identify and resolve systems issues consistent with a continuous quality improvement approach. The Contractor shall include a Corrective Action Plan (CAP) that defines the

corrective action response needed to arrive at a common solution to operations.

7. Disseminate relevant information to the IDHW, Members, providers, and key stakeholders, including families and caregivers.
8. Solicit feedback and recommendations from key stakeholders, subcontractors, Members, families, and caregivers, and use the feedback and recommendations to improve the quality of care and system performance.
9. Measure and enforce adherence with the goals and principles of the IDHW through the following strategies, at a minimum:
 - a. Methods and processes that include in-depth chart reviews and interviews with key persons in the Member's life.
 - b. Use of findings to improve practices at the subcontractor and Contractor levels.
 - c. Timely reporting of findings and improvement actions taken and their effectiveness.
 - d. Dissemination of findings and improvement actions taken and their effectiveness to key stakeholders, committees, Members, families, and caregivers, and posting on the Contractor's Website.

C. Practice Guidelines – The Contractor shall:

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

D. Performance Improvement Projects – The Contractor shall:

1. Have in progress a minimum of one (1) performance improvement project (PIP) and one (1) focused study with intervention or two (2) PIPs annually.
 - a. At least one (1) PIP or the focused study shall be outcome-focused.
 - b. The PIPs shall be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction.

- c. Each PIP shall be completed in a reasonable time period, so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.
- d. The PIPs shall involve the following:
 - i. Measurement of performance using objective quality indicators.
 - ii. Implementation of system interventions to achieve improvement in quality.
 - iii. Evaluation of the effectiveness of the interventions.
 - iv. Planning and initiation of activities for increasing or sustaining improvement.
- 2. Summarize the status and results of each PIP in the annual quality report and when requested by the IDHW.
- 3. Submit the status and results of each PIP on the agreed upon schedule in sufficient detail to allow the IDHW and/or its designee to validate the projects.
- 4. Ensure PIPs are validated by the IDHW's independent assessor. The primary objective of the PIP validation is to determine compliance with the following requirements:
 - a. Measurement of performance using objective valid and reliable quality indicators.
 - b. Implementation of system interventions to achieve improvement in quality
 - c. Empirical evaluation of the effectiveness of the Interventions.
 - d. Planning and initiation of activities for increasing or sustaining improvement
- 5. During the life of the contract, participate in the annual measurement and reporting of the performance measures required by the IDHW, with the expectation that this information will be placed in the public domain.
- 6. Calculate additional performance measures when they are developed and required by CMS or the IDHW.
- 7. Ensure the quality assurance program includes a system of performance indicators and Member and family outcome measures that address different audiences and purposes.
- E. Outcomes Assessment Process – The Contractor shall:
 - 1. Implement and maintain a formal outcomes assessment process that is standardized, reliable, and valid in accordance with industry standards.
 - 2. Work with the IDHW to develop agreed-upon measurement criteria, reporting frequency and other components of this requirement.
 - 3. Participate in developing, implementing, and reporting on performance measures and topics for PIPs required by the IDHW or other federal agencies, including performance improvement protocols or other measures, as directed by the IDHW and shall report the outcomes of such PIPs.
 - 4. Measure performance indicators for the provider network, as a whole, and for each provider individually.
 - 5. Have policies and procedures in place that detail how the Contractor will assess the quality and appropriateness of care and services furnished to all Members enrolled under

the contract.

6. Have policies and procedures in place that explain how the Contractor will ensure that providers are assessing Members outcomes in accordance with the requirements identified this contract.

F. Record System – The Contractor shall:

1. Establish, maintain, and use a Member record system that meets requirements at 42 CFR § 456.111 and 211 and IDAPA 16.03.09. The Member record system shall facilitate the documentation and retrieval of statistically-meaningful clinical information, as follows:
 - a. Clinical records shall be maintained in a manner that is current, detailed, and organized and that permits effective Member care and quality review;
 - b. The Contractor shall require providers to maintain records in the same manner;
 - c. Records may be written or electronic;
2. Have written policies and procedures regarding clinical records that include, at a minimum:
 - a. Content, confidentiality protections, retention, and access by Members to their individual records, which shall include the Member's right to see their individual medical records upon request during regular business hours and to copy those records for a reasonable fee, which will not exceed the actual cost of making the copies.
 - b. The processing and storage of records, disposal procedures, and retrieval and distribution.
 - c. A system to access and audit the content of clinical records to ensure that they are legible, organized, complete, and conform to its standards and that clinical records shall be made available to the IDHW immediately upon request by the IDHW.
 - d. A copy of the Contractor's policies and procedures shall be made available to the IDHW and to network providers upon request, and copies of the amendments or modifications to the policy will be promptly filed.
 - e. The Contractor and its providers shall have the ability to record and report data at the level of clinical transactions.
3. Support Medicaid's efforts currently underway to implement the use of electronic health records as described in Attachment 13 - Electronic Health Records, including effectively interfacing with primary care practices in the Medicaid Health Home Project that are required to use electronic health records.

G. Health Information System (HIS) in Quality Assurance Activities – The Contractor shall:

1. Maintain a health information system that collects, analyzes, integrates and reports data. Requirements for the development of a Health Information System for the provider network users are described in detail in this RFP.
2. Ensure the system provides information on areas including, but not limited to, grievances and appeals, third party liability, for other than loss of Medicaid eligibility.
3. Ensure the system collects data on Member and provider characteristics as specified by the IDHW and on services furnished to Members through an encounter data system.
4. Make all collected data available to the IDHW and/or designee and upon request by

CMS.

