



COMMONWEALTH of VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

600 East Broad Street, Suite 1300
Richmond, VA 23219

December 16, 2011

Dear Prospective Contractor:

The 2011 Acts of Assembly directed the Department of Medical Assistance Services (DMAS or the Department) to implement a coordinated care model for individuals in need of behavioral health services that are not currently provided through a managed care organization (Item 297, MMMM). The overall goals of this care coordination model are twofold: 1) improve the coordination of care for individuals receiving behavioral health services with acute and primary services; and 2) improve the value of behavioral health services purchased by the Commonwealth of Virginia without compromising access to behavioral health services for vulnerable populations.

Pursuant to this directive, the Department is soliciting a proposal for a Behavioral Health Services Administrator (BHSA) for members enrolled in Virginia's Medicaid/FAMIS Plus/FAMIS programs who are receiving behavioral health services that are not currently provided through a managed care organization, but through the fee for service system. Duties of the BHSA will include: strengthening behavioral health services in terms of increasing care coordination activities, authorizing, monitoring and encouraging appropriate behavioral health service utilization, effective program integrity activities, and paying claims. The qualified Contractor shall demonstrate exceptional provider relations and network recruitment/retention abilities, including proven strategies to: (1) provide clinical expertise and care coordination for individuals in need of behavioral health services; (2) maintain a network of behavioral health providers; (3) monitor member and provider satisfaction ratings; (4) effectively credential for participation of quality service providers; (5) assist with the development of a quality improvement strategy that will include the development and implementation of quality outcome measures, with outcomes reporting; and (6) work with DMAS and its contractors to administer the behavioral health services. The qualified Contractor shall also be responsible for behavioral health outreach and education activities. The BHSA must demonstrate effective utilization control and program integrity practices. The selected BHSA will handle enrollee and provider services issues; interface with the Virginia Medicaid Management Information System (VaMMIS); and, submit encounter data per established criteria outlined in this RFP. Specific details about this procurement are in the enclosed Request for Proposal (RFP) 2012-08.

The issuance of this RFP consisted of a two part process. The first step consisted of the issuance of a draft RFP for stakeholder comment for five (5) business days. This fulfilled the 2011 Appropriations Act (Item 297, MMMM(e)) requirement to develop a blueprint for behavioral health services not currently provided through a managed care organization. In the second step, comments received from stakeholders were taken into consideration as the RFP was developed and finalized.

The Commonwealth will not pay any costs that any Offeror incurs in preparing a proposal and reserves the right to reject any and all proposals received.

Potential Offerors are requested not to call this office. All issues and questions related to this RFP should be submitted in writing to the attention of Sandra Brown, Behavioral Health Manager, Policy and Research Division, 600 East Broad Street, Suite 1300, Richmond, VA 23219. In order to expedite the process of submitting inquiries, it is requested that vendors submit any questions or issues by email in MS Word format to RFP2012-08@dmas.virginia.gov no later than **2:00 P.M. EST on December 29, 2011.**

Offerors who wish to submit a proposal are required to submit a Letter of Intent which must be received by the Department no later than **2:00 P.M. EST on December 29, 2011.** The Letter of Intent may be filed electronically via e-mail or in hard copy. The prior submission of a Letter of Intent is a prerequisite for submitting a proposal; Proposals shall not be accepted from Offerors who have not submitted a Letter of Intent by the deadline specified above. Letters of Intent may be emailed to the address listed above with original hard copy to follow via USPS, overnight delivery or courier service. All Letters of Intent shall be addressed to:

Department of Medical Assistance Services
Attention: Christopher Banaszak
600 East Broad Street, Suite 1300
Richmond, VA 23219

Sincerely,
Christopher Banaszak
DMAS Contract Manager

Enclosure

**REQUEST FOR PROPOSALS
RFP 2012-08**

Issue Date: December 16, 2011

Title: Virginia Medicaid/FAMIS Plus/FAMIS Behavioral Health Services Administrator

Period of Contract: An initial period of three years from award of contract, with provisions for two twelve-month extensions.

All inquiries should be directed in writing via email in MS Word Format to: RFP2012-08@dmas.virginia.gov

Sandra R. Brown
Policy and Research Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Deadline for submitting inquiries and Letter of Intent: 2:00 P.M., EST, December 29, 2011

Proposal Due Date: Proposals will be accepted until **10:00 A.M., EST, January 27, 2012**

Submission Method: The proposal(s) must be sealed in an envelope or box and addressed as follows:

“RFP 2012-08 Sealed Proposal”
Department of Medical Assistance Services
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219
Attention: Christopher Banaszak

Facsimile Transmission of the proposal is not acceptable.

Note: This public body does not discriminate against faith-based organizations in accordance with the *Code of Virginia*, §2.2-4343.1 or against an Offeror because of race, religion, color, sex, national origin, age, disability, or any other basis prohibited by state law relating to discrimination in employment.

In compliance with this Request for Proposal and to all conditions imposed therein and hereby incorporated by reference, the undersigned proposes and agrees to furnish the services contained in their proposal.

Firm Name (Print)	F.I. or S.S. Number
Address	Print Name
Address	Title
City, State, Zip Code	Signature (Signed in Ink)
Telephone:	Date Signed
Fax Number:	E-Mail:
eVA Registration Vendor Number (Required):	eVA #:
State Corporation Commission ID Number (Required):(See Special Terms and Conditions)	SCC ID #:
Check Applicable Status: Corporation: _____ Partnership: _____ Proprietorship: _____ Individual: _____ Woman Owned: _____ Minority Owned: _____ Small Business: _____ If Department of Minority Business Enterprises (DMBE) certified, provide certification number: _____	

Submit this completed form with Technical Proposal under Required Forms

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
REQUEST FOR PROPOSALS
FOR
VIRGINIA MEDICAID/FAMIS Plus/FAMIS
BEHAVIORAL HEALTH SERVICES ADMINISTRATOR FOR THE MEDICAID AND FAMIS
PROGRAMS

DECEMBER 16, 2011

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RFP 2012-08 Virginia Behavioral Health Services Administrator

I. PURPOSE AND DEFINITIONS

The Department of Medical Assistance Services, hereinafter referred to as the Department or DMAS, is the single State agency in the Commonwealth of Virginia that administers the Medicaid program under Title XIX of the *Social Security Act* and the Virginia Child Health Insurance Program, known as the Family Access to Medical Insurance Security (FAMIS), under Title XXI of the *Social Security Act* for low-income people. These programs are financed by federal and state funds and administered by the state according to federal guidelines. Both programs include coverage of behavioral health services for eligible Medicaid and FAMIS members.

Behavioral health services are a Medicaid benefit for Medicaid members of all ages. Behavioral health services also are provided for members enrolled in Medicaid home-based and community-based service programs at the same amount, duration, and scope as covered for the Medicaid population. In addition, the Virginia State Plan for FAMIS, as provided for in the *Code of Virginia* § 32.1-320, as amended, includes provisions for coverage of select mental health and substance use services for FAMIS children. The Department is hereby soliciting proposals from qualified organizations through a competitive procurement process for a behavioral health services administrator (BHSA) to include comprehensive care coordination (including targeted case management); provider recruitment, network management, and training; member outreach and education; service authorization; utilization management; and reimbursement of behavioral health services that are currently provided for Title XIX Medicaid members of all ages and Title XXI FAMIS members who are in the fee for service system or for behavioral health services that are currently carved out of managed care. Behavioral health services also are provided for members enrolled in Medicaid home-based and community-based waiver programs at the same amount, duration, and scope as covered for the Medicaid population. A complete list of services is found in Section 2 of this RFP.

Number of Awards: An Offeror shall submit a proposal for statewide services only. The maximum number of contracts to be awarded under this RFP is one. Based on the proposals, DMAS is planning to select and enter into a contractual agreement with a qualified organization for the provision of behavioral health services in the Commonwealth.

Duration of Contract: The duration of the contract resulting from this RFP is three (3) years from award of contract. The Contract will be provided as an Administrative Services Only (ASO) Contract, which may be renewed by the Commonwealth upon written agreement of both parties for up to two (2) successive one-year periods, under the terms of the current contract, and at a reasonable time (approximately 90 days) prior to the expiration. The Department reserves the right to issue a request for proposal (RFP) which would move the BHSA to a full-risk Behavioral Health Organization (BHO) after the first three (3) years of this contract. The BHO RFP would be a separate procurement from this contract award.

General Scope of Responsibilities: The Commonwealth's goal is to improve the value of behavioral health services purchased by the Commonwealth of Virginia without compromising access to behavioral health services for vulnerable populations. The responsibilities of the BHSA, which are more fully described later in the RFP, include maintaining the Department's behavioral health provider network; monitoring member utilization of behavioral health services; handling service authorization requests; processing claims and submitting encounter data;

conducting provider and member outreach activities; handling member and provider services issues; quality outcomes and reporting; and interfacing with the Virginia Medicaid Management Information System (VaMMIS).

Current behavioral health providers will initially be grandfathered into the BHSA managed network. The Contractor shall submit a plan for credentialing and maintaining the behavioral health provider network based on licensure and DMAS regulatory requirements and geographical access needs, as well as through the use of quality outcome measures that will be developed and implemented with stakeholder input.

The Contractor selected in response to this RFP must be able to perform the services described in the RFP's Section 4 Technical Proposal Requirements, by July 1, 2012.

If there are changes to the services or type of services that are described within this RFP, the Contractor shall provide services as specified by the Department and DMAS reserves the right to negotiate the adjustment of payment under the contract resulting from this RFP. DMAS will notify the Contractor of any additional services and its projected impact on payment as soon as the Department has sufficient information to determine it has an impact on the Contractor.

In the event of changes to service authorization criteria for any of the services listed in this RFP or subsequently specified by DMAS, the Contractor shall provide services specified under this RFP utilizing the modified criteria and DMAS reserves the right to negotiate the adjustment of payments under this contract. DMAS will notify the Contractor of any change in criteria and its projected impact on payment as soon as the Department has sufficient information to determine it has an impact on the Contractor.

Enrollment

Table 1 below illustrates the total population of Medicaid/FAMIS Plus/FAMIS members under fee-for-service, PCCM and MCO programs for state fiscal years (SFYs) 2009 through 2012 (YTD).

Table 1

DMAS Enrollment Statistics ¹				
	SFY 09	SFY 10	SFY 11	SFY 12 ²
Total Enrolled in Medicaid³	721,456	796,024	850,622	873,884
Total Enrolled in Medicaid FFS	231,090	240,987	265,693	259,494
Total Enrolled in MEDALLION PCCM	52,477	55,663	54,057	0
Total Enrolled in Medallion II MCOs	437,889	499,375	530,872	614,389
Total Enrolled in FAMIS³	57,554	56,659	58,405	62,642
Total Enrolled in FAMIS FFS	6,490	7,067	6,485	4,846
Total Enrolled in FAMIS PCCM	1,155	1,084	1,252	0
Total Enrolled in FAMIS MCOs	49,909	48,508	50,668	57,796
Total Enrolled in Medicaid and FAMIS	779,010	852,684	909,027	936,525

Notes:

¹Reflects average monthly enrollment during the state fiscal year (7/1 - 6/30)

²Projected enrollment based on the November 2011 DMAS/DPB Enrollment Forecast.

³Medicaid in this context reflects individuals enrolled in the Title XIX Medicaid program and the XXI Medicaid Crossover program for children ages 6-9 between 100-133% FPL. FAMIS reflects enrollment in the stand alone Title XXI CHIP program for children above 133% FPL and FAMIS MOMS.

Fee-for-Service and Managed Care:

Overview

The Department provides Medicaid/FAMIS Plus and FAMIS coverage to individuals primarily through two delivery systems: managed care and fee-for-service (FFS). The Department oversees the development, implementation, and operation of the managed care and FFS programs.

Background of the Managed Care Organization (MCO) Program

DMAS' managed care program, Medallion II began January 1, 1996 in seven (7) Tidewater localities. The MCO program has expanded many times to include additional geographical areas and to include new populations and covered services. See the *Managed Care Coverage Map*; Attachment Ia to view the areas where MCOs currently participate and for chronological MCO program expansion information. For a more detailed history of the Department's Managed Care Program, visit the DMAS Managed Care webpage at http://dmasva.dmas.virginia.gov/Content_pgs/mc-home.aspx.

Managed Care Participation and Volume

The following MCO Partners serve the Medallion II and FAMIS programs: HealthKeepers, Inc. currently operating under Anthem HealthKeepers Plus, Inc., Optima Family Care by Optima Health Plan, CareNet Southern Health Services, Virginia Premier Health Plan, and Amerigroup Community Care. Majesticare will be a MCO Partner, effective July 1, 2012. MCO participation is currently based on operational regions and differs by locality. The operational regions control open enrollment timeframes as well as other operational aspects of the program.

Effective on January 1, 2012, managed care will expand into 5 localities that have previously been FFS (Alleghany, Bath, Highland, Craig, Covington). Also, new plans will be added to the Roanoke

region, effective July 1, 2012. There will be a total of six plans serving Virginia Medicaid and FAMIS members. For updates and additional information, please refer to the DMAS managed care website at http://dmasva.dmas.virginia.gov/Content_pgs/mc-home.aspx. Also, the managed care regions may be found on the DMAS website at http://dmasva.dmas.virginia.gov/Content_atchs/mc/mc-opn_enrl.pdf and managed care participation by locality at http://dmasva.dmas.virginia.gov/Content_atchs/mc/mc-mdl2_area.pdf.

Table 1 above illustrates coverage of all Medicaid and FAMIS individuals in 114 Virginia cities/localities. MEDALLION, a primary care case management program (PCCM), is located in 20 localities as the stand-alone managed care program and in 12 localities where only one MCO is contracted. The table below illustrates the number of Medicaid and FAMIS members participating in managed care and FFS for the past three (3) state fiscal years.

In the event of federal or State regulatory or program changes, or federally approved Medicaid waivers for Virginia that result in an increase or decrease in population, the Contractor shall provide services specified under this RFP to the impacted population and DMAS reserves the right to negotiate payment to the Contractor. DMAS also reserves the right to negotiate payment to the Contractor as a result of any increase or decrease in population due to federal or State regulatory changes, or federally approved Medicaid waivers for Virginia, such as the dual eligible pilot project or other managed care/care coordination initiatives described in Attachment VII. DMAS will notify the Contractor of any additions or deletions of programs and/or populations and its projected impact on payment as soon as the Department has sufficient information to determine it has an impact on the Contractor.

Coordination of Service Authorization for MCO Enrolled Individuals

The Contractor shall not be responsible for behavioral health services that are covered under the Department's MCO contracts. However, the Contractor must perform service authorization for MCO enrolled individuals for certain Medicaid, FAMIS Plus and FAMIS covered services *that are not covered under the MCO contract*. These services are generally referred to as MCO carved-out services and are detailed in Section 2 of this RFP.

Impact of Federal Health Reform on Enrollment and Eligibility of Individuals in Need of Behavioral Health Services

Under the federal health reform effort (The Patient Protection and Affordable Care Act (ACA), starting January 1, 2014, the Medicaid program will be expanded greatly and many if not most individuals with family incomes at or below 133 percent of the federal poverty level will be eligible for Medicaid. DMAS' initial estimate is that the monthly enrollment may increase by an additional 270,000 to 425,000.

In addition to the allowance under 6.2.2, the Department and the Contractor may enter into good faith negotiations and may agree upon revised payment terms to adjust to the change in member volume if the benefit package for newly eligible members includes non-traditional Medicaid behavioral health services. Data that resides at the Department will serve as the final authority for determination of member volume.

1.2 Definitions

The following terms when used in this RFP shall be construed and/or interpreted as follows, unless the context expressly requires a different construction and/or interpretation.

1. Abuse - (§ 37.2-100 of the Code of Virginia) means any act or failure to act by an employee or other person responsible for the care of an individual receiving services that was performed or was failed to be performed knowingly, recklessly, or intentionally, and that caused or might have caused physical or psychological harm, injury, or death to an individual receiving services. Examples of abuse include, but are not limited to, the following:
 - a. Rape, sexual assault, or other criminal sexual behavior;
 - b. Assault or battery;
 - c. Use of language that demeans, threatens, intimidates or humiliates the person;
 - d. Misuse or misappropriation of the person's assets, goods or property;
 - e. Use of excessive force when placing a person in physical or mechanical restraint;
 - f. Use of physical or mechanical restraints on a person that is not in compliance with federal and state laws, regulations, and policies, professional accepted standards of practice or the person's individual service plan;
 - g. Use of more restrictive or intensive services or denial of services to punish the person or that is not consistent with his individual service plan.
2. Acute Services – Medical or behavioral health services needed for an illness, episode, or injury that requires intensive care and hospitalization.
3. Administrative Costs and Services - All costs to the Contractor related to the administration of the activities required through this RFP. Costs of subcontractors engaged solely to perform a non-medical administrative functions for the Contractor specifically related to securing or fulfilling the Contractor's obligations to the Department under the terms of this RFP (including, but not limited to, service authorization, claims processing, postage, personnel, rent) are considered to be “administrative costs.”
4. Administrative Denial - A clinical supervisory reconsideration and review that renders adverse decisions based on complete absence of clinical information and/or other technical reasons as approved by the Department.
5. Administrative Rejection - Type of action that the Contractor takes on a submission request that is lacking key demographic information in order to review and process the request. The administrative rejection could also apply to a request received by the Contractor that should have been sent to one of the DMAS contracted managed care organizations.
6. Administrative Services Fee – The per member per month amount the Contractor shall charge for provision of the services outlined in this RFP.
7. Administrative Services Only Contract – An agreement with a third party administrator who agrees to provide administrative services to DMAS on an Administrative Services Fee basis. The Contractor will provide professional services for the administration of health care services in accordance with all DMAS regulations and requirements. DMAS funds the care costs associated with claim payments although the Contractor processes the claims.
8. Adverse Action – An action taken by the Contractor to deny, terminate, suspend, reduce services and/or date range(s) for services, or partially approve a covered service. The Contractor's failure to take action on a request for services within established timeframes is also an adverse action. “Adverse Action” and “Action” are used interchangeably.
9. Aid Category - A numerical identifier for the VaMMIS of the covered benefit group in which

- the person is enrolled.
10. Annually – For the purposes of contract reporting requirements, annually shall be defined as within 90 calendar days of the effective contract date.
 11. Appeal – A request made by a provider or member to review an adverse action taken by the Contractor to determine whether the action complied with the Medicaid laws, regulations, and/or policy. The appeal shall be governed by the Department’s regulations and any and all applicable laws and court orders.
 12. Behavioral Health Services Administrator (BHSA) - An entity that manages or directs a behavioral health benefits program on behalf of the program's sponsor. For the purposes of this RFP and resulting contract, the BHSA is responsible for administering the Department’s behavioral health benefits that are currently carved out of managed care on a statewide basis for Title XIX Medicaid members and Title XXI FAMIS and FAMIS Plus members to include care coordination, provider management, and reimbursement of such behavioral health services.
 13. Behavioral Health Services - An array of therapeutic and rehabilitation services provided in inpatient and outpatient psychiatric and community mental health settings. These services are designed to provide necessary support and address the special mental health and behavioral health needs in order to diagnose, prevent, correct, or minimize the adverse effect of a psychiatric or substance abuse disorder.
 14. Benefits - A schedule of behavioral health services to be administered by the Contractor to members pursuant to this RFP. This includes Covered Services.
 15. Business Days – Monday through Friday, 8:00 AM to 5:00 PM, Eastern Standard Time, unless otherwise stated.
 16. Care Coordination – The process of identification of patient needs and the development, implementation, monitoring, and revision (as necessary) of a plan of care to efficiently achieve the optimum quality patient outcomes in the most cost-effective manner.
 17. Care Coordinator - Any organization, provider or patient representative responsible for supervising, directing or managing the provision of initial and primary care to patients; for initiating and/or authorizing referrals for specialty care, and for monitoring the continuity of care based on patient clinical needs.
 18. Carved Out – A behavioral health service not covered under managed care.
 19. CFR – Code of Federal Regulations.
 20. Claim – An itemized statement requesting payment for services rendered by health care providers (such as hospitals, physicians, or other professionals, etc.), billed electronically or on the CMS 1500, and/or UB-92.
 21. Clean claim - A claim received by the Contractor for adjudication, and which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by the Contractor.
 22. CMS - Centers for Medicare and Medicaid Services, the federal Medicaid administrative agency.
 23. Community Service Board (CSB) - A citizens' board established pursuant to Virginia Code §37.2-500 and §37.2-600 which provides mental health, intellectual disabilities and substance abuse programs and services within the political subdivision or political subdivisions participating on the board. In all cases the term CSB also includes Behavioral Health Authority (BHA).
 24. Concurrent review - Encompasses aspects of patient management and care evaluation that occurs during the provision of services, such as at an inpatient level of care or during an ongoing outpatient course of treatment.
 25. Contract - The signed and executed document resulting from this RFP, which includes the terms of this RFP. The Contract shall also include the RFP, the winning Offeror's proposal and any modifications to the Contract.