5. Collect data and conduct data analysis with the goal of improving quality of care.
 6. Ensure the information system supports the quality assurance and program improvement process by collecting, analyzing, integrating, and reporting necessary data.
 7. Ensure that data received from providers is accurate and complete by:
 - a. Verifying the accuracy and timeliness of reported data.
 - b. Screening the data for completeness, logic, and consistency.
 - c. Collecting service information in standardized formats to the extent feasible and appropriate.
- H. Member Satisfaction – The Contractor shall:
1. Monitor Member perceptions of well-being and functional status, as well as accessibility and adequacy of services provided by the Contractor.
 2. Support the IDHW's efforts to collect Member satisfaction data.
 3. Conduct an annual Member satisfaction survey as directed and prior approved by the IDHW. The results of the survey shall be disclosed to Members upon request.
 4. Use the information from the Member satisfaction survey to improve services.
- I. Quality of Care Concerns – The Contractor shall:
1. Have a system for identifying and addressing all alleged quality of care concerns, including those involving physician providers.
 2. Take action as necessary to address all confirmed quality of care concerns.
 3. Not be required to disclose to the public any information that is confidential by law.
- J. Quality Assurance and Program Improvement Committee – The Contractor shall:
1. Form a quality assurance and program improvement Committee. The Contractor's Medical Director shall provide oversight of the Committee.
 2. Include practitioners and agencies that are enrolled in the Contractor's provider network in designing the work of the quality assurance processes.
- K. Independent Assessment – The Contractor shall:
1. Participate in annual independent reviews performed by a IDHW approved independent assessor of quality outcomes, timeliness of, and access to, services in order to validate performance improvement projects and performance measures and to review compliance with the IDHW standards and contract requirements.
 2. Provide any information required by the independent assessor to complete the review
- L. Performance Measures – The Contractor shall:
1. On an annual basis, ensure and report to the IDHW its performance, using standard measures required by the IDHW. In addition, CMS, in consultation with the IDHW's and other stakeholders, may specify performance measures and topics for performance improvement projects to be required by the IDHW in the contract with the Contractor.
- M. Methods of Data Analysis – The Contractor shall:

1. Use an industry recognized methodology, such as SIX SIGMA or another method(s) for analyzing data.
 2. Demonstrate inter-rater reliability testing of evaluation and assessment decisions.
 3. Measure the effectiveness of service delivery through the use of standardized, outcome-based instruments.
- N. Outcomes Management and Quality Improvement Plan – The Contractor shall:
1. Develop and implement an Outcomes Management and Quality Improvement Plan. The Contractor shall participate in the review of the quality improvement findings and shall take action as directed by the IDHW. The plan shall:
 - a. Delineate future quality assessment and performance improvement activities based on the results of those activities in the annual report.
 - b. Integrate findings and opportunities for improvement identified in studies, performance outcome measurements, Member satisfaction surveys, provider satisfaction surveys, and other monitoring and quality activities.
 - c. Be subject to the IDHW and/or designee's approval.
 - d. Include, but is not limited to, the following:
 - i. Call center performance in answering calls
 - ii. Child, youth, young adult and families/caregivers satisfaction with providers.
 - iii. Reliability and timeliness of service.
 - iv. Decision-making processes.
 - v. Network adequacy.
 - vi. Attainment of positive outcomes by service line and system wide, including clinical and functional outcomes and system-wide outcomes.
- O. Provider Quality Improvement Activities – The Contractor shall:
1. Monitor subcontracted provider quality improvement activities to ensure compliance with federal and state laws, regulations, IDHW requirements, this Contract, and all other Quality Management (QM) requirements.
 2. Make records and other documentation available to the IDHW, and ensure subcontractors' participation in, and cooperation with, any QM reviews. This may include participation in staff interviews and facilitation of Member/family/caregiver and subcontractor interviews.
 3. Use quality management review findings to improve quality of care.
 4. Take action to address identified issues, as directed by the IDHW.
- P. Provider Monitoring – The Contractor shall:
1. Monitor and evaluate qualified service providers in order to promote improvement in the quality of care provided to Members.
 2. Monitor all provider agencies and individual practitioners' performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the IDHW, consistent with industry standards, federal and state laws and regulations.

3. Update a provider monitoring plan in the required annual Quality Management Plan.
 4. In accordance with federal requirements 42 CFR § 438.206, ensure the provider monitoring plan addresses, at a minimum, the following requirements:
 - a. Maintaining and monitoring a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract.
 - b. Identifying deficiencies or areas for improvement and ensuring the provider agencies and individual practitioners shall take corrective action in the following areas:
 - i. Monitoring and reporting network turnover.
 - ii. Monitoring and reporting requests for a change in provider.
 - iii. Continually monitoring access to network services and provider capacity to maintain a sufficient number of qualified service providers, to deliver covered behavioral health services for Members, including provision of culturally informed services to persons with limited proficiency in English and those with cross-cultural treatment requirements and adapted service delivery for blind or deaf Members.
 - iv. Complying with service provider monitoring and reporting requirements in accordance with this Contract, including but not limited to a Member Access Rates Report.
 - c. Demonstrating that its providers are credentialed as required by 42 CFR § 438.206(b)(6) and 42 CFR § 438.214.
 - d. Ensure timely access to services:
 - i. Meeting and requiring its providers to meet IDHW standards for timely access to care and services, taking into account the urgency of the need for services per 42 CFR § 438.206(c)(1)(i);
 - ii. Ensuring that the network providers offer hours of operation that are no less than the hours of operation offered to non-Medicaid clients or comparable to Medicaid fee-for-service, if the provider serves only Medicaid Members. 42 CFR § 438.206(c)(1)(ii);
 - iii. Making services included in the Contract available twenty-four (24) hours a day, seven (7) days a week, when medically necessary. 42 CFR § 438.206(c)(1)(iii);
 - iv. Establishing mechanisms to ensure compliance by providers. 42 CFR § 438.206(c)(1)(iv);
 - v. Monitoring providers regularly to determine compliance. 42 CFR § 438.206(c)(1)(v); and
 - vi. Taking corrective action if there is a failure to comply. 42 CFR § 438.206(c)(1)(vi.)
- Q. Policies and Procedures for Managing Network – The Contractor shall.
1. Uniquely identify each practitioner, allowing for the association of multiple standardized and user defined identifiers and qualifiers, including Master Provider Index (MPI), National Provider Index (NPI), Drug Enforcement Administration (DEA), and National

Association of Boards of Pharmacy (NABP) identifiers.

2. Provide online access to the IDHW for all historical provider related information to include:
 - a. Claims;
 - b. Prior authorizations and referrals; and
 - c. Correspondence.
3. Perform data exchanges to obtain provider data from licensing boards, CMS, DEA, the NPI enumeration contractor, and other IDHW specified sources.
4. Maintain provider Clinical Laboratory Improvement Amendments (CLIA) data with full audit capabilities for those providers who have CLIA certification.
5. Provide online inquiry or lookup for the IDHW for a minimum of sixty (60) months of historical provider information, searchable by entering complete or partial identifying information:
 - a. Medicaid provider identification;
 - b. Provider name;
 - c. NPI;
 - d. Medicare number;
 - e. Social security number;
 - f. Phone number;
 - g. EIN/TIN;
 - h. DEA;
 - i. Type/specialty/taxonomy;
 - j. Previous identifier(s); and
 - k. Other identifiers used by the IDHW.
6. Display claims summary information, by provider, to include: month-to-date, quarter-to-date, and year to date levels that will indicate the total number of claims submitted, pending, denied, paid and the total dollar amounts of each category.
7. Display prior authorization by provider to include: month-to-date, quarter-to-date, and year-to-date levels that will indicate the total number of prior authorization's requested, approved, pending, denied, and the total dollar amount of each category.
8. Include provider data repository definition of provider entities to include:
 - a. Pay-to or tax entities;
 - b. Service entities including:
 - c. Licensed or certified entities providing services including physicians and all behavioral health practitioners;

- d. Medical groups and FQHCs; and
 - e. Non-traditional providers including transportation Providers.
9. Define provider's periods of eligibility using, at a minimum, eligibility begin and end dates and status indicator(s).
 10. Display provider eligibility information in reverse chronological order (i.e., most current information is displayed first).
 11. Affiliate one or more service provider(s) to one or more 'pay to' entities.
 12. Have the ability to capture, at a minimum, provider:
 - a. Address information;
 - b. Office contact person;
 - c. Phone number;
 - d. Fax number;
 - e. Emergency contact numbers; and
 - f. Office or facility profile (content will vary based on entity type).
 13. Accommodate Idaho Bureau of Occupational Licensing (IBOL) certification information which includes:
 - a. Type, specialty, and sub specialty;
 - b. Taxonomy;
 - c. Certification begin and end dates;
 - d. Certification type code;
 - e. Certifying agency;
 - f. Certifying state;
 - g. Verification date; and
 - h. Verification due date.
 14. Accommodate licensing, credentialing, sanction and certification information that includes:
 - a. License identification;
 - b. Certification type;
 - c. Certifying agency;
 - d. Certifying state;
 - e. Certification begin and end dates;

- f. Verification date;
 - g. Verification due date;
 - h. Verification type;
 - i. Sanctioning agency;
 - j. Sanctioning state; and
 - k. Sanction beginning and end dates.
15. Identify and create alerts and reports of providers due for re-certification or license verification, sixty (60) days prior to the end date of the current license, certification, or provider agreement.
 16. Define the relationship between a provider and an Electronic Data Interchange (EDI) submitter.
 17. Define surveillance status and pend or deny for CMS-1500 claims by date parameters and other qualifiers which may include:
 - a. Media type;
 - b. Healthcare Common Procedure Coding System (HCPCS) code begin and end range;
 - c. International Classification of Diseases (ICD) diagnosis code begin and end range; and
 - d. ICD procedure code beginning and end range
 18. Identify the affiliation a physician in the provider network may have with a hospital or multiple hospitals and indicate what types of privileges they have.
 19. Identify the providers panel information including:
 - a. Accepting new patient indicator;
 - b. Age range;
 - c. Gender;
 - d. Authorized enrollment; and
 - e. Current enrollment.
 20. Associate multiple service locations to the same provider base identifier.
 21. Identify provider 'on call' information to capture 'covering for' and 'covered by' providers.
 22. Indicate a Provider's financial information, at a minimum, EIN, SSN, W9, EFT bank account, 1099 information, hold payment indicators, and federal match rate.
 23. Identify the individual practitioner's insurance coverage information which includes carrier, effective and end dates, dollar limits, verification date, and verification due date for the following types of coverage:
 - a. Malpractice;

- b. Workers compensation; and
 - c. General liability.
24. Produce reports showing which practitioners or provider agencies a Member is using and each individual agency's caseload.
25. Provide an unlimited free-form text narrative at the base Provider level that:
- a. Identifies the user, date, and time entered; and
 - b. Provides the capability to display free form narrative in chronological or reverse chronological sequence.

XXXIII. Compliance and Monitoring (Utilization Management)

- A. The Contractor shall have a system for conducting utilization management, program integrity and compliance reporting activities. All aspects of the system shall be focused on providing high quality, medically necessary services in accordance with contract requirements.
- B. Program —The Contractor shall:
- 1. Develop, implement and maintain a utilization management program to monitor the appropriate utilization of covered services.
 - 2. Comply with CMS requirements described in 42 CFR §456
 - 3. Be under the direction of an appropriately qualified clinician; appropriateness of the qualifications of the assigned clinician shall be determined by matching the clinician's scope of expertise with the material under review.
 - 4. Ensure utilization determinations are based on written criteria and guidelines developed or adopted with involvement from practicing providers and nationally recognized standards.
 - 5. Ensure the utilization management process in no way impedes timely access to services.
- C. Policies and Procedures (P&P) - Utilization Management – The Contractor shall:
- 1. Have P&Ps regarding the management of service utilization. UM P&Ps shall include, but are not limited to, the following:
 - a. Annual Review and Evaluation of UM Program: P&P stating how the Contractor will evaluate the effectiveness of the UM program and subsequently revise the program as necessary. This information shall be made available to the IDHW?
 - b. Criteria:
 - i. P&P regarding the development, review and modification of utilization review criteria to include the practitioners involved and documentation of the involvement.
 - ii. Criteria shall be developed for all routinely provided care and services.
 - iii. P&P shall reflect that available criteria shall be applied to all utilization review (UR) decisions and that criteria are clearly written, are objective and evidence based whenever possible, appropriate and available to providers and Members upon request.
 - iv. There shall be a statement regarding the congruence between adopted clinical