26. Contract Modifications - Any changes to the Contract that are mutually agreed to in writing by the Contractor and the Department or are mandated by changes in Federal or State laws or regulations.
27. Contractor - The entity that contracts with the Department, pursuant to the Title XIX and XXI State Plans and in return for a payment, to process and pay claims for behavioral health services and to enhance the Department's capability for effective administration of the program.
28. Covered Service - Medically necessary behavioral health and case management services reimbursed through DMAS for Medicaid/FAMIS Plus and FAMIS members as described in Section 4 of the RFP.
29. DBHDS – The Department of Behavioral Health and Developmental Services.
30. Department - The Virginia Department of Medical Assistance Services.
31. Disenrollment - The discontinuance of a member's eligibility to receive covered services under the terms of this RFP, and deletion from the approved list of members furnished by the Department to the Contractor.
32. DMAS - The Department of Medical Assistance Services also referred to as “the Department” or “the Agency.”
33. DSS – Department of Social Services (LDSS refers to local Departments of Social Services.)
34. Eligible Person - Any person identified by the Department as meeting enrollment eligibility requirements to receive services and benefits under the Department's Program.
35. Emergency Behavioral Health Services (or Emergency Services) – Covered behavioral health services furnished by a qualified participating provider that are needed to evaluate or stabilize an emergency behavioral health condition that is found to exist using the prudent layperson standard. Services may be provided at the service provider's location or offsite with the member.
36. Emergency Medical Condition - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part.
37. Encounter – Any covered service received by a member and processed by the Contractor for payment.
38. Encryption – A security measure (process) involving the conversion of data into a format that cannot be interpreted by unauthorized parties.
39. Enrollment - The determination by a local department of social services or the FAMIS central processing unit of an individual's eligibility for Medicaid, FAMIS Plus or FAMIS and subsequent entry into VaMMIS.
40. EPSDT - The Early and Periodic Screening Diagnosis and Treatment services mandated by 42 U.S.C. § 1396d (e) and amended by OBRA 1989 for Medicaid enrolled individuals under age 21.
41. Facility – Any premises (a) owned, leased, used or operated directly or indirectly by or for the Contractor or its affiliates for purposes related to this RFP; or (b) maintained by a subcontractor to provide services on behalf of the Contractor. In regard to Medicaid covered programs, a facility may also be a place where services are rendered.
42. FAMIS Member - A person enrolled in the Department's FAMIS program who is eligible to receive behavioral health services under the State Child Health Insurance Plan under Title XXI, as amended.
43. FAMIS Plus Members – Children under the age of 19 who meet "medically indigent" criteria under Medicaid program rules, and who are assigned an aid category code of 90; 91 (under 6

years of age); 92 and 94. FAMIS Plus children receive the full Medicaid benefit package and have no cost-sharing responsibilities.

44. Federally Qualified Health Centers (FOHCs) - Those facilities as defined in 42 C.F.R. § 405.2401(b), as amended.
45. Federal Information Processing Standards Codes (FIPS codes) - A standardized set of numeric or alphabetic codes issued by the National Institute of Standards and Technology (NIST) to ensure uniform identification of geographic entities through all federal government agencies. The entities covered include: states and statistically equivalent entities, counties and statistically equivalent entities, named populated and related location entities (such as, places and county subdivisions), and American Indian and Alaska Native areas. Refer to the following link for the list of FIPS Codes. http://dmasva.dmas.virginia.gov/Content_atchs/pa/pa-fipscd.pdf
46. Fee-for-Service (FFS) - A method of making payment for health services based on a fee schedule that specifies payment amounts for defined services.
47. Fiscal Agent - A contracting organization which assumes all or part of the State Medicaid Agency's responsibilities with respect to claims processing, provider enrollment and relations, utilization review, and other functions. This is synonymous with Fiscal Intermediary.
48. Fiscal Year (State) - July 1 through June 30.
49. Fraud - As defined in 42 CFR 455.2, intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in payment of an unauthorized benefit. It includes any act that constitutes fraud under applicable Federal or State law.
50. FTE - Full time equivalent employment position.
51. Grievance - A complaint by a provider, member or member representative expressing dissatisfaction with the quality of services provided or authorized which may be reported to the Contractor or DMAS. A grievance does not constitute an appeal.
52. Health Insurance Portability & Accountability Act of 1996 (HIPAA) - Title II of HIPAA requires standardization of electronic patient health, administrative and financial data; unique health identifiers for individuals, employers, health plans, and health care providers, and security standards protecting the confidentiality and integrity of individually identifiable health information past, present, or future.
53. Home and Community-Based Waiver Services (HCBS) - The range of community support services approved by the Centers for Medicare and Medicaid Services (CMS) pursuant to §1915(c) of the Social Security Act to be offered to individuals who would otherwise require the level of care provided in an institutional setting. Virginia currently offers seven HCBS waiver programs and two demonstration projects: The AIDS Waiver; Alzheimer's Waiver; Day Support Waiver; Elderly and Disabled with Consumer Direction Waiver; Individual and Family Developmental Disabilities Support Waiver; Intellectual Disabilities Waiver; Technology Assisted Waiver; Children's Mental Health Waiver (Demonstration); and the Money Follows the Person Demonstration.
54. Inpatient Services - Services provided in a hospital setting to include Inpatient Medical/Surgical/Psychiatric and Intensive Inpatient Rehabilitation services. Reimbursement for inpatient medical/surgical services is based on the current 3M Company's "All Patient Diagnostic Related Groupings" (AP DRGs).
55. Inquiry - An oral or written communication by or on the behalf of a member that may be: 1) questions regarding the need for additional information about eligibility, benefits, plan requirement or materials received, etc.; 2) provision of information regarding a change in the member's status such as address, family composition, etc. or; 3) a request for assistance such as selecting or changing a provider, obtaining translation or transportation assistance, obtaining access to care, etc. Inquiries are not expressions of dissatisfaction.
56. Investigational/Experimental - Any medical procedure or treatment that does not have

sufficient evidence to establish improved clinical outcomes and effectiveness has not been proven

57. Length of Stay (LOS) - the total number of days a patient is in a Medicaid covered service. Acute Medical/Surgical hospital admissions do not use length of stay since they are reimbursed with DRGs.
58. Level of Care - The urgency and frequency of a particular service that will best meet the clinical needs of a member, based on their assessment.
59. Liquidated Damages - A dollar amount stipulated in this contract and determined by DMAS that would be owed to DMAS in the event of a breach by the Contractor.
60. "Licensed mental health professional" or "LMHP" - Means a licensed physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, a registered psychiatric clinical nurse specialist, or a licensed psychiatric nurse practitioner. An LMHP-E is a person who has been approved by the applicable Virginia health regulatory board as a supervisee in clinical social work or a resident in clinical psychology, professional counseling, substance abuse treatment practice, or marriage and family therapy may perform the functions of the LMHP for purposes of Medicaid reimbursement provided such supervisee or resident is in continuous compliance with the applicable board's requirements for supervised practice. For purposes of Medicaid reimbursement, these persons shall use the title "Supervisee" or "Resident" in connection with the applicable profession after their signatures to indicate such status. An individual may not perform the functions of the LMHP or be considered a "Supervisee" or "Resident" until the supervision for specific clinical duties at a specific site is pre-approved in writing by the appropriate Virginia health regulatory board. See Emergency Regulations amending 12VAC30-50-130, 12VAC30-50-226.
61. Managed Care Organization (MCO) - An organization that has an executed agreement with the Virginia Department of Health that offers managed care health insurance plans (MCHIP), as defined by Virginia Code § 38.2-5800, (an arrangement for the delivery of health care in which a health carrier undertakes to provide, arrange for, pay for, or reimburse any of the costs of health care services). For the purposes of this Contract, and in accordance with 42 CFR 438.2, means an entity that has qualified to provide the services covered to qualifying Medallion II and Medicaid/FAMIS Plus members within the area served, and meets the solvency standards of 42 CFR 438.116.
62. Mandated Reporters - Mandated reporters are certain professionals and health care providers that are required by law to report suspected abuse, neglect or maltreatment as defined in Sections 63.2-1606 A and 63.2-1509 of the *Code of Virginia*. All professional staff must be trained annually as mandated reporters.
63. Marketing - Any activity conducted by or on behalf of the Contractor where information regarding the services offered by the Contractor is disseminated in order to persuade eligible persons to utilize their covered behavioral health services and to be aware of the services offered by the Contractor pursuant to this RFP.
64. MEDALLION Program - A mandatory primary care case management program (PCCM) delivered through DMAS where a member's health care is managed by a primary care provider (PCP) and providers are reimbursed by DMAS on a fee-for-service basis for all covered services rendered and the PCP is reimbursed \$3 per member per month (PMPM).
65. Medallion II Program - A fully capitated, risk-based, mandatory Medicaid/FAMIS Plus managed care program in which qualified Medicaid/FAMIS Plus members choose between at least two contracted Managed Care Organizations; the contracted MCO receives a capitated PMPM payment that covers a comprehensive set of services, regardless of how much care is used by the member.

66. Medicaid Expansion – A Child age 6 years to 19 years with family income between 100% to 133% of the federal poverty limit who is uninsured and is enrolled in the program under aid category 94. The Medicaid Expansion program is funded by Title XXI funds.
67. Medicaid Management Information System (MMIS) - The medical assistance eligibility, enrollment, and payment information system of the Virginia Department of Medical Assistance Services (also referred to as VaMMIS).
68. Medical Necessity – An item or service provided for the diagnosis or treatment of a patient’s condition consistent with practice standards set forth for each service and in accordance with Medicaid regulations.
69. Medically Necessary – In the context of behavioral health, services or supplies provided by an institution, physician, or other provider that are required to identify or treat a member’s illness, disease, or injury.
70. Medical (Health) Record - A complete record maintained in a single patient file and kept at the site of the member's treatment(s), which documents all of the treatment plans developed, medical/health services ordered for the member and medical/health services received by the member.
71. Member – An individual having current Medicaid/FAMIS Plus or FAMIS eligibility who shall be authorized by the Department to receive behavioral health services.
72. Member Funding Category – For the purposes of this RFP, member funding categories shall include Medicaid Children under age 21, FAMIS Plus and Medicaid Expansion children (member aid category 94), FAMIS members, and Medicaid adults age 21 and over. Eligible Medicaid, FAMIS Plus, Medicaid Expansion, and FAMIS children categories make up the pediatric PMPM rate category. (See Section 6.2 of this RFP.)
73. Monthly – For the purposes of contract reporting requirements, monthly shall be defined as the 15th day of each month for the prior month’s reporting period. For example, January’s monthly reports are due by February 15th; February’s are due by March 15th, etc.
74. Network Provider - The health care entity or health care professional who is either employed by or has executed a provider agreement with the Department through the Contractor, or its subcontractor, to render covered services, as defined in this Contract.
75. Non-Contract Provider - Any person, organization, agency, or entity that is not directly or indirectly employed by or through the Contractor or any of its subcontractors pursuant to the RFP between the Contractor and the Department.
76. Offeror - The entity that seeks to contract with the Department and submits a proposal in response to this RFP.
77. Out-of-Plan Services - Services provided by a non-contract provider and paid at the established Medicaid rate.
78. Outpatient Services - Services that are provided in the home or community setting and to members who are able to return home after care without an overnight stay in a hospital or other inpatient facility.
79. Participating Provider - An institution, facility, agency, person, corporation, partnership, or association enrolled by the Department which accepts as payment in full for providing benefits the amounts paid pursuant to a provider agreement with the Department.
80. Patient Protection and Affordable Care Act (PPACA) - The federal health reform legislation enacted March 23, 2010 which will expand the Medicaid program, and reauthorizes the CHIP program through September 30, 2015, among many other provisions.
81. Plan of Care - Documents addressing needs in all life areas. Plan of care is comprised of an individualized, person-centered plan for services as dictated by the persons' health care and support needs within a particular level of care.
82. Post Payment Review - A process administered by the Contractor to provide review after service has been provided and payment has been made.

83. Primary Care Physician/Provider - A physician or nurse practitioner practicing in accordance with state law who is responsible for supervising, coordinating, and providing initial and primary medical care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care. A primary care physician is a generally a physician who has limited his practice of medicine to general practice or who is a Board Certified or Eligible Internist, Pediatrician, Obstetrician/Gynecologist, or Family Practitioner.
84. Protected Health Information (PHI) - Individually identifiable information, including demographics, which relates to a person's health, health care, or payment for health care. HIPAA protects individually identifiable health information transmitted or maintained in any form or medium.
85. Provider Agreement - An agreement between a Behavioral Health Services Administrator (BHSA), DMAS and a provider which describes the conditions under which the provider agrees to furnish covered services to DMAS' members. All provider agreements between the BHSA and a provider must be approved by DMAS.
86. Provider Class Type - A numeric code assigned to each Virginia Medicaid provider during the provider application and approval process. Each Medicaid covered service must be rendered by a provider with the specific provider class type and specialty code for that service, in order to be reimbursable. Many services have different authorization and reimbursement rules for out-of-state providers, as indicated by the provider class type and DMAS policy. Some out-of-state providers/facilities may be assigned an in-state provider class type for purposes of service authorization and billing. These providers/facilities are treated as *in-state* providers for those services.
87. Quality Monitoring (QM) - The ongoing review of assuring that the delivery of health care is appropriate, timely, accessible, available, and medically necessary and in keeping with established guidelines and standards and reflective of the current state of medical and behavioral health services standards.
88. Quarterly - For the purposes of contract reporting requirements, quarterly shall be defined as within 30 calendar days after the end of each quarter, unless otherwise specified by the Department.
89. Quarters - Calendar quarters starting on January 1, April 1, July 1, and October 1.
90. Referral - A request by a provider for a member to be evaluated and/or treated by a different physician, usually a specialist.
91. Registration - The process of notifying the department or its agent of the initiation of a behavioral health service, to include information regarding the evaluation findings and plan of treatment, which may serve in lieu of authorization if the service is one which has been designated by the Department as requiring registration only.
92. Secure Email - The generic term that usually applies to sensitive email being passed over the Internet in some form of encrypted format.
93. Semi-Annually - For the purpose of contract reporting requirements, semi-annually shall be defined as no later than 30 calendar days after the end of the six-month time frame.
94. Serious Emotional Disturbance - Serious Emotional Disturbance means a serious mental health problem that affects a child, age birth through 17, and can be diagnosed under the current edition of the Diagnostic and Statistical Manual of Mental Disorders or meets the following specific functional criteria. The child has problems in personality development and social functioning that have been exhibited over at least one year's time; problems that are significantly disabling based on social functioning of most children of the child's age; problems that have become more disabling over time, and service needs that require significant intervention by more than one agency.
95. Services - See covered service.
96. Service Authorization - The act of authorizing specific services or activities before they are rendered or activities before they occur (formerly called prior authorization).

97. Service Location - Any location at which a member obtains any behavioral health care service covered by the Contractor pursuant to the terms of this RFP.
98. Shall - Indicates a mandatory requirement or a condition to be met.
99. State - Commonwealth of Virginia.
100. State Plan for Medical Assistance (State Plan) - The comprehensive written statement submitted by the Department to CMS for approval, describing the nature and scope of the Virginia Medicaid program and giving assurance that it will be administered in conformity with the requirements, standards, procedures and conditions for obtaining Federal financial participation. The Department has the authority to administer the State Plan for Virginia under Code of Virginia § 32.1-325, as amended.
101. Subcontract - An agreement entered into by the Contractor with any other organization or person who agrees to perform any administrative function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to the Department under the terms of this RFP, (e.g., claims processing, marketing) when the intent of such an agreement is to delegate the responsibility for any major service or group of services required by this RFP. Agreements to provide covered services as described in Attachment IIa of this RFP shall be considered Provider Agreements and governed by 4.8 of this RFP.
102. Subcontractor - Any DMAS approved organization or person who provides any function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to the Department under the terms of this RFP.
103. Third Party Resource - Any entity or funding source other than the member or his/her responsible party, which is or may be liable to pay for all or part of the cost of medical/behavioral health care of the member.
104. Third Party Liability - Any amount due for all or part of the cost of medical care from a third party.
105. Utilization Management - The process of evaluating the necessity, appropriateness and efficiency of health care services against established guidelines and criteria.
106. Vendor - One who sells goods or services.
107. Virginia Administrative Code (VAC) - Contains regulations of all of the Virginia State Agencies.

2. BACKGROUND

Virginia Medicaid covers a range of behavioral health services. Services range from acute inpatient services to community-based services and case management. A description of services and limitations can be found in the Psychiatric Services, Mental Health Clinic, and Community Mental Health Rehabilitative Services Manuals. These manuals can be found online at <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManuals>.

Covered services include traditional and non-traditional behavioral health services. Traditional mental health and substance abuse services are commonly provided by commercial insurers. These services include inpatient acute psychiatric hospital care and physician and licensed professional services (outpatient individual, family, and group therapy). Non-traditional mental health and substance abuse services are services that are generally not provided by commercial plans. These services are geared to individuals with chronic mental illness, many of whom may have a disability and may not be employed. Non-traditional services are rehabilitative in nature and are geared towards this population. Some examples of non-traditional services include but not limited to residential treatment, intensive in-home services, therapeutic day treatment services and mental health support services. (See Section 4.5.2 of this RFP for additional types of covered non-traditional services.)

Medicaid/FAMIS/FAMIS Plus members who are in FFS receive and who receive traditional and non-traditional mental health and substance abuse treatment services from the FFS system will be the responsibility of the BHSA. DMAS will continue to be responsible for pharmacy services for these members.

Medicaid/FAMIS/FAMIS Plus members who are enrolled in a MCO will continue to receive traditional mental health services and pharmacy from the MCO. Non-traditional mental health and substance abuse treatment services will be the responsibility of the BHSA.

Summary of Services

Providers who have the appropriate licensure and qualifications may provide the services below. The exception is for “targeted case management services” for members receiving mental health targeted case management services (care coordination Level Two), which are restricted to Community Service Board/Behavioral Health Authority providers. Please refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations. Please refer to Attachment IIa of this RFP for identification coding for services listed below.

A. Community Mental Health & Substance Abuse Rehabilitative Services (State Plan Option Services)

1. Crisis Intervention (A.1) - Defined as immediate mental health care, available 24 hours a day, seven days a week, to assist individuals who are experiencing acute mental dysfunction requiring immediate clinical attention such as individuals who are a danger to themselves or others. This service’s objective is to prevent exacerbation of a condition, to prevent injury to the consumer or others, and to provide treatment in the context of the least restrictive setting. Crisis intervention includes assessing the crisis situation, providing short-term counseling designed to stabilize the individual and/or family unit, providing access to further immediate assessment and follow-up, and linking the individual and family unit with ongoing care to prevent future crises. Crisis intervention activities are limited to 180 hours annually and may include office visits, home visits, pre-admission screenings, telephone contacts, and other client-related activities for the prevention of institutionalization.

Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual, and the State Plan for Medical Assistance Services at 12VAC30-50-226.

2. Crisis Stabilization (A.2) - Is provided to non-hospitalized individuals experiencing an acute psychiatric crisis that may jeopardize their current community living situation. The goals are to avert hospitalization, provide normative environments with a high assurance of safety and security for crisis intervention, stabilize individuals in psychiatric crisis, and mobilize the resources of the community support system and family members and others for on-going maintenance and rehabilitation. The service is limited to 8 hours per day for up to 15 consecutive days in each episode, up to 60 days annually.

Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual, and the State Plan for Medical Assistance Services at 12VAC30-50-226.

3. Day Treatment/Partial Hospitalization Services for Adults (A.3) - Sessions of two or more consecutive hours per day are provided. Sessions may be scheduled multiple times per week, to groups of individuals in a nonresidential setting. These services include the major diagnostic, medical, psychiatric, psychological, and psycho-educational treatment modalities designed for individuals with serious mental disorders. The day treatment center could be attached to a psychiatric hospital or CSB clinic site. Services are for adults with a serious mental health disorder and goal is to keep them out of a psychiatric hospital.

Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual and the State Plan for Medical Assistance Services at 12VAC30-60-61, 12VAC30-50-226.A.

4. Intensive Community Treatment, or ICT (A.4) - Is an array of mental health services for adults with serious emotional illness who need intensive levels of support and service in their natural environment to permit or enhance functioning in the community. ICT is provided through a designated multi-disciplinary team of mental health professionals. It is available 24 hours per day. There is a service limit of 130 hours annually. Mental Health Clinic, crisis stabilization or targeted case management may not be billed concurrently with this service.

Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual and the State Plan for Medical Assistance Services at 12VAC30-50-226 and 12VAC30-60-143.