- guidelines and UR criteria.
- v. P&P for applying the criteria based on individual needs and taking into account the local delivery system.
 - vi. P&P for processing requests for initial and continuing authorizations of services per 42 CFR § 438.210(b)(1.)
2. Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and consult with the requesting provider when appropriate per 42 CFR § 438.210.
 3. Ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease per 42 CFR § 438.210(b)(3).
 - a. Monitoring Over- and Under-Utilization:
 - i. P&P stating that prior authorization shall be conducted for identified levels of care.
 - ii. P&P outlining the activities undertaken to specifically identify and address under-utilization as well as over-utilization.
 - iii. At a minimum, the P&P shall include routine trending and analysis of data on levels of care (including care not prior authorized) and by provider.
 - iv. P&P providing for peer review of quality of care concerns.
 - b. Utilization Review (UR) Decisions:
 - i. Evidence, available to the IDHW upon request, of formal staff training designed to improve the quality of UR decisions.
 - ii. P&P to evaluate and improve the consistency with which UR staff apply criteria (inter-rater reliability) across multiple levels of care.
 - iii. P&Ps and job descriptions to specify the qualifications of personnel responsible for each level of UR decision making (e.g., review, potential denial).
 - iv. P&P to ensure that a practitioner with appropriate clinical experience in treating the Member's condition reviews any potential denial based on medical necessity.
 - c. Timeframes.
 - i. P&Ps to address the timeliness of UR decisions made on the basis of medical necessity.
 - ii. P&Ps to address the timeframes for which prior authorization, concurrent and retrospective reviews decisions are made.
 - iii. P&Ps to address the timeliness of expedited reviews.
 - iv. P&Ps to assess the adherence to the timeframes in items i-iii.
 - d. Data and Communication:
 - i. P&P that specifies how Members and practitioners can access UM staff to discuss UM issues and decisions. This information shall be made available to

Members and providers.

- ii. P&P that describes how the organization will notify the providers and Members of UM decisions.
 - e. Obtaining Clinical Information:
 - i. P&P to obtain relevant clinical information and the circumstances under which the Contractor will consult with the treating providers when making a determination of medical necessity.
 - ii. P&P describing the decision-making process that identifies information needed to support UR decision making.
 - iii. P&P describing the process for obtaining any missing clinical information.
 - f. Other:
 - i. P&P to evaluate new technology and new applications of existing technology, to include behavioral health procedures.
 - ii. P&P to ensure any Contractor centralized triage and referral functions for behavioral health services are appropriately implemented, monitored, and professionally managed.
 - iii. P&P describing how practitioners are given information on the process to obtain the UR criteria.
- D. Documentation –The Contractor shall:
1. Maintain documentation that supports the activities described in the UM program and UM policies and procedures. The Contractor shall report service utilization by type of service to the IDHW on a monthly basis.
 2. Ensure supporting documentation includes, but is not limited to, committee meeting minutes, job descriptions, signatures on related materials and utilization review notes.
 3. Ensure the UM program description is written so that staff members and others can understand the program. The program description shall include, but not be limited to:
 - a. Program goals;
 - b. Program structure, scope, processes and information sources, including the identification of all intensive levels of care;
 - c. Roles and responsibilities;
 - d. Evidence of Medical Director leadership in key aspects of the UM program to include denial decisions and criteria development;
 - e. A description of how oversight of any delegated UM function will occur;
 - f. A description of how staff making Utilization Review (UR) decisions will be supervised;
 - g. A statement regarding staff availability at least eight (8) hours a day during normal business hours for inbound calls regarding UM issues;
 - h. The mechanisms that will be used to ensure that Members receive equitable access to care and service across the provider network; and

- i. The mechanisms that will be used to ensure that the services authorized are sufficient in amount, duration, or scope and can reasonably be expected to achieve the purposes for which the services are furnished.

E. Accountability – The Contractor shall:

1. Remain accountable for and have appropriate structures and mechanisms in place to oversee activities that are delegated to a subcontractor per 42 CFR § 438.230(a) and (b)(1), (2), (3), including a way to verify services were actually provided as required by 42 CFR§ 455.1(a)(2). This will include a written delegation agreement. The following items apply to sub-contracted activities and do not reflect the total requirements for any delegated subcontract or agreement. The Contractor shall have the following in place:
 - a. A written Delegation Agreement that includes:
 - i. A description of the responsibilities of the Contractor and the delegated entity as it relates to delegated activities;
 - ii. A description of the delegated activities;
 - iii. A description of reporting responsibilities;
 - iv. A statement that the subcontractor will comply with the standards specified in the contract between the Contractor and the IDHW for any responsibilities delegated to the subcontractor;
 - v. A description of the processes for ongoing monitoring (i.e., continuous quarterly reporting) and at least an annual formal review; and
 - vi. A description of the remedies available to the Contractor if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement and corrective action.
 - b. Oversight P&Ps:
 - i. A P&P describing the oversight (ongoing monitoring) activities that will be done (e.g., required reporting and report frequency, activities conducted by the Contractor in reviewing the required reports, actions that will be taken depending on the review). a) The procedure shall include who reviews the reports, whether or not a committee approval is required, etc. b) The scope of oversight activities shall include all delegated UR/UM functions. c) P&P describing the formal review, which shall occur no less than annually, and at a minimum include a visit to the organization, and a document or record review.
 - c. P&P describing how the quality (application of criteria, denial decisions, inter-rater reliability, etc.) of contracted services will be monitored and assessed.