5. Intensive In-home Services for Children and Adolescents under age 21, or IIH (A.5) - Time-limited interventions provided typically, but not solely, in the residence of an individual who is at risk of being moved into an out-of-home placement or who is being transitioned to home from out-of-home placement due to a disorder identified in the Diagnostic and Statistical Manual of Mental Disorders-IV-TR (DSM-IV-TR). These services provide crisis treatment; individual and family counseling; parenting (e.g., counseling to assist parents to understand and practice proper behavior management, etc.), and communication skills; case management activities and coordination with other required services. Services are limited to 26 weeks annually. Authorization is required for Medicaid reimbursement.

Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual and the State Plan for Medical Assistance Services at 12VAC30-50-130 and 12VAC30-60-61.

6. Mental Health Targeted Case Management (A.6) - Case management services assist individual children, adolescents, adults and their families in accessing needed medical, psychiatric, social educational, vocational, and other supports essential to meeting basic needs. Services are provided to the following target groups:
 - a) Seriously/Chronically Mentally Ill (Adults 18 years or older)
 - b) Serious Emotional Disturbance (Birth through 17 years old)
 - c) Youth at Risk of Serious Emotional Disturbance (Birth <7 years old)

Services include assessment and planning services, linking the individual to services and supports, assisting the individual in obtaining services, coordination services, follow-up and monitoring. These services are limited to Community Services Boards or their subcontractors.

Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual and the State Plan for Medical Assistance Services at 12VAC30-50-420 and 12VAC30-50-430.

7. Mental Health Support Services (A.7) - Training and supports to enable individuals to achieve and maintain community stability and independence in the most appropriate,

least restrictive environment. Authorization is required for Medicaid reimbursement. These services may be authorized for six consecutive months. This program shall provide the following services in order to be reimbursed by Medicaid: training in or reinforcement of functional skills and appropriate behavior related to the individual's health and safety, activities of daily living, and use of community resources; assistance with medication management; and monitoring health, nutrition, and physical condition.

Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual and the State Plan for Medical Assistance Services at 12VAC30-50-226.

8. Opioid Treatment (A.8) - Services that are similar to Substance Abuse Day Treatment, but it is provided to persons with Opioid dependence and who need medication to prevent withdrawal.

Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual and the State Plan for Medical Assistance Services at 12VAC30-50-228.

9. Psychosocial Rehabilitation (A.9) - (“Clubhouse Model”) for the severely mentally ill. Psychosocial rehabilitation is provided in sessions of two or more consecutive hours per day to groups of individuals in a nonresidential setting. These services include assessment, medication education, psycho-education, opportunities to learn and use independent living skills and to enhance social and interpersonal skills, family support, and/or education within a supportive and normalizing program structure and environment. The primary interventions are rehabilitative in nature. Staff may observe medication being taken, watch and observe behaviors and note side effects of medications. These services are limited to 936 units annually.

Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual, and the State Plan for Medical Assistance Services at 12VAC30-50-226.

10. Residential Substance Abuse Treatment for Pregnant and Post Partum Women (A.10) – Services are for pregnant and postpartum women with serious substance abuse problems for the purposes of improving the pregnancy outcome, treating the substance abuse disorder, strengthening the maternal relationship with existing children and the infant, and achieving and maintaining a sober and drug-free lifestyle. The member's care is supervised by a nurse case manager. The member must agree to actively participate in her care. Services provided are substance abuse rehabilitation, counseling, and treatment, pregnancy and fetal development education, symptom and behavior management, and personal health care training. There is a limit of 330 days of continuous treatment, once per lifetime, not to exceed 60 days postpartum. No reimbursement for any other Community Mental Health/Mental Retardation/Substance Abuse rehabilitative services are available while the member is participating in the program.

Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual and the State Plan for Medical Assistance Services at 12VAC30-50-510.

11. Substance Abuse Targeted Case Management (A.11)- Assists children, adults, and their families with accessing needed medical, psychiatric, substance abuse, social, educational, vocational services and other supports essential to meeting basic needs. The Medicaid eligible member shall meet the *Diagnostic and Statistical Manual of Mental Disorders*,

Fourth Edition, Text Revision (DSM-IV-TR) diagnostic criteria for an Axis I substance-related disorder. Nicotine or caffeine abuse or dependence is not covered.

Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual and the State Plan for Medical Assistance Services at 12VAC30-50-491.

12. Substance Abuse Crisis Intervention (A.12) - Substance abuse treatment services, available 24 hours a day, seven days per week, to provide assistance to individuals experiencing acute dysfunction related to substance use which requires immediate clinical attention. The objectives are to prevent exacerbation of a condition; and injury to the member or others; and to provide treatment in the least restrictive setting. Crisis intervention services are provided following a marked reduction in the member's psychiatric, adaptive, or behavioral functioning or an extreme increase in personal distress.

Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual and the State Plan for Medical Assistance Services at 12VAC30-50-420, 12VAC30-50-430 and 12VAC30-50-228.

13. Substance Abuse Day Treatment (A.13) - Services of two or more consecutive hours per day, which may be scheduled multiple times per week and provided to groups of individuals in a non-residential setting. The minimum number of service hours per week is 20 hours with a maximum of 30 hours per week. Substance abuse day treatment may not be provided concurrently with IOP or Opioid treatment services.

Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual and the State Plan for Medical Assistance Services at 12VAC30-50-228.

14. Substance Abuse Day Treatment for Pregnant and Post Partum Women (A.14) - Comprehensive intensive services in a central location lasting two or more consecutive hours per day, which may be scheduled multiple times per week for pregnant and postpartum women with serious substance abuse problems for the purposes of improving the pregnancy outcome, treating the substance abuse disorder, strengthening the maternal relationship with existing children and the infant, and achieving and maintaining a sober and drug-free lifestyle. Only mental health crisis intervention services or mental health crisis stabilization may be reimbursed for members of day treatment services. A billing unit is equal to a minimum of two hours, but less than four hours. There is a limit of 440 units in a 12 month, consecutive period, once in a lifetime, not to exceed 60 days postpartum.

Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual and the State Plan for Medical Assistance Services at 12VAC30-50-510.

15. Substance Abuse Intensive Outpatient Treatment (A.15) - Services two or more consecutive hours per day, which may be scheduled multiple times per week and provided to groups of individuals in a non-residential setting. The maximum number of service hours per week is 19 hours per week. This service should be provided to those members who do not require the intensive level of care of inpatient, residential, or day treatment services, but require more intensive services than outpatient services. The

maximum annual limit is 600 hours. Intensive outpatient services may not be provided concurrently with day treatment services or Opioid treatment Services.

Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual and the State Plan for Medical Assistance Services at 12VAC30-50-228.

16. Therapeutic Day Treatment for Children and Adolescents (A.16) - Therapeutic interventions are provided in sessions of two or more hours per day, to groups of seriously emotionally-disturbed children and adolescents or children at risk of serious emotional disturbance. The service may be provided in the school setting or in an offsite program. Day treatment programs provide evaluation; medication education and management; opportunities to learn and use daily living skills and to enhance social and interpersonal skills (e.g., problem-solving, anger management, community responsibility, increased impulse control, and appropriate peer relations, etc.); and individual, group, and family counseling. Day treatment services are limited to 780 units annually (one unit in day treatment equals at least two hours but less than three hours). Authorization is required for Medicaid reimbursement.

Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual and the State Plan for Medical Assistance Services at 12VAC30-50-130 and 12VAC30-60-61.

17. Temporary Detention Orders (TDO) (A.17) - A TDO is an order issued by a magistrate for a person who is in imminent danger to themselves or others as a result of mental illness or is so seriously mentally ill to care for self and is incapable or unwilling to volunteer for treatment.

The TDO's time duration shall not exceed 48 hours prior to a commitment hearing unless the 48 hours terminates on a Saturday, Sunday, legal holiday or there is an unusual circumstance. The hearing must be held on the next workday. Coverage and reimbursement is provided to the facility and for physician services provided that relates to emergency medical or psychiatric care. Medical screenings or services provided that do not relate to the mental illness are excluded from coverage.

Service criteria for TDOs as an inpatient acute hospitalization are described in detail in the Hospital Manual.

B. Residential Treatment

1. Community-Based Residential Services for Children and Adolescents Under 21 – Level A (B.1) - Is a combination of therapeutic services rendered in a residential setting. This residential service provides structure for daily activities, psycho-education, and therapeutic supervision and activities to ensure the attainment of therapeutic mental health goals, as identified in the treatment plan. The child/adolescent must also receive psychotherapy services in addition to the therapeutic residential services. Room and board costs are not included in the reimbursement for this service. Only programs/facilities with 16 or fewer beds are eligible to provide this service. This service does not include interventions and activities designed only to meet the supportive non-mental health special needs, including but not limited to personal care, habilitation, or academic-educational needs of the member.

Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual, and the State Plan for Medical Assistance Services at 12VAC30-50-130 and 12VAC30-60-61.

2. Therapeutic Behavioral Services - Level B (B.2) - Community-Based Residential Services for Children and Adolescents under age 21 are a combination of therapeutic services rendered in a residential setting. This residential service provides structure for daily activities, psycho-education, and therapeutic supervision and activities to ensure the attainment of therapeutic mental health goals, as identified in the treatment plan. The child/adolescent must also receive psychotherapy services in addition to the therapeutic residential services. Room and board costs are not included in the reimbursement for this service. Only programs/facilities with 16 or fewer beds are eligible to provide this service. This service does not include interventions and activities designed only to meet the supportive non-mental health special needs, including but not limited to personal care, habilitation, or academic-educational needs of the member.

Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual, and the State Plan for Medical Assistance Services at 12VAC30-50-130 and 12VAC30-60-61.

3. Freestanding Hospital and Residential Treatment Facility Under Age 21 – Level C (B.2) are available in a freestanding hospital and in residential treatment facilities for individuals under 21 whose need for services is identified through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Certification of the need for admission by an independent team is required for any member requesting admission to a freestanding, psychiatric facility. Level C Residential Services must be medically necessary and service authorization is required.

Service criteria are described in detail in the Psychiatric Services Manual and the State Plan for Medical Assistance Services at 12VAC30-50-130 and 12VAC30-130-50-850 et. Seq.

- C. **Treatment Foster Care Case Management (C)**- Children under 21 years of age in treatment foster care who are seriously emotionally disturbed or have behavioral disorders. Case managers coordinate specialized services to children and their foster families.

Service criteria are described in detail in the Psychiatric Services Manual, and the State Plan for Medical Assistance Services at 12VAC30-50-480, 12VAC30-60-170, and 12VAC30-130-900 et seq.

D. Inpatient Psychiatric Hospital Services

1. General Acute Care Hospital (D.1) - Provided in psychiatric units of general hospitals for all age groups and if the patient is under 21 years of age, can be provided in State or private, free-standing psychiatric facilities. Federal law prohibits admission to freestanding psychiatric facilities for members over the age of 21. FAMIS fee-for-service patients can receive these services in psychiatric units of general hospitals, but are not covered in State or private, freestanding psychiatric facilities. Authorization is required for Medicaid reimbursement. Inpatient psychiatric services are reimbursed on a per diem basis and concurrent review of medical necessity is required for all covered days. The provider must contact the Contractor to conduct concurrent or on-going review. Review will continue in this manner until the member is discharged.

Service criteria are described in detail in DMAS' Psychiatric Services Manual, and the State Plan for Medical Assistance Service at 12VAC 30-50-100.

2. Freestanding Psychiatric Hospital Services (D.2) – Inpatient care may be provided in psychiatric units of general hospitals for all age groups. If the patient is under 21 years of age, inpatient care can be provided in State or private, free-standing psychiatric facilities. Federal law prohibits admission to freestanding psychiatric facilities for members over the age of 21. FAMIS fee for service patients can receive these services in psychiatric units of general hospitals, but are not covered in State or private, freestanding psychiatric facilities. Authorization is required for Medicaid reimbursement. Inpatient psychiatric services are reimbursed on a per diem basis and concurrent review of medical necessity is required for all covered days. The provider must contact the Contractor to conduct concurrent or on-going review. Review will continue in this manner until the member is discharged.

Service criteria are described in detail in DMAS' Psychiatric Services Manual, and the State Plan for Medical Assistance Service at 12VAC 30-50-100.

- E. Outpatient Psychiatric Services (E)** - Outpatient psychiatric services are provided in a practitioner's office, mental health clinic, patient's home, hospital or skilled nursing facility. Outpatient Psychiatric services are limited to an initial availability of 26 sessions without Service authorization during the first treatment year. If the member is in need of services beyond the initial 26 sessions in the first treatment year, up to an additional 26 sessions may be authorized. Each subsequent year of treatment may not exceed 26 sessions and must be authorized by the Contractor. If the service limit is met for children under the age of 21, additional sessions may be available when medically necessary, through EPSDT. The Contractor will automatically perform the EPSDT review in its operational workflow.

Service criteria are described in detail in DMAS' Psychiatric Services Manual, Chapter IV, and the State Plan for Medical Assistance Service at 12VAC 30-50-140, 12VAC 30-50-150 and 12VAC 30-50-110.

- F. Outpatient Substance Abuse Services (F)** - Outpatient substance abuse services are provided in a practitioner's office, mental health clinic, patient's home, hospital or skilled nursing facility. Psychiatric services are limited to an initial availability of 26 sessions without authorization during the first treatment year. If the member is in need of services beyond the initial 26 sessions in the first treatment year, up to an additional 26 sessions may be authorized. Each subsequent year of treatment may not exceed 26 sessions and must be authorized by the Contractor. If the service limit is met for children under the age of 21, additional sessions may be available when medically necessary, through EPSDT. The Contractor will automatically perform the EPSDT review in its operational workflows.

Service criteria are described in detail in the Psychiatric Services Manual, and the State Plan for Medical Assistance Services at 12VAC30-50-141.

- G. EPSDT Covered Services** - EPSDT is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. Federal law (42 CFR § 441.50 et seq) requires a broad range of outreach, coordination, and health services under EPSDT distinct from general state Medicaid program requirements. Any treatment service which is not otherwise covered under the State Plan for Medical Assistance can be covered for a child through EPSDT as long as the service is allowable under the Social Security Act Section 1905(a) and the service

is determined by DMAS or a DMAS designated contractor as medically necessary. Reimbursement for EPSDT services is limited to the hours of treatment and medical or clinical supervision as specified in the treatment plan and as approved by the Contractor. All specialized service requests require physician documentation outlining the medical necessity, frequency and duration of the treatment. To qualify for reimbursement through the EPSDT program all EPSDT services must be approved before the service is rendered by the provider. The only exception to this requirement is in cases of retroactive Medicaid eligibility.

Medicaid requirements for the coverage of services under the EPSDT program can be found in 12VAC30-50-130.B.

Utilization & Expenditures

Table 2 summarizes Virginia Medicaid Behavioral Health utilization and expenditure data. Reference Attachment IIa of this RFP for more detailed utilization and expenditure data by individual service category. The summary data shows that in state fiscal year (SFY) 2011 almost 112,000 Medicaid/FAMIS Plus/FAMIS members received behavioral health services. This reflects a 17% increase in the number of individuals utilizing behavioral health services between state fiscal year 2009 to fiscal year 2011, however the proportion of the total population utilizing these services remains approximately 12%. Expenditures for these services have increased correspondingly, from \$620 million in SFY 2009 to \$742 million in SFY 2011.

Table 2: Virginia Behavioral Health Services Utilization & Expenditures

	SFY 2009	SFY 2010	SFY 2011
Number of Individuals Receiving Behavioral Health Services	95,836	107,128	111,975
Total Medicaid/FAMIS Population	779,010	852,684	909,027
Proportion of Total Population Receiving Behavioral Health Services	12.3%	12.6%	12.3%
Annual Expenditures for Behavioral Health Services	\$620,420,447	\$713,827,704	\$742,215,504

A breakdown of behavioral health service expenditures for traditional services is located in Attachment XVII.

2.1 Directives from the General Assembly and Stakeholder Involvement

The 2011 Acts of Assembly directed DMAS to implement a coordinated care model for individuals in need of behavioral health services that are not currently provided through a managed care organization (Item 297, MMMM). The overall goals of this care coordination model are twofold: 1) improve the coordination of care for individuals receiving behavioral health services with acute and primary services; and 2) improve the value of behavioral health services purchased by the Commonwealth of Virginia without compromising access to behavioral health services for vulnerable populations. Stakeholders were included in the development of the budget language.

Principles were developed to guide the implementation of the coordinated care model (see Attachment VII.) The principles, derived from the budget language, are described below:

- 1. Improves value so that there is better access to care while improving equity.*
- 2. Engages consumers as informed and responsible partners from enrollment to care delivery.*
- 3. Provides consumer protections with respect to choice of providers and plans of care.*
- 4. Improves satisfaction among providers and provides technical assistance and incentives for quality improvement.*
- 5. Improves satisfaction among consumers by including consumer representatives on provider panels for the development of policy and planning decisions.*
- 6. Improves quality, individual safety, health outcomes, and efficiency.*
- 7. Develops direct linkages between medical and behavioral services in order to make it easier for consumers to obtain timely access to care and services, which could include up to full integration.*
- 8. Builds upon current best practices in the delivery of behavioral health services.*
- 9. Accounts for local circumstances and reflects familiarity with the community where services are provided.*
- 10. Develops service capacity and a payment system that reduces the need for involuntary commitments and prevents default (or diversion) to state hospitals.*
- 11. Reduces and improves the interface of vulnerable populations with local law enforcement, courts, jails, and detention centers.*
- 12. Supports the responsibilities defined in the Code of Virginia relating to Community Services Boards and Behavioral Health Authorities (CSBs/BHAs).*
- 13. Promotes availability of access to vital supports such as housing and supported employment.*
- 14. Achieves cost savings through decreasing avoidable episodes of care and hospitalizations, strengthening the discharge planning process, improving adherence to medication regimens, and utilizing community alternatives to hospitalizations and institutionalization.*
- 15. Simplifies the administration of acute psychiatric, community mental health rehabilitation, and medical health services for the coordinating entity, providers, and consumers.*

16. Requires standardized data collection, outcome measures, customer satisfaction surveys, and reports to track costs, utilization of services, and outcomes. Performance data should be explicit, benchmarked, standardized, publicly available, and validated.

17. Provides actionable data and feedback to providers.

18. In accordance with federal and state regulations, includes provisions for effective and timely grievances and appeals for consumers.

DMAS involved the Department of Behavioral Health and Developmental Services (DBHDS), Community Services Boards, and numerous stakeholders in planning for the development of the new care coordination model.

Specifically, four focus group meetings and a general stakeholder meeting were convened over the course of four weeks to obtain input from interested stakeholders. The first four focus group meetings were convened on August 16 and 17, 2011. The groups were divided into interest groups to allow free expression. The groups included (1) state agency representatives; (2) vendors/managed care organizations; (3) service providers; (4) advocates and individuals who have behavioral health disorders and families. Overall, 102 participants attended the focus group sessions.

As shown in Table 3, over 102 participants attended the focus group meetings.

Advocates/Individuals with Behavioral Health Disorders/Families	6
State Agency Representatives	8
Behavioral Health Organization Vendors/MCOs	22
Behavioral Health Service Providers	31
All Stakeholder Group	35
TOTAL	102

A summary of the focus group meetings can be accessed at http://dmasva.dmas.virginia.gov/Content_atchs/obh/focus-grps.pdf.

The general stakeholder meeting was convened on September 14, 2011, to discuss the general concept of the care coordination model being considered by the Department, and to obtain input from stakeholders.

The issuance of this RFP consisted of a two part process. The first step consisted of the issuance of a draft RFP for stakeholder comment for five business days. This fulfilled the requirements of developing a blueprint for behavioral health services not currently provided through a managed care organization. In the second step, comments received from stakeholders were taken into consideration as the RFP was developed and finalized.

3. NATURE AND SCOPE OF SERVICES

The Contractor shall be responsible for the development, implementation and operation of an enhanced behavioral health provider network matching in scope of the existing behavioral health provider network. There are currently 10,473 providers in the FFS behavioral health service network including:

- 2,686 psychiatrists;
- 1,268 clinical psychologists;
- 3 school psychologists;
- 2,257 licensed clinical social workers;
- 1,743 licensed professional counselors;
- 65 licensed marriage & family therapists;
- 70 psychiatric clinical nurse specialists;
- 7 substance abuse practitioners;
- 1,712 community mental health rehabilitative service providers;
- 75 treatment foster care providers;
- 40 TDO providers;
- 8 private mental health hospitals;
- 40 community services boards/behavioral health authorities; and
- 164 residential treatment center providers, including Levels A, B providers, and Residential Treatment Centers (Level C).

A Behavioral Health Services Administrator (BHSA) is being sought in an effort to achieve the following overall objectives:

- Ensure Medicaid/FAMIS Plus and FAMIS members receive high quality, appropriate, and cost-effective behavioral health services;
- Provide an effective and efficient operation that 1) coordinates complex behavioral health care, including acute and primary health services; 2) reduces the administrative burden on behavioral health providers and members; 3) maximizes the use of current information technology; 4) provides flexible operations allowing the State to react to program changes in a timely manner; and 5) implements provider and member outreach;
- Ensure provider network adequacy based on geographical access needs and establish a level of participation and provider satisfaction, and develop outcome measures;
- Assure compliance with applicable requirements set forth in state and federal health care reform initiatives;
- Conduct regularly scheduled outreach activities designed to educate Medicaid/FAMIS Plus and FAMIS members regarding behavioral health services about 1) the availability and importance of receiving behavioral health services; 2) keeping behavioral health appointments; and, 3) how to access behavioral health care services;
- Works with the Department and its contractors in program implementation, operations, and evaluation;

- Assist with the development of a quality improvement strategy that will include the development and implementation of quality outcome measures, with outcomes reporting;
- Ensure that input from interested stakeholders, including individuals and families who use behavioral health services, is considered in the ongoing development, administration, and implementation of behavioral health services ; and,
- Assure compliance with federal law including, but not limited to H.R. 2, the Children's Health Insurance Program Reauthorization Act of 2009, or CHIPRA and federal/state health care reform.

The Contractor shall perform all services under this RFP. The contractor shall comply with all applicable administrative rules and the Department's written policies and procedures, as such policies and procedures may be amended periodically. Copies of all such rules and policies are available from the Department.

4. TECHNICAL PROPOSAL REQUIREMENTS

This section contains the technical proposal requirements for this RFP. The Offeror shall provide a detailed narrative of how it will define and perform each of the required tasks listed in this section and by cross-referencing the Offeror's proposal response to each RFP requirement. The narrative shall demonstrate that the Offeror has considered all the requirements and developed a specific approach to meeting them that will support a successful project. It is not sufficient to state that the requirements will be met. The description shall correspond to the order of the tasks described herein.

The Offeror may perform all of these processes internally or involve subcontractors for any portion. Subcontractors shall be identified by name and by a description of the services/functions they will be performing. The Offeror shall be wholly responsible for the entire performance of this contract whether or not subcontractors are used.

The Offeror shall make maximum efforts to ensure minimum disruption in service to members and providers and a smooth interface of any claims processing or system changes to transfer necessary information without material disruption during implementation of the program.

4.1 Enrollment and Eligibility Determination

4.1.1 Enrollment

The local Departments of Social Services (DSS) offices and the FAMIS Central Processing Unit (CPU) enroll individuals into Medicaid, FAMIS Plus and FAMIS on a daily basis. In addition, individuals can be enrolled into Medicaid for retroactive dates of service. The Department is responsible for the enrollment of members with the Contractor. For the purposes of this contract, all Medicaid/FAMIS Plus/FAMIS eligible individuals are considered enrolled with the Contractor.

Additionally, for the terms set forth in this Contract, FAMIS Plus and Medicaid members shall be treated in the same manner. Any information sent to FAMIS Plus and Medicaid members must appropriately address the entire intended population. For example, enrollment and benefit materials cannot specify "Medicaid" unless they also specify "FAMIS Plus." If the material does not specify "Medicaid," it does not need to specify "FAMIS Plus." (Note: Some of these

designated program categories may change under the federal health reform effort starting in 2014.)

Eligibility and enrollment verification must be based upon VaMMIS on-line eligibility information as this represents the most up-to-date eligibility information. Enrollment shall begin at 12:01 a.m. on the effective date that the member is enrolled with the Contractor and shall end at 12:00 midnight on the date that the member is disenrolled pursuant to the criteria in Department policy and/or Department regulations.

4.1.2 Health Care Reform/ Eligibility Increases

The Contractor shall accept additional enrollment from the Department which may result from state and federal health reform, budgetary, or eligibility initiatives.

4.1.3 Disenrollment

The Department is responsible for the disenrollment of members from the Contractor. The Contractor shall not disenroll members. The Contractor may, however, provide the Department with any information it deems appropriate for Department use in making a decision regarding loss of eligibility or disenrollment of a particular member. Disenrollment actions taken by the Department cannot be altered by the Contractor.

4.1.4 Eligibility Verification

The Contractor shall verify member eligibility through the Contractor's access to the Department's VaMMIS. The Contractor shall be responsible for expenses associated with accessing VaMMIS screens. The Contractor shall be responsible for the provision of all services covered under this RFP (including but not limited to call center services, outreach, member materials, service authorization, claims processing, etc.) and resulting Contract for eligible members if in VaMMIS regardless of their current status.

4.1.5 Behavioral Health Services Rendered Outside of Eligibility Effective Dates

Except where required by this Contract with the Department or by applicable federal or state law, rule or regulation, the Contractor shall not make payment for the cost of any behavioral health services provided prior to the effective date of the member's Medicaid/FAMIS Plus or FAMIS eligibility begin date or prior to the begin date with the Contractor. Additionally, the Contractor shall not make payment for the cost of any behavioral health services after the effective date of the disenrollment. The Contractor shall make payment for the cost of any covered services obtained on or after 12:01 a.m. on the effective date of member's Medicaid/FAMIS Plus or FAMIS eligibility begin date and on or after the begin date of the BHSA Contract.

4.2 Member Materials and Communications

The Contractor shall design, produce and distribute (to include all distribution costs such as postage) various types of member materials, including but not limited to brochures, provider directories, fact sheets, notices, and other materials necessary to provide information to members as agreed upon and required by the Contract resulting from this RFP. In response to this RFP, the Offeror must submit copies and examples of materials utilized in contracts of a similar scale to the requirements outlined in this RFP with a description of how the materials will be used.

The Contractor may distribute additional materials and information, other than those required in this Section, to members in order to promote health and/or educate members. Any cost added for services provided above the base requirements (described in Section 4.2) must be listed separately in the Offeror's Cost Proposal. All member materials including form letters, mass mailings and system generated letters, whether required or otherwise, shall require written approval by the Department prior to dissemination as described herein and shall be designed and distributed in accordance with the minimum requirements as described in this RFP. Letters sent to members in response to an individual query do not require prior approval.

4.2.1 Member Information

The Offeror shall specify within its response to this RFP how it plans to educate members about the available behavioral health services and the participating provider network, and how the Offeror will disseminate such information to members. Member information must be at a 6th grade reading level and be sent to members and within 30 days of enrollment.

Member information materials shall, at a minimum, be in accordance with all applicable requirements described in this RFP. The member materials shall include information about behavioral health services for individuals who meet service eligibility criteria, and provide notice that services are available at no cost and without cost sharing responsibilities. Additionally, the material must list the BHSA's toll-free telephone number combined with a statement that the member may contact the plan regarding questions and to obtain appointment assistance within the behavioral health network or referral to the member's MCO for necessary services. The material should also advise the member how to obtain emergency behavioral health services.

4.2.2 Provider Listing

The Contractor shall make available to the MCOs, individuals or their families upon request, a provider listing, sorted by region and specialty, and listing all satellite offices if possible. This listing shall include current provider name, address, telephone numbers, office hours, languages spoken and specialty. This list shall be maintained and regularly updated at least monthly on the Contractor's web site as providers are added or terminated and made available at all times electronically and in written format.

4.2.3 Prior Authorization Process for Member Materials

The Offeror shall submit a detailed description of any materials it intends to use and a description of any activities prior to implementation or use. This includes but is not limited to all policies (including confidentiality) and manuals, advertisement copy, brochures, posters, fact sheets, video tapes, story boards for the production of videos, audio tapes, letters, social internet media, and any and all other forms of advertising as well as any other forms for the facilitation of public contact.

All materials submitted by the Contractor shall be accompanied by a plan that describes the Contractor's intent and includes procedures for the use of the materials. All written material submitted by the Contractor shall be submitted on paper and on electronic file media. Materials developed by a recognized entity having no association with the Contractor that are related to management of specific behavioral health disorders shall be submitted for approval prior to use; however, an electronic file for such materials may not be required. The electronic files, when

required, shall be submitted in a format acceptable to the Department. Electronic files submitted in formats other than those approved by the Department cannot be processed.

The Department will review the Contractor's materials and either approve, deny or return the plan and/or materials (with written comments) within thirty 30 calendar days following their date of submission. Once the Department has approved materials, the Contractor shall submit one (1) electronic copy of the final product to the Department's Behavioral Health Program Manager. Problems may not be evident from the materials submitted, but may become apparent upon use. The Department reserves the right to notify the Contractor to discontinue or modify materials, or activities after approval.

4.2.4 Written Material Guidelines

- All materials shall be worded at a 6th grade reading level, unless the Department approves otherwise.
- All written materials shall be clearly legible with a minimum font size of 12 pt. unless otherwise approved by the Department.
- All written materials shall be printed with an assurance of non-discrimination.
- The following shall not be used on communication material without the written approval of the Department:
 - a. The Seal of the Commonwealth of Virginia;
 - b. The word "free" can only be used if the service is at no cost to all members.
- All documents and member materials shall be translated and available in Spanish. Within ninety (90) days of notification from the Department all documents designated by the Department must be translated and available to each Limited English Proficiency group identified by the Department constituting five percent (5%) or more of the Department population.
- All written materials shall be made available in alternative formats upon request for persons with special needs or appropriate interpretation services shall be provided by the Contractor.
- To assure that members have access to current policies and procedures, the Contractor shall provide the Department and the MCOs with an updated electronic version of the member handbook on a monthly basis. The member handbook shall be sent to the Department in PDF format and the Department will post the updated version on the Behavioral Health Services section of the Department's website for member use. The Contractor shall also mail the member an updated member handbook upon request. The cost of design, printing, and distribution (including postage) of all member materials shall be borne by the Contractor. The Contractor shall comply with all Federal postal regulations and requirements for the mailing of all materials. Any postal fees assessed on mailings sent by the Contractor in relation to activities required by this RFP due to failure by the Contractor to comply with Federal postal regulations shall be borne by the Contractor and be at no expense to the Department.

4.2.5 Failure to Comply with Member Material and Communication Requirements

All services listed in Attachment IIa shall be provided as described and the materials must adhere to the listed requirements. Failure to comply with the communication limitations/standards contained in this RFP, including but not limited to the use of unapproved and/or disapproved processes and communication material, may result in the imposition by the Department of one or

more of the following liquidated remedies which shall remain in effect until such time as the deficiency is corrected:

- i. Revocation of previously authorized communication methods;
- ii. Application of liquidated remedies as provided in Attachment III of this RFP.

4.3 Requirements for Establishing and Maintaining a Call Center

The Contractor shall provide and maintain a toll-free telephone Call Center. The Call Center is required to be within the borders of the Commonwealth of Virginia. The Contractor shall provide the capacity for the Department to timely monitor calls remotely from DMAS offices at no cost to the Department. The Offeror's proposal shall include a description of methods to enable the DMAS Contract Monitor to perform routine monitoring of calls for all populations covered under the contract resulting from this RFP. Offeror shall enumerate the geographical locations of its firm at the national, regional, and local levels, as applicable. Offeror shall identify all locations that will be used to support a resultant contract and the operations handled from these locations (particularly note any Virginia-based locations that will be used). Offeror should clearly identify any overseas locations, which may be used to support the resultant contract or any related transactions. As it is anticipated that the majority of the inquiries and requests for behavioral health services shall be received through the Call Center, DMAS requires a highly effective and responsive operation. The Call Center shall be sufficiently staffed and available 24 hours per day, seven (7) days per week.

The Call Center shall provide professional, prompt, and courteous customer service. Telephone staff shall greet the caller and identify themselves by name when answering. The Call Center shall establish and maintain an adequately staffed Call Center and shall ensure that the staff treats all callers with dignity and respects the caller's right to privacy and confidentiality. The Call Center shall process all incoming telephone inquiries for behavioral health services in a timely, responsive, and courteous manner. Staff shall have clinical expertise and experience in working with behavioral health populations.

Call volume may change with the Medicaid expansion in 2014 that is part of the overall federal health care reform effort. The Department will provide further information as soon as it is available on this item.

The Contractor shall install, operate, monitor and support an automated call distribution system that has the capability to accept registration and service authorization requests via direct data entry. The Call Center is to be utilized for the following general functions:

- Documentation of all call inquiries and requests by caller and call types.
- Initiate service authorization requests.
- Complete service registration.
- Handle provider inquiries, grievances, appeals, and reconsiderations.
- Provide technical and clinical support functions for providers and members who request assistance on how to complete the functions described under this RFP.
- Provide general information about the program in response to inquiries.
- Provide assistance to members in locating a participating behavioral health service provider.
- Provide assistance to providers regarding provider status and claims processing questions.
- Accurately respond to questions regarding covered services.

Communication and Language Needs: The Call Center shall ensure that varying communication and language needs are addressed. This applies to all non-English speaking members and is not limited to prevalent languages. The member cannot be charged a fee for translator or interpreter services. The Virginia Relay service for the deaf and hard-of-hearing shall be used when appropriate.

- The Contractor agrees to relinquish ownership of the toll-free numbers upon contract termination, at which time the Department will take title to these telephone numbers. Any amount owing on these numbers shall be the sole obligation of the Contractor. The call center toll-free number shall be established such that DMAS' continued use of such toll-free number shall not be interrupted, impeded or cost DMAS any additional funds for DMAS to continue use of the toll-free number in the event the contract is terminated or expires on its own terms. The Contractor shall be responsible for all costs associated with the toll-free number during the term of the contract as well as for all costs accrued or due and owing as of the date of termination or expiration of the contract, including, but not limited to, any taxes, penalties or fines.

The Call Center shall:

- Provide a sufficient number of properly functioning toll-free Voice and Telecommunication Device for the Deaf or a dedicated (TDD/TTY) (telephone typewriter or teletypewriter) telephone numbers/lines (in-state and out-of state) for members, providers, and other responsible parties to call for behavioral health care and other program services as described in this RFP.
- Ensure that personnel responding to inquiries and requests are fully trained and knowledgeable about Virginia Medicaid standards and protocols.
- Have the capacity to handle all telephone calls at all times during the hours of operation; have the upgrade ability to handle any additional call volume. Any additional staff or equipment needs, including the cost of addressing such needs, shall be the responsibility of the Contractor. The Contractor is responsible for adequate staffing and equipment during high peak times.
- Provide sufficient telecommunications capacity to meet the Department's needs with acceptable call completion and abandonment rates as specified in the performance standards. This capacity shall be scalable (both increases and decreases) to demand in the future.
- Provide assistance to providers participating in the behavioral health services network during all hours of Call Center operation by responding to behavioral health service related questions requiring clinical interventions, reconsiderations and consultation. Provide support for responses to service authorization and prepayment review requests.
- Effectively manage all calls received by the automated call distributor and assign incoming calls to available staff in an efficient manner.
- Provide detailed analysis of the quantity, length, and types of calls received, and the amount of time required to initially answer them.
- Track the number of callers encountering busy signals or hanging up while on hold.
- Track the amount of time callers are placed on hold.
- Digitally record and store all incoming and outgoing calls for quality assurance purposes for a period no less than 12 months. DMAS shall have full remote access to call recordings.
- Make certain that Contractor staff is responsive, helpful, courteous and accurate when responding to inquiries, and that they maintain member confidentiality. The Contractor will be responsible for an ongoing Quality Assurance program implemented to sample calls and follow up on calls to confirm the quality of responses, and caller satisfaction. The Contractor

is responsible for reporting on the outcomes of the Quality Assurance program, and for any training required to maintain the highest level of quality.

- Design and implement a call tracking and reporting system capable of tracking all calls generating an electronic record. The system must be able to capture all incoming and outgoing calls so that a complete record of communication with providers, members and other interested parties is generated. Reports must be made available regarding call center activity as specified in section 4.15.
- Provide complete on-line access by the Department to all computer files and databases supporting the system for applicable behavioral health programs.
- Develop, maintain, and ensure compliance with Medicaid confidentiality procedures/policies, including HIPAA requirements, within the call line unit.
- Provide a greeting message (when necessary) and educational messages approved by the Department while callers are on hold.
- Install and maintain a telephone line in a way allowing calls to be monitored by a third party for the purposes of evaluating Contractor performance and including a message informing callers that such monitoring is occurring. Call monitoring by a third party, for accuracy and quality of information, shall be available at the Call Center location.
- Ensure that telephone interpreter services are accessible via the toll-free number and that providers/members will not have to hang up to access these services.
- Track and assess the busiest day by number of calls, to be included in a report format as specified by the Department.
- Provide detailed weekly reports of abandonment rate, wait time, service levels, etc. The reports should segregate member and provider information and generate cumulative weekly information as required in Attachment XII.
- Track the number of calls in the queue at peak times.
- Provide adequate staff to handle service authorization and prepayment review requests received by direct data entry.
- Provide reports on the number of service authorizations and prepayment review requests received by direct data entry.
- Provide reports on call volume, caller and call types.
- Make referrals of non-network providers to appropriate staff to assist with the network application process.
- Make referrals to staff having VaMMIS access when providers or members question eligibility status.
- Ensure that there is a back-up telephone system in place that will operate in the event of line trouble or other problems so that access to the toll free-line is not disrupted.
- Effectively manage all calls received by the automated call distributor and assign incoming calls to available staff in an efficient manner. The Offeror must include a diagram of the automated call distribution center.
- Provide TDD/TDY access to the processing center.
- Provide CDs of both member and provider calls monthly.
- Identify call types by level of urgency of request i.e. routine, urgent, non-life threatening and life threatening. Protocols to respond to each level of urgency must be defined.
- Provide reports on response time to all call types and number of contacts to resolve call.

4.3.1 Call Center Performance Standards

The Contractor is responsible for meeting the following performance standards and is required to provide reports demonstrating performance as follows:

- The Call Center shall be available to respond to inquiries and service authorization requests, except for prior written approved down time.
- The Contractor shall provide sufficient staff, facilities, and technology so that ninety-five percent (95%) of all call line inquiry attempts are answered. The total number of busy signals and abandoned calls measured against the total calls attempted shall not exceed five percent (5%) per week.
- Calls shall be answered within three (3) rings or fifteen (15) seconds. If an automated voice response system is used as an initial response to inquiries, an option shall exist allowing the caller to speak directly with an operator. The wait time in the queue should not be longer than 3 minutes for 95% of the incoming calls.
- All routine call line inquiries that require a call back, including general inquiries and service authorization requests, shall be returned within one business day of receipt one hundred percent (100%) of the time.
- In responding to telephone messages, the Contractor shall have a tracking system in place to identify who returned the call, record when the call was returned, the nature of the call and document the outcome of the call.
- The Call Center shall respond to members seeking assistance in locating a behavioral health provider. The level of urgency must be recorded and tracked for resolution for all non-routine calls.
- Records of Call Center response times identified in Attachment XII of the RFP shall be kept by the Contractor and reported to the Department weekly and monthly.

The Offeror must propose a procedure for the Call Center staff to respond to members who may call in a crisis situation.

The Offeror must propose a procedure for the Call Center staff to assess members calling and seeking a referral in order to determine the appropriate level of care and provider type.

Because Call Center performance is critical to the success of this project, the Offeror shall describe in detail how it will train staff to perform their duties accurately and efficiently and how it will monitor these standards and perform corrective actions when necessary. Additionally, the Contractor shall notify the Department of any variance from the contractual requirements as outlined in this RFP and shall provide a written plan for corrective action addressing the deficiency at the time of notice. The corrective action plan shall include a work plan and date of resolution and shall be submitted within five (5) business days of the discovery.

In response to this RFP, the Offeror shall submit Call Center performance data for contracts of a similar scale as outlined in this RFP.

4.3.2 Call Center Reporting

The Department reserves the right to modify the frequency of requested reports.

Call Center reporting shall be provided weekly for the first three months and monthly thereafter and, at a minimum, shall include the following:

- a. Total hours of daily Call Center access provided, and any downtime experienced, as outlined in Attachment XII.
- b. Overall call volume, by type of call, including nature of inquiry and source of call (shall provide a separate report for provider and member calls) and shall include counts and percentages of the ten most frequent types of calls.
- c. Call abandonment rate, and average time prior to abandonment, including for calls placed on hold, number and percentage of calls answered with wait time 3 minutes or less as outlined in Attachment XII.
- d. Detailed statistics regarding member or provider grievances to include but not limited to: (1) the member's inability to locate a provider within Contract standards; (2) provider service authorization and billing issues; (3) handling of grievances or appeals, and (4) resolutions taken to resolve grievances.
- e. The number of member and provider grievances, reconsideration requests, and appeal requests
- f. Average time required to call back providers and members when a call back was required for each level of service call e.g. routine, urgent, etc.
- g. Average length of calls handled as outlined in Attachment XII.
- h. Report the number of calls in the queue and abandoned based on 30 minute intervals.
- i. Outcomes of quality improvement measurements.
- j. Ad Hoc reports as requested by the Department.
- k. The Call Center shall have the capacity to track individual provider and member call activity and capture all important aspects of the call transaction. The Contractor shall report individual call activity data to the Department upon request. The Department will also be able to monitor provider and member calls.