F. Guidelines – The Contractor shall:

1. Develop or adopt Utilization Management Guidelines to interpret the medical necessity of behavioral health services provided to Members. Medical necessity is defined in IDAPA 16.03.09. The IDHW shall be the final authority regarding all disputed medical necessity decisions.
2. Ensure the guidelines for interpreting medical necessity shall:
 - a. Be based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
 - b. Consider the needs of the Members;

- c. Be adopted in consultation with contracting health care professionals, and
 - d. Be reviewed and updated periodically as appropriate.
3. Disseminate the guidelines to all providers and, upon request, to Members.
 4. In the development and implementation of Utilization Management Guidelines, include policies and procedures which recognize the need for long-term services for some Members and the need for some Members to access several services concurrently. These needs shall be recognized for both children and adults.
 5. Ensure all guidelines developed by the Contractor and any modifications made to the guidelines are approved by the IDHW and shared with providers at least thirty (30) calendar days prior to implementation of the guidelines.
 6. Ensure that contracted providers use the required criteria for determination of level of service, even when authorization from Contractor is not required.
 7. Ensure that decisions for utilization management, Member education, coverage of services, and other areas to which the guidelines apply shall be consistent with the guidelines.
 8. Limit payment to only those services that the Contractor has authorized under the guidelines which the Contractor has developed and the IDHW has approved. Any denial of payment for services funded through the Medicaid capitation payment is subject to appeal to the IDHW pursuant to standards in both state administrative rules and the State Plan or waiver.
 9. Provide a forum to receive practitioner suggestions for UM Guideline revisions at least annually, and shall document all changes made subsequent to practitioner input.
- G. Health Information System (HIS) in Utilization Management – Currently the IDHW's Division of Medicaid does not require mental health providers to operate any uniform HIS. The IDHW's Division of Behavioral Health operates the WITS system which is described in greater detail in Attachment 16 - Web Infrastructures for Treatment Services (WITS). The network of substance use disorder providers currently uses this system. The Contractor shall maintain a health information system that:
1. Supports WITS or at the very least, uses a system that shall interface with WITS.
 2. Supports the utilization management process by collecting, analyzing, integrating, and reporting necessary data.
 3. Provides information on the utilization of services.
 4. Collects data on Member and provider characteristics as specified by the IDHW and on services furnished to Members through an encounter data system.
 5. Makes all collected data available to the IDHW and/or designee and upon request by CMS.
 6. Ensures that data received from providers is accurate and complete by:
 - a. Verifying the accuracy and timeliness of reported data
 - b. Screening the data for completeness, logic, and consistency
 - c. Collecting service information in standardized formats to the extent feasible and

appropriate.

7. Conducts comparative analysis such as the Health and Effectiveness Data and Information Set (HEDIS).

H. Compliance and Management – The Contractor shall:

1. Have a mandatory compliance plan and administrative and management arrangements or procedures designed to prevent and detect fraud, abuse and misuse of Medicaid funds and resources.
2. Diligently safeguard against the potential for, and promptly investigate reports of, suspected fraud and abuse by employees, subcontractors, providers, and others with whom the Contractor does business by having controls in place to detect fraud and abuse, including technology to identify aberrant billing patterns, claims edits, post processing review of claims and records reviews.
3. Provide the IDHW with the Contractor's policies and procedures on handling fraud and abuse including responding to IDHW requests for records and documentation of any sort such as provider agreements and all written and telephonic communications with a provider per the terms of the contract.
4. Report possible instances of Medicaid fraud to the IDHW within contractual timeframes. This information shall be reported in the quarterly Surveillance Activities Report.
5. Describe how frequently, and by what method, it shall assure that providers' CPT billing accurately reflects the level of services provided to Members so that there is no intentional or unintentional up-coding or miscoding of services.
6. Have in place a method to verify whether services reimbursed by the Contractor were actually furnished to eligible Members as billed by providers.
7. Provide the IDHW with a quarterly update of surveillance activity, including corrective actions taken. This information should be reported in the Surveillance Report.
8. Have administrative and management arrangements or procedures, and a mandatory compliance plan that are designed to guard against fraud and abuse and include the following:
 - a. Written policies, procedures, and standards of conduct consistent with all applicable federal and state laws pertaining to fraud and abuse;
 - b. The designation of a compliance officer and a compliance committee that are accountable to senior management;
 - c. Effective training and education for the compliance officer and the staff;
 - d. Effective lines of communication between the compliance officer and staff;
 - e. Enforcement of standards through well-publicized disciplinary guidelines;
 - f. Provision for internal monitoring and auditing, including inspection and audit of financial records per 42 CFR § 438.6(g);
 - g. Provisions for prompt response to detected offenses, and for development of corrective action initiatives relating to the contract services;
 - h. Written procedures in place to suspend payment in accordance with Affordable Care

Act provisions, Section 6402(h)(2), as well as IDAPA 16.05.07, The Investigation and Enforcement of Fraud, Abuse, and Misconduct;

- i. Responsibility to check the Medicaid Program Integrity Unit's Termination and Outstanding Debt List and not enter into agreements with providers who have been terminated or have outstanding debts. The list can be found at: <http://www.healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/ProviderExclusionList.pdf>;
- j. Provision of a comprehensive written Work Plan which shall include timelines for formal communications and trainings to the provider network, no less than annually, on topics of fraud and abuse, including the Medicaid Program Integrity Unit's contact information. The trainings need to be reported in the annual Provider Training Report; and
- k. Reporting receipt of any complaints of fraud or abuse from any sources to the Medicaid Program Integrity Unit. Additionally, any information obtained regarding the abuse or exploitation of adults shall be reported to the Medicaid Program Integrity Unit.

Report of Fraud, Waste, Abuse – The Contractor shall:

1. Submit, quarterly, a Surveillance Report to the IDHW detailing all incidents of fraud, waste and abuse detected, reported to, reviewed or investigated by the Contractor. The report shall, at a minimum, provide:
 - a. The current status and resolution of all fraud, waste, and abuse incidents detected or referred to the Contractor including the name and identification number, sources of complaint, type of provider, nature of complaint, approximate dollars involved and legal and administrative disposition of the case;
 - b. The number of provider reviews opened, pending, and completed for the current quarter, year to date, and averages per quarter;
 - c. Fraud and/or abuse issues identified;
 - d. Overpayment amounts identified in the quarter, contract to date, and average amount per quarter;
 - e. Means by which overpayments were identified;
 - f. Actions taken;
 - g. Recoupment amount collected in the previous quarter, contract to date, and average amount per quarter;
 - h. Any provider education that the Contractor delivered;
 - i. Number of cases before the IDHW awaiting approval;
 - j. Number of cases recommended for referral to Bureau of Audits and Investigations and the Medicaid Fraud Control Unit (MFCU);
 - k. Number of provider appeals filed;
 - l. Case status of appeals; and
 - m. Discussion that may include, but is not limited to, problems encountered provider

specific or statewide trends noted, and regulation revisions needed.

- n. In partnering with the Medicaid Program Integrity Unit the Contractor shall make available to the IDHW within five (5) business days upon request:
 - i. Copies of individual provider contracts
 - ii. Copies of prior authorizations
 - iii. All written communication between the Contractor and a specified provider.
2. Furnish the IDHW, the Secretary of the U.S. Department of Health and Human Services (DHHS), or the IDHW's Idaho Medicaid Fraud Control Unit (MFCU) with such information as it may request regarding payments claimed for services provided.
3. Grant the IDHW, DHHS and/or MFCU access during the Contractor's or subcontractors' regular business hours to examine health service and financial records related to a health service billed to a program. The IDHW will:
 - a. Notify the Contractor or subcontractor before obtaining access to a health service or financial record, unless the Contractor or subcontractor waives notice.
 - b. Access records in accordance with 45 CFR 160-164.
 - c. Send a monthly Excel file to the Contractor of any providers that have had payment suspended or have been terminated by CMS.
- J. Compliance Program Plan – The Contractor shall:
 1. Submit, annually for approval, its Compliance Program Plan.
 2. Submit, within forty five (45) calendar days of the effective date of this contract, a copy of the written policies identified in the Program Integrity section of the base contract detailing compliance with:
 - a. The False Claims Act, 31 USC §§ 3729, et seq.;
 - b. Administrative remedies for false claims and statements;
 - c. State laws relating to civil or criminal penalties and statements;
 - d. State laws relating to civil or criminal penalties for false claims and statements; and
 - e. Whistleblower protections under such laws.
 3. Submit, annually, within thirty (30) business days of the IDHW's notification letter, written assurance of compliance with the False Claims Act to the IDHW's Program Integrity Unit.
 4. Not knowingly have a relationship with the following per 42 CFR § 438.6-10(a) and (b):
 - a. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under presidential Executive Order No. 12549 or under guidelines implementing presidential Executive Order No. 12549; or
 - b. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (a)(1) of the regulation.
 - c. For the purposes of this section, "Relationship" is defined as follows:
 - i. A director, officer, or partner of the Contractor;

- ii. A person with beneficial ownership of five percent or more of the Contractor's equity; or
 - iii. A person with an employment, consulting or other arrangement with the Contractor under its contract with the IDHW.
- 5. Notify the IDHW of any person or corporation that has 5% or more ownership or controlling interest in the Contractor.
- 6. Not expend Medicaid funds for providers excluded by Medicare, Medicaid, or SCHIP.
- K. Unique Identifier -- The Contractor shall require each individually contracted provider to have a unique identifier.
- L. Encounter Data -- The Contractor shall:
 1. Submit encounter data to the IDHW and/or its designee on all State Plan services. The Contractor shall submit data certifications for all data utilized for the purposes of rate setting (42 C.F.R. 438.604 and 438.606).
 2. Ensure data certification includes certification that data submitted is accurate, complete and truthful, and that all "paid" encounters are for covered services provided to or for enrolled Members.
 3. Ensure data submission complies with the federal confidentiality requirements of 42 CFR Part 2, and may require the development of Qualified Service Organization Agreements (QSOA).
 4. Submit encounter claims data to the IDHW for submittal to the Medicaid Management Information System (MMIS) on a monthly basis, no later than thirty (30) calendar days following the data collection month.
 5. In addition, submit encounter data to the IDHW on a quarterly basis in a flat data file format. These files are due no later than sixty (60) calendar days following the data collection quarter. The IDHW reserves the right to change format requirements at any time, following consultation with the Contractor and retains the right to make the final decision regarding format submission requirements.
- M. Record-Keeping -- The Contractor shall:
 1. Maintain records in accordance with requirements at 45 CFR § 4.53(a) and (b):
 - a. Books, records, documents, and other evidence (hereinafter referred to as records) documenting the costs and expenses of the contract to the extent and in such detail as will properly reflect all net costs (direct and indirect) of labor, materials, equipment, supplies, services, etc., for which payment is made under the contract.
 - b. All medical records pertaining to treatment services and supports provided under the contract.
 - c. All records for the duration of the contract period and for six (6) years after the date the final payment is made to the Contractor or for the duration of contested case proceedings, whichever is longer.
 2. At the contract conclusion, turn over a copy or the originals of all records to the IDHW or a party designated by the IDHW.
 3. Transfer medical records to a new Contractor upon request of the IDHW.

N. Access – The Contractor shall:

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

XXXIV. Annual Network Development and Management Plan

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

XXXV. Data Tracking and Utilization Information System

- A. The Contractor shall provide a Data Tracking and Utilization Information System to collect and compile data, analyze the data, generate both electronic and hard copy reports in an Excel format, and store, maintain and manage data as required in this RFP, and outlined in Attachment 6 - Technical Requirements.
- B. The Contractor shall be responsible for all programming functions and costs associated with the use and maintenance of the system.
- C. The Contractor shall adhere to the timelines established in Attachment 9 - Initial Deliverables, and Attachment 10 - Readiness Review.
 - 1. The Data Tracking and Utilization Information System shall be fully operational within one-hundred twenty (120) calendar days of the effective date of the contract.
- D. The Contractor shall:
 - 1. Ensure system is functional and accessible to allow the IDHW to retrieve reports via Secure File Transfer Protocol (SFTP) from the Contractor.
 - 2. Ensure all of the required data elements identified in the Scope of Work and Reports section are included into the Data Tracking and Utilization Information System.