4.3.3 Communication and Language Requirements

The Contractor shall ensure that the communication and language needs are addressed. This applies to all non-English speaking callers and is not limited to prevalent languages. The caller cannot be charged a fee for translator or interpreter services. The Contractor shall have the capacity and sufficiently trained staff available to utilize the Virginia Relay service for the deaf and hard-of-hearing or a dedicated TDD/TTY line.

4.4 Staffing Requirements

4.4.1 Office Location

The Contractor must maintain a physical business office in Virginia. At minimum, the Project Director staff shall be located in the Virginia business office.

4.4.2 Staffing Plan

- 4.4.2.a The Contractor shall not have an employment, consulting or any other agreement with a person that has been excluded or suspended by any state or federal agency from the provision of items or services that are significant and material to the entity's contractual obligation with the Department.
- 4.4.2.b The staffing for this RFP shall be capable of fulfilling the requirements of this RFP. The Contractor shall be responsible for adjusting staffing

needs accordingly. A single individual may not hold more than one (1) position unless otherwise specified. The minimum staff requirements are as follows:

1. A full-time administrator e.g. Program Director, Chief Executive Officer, dedicated 100% to the project, tasked with overall responsibility for all aspects of performance, including the coordination and operation, of this RFP. This person shall be at the Contractor's officer level and must be approved by the Department, including upon replacement.
2. Sufficiently trained and experienced full-time support staff to conduct daily business in an orderly manner, including but not limited to functions such as administration, accounting and finance, service authorizations, appeal resolution system, and claims processing and reporting, as determined through management and medical reviews.
3. A full-time licensed Clinical Director, tasked with the responsibility of managing and supervising experienced, sufficiently trained administrative and clinical full-time staff who can address the unique needs of the members while addressing any participating behavioral health provider service limitations to assure that services are provided in the most economical manner.
4. Provider Relations Director, and provider relations staff, whose primary duties include development and implementation of the Contractor's on-going strategies to increase provider participation and carry out related provider relations activities. The Offeror shall describe its staffing plan in relation to provider network development and maintenance strategies and retention activities. This position shall be directly accessible to providers.
5. A full-time Virginia based Outreach Coordinator/Care Coordinator and/or outreach staff, whose primary duties include development and implementation of the Contractor's on-going strategies to increase the appropriate utilization of behavioral health services, to lead the Contractor's program for dealing with non-compliant members, as described in Section 4.8, and to perform other necessary outreach and follow up activities to ensure members are getting the care they need.
6. A staff of qualified, clinically trained personnel licensed in the Commonwealth of Virginia, whose primary duties are to assist in evaluating medical necessity, determining levels and urgency of care, and facilitating appropriate provider selection and referral as necessary.
7. A Quality Improvement Director to coordinate and manage the requirements described in Section 4.13 of this RFP.
8. A MCO Liaison to coordinate the requirements described in Section 4.8.2 of this RFP. This person will also coordinate activities with other DMAS vendors e.g. transportation, pharmacy, etc.

9. A person who is trained and experienced in information systems, data processing and data reporting to provide necessary and timely reports to the Department as well as resolve system interface, operational problems.
10. Sufficiently trained and experienced full-time staff to maintain a toll-free Member or Customer Service phone line to be operated during regular call center hours to be responsible for explaining the program, assisting members in the selection of behavioral health providers; assisting members in making appointments and obtaining services; and to handle member inquiries and grievances. The Contractor shall appoint a Call Center Manager to ensure adequate maintenance of all DMAS dedicated phone lines adhering to high customer service standards.
11. The Contractor shall appoint a staff person to be responsible for communicating with the Department regarding provider service issues. Further, the Contractor shall have a provider service line staffed adequately to respond to providers' questions during regular call center business hours, to include appropriate and timely responses regarding service authorization requests as described in this RFP. The provider service lines shall be adequately staffed and trained to accurately respond to questions regarding the Department's program, including but not limited to EPSDT behavioral health, billing and other benefit related inquiries. An appeals coordinator will also be identified to manage provider appeal activities.
12. The Contractor's staffing plan shall include the materials and methods used (on-going) for training staff, including the handling of telephone requests from members and participating behavioral health providers. The Contractor shall include copies of all training materials and a description of methods used for training staff with this RFP submission and to the Department annually thereafter.
13. The Contractor shall identify in writing the name and contact information for the Program Director/Executive Director, Clinical Director (a Psychiatrist, Physician or other Licensed Mental Health Professional licensed in the Commonwealth of Virginia), MCO Liaison, QI Director, Provider Relations Director and Outreach Coordinator. Key contact persons shall also be provided for Accounting and Finance, Service authorizations, Claims Processing, Information Systems, Member Services, Provider Services, and Appeal Processes, within thirty (30) days of RFP execution. The Department shall approve all staffing plans and reserves the right to require the Contractor to select another applicant for any of these positions. The Contractor must notify the Department of any changes in staff persons during the term of this RFP in writing within 10 business days.
14. If any member of the project management team, as identified in the Contract, becomes unavailable for any reason, the Contractor shall advise the Department immediately, shall provide an expected timeline for the re-hire and a plan for coverage until the position is filled. The Department reserves the right to approve rehires to project management level positions.

15. Failure to maintain the required staffing level to meet contract requirements may result in a reduction in the Department's reimbursement to the Contractor. Reductions in staffing levels may only be made with the prior approval of the Department and may result in a loss of revenue for the Contractor. The Contractor shall not maintain positions deemed nonessential for the purpose of maintaining the current reimbursement level.

4.4.2.2.c The Contractor's failure to comply with staffing requirements as described in this RFP shall result in the application of liquidated remedies specified in Attachment III of this RFP.

4.4.3. Licensure

The Contractor is responsible for assuring that all persons, whether they are employees, agents, subcontractors, providers or anyone acting for or on behalf of the Contractor, are legally authorized to render service under applicable state law and/or regulations. Failure to adhere to this provision shall result in assessment of \$250 per calendar day for each day that personnel are not licensed as required by applicable state law and/or regulation and the Department may terminate this RFP for cause as described in Section 10.7 of this RFP.

4.4.4 Accreditation Status

The Contractor shall provide documentation of any accreditation by a nationally recognized accrediting body and licenses held relative to functions required by this RFP.

4.5 Provision of Covered Benefits

The Contractor shall be responsible for administering the Medicaid/FAMIS Plus and FAMIS State Plan behavioral health service package as defined in this RFP to members in accordance with 12VAC 30-50-190, 12VAC30-141-200, as amended, and the terms of this RFP. The following represents a summary of the Medicaid/FAMIS Plus and FAMIS State Plan covered benefits. Please refer to Attachment IIa of this RFP for a complete listing of services.

4.5.1 Registration and Service Authorization

The Contractor shall install, operate, monitor and support a web-based automated registration and service authorization submission processing system that has the capability to accept service authorization requests via telephone, facsimile, X12 278 compliant, and/or direct data entry. (Registration is the notification to DMAS that a behavioral health service was initiated.) The Contractor however will educate providers that the preferred method is direct data entry into their system. The Contractor will have an automated authorization system in place that allows prior authorization requests (pre-treatment plans) to be reviewed by the Contractor for medical necessity. The Offeror shall submit with its proposal its registration and service authorization requirements and any other options (such as the pended claims option for services requiring service authorizations). The Offeror shall also describe any processes used to amend service authorization requirements based upon internal research of trends, professional guidelines, etc. Service authorization requests must be accepted via multiple media, per the X12 278 industry standards, including but not limited to mail, email, fax, internet, web-based direct data entry, or

phone. The Department shall approve final registration and service authorization procedures prior to implementation and upon any revision.

The Contractor shall render a decision (approve, deny, pend or reject) as expeditiously as the member's behavioral health condition requires not to exceed three (3) business days from the date of receipt. In cases where the Contractor is unable to fully coordinate the member's behavioral health care treatment due to lack of service authorization, the Contractor shall continue to coordinate the remaining service authorization with the care coordinator as quickly as possible. The Contractor shall apprise the service provider of the authorization status. Notification of the authorization determination(s) for all non-emergent cases is sent by Contractor to the provider within 24 hours of the determination. Notification of the authorization determination(s) for all urgent cases is faxed or sent by other secure means by the Contractor to the provider. This system will not preclude the Contractor from requesting additional documentation if required for medical necessity review in accordance with the Department's criteria and industry standards of practice. In instances where the Contractor has requested additional medical justification from the behavioral health provider, the Contractor shall render a final decision within three (3) business days from the receipt of additional documentation from the provider.

The Contractor's methods and procedures must comply with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. The Contractor shall not charge providers for submission, via any media, of service registrations or service authorization requests.

The Contractor shall ensure that any final determination to deny a service authorization request be made by a professional with a clinical license in Virginia who has appropriate clinical expertise in treating the member's condition. The Offeror's proposal shall:

- A. Outlines an automated rule based review process and indicate cost savings to the Department, if any;
- B. Provide registration and service authorization turn around processing timeframes for all services that require registration; indicate processing timeframes starting at the time when the provider submits a registration or a request for service authorization to the time a service authorization decision is rendered. Include timeframes if additional information is required from the provider in order to make the final determination. Refer to Attachment VIII for acceptable/required minimum timeframes for requests;
- C. Demonstrate methods for compliance with all Federal and State service authorization requirements;
- D. Provide a seamless transition for the Medicaid and FAMIS program's providers and members; and
- E. Establish a staffing plan to handle the anticipated review volume and any increases in volume.
- F. Establish an expedited review process to accommodate members in crisis or in need of urgent care.
- G. Establish a peer review process to occur when a service authorization is not initially approved.

The Offeror shall also describe any processes used to amend registration or service authorization requirements based upon internal research of trends, professional guidelines, etc. The Department will approve final service authorization procedures prior to implementation and upon any revision throughout the term of the contract period.

The Business Rules for Inpatient, Outpatient and Behavioral Health Services are located in Attachment XVI.

4.5.2 Traditional, Non-Traditional Services and EPSDT Services

4.5.2.1 Traditional Services:

The Department currently requires utilization of McKesson InterQual Criteria, with DMAS approved modifications when making final decisions. McKesson InterQual Criteria is an established and nationally recognized set of criteria. Service authorization requests that are not addressed in McKesson InterQual criteria or the selected standardized criteria shall be reviewed by the Contractor's physician reviewer. The Contractor shall provide DMAS annual updates 30 days prior to the fiscal year start date to be implemented July 1 of each year. The Contractor shall indicate how they are going to advise the providers of criteria requirements and any annual updates. While McKesson InterQual Criteria is the required method, the Department is open to review other criteria where the criteria provides evidence of better outcomes and is cost effective. DMAS requires the Offeror to have a web based system for direct data submissions with fax, phone and mail as a default method. Service authorization volumes for traditional services are located in Attachment XVII.

4.5.2.2 Non-Traditional Services:

The Department requires utilization of McKesson InterQual Criteria, with DMAS approved modifications when making final decisions. McKesson InterQual Criteria is an established and nationally recognized set of criteria. When nationally standardized criteria are not available or utilized, the Contractor shall use criteria as set out in DMAS policies, procedures and manuals when making final determinations. Service authorization requests that are not addressed in McKesson InterQual criteria or the selected standardized criteria shall be reviewed by the Contractor's physician reviewer. The Contractor shall provide DMAS annual updates 30 days prior to the fiscal year start date to be implemented July 1 of each year. The Contractor shall indicate how they are going to advise the providers of criteria requirements and any annual updates. While McKesson InterQual Criteria is the required method, the Department is open to review other criteria where the criteria provides evidence of better outcomes and is cost effective.

Non-traditional services requests are document intensive for certain services and have proven to be more difficult and time consuming for some providers when submitting requests via direct data entry. The Offeror shall provide a plan for providers to increase service authorization requests via direct data entry where the services are document intensive. Service authorization volumes for non-traditional services are located in Attachment XVII.

4.5.2.3 Early and Periodic Screening, Diagnosis and Treatment (EPSDT):

EPSDT is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. Federal law (42 CFR § 441.50 et seq) requires a broad range of outreach,

coordination, and health services under EPSDT distinct from general state Medicaid program requirements. EPSDT is geared to the early assessment of children's health care needs through periodic examinations. The goal of EPSDT is to assure that health problems are diagnosed and treated as early as possible, before the problem becomes complex and treatment more costly.

Any treatment service which is not otherwise covered under the State Plan for Medical Assistance can be covered for a child through EPSDT as long as the service is allowable under the Social Security Act Section 1905(a) and the service is determined by DMAS or a DMAS designated contractor as medically necessary.

Reimbursement for EPSDT services is limited to the hours of treatment and medical or clinical supervision as specified in the treatment plan and as approved by the Contractor. All specialized service requests require physician documentation outlining the medical necessity, frequency and duration of the treatment. To qualify for reimbursement through the EPSDT program all EPSDT services must be approved before the service is rendered by the provider. The only exception to this requirement is in cases of retroactive Medicaid eligibility.

In-Home Behavioral Therapy

The EPSDT Behavioral Therapy Program allows reimbursement for systematic treatment interventions provided typically in the home of an individual. Services are designed to enhance communication skills and decrease maladaptive behaviors which, if left untreated, would lead to significant long term impairments in adaptive functioning.

Behavioral therapy may be provided to persons with developmental delays such as autism and intellectual disabilities. Children must exhibit intensive behavioral challenges to be authorized for services. Children who have attained behavioral control and who require services such as social skills enhancement are not appropriate for the service. Children with severe emotional disturbances and traditional psychiatric care needs who meet the eligibility requirements under the Community Mental Health Rehabilitation programs are not eligible for EPSDT Behavioral Therapy services.

The Contractor shall be required to process all requests received for in home behavioral therapy for members under the age of 21 using the criteria established for the requested service, which includes but is not limited to McKesson InterQual® (which has been modified for this service), DMAS established criteria, and physician reconsideration review. If the service is denied for a child under 21 under the existing program criteria based on medical necessity, then the Contractor must immediately conduct a secondary review under the EPSDT criteria. EPSDT clinical reviews must be individualized. Medical necessity must be determined based on the unique factors regarding the treatment method and the targeted health conditions as requested with each case.

EPSDT criteria states that services may be approved for persons under the age of 21 if the diagnosis or treatment service/item is physician ordered and is medically necessary to correct, ameliorate (make better) or maintain the individual's health or mental health condition. In situations where the item is not appropriate to approve using existing criteria such as McKesson InterQual®, DMAS established criteria, and physician reconsideration review but the diagnostic or treatment service/item is medically necessary under EPSDT criteria, then the service/item may be considered for approval.

The Contractor shall:

- A. Ensure their database can track cases reviewed under the EPSDT criteria. DMAS shall

- request reports to determine the status of EPSDT reviews and shall request additional documentation from the Contractor as needed;
- B. Maintain the responsibility of handling the reconsideration process and appeal related activities for any of the services partially or fully denied after the EPSDT criteria has been applied consistent with current processes and procedures. However, DMAS will review appeal summaries and maintain the right to over ride the Contractor's decisions to deny at any point of the process. The Contractor shall develop a mechanism to track overrides for tracking and reporting purposes.

The DMAS Maternal and Child Health Division will meet with the Contractor as needed to provide updates, training and feedback on the EPSDT review process for in home behavioral therapy.

General EPSDT guidelines are described in detail in the EPSDT Supplement Manual and in the State Plan for Medical Assistance Service at 12VAC30-50-130 and 12VAC30-60-61. Further federal guidance may be found in the CMS State Medicaid Manual, Section 5122. Specific medical necessity criteria for In-Home Behavioral Health Therapy may be found in Attachment Iib.

As part of the response to this RFP, the Contractor shall:

- A. Note its experience and track record in providing review and final determinations regarding EPSDT and specifically services for children on the autism spectrum;
- B. Discuss the review process for EPSDT criteria application; and
- C. Provide statistics for these services, including but not limited to the number of reviews conducted, the types of services reviewed, final determinations made, and outcomes of appeals.

4.5.2.4 Outline of Traditional and Non-Traditional Registration and Service Authorization Services

The complete list of services that require registration or service authorization for both current and retrospective reviews, by the Contractor, included in this RFP, are outlined below:

*Any forthcoming regulatory changes to the services listed above will be communicated as an addendum to the RFP or as a contract modification. Regulatory changes may affect current operational protocols and clinical review processing. Refer to section 6.2, Payment Methodology, in the event the contract costs need to be re-negotiated based on these changes.

Behavioral Health Services: Traditional Services

Inpatient Psychiatric Services

Authorization is required for inpatient psychiatric services. Inpatient psychiatric services are reimbursed on a per diem basis and concurrent review of medical necessity is required for all covered days. The provider must contact the Contractor to conduct concurrent or on-going review. Review will continue in this manner until the member is discharged.

In order to determine medical necessity for inpatient psychiatric services, McKesson InterQual® criteria is currently utilized and required by the Department.

Outpatient Psychiatric Services

If the member is in need of services beyond the initial 26 sessions in the first treatment year, up to an additional 26 sessions may be authorized. Each subsequent year of treatment may not exceed 26 sessions and must be authorized by the Contractor. If the service limit is met for children under the age of 21, additional sessions may be available when medically necessary, through the EPSDT program. The Contractor will automatically perform the EPSDT review in its operational workflow. The Contractor shall manage and provide for initial and concurrent review as requested.

McKesson InterQual® Criteria for Behavioral Health is currently utilized and required by the Department in order to determine medical appropriateness for outpatient psychiatric services. Refer to Attachment IIa for the list of Medicaid approved CPT codes requiring service authorization.

Outpatient Substance Abuse Services

Each subsequent year of treatment may not exceed 26 sessions and must be authorized by the Contractor. If the service limit is met for children under the age of 21, additional sessions may be available when medically necessary, through the EPSDT program. The Contractor will automatically perform the EPSDT review in its operational workflows.

The Contractor shall manage and provide for initial and concurrent review as requested. McKesson InterQual® Criteria for Behavioral Health is currently utilized and required by the Department in order to determine medical appropriateness for outpatient substance abuse services. Refer to Attachment IIa for the list of Medicaid approved CPT codes requiring service authorization.

Community Mental Health Rehabilitative & Substance Abuse Services - Non-Traditional Services

Community Based Residential Services for Children and Adolescents under age 21 – Level A and Therapeutic Behavioral Services (Levels A and B)

The Contractor shall manage and provide for initial and concurrent review as requested. McKesson InterQual ® Criteria for Behavioral Health Residential and Community-Based Treatment is currently utilized and required by the Department in order to determine medical appropriateness for Level A & Level B services.

Refer to Attachment IIa for the list of Medicaid approved procedure codes and modifiers requiring service authorization. Level A and Level B services require a modifier (HK-CSA; HW-Non-CSA) when requesting service authorization. The procedure code and modifier must be maintained by the Contractor in the Contractor's database for reporting requirements.

Day Treatment/Partial Hospitalization for Adults

The Contractor shall manage and provide for initial and concurrent review as requested. Refer to Attachment IIa for the list of Medicaid approved procedure codes requiring service authorization.

Intensive Community Treatment (also referred to as PACT)

The Contractor shall manage and provide for registration as requested. Refer to Attachment IIa for the list of Medicaid approved procedure codes requiring registration.

Intensive In-Home Services (IIH)

Additional services beyond the annual service limits may be requested by the provider under EPSDT. The Contractor must automatically perform the EPSDT review in its operational workflows: The Contractor shall manage and provide for initial and concurrent review as requested. Refer to Attachment IIa for the list of Medicaid approved procedure codes requiring service authorization.

Mental Health Support Services

The Contractor shall manage and provide for initial and concurrent review as requested. Refer to Attachment IIa for the list of Medicaid approved procedure codes requiring service authorization.

Mental Health Targeted Case Management

This is the Level II component of care coordination referenced in Section 4.6 of the RFP. Refer to Attachment IIa for the list of Medicaid approved procedure codes that do not require service authorization. Services that are not authorized in advance require registration.

Psychiatric Residential Treatment Facility Services (PRTF)

The Contractor shall manage and provide for initial and concurrent review as requested in the manner currently allowed for Medicaid only and Medicaid eligible Comprehensive Services Act (CSA) members. In addition to the standard information collected as part of the service authorization process, the Contractor is required to capture the authorizing locality code and contracted rate submitted by providers for Medicaid eligible CSA children and maintain it in the Contractor's database for reporting purposes.