XXXVI. Disaster Recovery Plan

- A. The Contractor shall provide and maintain a comprehensive Disaster Recovery Plan that identifies how the Contractor will manage services in the event of a catastrophe (disaster, emergency, flooding, power failure, weather conditions, loss of phone systems, etc.).
 - 1. The Disaster Recovery Plan shall include, but is not limited to, how the Contractor will notify the IDHW when the Contractor's site requires the implementation of the Disaster Recovery Plan, how the Contractor will work with IDHW and Behavioral Health network providers and Members if a catastrophe occurs in Idaho, how services will continue with minimal disruption, how data will be safeguarded and accessible, and how Members will continue to receive behavioral health services.
- B. The Contractor may be required to submit a revised Disaster Recovery Plan for review as outlined in Attachment 10 - Readiness Review.
- C. The Contractor shall have a detailed description of their back-up plan and system to ensure that, in the event of a power failure or outage, the following are in place and functioning:
 - 1. A back-up system capable of operating the telephone system for the entire time the main system is inoperative, at full capacity, with no interruption of data collection;
 - 2. A notification plan that ensures the IDHW is notified when the Contractor's phone system is inoperative or a back-up system is being utilized; and
 - 3. Manual back-up procedure for processing requests if the system is down
- D. The Contractor shall:
 - 1. Maintain business continuity in the occurrence of unforeseeable events impacting business operations
 - 2. Maintain and update the Disaster Recovery Plan.
 - 3. Implement the Disaster Recovery Plan in the event of a catastrophe impacting the Contractor's site.

4. Implement the Disaster Recovery Plan in the event of a catastrophe in Idaho.
5. Ensure Members continue to receive behavioral health services with minimal interruption.
6. Ensure data is safeguarded and accessible.
7. Train staff and network providers to the requirements of the Disaster Recovery Plan to ensure all systems remain intact and all files and data are restored within twenty four (24) hours in the event of a disaster.

XXXVII. Reports/Records/Documentation

- A. The Contractor shall provide reports as outlined in Appendix C - Reports. Reports shall include data current through the respective reporting timeframe and shall be submitted within the required timeframes.
- B. The Contractor shall:
 1. Comply with all reporting requirements
 2. Ensure reports are accurate and available within the required timelines.
 3. Ensure copies of complete and valid provider insurance certificates are maintained for each qualified network provider and make them available to the IDHW upon request.

XXXVIII. Contract Transition Plan

- A. The Contractor shall provide and maintain a Contract Transition Plan that complies with the requirements of the contract. The objectives of the Contract Transition Plan are to minimize disruption of services provided to the IDHW and to provide for an orderly and controlled transition of the Contractor's responsibilities to a successor at the conclusion of the contract period or for any other reason the Contractor cannot complete the responsibilities of the contract. The Contractor shall submit their Contract Transition Plan as outlined in Attachment 10 - Readiness Review. In addition, the Contractor shall submit an updated Contract Transition Plan to the IDHW within one-hundred-eighty (180) calendar days prior to the conclusion of the contract.
- B. The Contract Transition Plan shall include, but not be limited to:
 1. A realistic schedule and timeline to hand-off responsibilities to the replacement contractor or the IDHW.
 2. The staff that shall be utilized during the hand-off of duties and their responsibilities such that there shall be clear lines of responsibility between the Contractor, the replacement contractor and the IDHW.
 3. The actions that shall be taken by the Contractor to cooperate with the replacement Contractor and the IDHW to ensure a smooth and timely transition.
 4. A plan on how to best inform and keep the Contractor's employees informed during the transition process.
 5. A matrix listing each transition task, the functional unit and the person, agency or Contractor responsible for the task, the start and deadline dates to complete the planned tasks, and a place to record completion of the tasks.

6. All information necessary for reimbursement of outstanding claims.

C. The Contractor shall:

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

date of the Notice of Termination, the Contractor shall perform work consistent with the requirements of this contract and in accordance with the written Contract Transition Plan approved by the IDHW for the orderly transition of Members to another contractor or the IDHW.

7. Unless otherwise directed by the IDHW, the Contractor shall direct subcontracted providers to continue to provide services consistent with the Member's treatment plan or plan of care.
8. Transfer all required telephone numbers associated with the toll-free call center line telephone number(s) to the IDHW or the successor contractor, as directed by the IDHW to allow for the continuous use of the number of Member services and providers.
9. Supply all information necessary for reimbursement of outstanding claims.

XXXIX. Incentives for Stabilization and Reduction of Behavioral Health Inpatient Costs

- A. The Contractor shall provide an array of outpatient services designed to prevent or limit the need for inpatient services. An initial withhold from the capitation rate for the non-dual population of 5% will be used as an incentive. Six (6) months after the first year the contractor has begun administering services, the IDHW will calculate the previous year expenditures and the prior year fee-for-service expenditures. The amounts are calculated on a PMPM basis.
- B. If Medicaid does not experience an increase in BH inpatient expenditures above its' historical trend rate, the total amount of the withheld amount will be paid to the Contractor. An annual trend will be calculated using the most current data available each year. Should Medicaid experience an increase in inpatient costs in an amount greater than its' anticipated trend rate, the amount of the increase above the trend rate will be subtracted from the amount withheld from the PMPM on a dollar to dollar basis, up to the total of the withheld amount. Any remaining funds are then paid to the Contractor.
- C. Additionally, should the IDHW experience a 5% or greater reduction in inpatient costs, 50% of the savings realized will be paid to the contractor. The calculations will occur on an annual basis throughout the life of the contract. The incentive payment for reduction of inpatient costs is capped at 5% of the net PMPM (the proposed PMPM less the 5% withhold). The net PMPM must be certified by the IDHW's actuary as a sound rate.

Insurance

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

- Commercial General Liability Insurance and, if necessary, Commercial Umbrella Liability Insurance with a limit of not less than one million dollars (\$1,000,000) each occurrence. Insurance required by this section shall name the State of Idaho, Department of Health and Welfare as an additional insured.
- Automobile Liability Insurance and, if necessary, Umbrella Liability Insurance with a limit of not less than one million dollars (\$1,000,000) each accident. Insurance required by this section shall name the State of Idaho, Department of Health and Welfare as an additional insured.
- Professional Liability Insurance with a limit of not less than one million dollars (\$1,000,000) each occurrence.
- Workers' Compensation Insurance which includes Employer Liability Insurance and shall comply with Idaho Statutes regarding Workers' Compensation in the amount of: \$100,000 per accident; \$500,000 disease policy limit; and \$100,000 disease, each employee.

Prior to performing any services, the Contractor shall provide certificates of insurance to the Department. The Contractor is also required to maintain current certificates on file with the Department and to provide updated certificates upon request. Failure to provide the required certificates of insurance shall constitute a default under this Contract and upon such failure the Department may, at its option, terminate the Contract. Insurance required by this section shall be policies or contracts of insurance issued by insurers approved by the Department. Insurance certificates shall provide for thirty (30) days' prior written notice to the Department of cancellation or material change of such insurance. The Contractor shall further ensure that all policies of insurance are endorsed to read that any failure to comply with the reporting provisions of this insurance, except for the potential exhaustion of aggregate limits, shall not affect the coverage(s) provided to the State of Idaho, Department of Health and Welfare.

Please send updated certificates to:

**Idaho Department of Health and Welfare
Contracting & Procurement Services – 9th Floor
450 West State Street
Boise, ID 83702**

Ownership Of Information

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

Certification Regarding Environmental Tobacco Smoke

The Pro-Children Act of 1994 (20 U.S.C. § 6081-84) prohibits smoking in facilities, or in some cases portions of facilities, where certain federally funded services are provided on a routine or regular basis for children under the age of 18. The Act applies if funds are being provided through an applicable federal grant, loan, loan guarantee, or contract. The law applies to public elementary and secondary education and library facilities. It also applies to facilities used for the Head Start program, the WIC program (the supplemental food and nutrition program for women and children), and certain health care services for children. The smoking prohibition does not apply to private residences, to service providers whose sole source of federal funds is Medicare or Medicaid, or to portions of facilities used for inpatient treatment of individuals who are dependent on or addicted to drugs or alcohol. Civil money penalties, not exceeding \$1000 for each day of violation, not exceeding the amount of applicable federal funds received, may be imposed for non-compliance. Also, federal funds may be withheld or the award may be terminated. Recipients must certify, as a condition for receiving applicable federal funds, that smoking will not be permitted within facilities, or portions of facilities, covered by the Act. By signing the Contract, the Contractor certifies that it will comply with the requirements of the Act, and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The Contractor shall include the language of this certification in any subcontract that contains provisions for children's services and shall ensure that all subcontractors shall certify accordingly.

Criminal History Background Checks

IDAPA 16.05.06 Rules Governing Mandatory Criminal History Checks -- These rules have been established to assist in the protection of children and vulnerable adults by requiring criminal history checks for individuals (Contractors, Contractor's employees and all subcontractors) who provide care or service that are financially supported, licensed or certified by the Department of Health and Welfare. Contractors, Contractor's employees and all subcontractors are required to complete a criminal history and background check pursuant to IDAPA 16.05.06. Those who have had a fingerprint based criminal history background check through their employment with the Department of Education, or their employment as a law enforcement officer may be exempt from the fingerprint based check; however, the Contractor must complete at a minimum, an Idaho name based check through the Idaho State Police. For information on how to obtain a Department of Health and Welfare criminal history and background check, please go to the Department's criminal history check website at <http://chu.dhw.idaho.gov> or call 1-800-340-1246.

Business Associate

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

- a. The Contractor agrees to not use or disclose confidential information other than as permitted or required by the Contractor as required by law.
- b. The Contractor agrees to use appropriate safeguards to prevent use or disclosure of confidential information other than as provided for by this contract.
- c. The Contractor agrees to mitigate, to the extent practicable, any harmful effect that is known to the Contractor of a use or disclosure of confidential information by the Contractor in violation of the requirements of this contract.
- d. The Contractor agrees to report to the Department any use or disclosure of confidential information not provided for by this contract of which it becomes aware.
- e. The Contractor agrees to ensure that any agent, including a subcontractor, to whom it provides confidential information received from, or created or received by the Contractor on behalf of Department agrees to the same restrictions and conditions that apply through this contract to the Contractor with respect to such Information.
- f. The Contractor agrees to provide access, at the request of Department, and in the time and manner as directed by Department, to an individual in order to meet the requirements under 45 CFR § 164.524.
- g. The Contractor agrees to make any amendment(s) to confidential information that the Department directs or agrees to pursuant to 45 CFR § 164.526 at the request of Department or an individual.
- h. The Contractor agrees to make internal practices, books, and records, including policies and procedures relating to the use and disclosure of confidential information received from, or created or received by the Contractor on behalf of the Department available to the Secretary of Health and Human Services, in a time and manner designated by the Secretary, for purposes of the Secretary determining Department's compliance with the Privacy Rule.
- i. The Contractor agrees to document any disclosures of confidential information and information related to such disclosures as would be required for Department to respond to a request by an individual for an accounting of disclosures of confidential information in accordance with 45 CFR § 164.528.
- j. The Contractor agrees to provide to Department or an individual information collected in accordance with this contract, to permit Department to respond to a request by an individual for an accounting of disclosures of confidential information in accordance with 45 CFR § 164.528.

Permitted Uses and Disclosures by the Contractor

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

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

Obligations of Department

- a. Department shall notify the Contractor of any limitation(s) in its notice of privacy practices of Department in accordance with 45 CFR § 164.520, to the extent that such limitation may affect the Contractor's use or disclosure of confidential information.
- b. Department shall notify the Contractor of any changes in, or revocation of, permission by an individual to use or disclose confidential information, to the extent that such changes may affect the Contractor's use or disclosure of confidential information.
- c. Department shall notify the Contractor of any restriction to the use or disclosure of confidential information that Department has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect the Contractor's use or disclosure of confidential information.

Permissible Requests by Department

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

a. Action upon Termination of the Contract

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

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