As part of the response to this RFP, the Offeror shall describe in detail their experience using care coordinators (in collaboration with FAPT equivalent teams) to assist with reducing the length of stay and transitioning the most appropriate level of care for members who have been in a PRTF for greater than 9 months. The Offeror shall also detail how specialty matched physician peer to peer consultants will be used to perform critical reviews of such cases and work with the facility to reduce the length of stay for PRTF members.

McKesson InterQual® Criteria for Behavioral Health Residential and Community-Based Treatment is currently utilized and required by the Department in order to determine medical appropriateness for initial PRTF services. Concurrent stays are determined based on DMAS' criteria identified in the Psychiatric Services Manual. Refer to Attachment IIa for the list of Medicaid approved procedure codes requiring service authorization.

Psychosocial Rehabilitation

The Contractor shall manage and provide for initial and concurrent review as requested. Refer to Attachment IIa for the list of Medicaid approved procedure codes requiring service authorization.

Substance Abuse Case Management

The Contractor shall manage and provide for initial and concurrent review as requested. Refer to Attachment IIa for the list of Medicaid approved procedure codes requiring service authorization.

Substance Abuse Crisis Intervention

The Contractor shall manage and provide for initial and concurrent review as requested. Refer to Attachment IIa for the list of Medicaid approved procedure codes requiring service authorization.

Substance Abuse Day Treatment

The Contractor shall manage and provide for initial and concurrent review as requested. Refer to Attachment IIa for the list of Medicaid approved procedure codes requiring service authorization.

Substance Abuse Day Treatment for Pregnant and Post Partum Women

The Contractor shall manage and provide for initial and concurrent review as requested. Refer to Attachment IIa for the list of Medicaid approved procedure codes requiring service authorization.

Substance Abuse Intensive Outpatient Treatment

The Contractor shall manage and provide for initial and concurrent review as requested. Refer to Attachment IIa for the list of Medicaid approved procedure codes requiring service authorization.

Therapeutic Day Treatment for Children and Adolescents

Additional services beyond the annual service limits may be requested by the provider under EPSDT. The Contractor must automatically perform the EPSDT review in its operational workflows. The Contractor shall manage and provide for initial and concurrent review as requested. Refer to Attachment IIa for the list of Medicaid approved procedure codes requiring service authorization.

Treatment Foster Care Case Management Services (TFC-CM)

Authorization is required for all TFC-CM services. On admission the patient must meet DMAS criteria for TFC-CM. Service authorization must be requested within ten calendar days of admission. The Contractor shall manage and provide for initial and concurrent review as requested.

For TFC-CM program, in addition to the medical and clinical information collected as part of the service authorization request, the Contractor shall be required to capture the authorizing locality code, submitted by providers for Medicaid eligible CSA children. Federal Information Processing Standards Codes (FIPS codes) must be maintained by the Contractor in the Contractor's database for reporting requirements. Refer to the following link for the list of FIPS codes: http://dmasva.dmas.virginia.gov/Content_atchs/pa/pa-fipsd.pdf. Refer to Attachment IIa for the list of Medicaid approved procedure codes.

Estimated Volume of Service Authorization Requests

The volume of service authorization requests are detailed by service type in Attachment XVII. The data detailed is not a guarantee of the volume of future service authorization requests. Changes in DMAS policies or industry practices can possibly alter the future volume of service authorization requests.

The Contractor shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions and consult with the requesting provider when appropriate.

The Contractor shall have a method in place that compares newly disenrolled members to the Contractor's service authorization file. If a method is not in place, the Contractor must communicate to the provider that the authorization is not evidence of eligibility and does not guarantee payment. The Contractor must inform providers to verify member eligibility prior to rendering the behavioral health service. The member must have eligibility on the date of service or the authorization is invalidated. When someone loses eligibility, the continuation of any behavioral health appointments and treatment shall be between the provider and the member.

4.5.3 Coordination of Transportation Services

Non-emergency transportation to covered behavioral health services is a covered service for Medicaid/FAMIS Plus members and is the responsibility of the member's MCO or the Department's contracted transportation broker, Logisticare, for FFS Medicaid/FAMIS members. Non-emergency transportation is not covered for FAMIS children enrolled in an MCO. FAMIS children enrolled in the Department's FFS FAMIS program may receive transportation services through the Department's contracted transportation broker. Transportation services are covered under a separate contract by the Department with the member's MCO or the Department's contracted transportation broker for Medicaid/FAMIS Plus FFS children. Logisticare also subcontracts with five of Virginia's Medicaid MCOs to provide transportation services.

The primary responsibility for transportation belongs to the spouse of an adult or the custodial parent or guardian of a child. Transportation can be provided by the contracted vendor if the parent or guardian does not have a car; if the car is unavailable at the time of the appointment; if the frequency or length of the trip creates a financial hardship for the spouse, parent or guardian; if the spouse, parent/guardian has to work or if the member is in foster care. Questions pertaining to eligible transportation services should be directed to the contracted broker. In cases where the Contractor is made aware that transportation issues are preventing access to behavioral health services, the Contractor shall notify the MCO or the FFS Transportation Contractor to coordinate transportation services. If a general question or complaint is received by the broker, the caller should be referred to the appropriate party for resolution. The Contractor shall also notify the Department when the MCO or FFS transportation broker fails to respond to or resolve a transportation related issue.

The Contractor shall receive data from the Transportation broker that will assist the Contractor with identifying access to care issues that may be addressed through care coordination for behavioral health members.

4.5 Enrollment and Eligibility Verification

4.5.1 Enrollment and Eligibility Verification

The Department will be responsible for the enrollment of Medicaid, FAMIS Plus and FAMIS members into the Medicaid and FAMIS fee-for-service and MCO Programs. The Contractor shall verify eligibility and enrollment through the Contractor's access to the Department's VaMMIS or through a daily download of member eligibility and enrollment information into the Contractor's system. The Contractor's system must be able to accept and display the member's complete eligibility history, including MCO enrollment. Eligibility and enrollment verification must be based upon VaMMIS on-line eligibility information as this represents the most up-to-date

eligibility information as enrollment can be revised, including for retroactive coverage. The Contractor must have the capability to verify eligibility and enrollment periodically, preferably through a system of automated edits. It is important to recognize that there are limited circumstances that cause individuals move between the FFS and MCO programs, in accordance with MCO participation criteria. For more information on MCO participation criteria, see the Medallion II Contract, Article II.D. available on the DMAS website at http://dmasva.dmas.virginia.gov/Content_pgs/mc-medallion2.aspx.

The Department will send eligibility data to the Contractor. Prior to the transfer of protected health information, the Department and the Contractor shall execute the DMAS Business Associate Agreement to ensure compliance with HIPAA.

The Contractor shall be responsible for the provision of all services covered under this RFP (including but not limited to processing center services, service authorizations, etc.) and resulting Contract for eligible members.

4.5.2 Disenrollment

The Department will be responsible for the disenrollment of Medicaid, FAMIS Plus and FAMIS members from the Medicaid, FAMIS Plus and FAMIS FFS and MCO programs.

4.5.3 Care Outside of Eligibility and/or Enrollment Effective Dates

Except where required by this Contract with the Department or by applicable federal or state law, rule or regulation, the Contractor shall not preauthorize any health care provided prior to the effective date of the member's Medicaid/FAMIS Plus or FAMIS eligibility begin date. Additionally, the Contractor shall not preauthorize any health care after the effective date of the individual's eligibility termination date. The Contractor shall have a mechanism to preauthorize any covered services obtained on or after 12:01 a.m. on the effective date of member's Medicaid/FAMIS Plus or FAMIS eligibility begin date.

As described in Section 4.5.5 of this RFP, except for certain limited circumstances, the Contractor shall not handle authorization activities for individuals enrolled in a DMAS contracted MCO. MCO enrollment information will be communicated in the eligibility download briefly described in Section 4.13 of this RFP. The Contractor must have a method of verifying MCO enrollment, preferably prior to initiating the clinical portion of the service authorization review. Any requests received for MCO enrolled members, for services other than those listed as an MCO carved-out service or as a service that qualifies for the individual for exemption from the MCO (see Section 4.5.5 of this RFP) shall be rejected.

4.5.4 Retrospective Reviews

The Contractor shall perform retrospective service authorization reviews and shall receive these reviews via X12 278 transactions, direct data entry, telephonic, fax and US Mail. Retrospective review is warranted when a patient's eligibility for Medicaid coverage has been determined after the service has occurred and retroactive eligibility has been granted or as permitted by DMAS regulation or policy.

Retrospective review may also be required for patients who have Medicare Parts A or B coverage. Service authorization is not required for patients dually eligible for Medicare Parts A

or B unless Medicare has denied the service or the Part A or B coverage has been exhausted. Once Medicare has issued a denial or has indicated that the Part A or B coverage is exhausted, Medicaid coverage becomes primary and authorization will be required retrospectively. Offerors shall submit in their proposal a method to recognize exhaustion or denial of Medicare Parts A or B coverage.

4.5.5 MCO Carved-Out Services and Services that Exclude Individuals from MCO Participation

As previously described in this RFP, the MCOs provide coverage including service authorization activities for most Medicaid/FAMIS covered services for its members. There are some Medicaid/FAMIS covered services that are “carved-out” of the MCO contracts. For MCO enrolled individuals, coverage for carved-out services is handled through the FFS program. Some of these carved-out services require service authorization by the Contractor.

Carved-out services include, but are not limited to, the following: community mental health rehabilitation and substance abuse treatment services (Medicaid and FAMIS); home and community based care waiver services (Medicaid); EPSDT personal care (Medicaid); specialized nutritional supplements for children under age 21 (Medicaid and FAMIS); early intervention services (Medicaid and FAMIS); and, school health services (Medicaid and FAMIS). Reference the complete listing of carved-out services at http://www.dmas.virginia.gov/downloads/pdfs/mc-mdlnII_covout_srvcs.pdf.

In addition, there are also some Medicaid covered services that require an MCO member to be excluded from managed care participation, based upon approval by the Contractor. These services include:

- Inpatient care (hospitalized) at the time of MCO enrollment (includes inpatient acute, psychiatric, EPSDT psychiatric, and inpatient rehabilitation settings) – Individuals who are admitted as FFS members, and who subsequently become enrolled with the MCO prior to discharge from an inpatient setting, will be excluded from MCO participation until after they are discharged. MCO enrollment will not occur until the first of the month following the month in which the individual is discharged. DMAS’ managed care staff is notified by area hospitals at the end of each month regarding all Medicaid individuals who have not been discharged by the last day of the month. Hospitals follow the process described on the DMAS website at: http://www.dmas.virginia.gov/downloads/pdfs/mc_mdlnII_hsptlzd_enrlmnt.pdf;
- Admission to a state owned mental health/psychiatric hospital beyond the TDO timeframe;
- Admission to an approved residential treatment facility (under age 21 only); and
- Authorized services for treatment foster care case management (TFC-CM).

The Contractor shall:

- A. notify DMAS’ managed care staff of any instance in which a service authorization entry is needed for individuals who meet the *hospitalized at the time of enrollment* criteria. DMAS managed care staff will delay MCO enrollment in accordance with the established managed care enrollment guidelines.
- B. have a method in place to honor the MCO service authorization for individuals that transition from the MCO to FFS during the service authorization timeframe. Conversely, the MCO will honor the FFS authorization for individuals who transition from FFS to the MCO during the service authorization timeframe.

The Contractor shall not be responsible for authorization of services that are covered under the Department's MCO contracts. However, the Contractor must perform service authorization for MCO enrolled individuals for certain Medicaid and FAMIS covered services *that are not covered under the MCO contract*. Currently, these services include:

- Carved-Out Services (described above)
- Services that exclude an individual from MCO participation (described above)

4.5.6.1 Behavioral Health - Virginia Independent Clinical Assessment Program (VICAP)

The Independent Clinical Assessment (ICA) process is an administrative Medicaid pilot program that is required as a part of the service authorization process for individuals under 21 years of age receiving Community Mental Health Rehabilitative Services (CMHRS) until the Contractor assumes the responsibility of conducting clinical assessments. DMAS currently contracts with local Community Services Boards (CSBs) or the Behavioral Health Authority (BHA) to conduct the independent clinical assessment for youth receiving or referred for Intensive In Home (IIH), Therapeutic Day Treatment (TDT), and Mental Health Support Services (MHSS). Children and adolescents who are being discharged from residential treatment (DMAS Levels A, B, or C) do not need an independent clinical assessment to access IIH, TDT, or MHSS. They are required to have an independent clinical assessment as part of the first service reauthorization.

Individuals completing clinical assessments shall be conducted by an individual who meets the licensed mental health professional definition listed in Section 1.2. In addition, individuals who conduct the independent clinical assessment shall not supervise the provision of recommended mental health or substance abuse services nor directly provide the recommended services for that child and family.

The Offeror shall outline its own proposed assessment process as a component of its Care Coordination strategy to stratify members into different levels of care, based on a member's comprehensive needs assessment as outlined in Section 4.6. This process will ensure that clinical assessments are performed efficiently and correctly so that the appropriate individuals receive the appropriate services in a timely manner.

4.6 Care Coordination

The Offeror must develop a strategy to stratify members into different levels of care, based on a member's comprehensive needs assessment. The Offeror's risk stratification shall consist of a minimum of the following components:

- Level One: Administrative Care Coordination For All Members. All members seeking non-traditional or traditional services that are not covered by managed care organizations will contact the Contractor. The Contractor will triage the member's needs via an assessment and determine if outpatient clinic services or other CMHRS are needed. Level 1 care coordination consists of the following:
- i. Access to a toll-free customer service line;
 - ii. Provide information on behavioral health service options;

- iii. Clinical assessment of the member's behavioral health status. This may include a brief assessment for traditional services, but must include a more comprehensive needs assessment process similar to the current independent clinical assessment process as described in Section 4.5.6.1 for all individuals in need of non-traditional behavioral health services. Clinicians who perform assessments cannot directly provide behavioral health services to the individual without approval by the Department. Assessments may be performed face to face or through using telehealth approaches as defined in DMAS policy;
- iv. Referral of member to appropriate community resources in the member's region;
- v. Conduct service authorization for members who may need behavioral health services; and
- vi. Monitor service utilization and trends.

Level Two: Expanded Care Coordination (also known as Targeted Case Management) for Members Who Have a SED or SMI diagnosis and who may have been hospitalized, have complex needs, or who are at risk of SED and/or out of home placement. Members who have serious mental illness or serious emotional disturbance requiring significant service coordination or intensive services including intensive in-home services, therapeutic day treatment, mental health support services or psycho-social services may receive Targeted Case Management including:

- i. Developing a person-centered, recovery oriented comprehensive service plan;
- ii. Ensuring that member-level interventions are implemented;
- iii. Continuously monitoring the progress of the member;
- iv. Ongoing assessment of individual's needs and resources to identify service needs.
- v. Coordination with all local human services agencies and social service agencies;
- vi. Maintaining and monitoring individual service records;
- vii. Identifying gaps between care recommended and actual care provided, and propose and implement interventions to address the gaps;
- viii. Re-evaluating the member's risk level and adjust the level of care management services accordingly.
 - ix Participating in pre-admission behavioral health screening prior to and in discharge planning (to include institutional discharge), when appropriate, to ensure awareness of and access to community-based services;
 - x Assure access to and coordination with primary healthcare services i.e. health navigator or health connector
 - xi Setting up appointments and transportation as needed; and
 - xii. Shepherding information between providers.

Level Two Care Coordination (targeted case management), while monitored by the Contractor, shall be provided by the Community Services Boards or their subcontractor at the payment rate set by the Department utilizing systems of care methodologies, as appropriate.

4.7 Access to and Availability of Care

The Contractor shall arrange for the provision of behavioral health services as described as covered by the Contractor in this RFP for individuals across the lifespan. The Contractor shall maintain under contract, a statewide provider network of behavioral health providers at geographical locations that meet the accessibility requirements outlined in this RFP.

4.7.1 Access to Care

The Contractor shall maintain a network of behavioral health providers with a sufficient number of providers who accept covered Medicaid/FAMIS Plus and FAMIS members within each geographical location in the Commonwealth. The Offeror shall document in its proposal its standards for appointment waiting times and how it will provide access to behavioral services for crisis situations without requiring service authorization.

Where there is not a participating provider within the contract access standards, the Contractor must provide care coordination services, as described in Section 4.6 of this RFP, to assist the member in accessing timely services from the nearest participating provider available. Additionally, the Contractor must notify the Department of any variance from the network requirements as outlined in this RFP and must provide a plan for corrective action that addresses the network deficiency and includes the requirements described in Section 4.9 of this RFP.

4.7.2 Provider Choice

Each member shall be permitted to obtain covered services from appropriate behavioral health provider participating in the Contractor's network that is accepting new members.

4.7.3 Contract Time and Distance Standards

The Contractor shall maintain under contract a network of behavioral health providers to provide the covered services described in Section 2 statewide. The Contractor shall make services and service locations available and accessible so that patient transport time to behavioral health providers will not exceed thirty (30) minutes, with the exception of Levels A and B Residential Services, PRTFs, Inpatient Services, and in rural areas where documented community standards will apply.

The Contractor shall ensure that a member is not required to travel in excess of thirty (30) miles in an urban area and sixty (60) miles in a rural area to receive behavioral health services, unless the member so chooses. An exception to this standard may be granted when the Contractor has established, through utilization data provided to the Department, that a normal pattern for securing behavioral health services within an area falls beyond the prescribed travel distance.

4.7.4 Monitoring Access to Care

The Contractor shall establish a system to monitor access to care to ensure that the access standards set forth in this Contract are met. The Contractor shall be prepared to demonstrate to the Department that these access standards have been met or must take corrective action when there is a failure to comply.

4.8 Outreach Activities

4.8.1 Appointment Assistance

The Contractor shall make reasonable efforts to directly assist members in obtaining appointments for covered services, including facilitating member contact with a participating behavioral health provider to establish an appointment. If the member has a Case Manager (Level Two Care Coordinator), the Contractor shall refer the member to the Case Manager to assist with this process. The Contractor shall make reasonable efforts to identify causes of member non-compliance with recommended services and assist in the provision of appropriate services. Contractor shall provide special assistance to individuals calling to express their difficulty in accessing an appointment with an in-network provider. This special assistance includes following-up with the member (and when necessary the behavioral health provider) to make sure that the member receives an appointment for the needed services within the contract appointment and distance standards. The Contractor shall track and report to the Department monthly the number of requests for assistance to obtain an appointment, including the city/county area, percentage of requests per city/county area and the average length of time required to assist the member(s).

Where there is not a participating provider within the contract access standards, the Contractor must provide assistance to the member in accessing timely services from the nearest participating provider available including coordinating/calling transportation services when needed. Additionally, the Contractor must notify the Department of any network deficiencies and must provide a detailed, written plan for corrective action with a timeline that addresses the network deficiencies.

4.8.2 Coordination with Managed Care Organizations

The Contractor shall work closely and cooperatively with the managed care organizations(s) to accomplish the goals of their acute, primary, and behavioral health programs. Identification of eligible MCO members with urgent behavioral health needs as well as identification of members with unmet acute/primary health needs will require the Contractor to refer them to the MCO to obtain care for these eligible individuals according to the access standards identified in Section 4.7 of this RFP. Close coordination between the Department's Behavioral Health Unit, the MCOs and the Contractor will be necessary to facilitate referral arrangements.

The Department will work with the Contractor and the MCOs to identify encounter data that will be shared monthly among the MCOs and the Contractor to ensure care coordination is facilitated between acute, primary and behavioral health services.

4.8.3 Coordination with Other Entities

The Contractor shall work closely and cooperatively with external and community entities, including but not limited to case management providers in local communities, community services organizations, advocacy groups, behavioral health providers, managed care organizations, transportation vendors, schools, health departments, local departments of social services, family members, dental vendor, and other interested parties, when such parties are working on behalf of the member in relation to securing needed behavioral health care for the member. The Contractor's response shall comply with HIPAA and Medicaid confidentiality requirements, and at minimum shall include following up with the member or the member's responsible party in relation to the issue/need communicated by the interested party.

4.9 Network Development and Provider Relations Requirements

Medicaid/FAMIS Plus and FAMIS members' access to behavioral health is highly dependent on a reliable network of providers who are treated respectfully for their work. The Contractor shall have an effective and efficient program for network development and management. As described in Section 4.8.8, the Department's Medicaid agreement shall be included as part of the Contractor's provider credentialing packet. The Contractor's network development and management program shall include strategies to address barriers to provider participation throughout the Commonwealth, but should also reflect targeted efforts for the rural areas of the Commonwealth. The Contractor shall report the provider development and management activities (including what, when, where and how) to the Department on a monthly basis, and must include a network and service analysis (GeoAccess study) reflecting totals by region. Service analysis shall include service gaps and areas in which there is provider saturation by region. The Contractor shall coordinate its efforts with the behavioral health provider community and Community Services Boards. The DMAS Behavioral Health Provider Listing is available on the Department's website at http://www.dmas.virginia.gov/provider_search.ASP.

The number of Medicaid enrolled behavioral health providers who were reimbursed for providing services are located in Attachment XVII.

The Contractor shall educate providers to follow program requirements identified by the Department consistent with manual and regulatory requirements and with EPSDT program requirements. (See Attachment IIb of this RFP.) The Offeror shall propose a schedule for provider trainings. All training methods and materials to be utilized must be approved by DMAS.

Ad hoc reports related to network status may be requested by the Department at no additional cost to the Department not to exceed five (5) requests per contract year.

4.9.1 Behavioral Health Services Delivery System

The Contractor shall arrange for and administer covered behavioral health services to Medicaid/FAMIS Plus and FAMIS eligible members and must ensure that its behavioral health services delivery system will provide available, accessible and adequate numbers of behavioral health providers, and appropriate locations for the provision of covered services. The Contractor shall document in the response to this RFP how this delivery system will be established. In establishing and maintaining the network, the Contractor shall consider all of the following:

- i. the anticipated Medicaid/FAMIS Plus and FAMIS enrollment;
- ii. the expected utilization of services, taking into consideration the characteristics and behavioral health care needs of the anticipated Medicaid/FAMIS Plus and FAMIS population to be served;
- iii. the numbers and types (in terms of training and experience, and specialization) of providers required to furnish the contracted services;
- iv. the geographic location of providers and members, considering distance, travel time, and the means of transportation (including public transit) ordinarily used by Medicaid/FAMIS Plus and FAMIS members; and
- v. whether the location of service provision provides physical access for members with disabilities.

4.9.2 Provider Network Requirements

The Contractor's network shall include the following classes of providers in numbers that are sufficient to enable Contractor to furnish services described in this RFP in accordance with the timeline, geographic and other standards described within this RFP:

- a Community mental health rehabilitative service providers; and
- b Levels A and B Residential Treatment providers; and
- c Psychiatric Residential Treatment Facility (Level C) providers; and
- d Substance use providers; and
- e Outpatient psychiatric providers; and
- f Inpatient psychiatric providers.

The Offeror shall describe how it will grandfather the existing Medicaid FFS behavioral health provider network upon implementation of this contract, and accept willing qualified behavioral health service providers who request to be enrolled, providing they meet enrollment requirements outlined within this section. As described in Section 4.9.7, the Department's Medicaid agreement shall be included as part of the provider credentialing packet. The Contractor is also encouraged to develop and maintain a list of referral sources which includes community agencies, State agencies, "safety net" providers, teaching institutions and facilities that are needed to ensure that the members are able to access and receive the full continuum of treatment services and support.

4.9.3 Comprehensive Network of Service Providers with Appropriate Demographic Placement

The Offeror shall submit the following provider network analysis report as part of its proposal package. In lieu of letters of intent, the Offeror can provide a detailed strategy for provider development and maintenance activities. The Offeror's strategy should include a quantitative analysis of the planned activities and expected recruitment results based upon the Offeror's prior experience or related research analysis. Additionally, upon implementation of the Contract resulting from this executed RFP, the Contractor must submit the required network analysis information on a monthly basis and annually:

- i. A listing in Microsoft Excel, on diskette or CD, in a format agreed upon by the Department and the Contractor, of all enrolled providers within the Contractor's proposed network. (Letters of intent will be acceptable for purposes of this RFP). Column headings shall be those listed below:
 - Provider First name
 - Provider Last name
 - Provider organization name
 - Provider service type and level of care
 - Specialty
 - City, State, Zip of the physical office location(s) NOT the billing/payment location
 - County

- Office telephone number
 - Tax ID number
 - License number
 - NPI number
 - Email address
 - LEIE verification date
 - Additional language abilities (other than English)
 - Status of contract (letter of intent or signed contract)
- ii. Sample contracts for each provider type.
- iii. A description of educational, outreach, training programs and any other services that are rendered by the Offeror to its providers, including any provider telephone help lines. The Contractor must develop an annual schedule and provide trainings for all Medicaid behavioral programs. The Department will review and approve all training methods and materials prior to being utilized by the Contractor.
- v. A description of claims and service authorization processing policy and procedures, including service authorization and claims submission options for services requiring service authorization, timeframes/standards for authorization approvals and provider payment.
- vi. As part of on-going network management activities, the Contractor shall track provider network changes to include office location and provider changes/terminations, and when possible shall capture the reasons for provider termination/disenrollment. Reasons for provider termination/disenrollment and attempts made to retain provider (if attempt is warranted) must be reflected in the Contractor's monthly and annual provider network analysis report to the Department.

4.9.4 Policy of Nondiscrimination

The Contractor shall ensure that its providers provide contract services to members under this Contract at the same quality level and practice standards as provided to non-Medicaid members.

4.9.4a Nondiscrimination-Special Needs

The Contractor shall ensure that its providers provide contracted services without discrimination to Medicaid members with special needs to include communication and language barriers.

4.9.4b Effective Communication

The Contractor shall ensure that its providers can communicate effectively and when necessary, can assist the provider in obtaining the appropriate accommodation requirements. Providers shall not be required to accept or continue treatment of a member with whom the Provider feels he/she cannot establish and/or maintain a professional relationship, or is beyond the scope of Provider's expertise or ability.

Should a provider discontinue treatment with a member, the Offeror shall propose a procedure to appropriately transfer member care to another treating provider including time frames and clinical support.

4.9.5 Provider Licensure, Credentialing and Certification Standards

The Contractor shall demonstrate that service providers in the behavioral health network are licensed by the State, are in compliance with state and federal regulations, and have been enrolled by the Contractor to perform behavioral health services contracted for under this RFP. Should the network include behavioral health service providers from states in close proximity to the Commonwealth, the Contractor shall demonstrate that service providers are licensed in the state in which they practice and have licensure to provide services that are similar to Virginia's licensing requirements for those services contracted for under this RFP.

The Contractor shall not execute provider agreements with providers who have been excluded from participation in the Medicare and/or Medicaid programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with the Department of Behavioral Health and Developmental Services or applicable licensing board/agency. Licensing regulations for the Department of Behavioral Health and Developmental Services may be found at 12 VAC 35-105 et seq.

The Contractor's standards for licensure and certification shall be included in its participating provider network agreements. The Contractor shall ensure that providers include any disciplinary or adverse action histories from the Virginia Department of Behavioral Health and Developmental Services or the appropriate Licensing Boards through the Department of Health Professions.

The Contractor shall have written policies and procedures for their credentialing process. The Contractor's recredentialing process shall include the consideration of performance indicators obtained through the quality improvement plan (QIP), utilization management program, grievance and appeals system, and member satisfaction surveys. The Contractor shall perform an annual review on all subcontractors to ensure that vendors under contract with the subcontractor are qualified to perform the services covered under this RFP and resulting Contract. The Contractor must have in place a mechanism for reporting to the appropriate authorities any actions that seriously impact quality of care and which may result in suspension or termination of a service provider's license. The Offeror shall submit a copy of their provider credentialing standards in the response to this RFP. The Department reserves the right to negotiate final approval of the Contractor's credentialing requirements. The BHSA's credentialing packet shall include Federal, State, and DMAS' provider participation requirements. See the current Provider agreement, which includes these requirements (Federal, State, and DMAS) as well as the current BHSA's participation requirements, available on the web at: <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderEnrollment>. DMAS reserves the right to approve the BHSA's credentialing packet/participation agreement at start-up and prior to implementing any changes.

The Contractor shall ensure provider adherence to marketing requirements as outlined in 12VAC30-130-2000 Marketing Requirements and Restrictions. (Reference Virginia Register July 18, 2011)

4.9.6 Provider Enrollment into Medicaid

The Contractor shall ensure that all qualified behavioral health providers enroll in the Virginia Medicaid program. The Contractor shall coordinate provider enrollment of behavioral health providers into the Medicaid program with the DMAS Provider Enrollment Contractor.

4.9.7 Provider Contract Agreements

The Offeror shall submit with its proposal a complete copy of the provider agreement packet. The Contractor's final provider network agreement for participation shall be consistent with all applicable Federal and State laws and regulations and the requirements described in this RFP. The final provider network agreement language shall be developed by the Contractor and the Department, and must be approved by the Department prior to implementation and upon any revision.

All provider agreements executed by the Contractor, and all provider agreements executed by subcontracting entities or organizations, pursuant to this RFP shall comply with HIPAA privacy and security rules and regulations as described in this RFP.

Provider agreements shall specify that the provider shall accept payment or appropriate denial made by the Contractor (or, if applicable, payment by the Contractor that is supplementary to the member's third party payer) as payment in full for covered services provided and shall not solicit or accept any surety or guarantee of payment from the member. Member shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the patient being served.

Provider agreements shall include a provision whereby either the Contractor or the provider may terminate the provider agreement without cause within 30 days advance notice. The Contractor shall maintain an electronic copy of the provider application on file, and shall provide a copy of the provider application to the Department upon request.

4.9.8 Provider Termination

The Contractor or the behavioral health provider may terminate the provider agreement without cause with 30 days advance notice. If the Contractor terminates a provider agreement, the Contractor shall notify the provider of its appeal rights. The Contractor shall provide written notice to members receiving care within fifteen (15) calendar days from the date that the Contractor becomes aware that the provider will no longer be available to render services. Additionally, the Contractor shall provide the names of other behavioral health providers accepting Medicaid/FAMIS Plus and FAMIS patients in the member's locality. Each notice shall include all components identified in the notice template to be developed by the Contractor and approved by the Department. The timing requirement for the provision of this notice shall be waived in instances where a provider becomes physically unable to care for members due to illness, death or the provider moves from the service area and fails to notify the Contractor or when a provider fails credentialing, and instead the Contractor shall ensure that patients are made aware immediately upon the Contractor becoming aware of the circumstances. (Notice shall be issued in advance of the provider termination when possible or immediately upon the Contractor becoming aware of the circumstances.) In addition, the Contractor must notify and receive approval by DMAS prior to the termination of any participating provider.

DMAS will review and approve Contractor provider termination policies prior to their implementation by the Contractor.

4.9.9 Change in Provider Network Status

Upon final notification of a change in provider network status, or any variation from the requirements of this RFP, which shall be based on the requirements of this RFP, the Contractor shall immediately provide written notice to members living in the affected area of change in the

Contractor's network. The notice content shall be consistent with the notice template to be developed by the Contractor and approved by the Department. Additionally, the Contractor shall prepare and submit to the Department within five (5) business days of identifying any network deficiency a plan of corrective action to include a timeline for correction. The plan must detail the activities and associated time-lines the Contractor will employ to address the network deficiency and the assistance in locating a provider that it will provide to members that reside in the locality experiencing the deficiency.

4.9.10 Notice of Provider Termination to the Department

The Contractor shall notify the Department of any provider termination and submit a template copy of the member notice sent as well as an electronic listing identifying each member to whom a notice was sent. The Contractor shall maintain a copy of the actual notice on-site and forward a copy of the notices upon request from the Department. If the provider initiated the termination, said notice shall include a copy of the provider's notification to the Contractor.

4.9.11 Provider Orientation, Education and Training

Prior to July 1, 2012, the Contractor shall submit a training plan that will indicate how the Contractor will conduct the initial statewide provider orientation initiative. The schedule and specific locations for the orientation sessions shall be submitted to and approved in advance by the Department.

4.9.11.a The Contractor shall work with representatives of the provider community and the Department to develop the agenda for the initial statewide provider orientation to identify the most effective ways to encourage attendance.

4.9.11.b The Contractor shall alert providers to the various meetings through direct mailings, coordination with professional organizations, notices posted to the Contractor's website and through personal invitations issued by Contractor staff.

4.9.11.c The Contractor shall, following the initial statewide and local provider orientation sessions, determine in conjunction with the Departments, whether the initial orientation sessions should be repeated at one or more locations to further encourage provider participation.

The Contractor shall also submit a training plan that will describe semi annual training for participating behavioral health providers throughout the Commonwealth and must include methods offered toward helping providers to interface their system with the Contractor's system. At a minimum, training shall address behavioral health service eligibility criteria, definitions and documentation requirements, service authorization, utilization, billing procedures, and other pertinent provisions of these services. The Contractor may hold on-site or web-based provider training with the Department's approval of schedule, content and training materials (e.g., teleconferencing, web-based training, etc.). Updated training materials shall be available on the Contractor's website within two weeks of the initiation of provider training. The Contractor shall submit all training material to the Department for approval at least sixty (60) calendar days prior to the training session. The Department will have fifteen (30) calendar days to review and request changes, if necessary. If changes are requested, the Contractor must resubmit the training material within ten (10) calendar days of receipt of the Department's comments.

The Contractor shall also have the ability to provide individual training and targeted technical assistance as needed and as requested by providers using both clinical and administrative staff.

The Contractor shall have systems capability to educate and update providers through e-mail blasts and text messaging.

The Contractor shall provide documentation of all formal training activities and individualized corrective action assistance to the Department on a quarterly basis.

4.9.12 Provider Manuals

The Contractor must publish on their website the DMAS provider regulations, manuals, and memos for services which require registrations and service authorizations or have a direct link to the DMAS website manuals home page. The Contractor shall have a link on their website to the DMAS website. The Contractor must update the website with revised manuals as notified by DMAS, if the actual manuals are published on the Contractor's website.

4.9.13 Provider Reconsideration Process

The Contractor shall develop policies and procedures to allow providers an opportunity for review and reconsideration of Contractor decisions. The reconsideration process shall be defined in the Contractor's agreement with the behavioral health provider. The Contractor's review and reconsideration process must be reviewed and approved by the Department prior to implementation. The Contractor shall notify providers of their rights to appeal adverse actions to the Department if the review and reconsideration does not resolve the provider's challenge(s). The Contractor will provide DMAS with monthly reports indicating the number of reconsideration requests received as well as their detailed analysis and final disposition.

4.9.14 Provider Appeals to DMAS

Medicaid providers have the right to appeal adverse decisions to the Department. The Contractor shall inform providers of their right to appeal to the Department. The Contractor shall assist DMAS by presenting the Department's position in the administrative appeals process in conjunction with appeals of Contractor actions filed by providers. In addition to the reconsideration process, DMAS has two levels of administrative appeals generally referred to as the informal level and the formal level. At the informal level the Contractor prepares the DMAS appeal summary and represents DMAS at an informal conference with the provider before a DMAS employee Appeals Agent. At the formal level, the Contractor assists DMAS staff counsel in preparing the case summary, complies with any subpoena or deposition requests that may be issued pursuant to the Virginia Administrative Process Act, and acts as a witness at a hearing before a hearing officer as appointed by the Virginia Supreme Court. Upon receipt of notification of an appeal by the Department, the Contractor shall prepare and submit appeal summaries to the DMAS Appeals Division, the DMAS Contract Monitor, and the provider involved in the appeal in accordance with required applicable regulatory requirements and timeframes. The appeal summary content and timelines are specified by appeal regulations. The Contractor shall comply with all state and federal laws, regulations, and policies regarding the content and timeframes for appeal summaries. Failure to submit appeals summaries within the required timeframe and according to the applicable regulatory requirements shall result in the Contractor being liable for any costs that DMAS incurs as a result of the Contractor's noncompliance, including but not limited to the amount in dispute together with costs and legal fees.

The Contractor shall attend and defend the Contractor's decisions at all appeal hearings or conferences, whether informal or formal, or whether in person or by telephone, or as deemed necessary by the DMAS Appeals Division. All appeal activities, including but not limited to, travel, telephone expenses, copying expenses, staff time, document retrieval and storage, shall be borne by the Contractor. Failure to attend or defend the contractor's decisions at all appeal hearings or conferences shall result in the Contractor being liable for any costs that DMAS incurs as a result of the Contractor's noncompliance, including but not limited to the amount in dispute together with costs and legal fees and as provided in Attachment III of this RFP.

4.9.15 Provider Grievance Process to the Contractor

The Contractor shall have a grievance process in place available to providers who wish to file a grievance. This process must assure that appropriate decisions are made as promptly as possible. The Contractor must develop policies and procedures regarding the grievance process. These must be reviewed and approved by the Department prior to implementation. The Contractor shall notify providers of the grievance process with the Contractor. The Contractor will provide DMAS with monthly reports indicating the number of grievance requests received as well as the detailed analysis and disposition.

4.10 Member Grievance Process and Appeals to the Contractor

The Contractor shall have a grievance and appeal process in place available to Medicaid/FAMIS Plus and FAMIS members who wish to file a grievance or an appeal. This process must assure that appropriate decisions are made as promptly as possible. The appeals process shall include provisions for expedited appeals within three (3) working days. The Contractor must develop policies and procedures regarding the grievance and appeal processes. These must be reviewed and approved by the Department prior to implementation. The Contractor shall notify members of their rights to grievances and appeals with the Contractor. The Contractor will provide DMAS with monthly reports indicating the number of grievances and appeal requests received as well as the detailed analysis and disposition.

4.11 Member Appeals to DMAS

Medicaid/FAMIS Plus and FAMIS Members have the right to appeal most adverse actions by the Contractor directly to the Department as described in 42 CFR §431 *et seq.*, and the Virginia Administrative Code at 12VAC30-110-10 through 370. The Contractor shall notify the members of their right to appeal to the Department. Upon receipt of notification by the Department of an appeal, the Contractor shall prepare and submit appeal summaries to the DMAS Appeals Division, the DMAS Contract Monitor, and member involved in the appeal in accordance with required time frames. The Contractor shall comply with all state and federal laws, regulations, and policies regarding the content and timeframes for appeal summaries. Failure to attend and defend the Contractor's actions at all appeal hearings and/or conferences shall result in the application of liquidated remedies as described in Attachment III of this RFP.

The Contractor shall attend and defend the Contractor's decisions at all appeal hearings or conferences, or whether in person or by telephone, or as deemed necessary by the DMAS Appeals Division. Contractor travel and telephone expenses in relation to appeal activities shall be borne by the Contractor.

4.12 Excluded Entities and Disclosure of Ownership and Control Information

4.12.1 Legal Responsibility

In accordance with requirements described in 42 C.F.R. § 455 Subpart B, and the State Medicaid Director Letter SMDL #08-003 (available at <http://www.cms.gov/smdl/downloads/SMD061208.pdf>), the Contractor shall comply with all of the following Federal requirements. Failure to comply with accuracy, timeliness, and in accordance with Federal and Contract standards may result in refusal to execute this Contract, termination of this Contract, and/or liquidated remedies by the Department.

1. Contractor Owner, Director, Officer(s) and/or Managing Employees

(a) The Contractor and or its subcontractors shall not knowingly have a relationship of the type described in paragraph (b) of this section with:

- (1) An individual or entity who is debarred, suspended, or otherwise excluded from participating in Federal health care programs, as listed on the federal List of Excluded Individuals/ Entities (LEIE) database at http://www.oig.hhs.gov/fraud/exclusions/exclusions_list.asp or excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
- (2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (a)(1) of this section.

(b) The relationships described in this paragraph are as follows:

- (1) A director, officer, or partner of the Contractor
- (2) A person with beneficial ownership of five percent or more of the Contractor's equity.
- (3) A person with an employment, consulting or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under this contract with the Department.

(c) Consistent with Federal disclosure requirements described in 42 C.F.R. § 455.100 through 42 C.F.R. and § 455.106 the Contractor and its subcontractor(s) shall disclose the required ownership and control, relationship, financial interest information; any changes to ownership and control, relationship, and financial interest, and information on criminal conviction regarding the Contractor's owner(s) and managing employee(s). The Contractor shall provide the required information using the *Disclosure of Ownership and Control Interest Statement (CMS 1513)* included as part of the MCO Specific Contract Terms and Signature Pages, annually at the time of Contract signing.

(d) The Contractor and its subcontractor(s) shall perform, at a minimum, a monthly comparison of its owners and managing employees against the LEIE database to ensure compliance with these Federal regulations. The LEIE database is available at http://www.oig.hhs.gov/fraud/exclusions/exclusions_list.asp.

(e) The Contractor shall report to the Department within five business days of discovery of any Contractor or subcontractor owners or managing employees identified on the Federal List of Excluded Individuals/Entities (LEIE) database and the action taken by the Contractor.

(f) Failure to disclose the required information accurately, timely, and in accordance with Federal and Contract standards may result in refusal to execute this Contract, termination of this Contract, and/or liquidated remedies by the Department.

2. Contractor and Subcontractor Service Providers

(a) In accordance with 1902(a)(39) and (41), 1128, and 1128A of the Social Security Act, § 438-610, 42 C.F.R. § 1002, and 12 VAC 30-10-690 of the Virginia Administrative Code and other applicable federal and state statutes and regulations, the Contractor (including subcontractors and providers of subcontractors) shall neither participate with nor enter into any provider agreement with any individual or entity that has been excluded from participation in Federal health care programs or who have a relationship with excluded providers of the type described in paragraph 1(b) above. Additionally, the Contractor and its subcontractor are further prohibited from contracting with providers who have been terminated from the Medicaid or FAMIS programs by DMAS for fraud and abuse. Additional guidance may be found in the Department's 4/7/09 Medicaid Memo titled Excluded Individuals/Entities from State/Federal Healthcare Programs.

(b) The Contractor shall inform providers and subcontractors about Federal requirements regarding providers and entities excluded from participation in Federal health care programs (including Medicare, Medicaid and CHIP programs). In addition, the Contractor should inform providers and subcontractors about the Federal Health and Human Services – Office of Inspector General (HHS-OIG) online exclusions database, available at <http://exclusions.oig.hhs.gov/>. This is where providers/subcontractors can screen managing employees, contractors, etc., against the HHS-OIG website on a monthly basis to determine whether any of them have been excluded from participating in Federal health care programs. Providers and subcontractors should also be advised to immediately report to the Contractor any exclusion information discovered. The Contractor must also require that its subcontractor(s), have written policies and procedures outlining provider enrollment and/or credentialing process. The Contractor and its subcontractor(s) shall perform, at a minimum, a monthly comparison of its providers against the LEIE database to ensure that their contracted health care professionals have not been included on the Federal List of Excluded Individuals/ Entities (LEIE) database, available at http://www.oig.hhs.gov/fraud/exclusions/exclusions_list.asp. Federal health care programs include Medicare, Medicaid, and all other plans and programs that provide health benefits funded directly or indirectly by the United States.

(c) The Contractor shall report to the Department within five business days of discovery of any network providers or its subcontractor providers that have been identified on the Federal LEIE database and the action taken by the Contractor.

(d) Failure to disclose the required information accurately, timely, and in accordance with Federal and Contract standards may result liquidated remedies by the Department in accordance with this subsection of the Contract.

4.12.2 Claims Processing

All claims for services furnished to a member filed with the Contractor must be processed by either the Contractor or by one (1) subcontractor retained by the organization for the purpose of processing claims.

4.12.3 Notice of Subcontractor Termination

When a subcontract that relates to the provision of services to members or claims processing services is being terminated between the Contractor and a subcontractor, the Contractor shall give at least thirty (30) days prior written notice of the termination to the Department. Such notice shall include, at a minimum, a Contractor's intent to change to a new subcontractor for the provision of said services, an effective date for termination and/or change, as well as any other pertinent information that may be needed. In addition to prior written notice, the Contractor shall also provide the Department with a transition plan, when requested, which shall include, at a minimum, information regarding how service authorization requests will be handled during and after the transition, and how continuity of care will be maintained for the members. The Contractor's transition plan shall also include provisions to notify impacted or potentially impacted providers and members of the change. Failure to adhere to guidelines and requirements regarding administrative responsibilities, including subcontract requirements may result in the application of liquidated remedies as described in Attachment III of this RFP. The Department reserves the right to require this notice requirement and procedures for other subcontracts if determined necessary upon review of the subcontract for approval.

4.13 Quality and Utilization Management

4.13.1 Quality and Appropriateness of Care

The Contractor shall prepare for the Department's approval a written description of a quality monitoring/quality improvement (QM/QI) program and peer review program to include policies and procedures outlining the objectives, scope, activities for ongoing monitoring, evaluation and improvement of the quality and appropriateness of behavioral health services, including a strategy to improve broken appointment rates. The written program shall include an outcomes measurement tool for reporting and measuring results. The plan(s) shall describe who is responsible and the role of the Contractor's Behavioral Health Director in utilization review.

The QM/QI program shall also include a plan to monitor and report individual member utilization where members routinely seek care from multiple behavioral health providers and shall include a strategy to intervene and educate the member on the importance of establishing a behavioral health home for care. The Department will work with the Contractor to establish additional reporting parameters. Applicable reporting shall occur quarterly.

In response to this RFP, the Offeror must submit QM/QI materials from contracts similar in scale to the requirements outlined in this RFP.

4.13.2 QM/QI Meeting Requirements

The Contractor shall provide the DMAS Behavioral Health Manager with ten (10) calendar days advance notice of all regularly scheduled meetings, to occur twice per year, of the Quality Monitoring/Quality Improvement Committee and Peer Review Committee. The Quality Monitoring/Quality Improvement Committee shall include at least two individuals who have a behavioral health disorder, two participating behavioral health providers, one MCO representative, and at least two family members of an individual with a behavioral health

disorder. The Contractor will submit the names of proposed Quality Monitoring/Quality Improvement Committee members to the Department within sixty (60) calendar days after the execution date of this RFP for review and approval.

To the extent allowed by law, the DMAS Behavioral Health Manager of the Department, or his/her designee, may attend the QM/QI meetings at his/her option. In addition, written minutes shall be kept of all meetings of the QM/QI Committee. A copy of the written minutes for each meeting shall be forwarded to the Department within thirty (30) calendar days after the meeting date.

4.13.3 Peer Review Committee

The Contractor shall establish a Provider Peer Review Committee that shall meet two times per year (unless additional case reviews are needed) to review the processes and outcomes of Medicaid/FAMIS Plus and FAMIS behavioral health services provided to members. Contractor will submit the names of proposed members to the Department within sixty (60) calendar days after the execution date of this RFP for review and approval. The Committee shall include at least five (5) participating behavioral health providers who file at least twenty five (25) Medicaid claims per year for each year they are on the Committee. The Contractor's Behavioral Health Director shall be the committee chairperson. The Department reserves the right to attend the meetings.

Responsibilities of the Committee Shall Include:

- i. Reviewing and recommending appropriate remedial action for any participating behavioral health provider who has provided poor quality of care, including referrals to the appropriate licensing agency.
- ii. Coordinating with the Department regarding imposition of any sanctions against a participating behavioral health provider who has provided poor quality of care, including termination.
- iii. Coordinating with the Department in regard to issues involving fraud or abuse by any participating behavioral health provider.
- iv. Reviewing and recommending appropriate action on grievances, appeals, or inquiries provided by members, participating behavioral health providers, or other persons regarding quality of care, access or other issues related to the behavioral health service delivery system program.

4.13.4 Policies and Procedures

The Contractor shall provide annually or more frequently as revisions occur, and upon request a written copy of its behavioral health management policies and procedures to the Department for approval. Said policies and procedures must clearly identify any services for which the Contractor will require network providers to obtain authorization prior to the provision of the service as well as any additional submissions that may be required for approval of a service. The Department will have thirty (30) calendar days to review and approve or request modifications to the policies and procedures. Should the Department not respond in the required amount of time, the Contractor shall not be penalized as a result of implementing the policies and procedures. However, failure

to respond timely shall not preclude the Department from requiring the Contractor to respond or modify the policy or operating guideline prospectively.

4.13.5 Standards of Care

Standards of care shall reflect published recommendations of nationally recognized authorities. Participating behavioral health providers shall not differentiate or discriminate in the treatment of any member on the basis of race, color, sex, religion, national origin, age, handicap, health, economic status or payment source.

The Contractor shall monitor provider compliance with state licensure and federal and state regulatory requirements, including EPSDT, related to behavioral health care and standard behavioral health clinical practice. The Contractor shall work with participating behavioral health providers to develop corrective action plans as appropriate in concert with state licensing authorities and/or DMAS to bring participating providers into compliance state licensure and federal and state regulatory requirements.

4.13.6 Exceptional Quality Improvement and Utilization Management Processes

The Offeror shall submit the following as part of its proposal:

- i. The Offeror's proposed quality improvement plan (QIP), to include linkages with administrative areas, and a description of the QI committee and its composition.
- ii. A description of provider credentialing and monitoring processes, including provider profiling reports.
- iii. A description of how the Offeror's member grievance and appeals process is linked to the QI program.
- iv. A description of the Offeror's system to identify over- and under-utilization of member services, and a description of how this system would extend to network providers.

4.13.7 Performance Reviews

The Contractor shall cooperate with any performance review conducted by the Department, including providing copies of all records and documentation arising out of Contractor's performance of obligations under the RFP. Upon reasonable notice, the Department may conduct a performance review and audit of Contractor to determine compliance with the RFP. At any time, if the Department identifies a deficiency in performance, the Contractor will be required to develop a corrective action plan to correct the deficiency including an explanation of how members will continue to be served until the deficiency is corrected.

4.13.8 RFP Transition Plan

The Offeror shall submit, as part of the proposal response, a transition or continuation of coverage plan that documents how it will provide coverage to the member who is under treatment for medically necessary covered behavioral health services the day before the effective date of this RFP. Offeror's transition plan shall describe any data needed from the Department. The Contractor shall authorize the continuation of said covered services without any form of service

authorization. The Offeror shall include how credentialing of current service providers will occur.

In order to ensure uninterrupted service delivery, the Contractor shall accept authorization files from the Department's contracted Service Authorization vendor, MCOs and/or the Department as directed to identify members for whom prior approvals were issued prior to the effective implementation date of this RFP. To the extent that the approvals are for covered services and are within the parameters of the Department approved policies and procedures for prior approvals, the Contractor will accept and honor those prior approvals.

4.13.9 Service Authorization Request Tracking

Each prior approval request processed by the Contractor shall be assigned a unique number and be maintained in a database designed by the Contractor that will contain all pertinent information about the request and be available to Call Center staff. This information will include, but will not be limited to: provider name and DMAS provider ID number, member name and Medicaid/FAMIS Plus or FAMIS ID number, procedure code(s) requested, requested units/visits, requested begin and end dates, procedure code(s) registered and/or authorized, registration and/or service authorized begin and end dates, and request disposition (approved, reduced or denied). The Contractor shall report to the Department a summary of all registration and service authorization activity on a monthly basis.

4.14 Claims Processing Requirements

The Contractor shall have in place an automated claims processing system capable of accepting and processing paper claims and claims submitted electronically. As part of their proposal submission, Offerors must describe its claim processes and how it will reimburse providers through Electronic Funds Transfer.

The Contractor shall ensure compliance with all DMAS service authorization and claims processing rules. Final claim processing requirements must be approved by the Department prior to implementation and upon any revision.

The Contractor shall process, as described herein, the provider's claims for covered benefits provided to members consistent with the Department's applicable policies and procedures and the terms of this RFP. Contractor shall also participate in the Department's efforts to improve and standardize billing and payment procedures. Claims processed volumes for behavioral health services are located in Attachment XVII.

The Contractor shall have a system in place that any functionality requiring an ICD must be ICD-10 compliant as of October 1, 2013.

4.14.1 Electronic Billing System

The Contractor shall maintain and promote an electronic data processing system for claims payment and processing and shall implement an electronic billing system for interested participating behavioral health providers in HIPAA X12 837 compliant transaction formats. The Contractor must make available to providers an electronic means of submitting claims. In

addition, the Contractor shall make every effort to assure at least ninety (90%) percent of claims received from providers are submitted electronically by 2014.

All participating behavioral health providers shall be provided the training necessary to submit their claims electronically and the Contractor shall submit strategy to ensure the use of electronic billing systems which rely on technology. The Contractor or any entities acting on behalf of the Contractor shall not charge providers for filing claims electronically. Providers may engage in electronic billing services from their Practice Management Service or through a Value Added Network (VAN) at their own cost. However, this provision shall not be construed to imply that providers may not be responsible for payment of applicable line fees and/or charges. The Contractor shall comply at all times with all recognized standardized paper billing forms/format.

The Contractor shall not revise or modify the standardized form or format itself. Further, the Contractor agrees to adopt national standards and standardized instructions and definitions that are consistent with industry norms for the forms identified above when developed by the Department in conjunction with appropriate workgroups.

4.14.2 HIPAA and Industry Recommendations

The Contractor shall comply with Health Insurance Portability and Accountability Act (HIPAA) and applicable State privacy law requirements. Further, the Contractor agrees that the Department may present recommendations concerning claims billing and processing that are consistent with industry norms. The Contractor shall comply with said recommendations within sixty (60) calendar days from receipt of notice by the Department and at no additional charge to the Department.

4.14.3 Timeliness and Accuracy of Payment

The Contractor agrees to comply with prompt pay claims processing requirements in accordance with 42 C.F.R. § 447.45. The Contractor shall ensure that ninety percent (90%) of clean claims for payment of services delivered to members (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) calendar days of receipt of such claims. The Contractor shall process, and, if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all provider claims for services delivered. "Pay" means that the Contractor shall either send the provider cash or cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to Contractor. "Process" means the Contractor must send the provider a written remittance advice or other appropriate written notice evidencing either that the claim has been paid or informing the provider that a claim has been either partially or totally "denied" and specify all known reasons for denial. With the implementation of HIPAA requirements, this process must be electronic, resulting in the submission of an X12 835 transaction remittance advice to the provider. If a claim is partially or totally denied on the basis that the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written notice must specifically identify all such information and documentation. Resubmission of a denied claim with further information and/or documentation shall constitute a new claim for purposes of establishing the time frame for claims processing.

The Contractor shall provide to the Department a detailed claim processing report in the format reflected in Attachment VIII Behavioral Health Monthly Report. The report shall capture the

Contractor's performance with timely claims processing requirements and claim adjudication status applied (paid, denied, etc.)

Failure to comply with the aforementioned claims processing requirements shall result in the Contractor being required to implement a corrective action plan and shall result in the application of liquidated damages and/or immediate liquidated remedies as described in Attachment III of this RFP.

4.14.4 Reimbursement Rates for Behavioral Health Services

When the Department has established eligibility and the member has incurred behavioral health expenses that are covered benefits within the plan, the Contractor shall make reimbursement for behavioral health services at the Medicaid established fee-for-service rates. The DMAS Behavioral Health Fee File can be downloaded from the Department's web site at http://dmasva.dmas.virginia.gov/Content_pgs/obh-home.aspx. The Contractor shall not use capitation payment reimbursement methods or any type of non fee-for-service reimbursement methodology for services provided under this RFP and resulting contract. The Contractor shall require the provider to be enrolled with Virginia Medicaid prior to rendering services. The Contractor shall require that participating providers hold the member harmless for covered services, including any costs above the fee-for-services rates. The Contractor shall require, as a condition of payment, that the service provider accept the amount paid by the Contractor as payment in full.

As part of their proposal submission, Offerors shall provide a description of their timely filing requirements as based upon business practices. The Contractor shall process claims received within no more than 180 calendar days of the date of service. Additionally, the Contractor shall provide a process claims, including payments, voids, and adjustments, outside of timely filing requirements in cases of retroactive or delayed eligibility, accident cases, and as a result of delayed payment from the member's primary insurance payer. The Contractor shall maintain all claim record detail for at least 6 years from the claim adjudication date.

4.14.5 Behavioral Health Service Payments

The Contractor is not at financial risk for the provision of covered benefits to members. The Contractor shall prepare checks for payment to providers on a weekly basis and shall notify the Department of the amount to be paid in accordance with the terms described in Section 6 of this RFP.

Claims paid through the Contractor's system will be based upon enrollment information downloaded from the X12 5010 834 Benefit Enrollment and Maintenance transaction sent to the Contractor weekly. There could occur instances where the Contractor receives claims for eligible members, per the VaMMIS, but who were not included on the 834 Benefit Enrollment and Maintenance transaction sent by the Department to the Contractor. In these cases, the Contractor must pend the claim for the next 30 days following the weekly receipt of the updated 834 eligibility file and recycle such claims instead of denying them for eligibility/enrollment reasons.

4.15 Other Coverage

4.15.1 Other Insurance Coverage

The Contractor shall reject claims that should rightly be processed by a member's primary health care carrier. In addition, the system must allow for coordination of benefits in accordance with the Medicaid/FAMIS Plus and FAMIS "payer of last resort" rules. The Contractor is responsible for deductibles and coinsurance up to the maximum reimbursement amount that would have been paid in the absence of other primary insurance coverage for Medicaid/FAMIS Plus and FAMIS covered services.

4.15.2 Withholding Payments

The Contractor shall not withhold payment for services provided to a member if third party liability or the amount of liability cannot be determined, or third party liability payment will not be available within a reasonable time.

4.15.3 Recovery of Funds

All funds recovered from third parties shall be reported to the Department and treated as offsets to claims payments.

4.16 Subrogation Recoveries

The Department retains the responsibility to pursue, collect, and retain all non-health insurance resources such as casualty, liability, estates, child support, and personal injury claims. The Contractor is not permitted to seek recovery of any non-health insurance funds.

The Contractor shall notify the Department on a monthly basis of any members identified during that past month who are discovered to have any coverage not previously reported to the Contractor by the Department. The Contractor shall provide all claims data associated with care given to members in relation to accidents/traumas, and other coverage not reflected in the Department's enrollment information.

4.17 IRS Form 1099

The Contractor shall prepare and mail Internal Revenue Service ("IRS") Form 1099 to the IRS on behalf of providers who receive payments under this RFP. The Contractor shall provide a hard copy and, if requested, a magnetic tape transfer of form 1099 information to the providers for subsequent reporting of Form 1099 information to the IRS. In addition, the Contractor shall provide a hard copy, and if requested, a magnetic tape transfer of the 1099 information to the Department.

4.18 Interfaces, Supporting Files, and VaMMIS Access Requirements

In response to this RFP, the Offeror shall receive member eligibility data from VaMMIS, send encounter data, and provide supporting payment documentation of claims data, along with other information as required by the Department used for program monitoring and analysis as described in Section 4.18 and 4.19 of this RFP. The contractor must also be able to access VaMMIS via the internet.

Interface File Transfer Requirements

This contract requires that the Contractor establish connectivity with the Commonwealth's fiscal agent to exchange data files.

Currently, the fiscal agent uses a product named DMZ MoveIT for file data exchange. All files must be exchanged using this product maintained by the fiscal agent. During the requirements phase of this project it will be determined if these files will be pushed to or pulled from the fiscal agent's site.

4.18.1 Member Eligibility (834)

The Contractor will receive a weekly HIPAA compliant 834 Benefit Enrollment and Maintenance version 5010 transaction from the fiscal agent's secure FTP server. The Contractor will receive daily updates with newly added enrollees. The Contractor is responsible for completion of all data mapping necessary to update the Contractor's system with eligibility information to provide services to the covered members and support the reporting needs of the Commonwealth at no additional cost to the Department. The Contractor must have staff available to make mapping and system changes during the contract term. The 834 version X12 5010 Companion Guide can be found in Attachment XIII.

4.18.2 Encounter Data

The Contractor shall send a weekly HIPAA compliant 5010 Version 837I or 837P Health Care Claim transaction to the Commonwealth's fiscal agent's secure FTP server on a schedule set by DMAS. The current 5010 versions 837 Companion Guides can be found in Attachment XIV.

4.18.3 Supporting Claim File Documentation

In addition to the encounter data, the Department requires that the Contractor submit a weekly Excel spreadsheet summarizing claim payment information, which supports the funding of the Contractor's claims payment account. In addition, the Contractor must submit a weekly Excel spreadsheet containing claim detail information coinciding with the funding spreadsheet. The Excel version currently used is 2003. The Contractor must use an Excel version compatible with what is used by the Commonwealth. These spreadsheets must be emailed to the Contract Monitor by 5:00 PM EST on Wednesday or as requested.

Claims detail information shall be verified by the Department before funding is released. The Department reserves the right to modify this process at a future time.

Connectivity to the Virginia Medicaid Management Information System (VaMMIS)

The Contractor's staff will be granted access to VaMMIS through the web portal (<https://www.viriniamedicaid.dmas.virginia.gov>) with an ACF2 secure sign on. This will enable the Contractor to view eligibility and other pertinent MMIS data as deemed necessary by DMAS. The Contractor's Help Desk employees supporting this contract must have access to the Internet. The Department will ensure the Contractor and their staff members receive VaMMIS training.

4.18.4 Contractor Database and Processing System

In order to meet information system requirements and to support the timely provision of Departmental services, the Contractor shall operate a database maintained with the highest level of privacy and security as defined in HIPAA regulations. The database shall be capable of maintaining and recording member protected health information (PHI). Data stored in the

database shall be kept current, based on updates received from the Department's fiscal agent and the Contractor's claims processing system.

The Contractor's database and processing system shall ensure the timeliness and accuracy of data used in the business processes for final claims payment determination based on the Department's rules and regulations. This system shall be capable of allowing for future growth and flexibility in behavioral health services coverage at no additional cost to DMAS.

Although the Contractor will maintain the database and processing system at their facility, DMAS and DMAS authorized agents must have access to the Contractor's database to support the Virginia Medicaid behavioral health. DMAS requires eight (8) access/licenses to the database and the various applications used by the Contractor at no additional cost to the Department. All data and other information used to maintain Virginia Medicaid behavioral health services is the property of the Department.

4.18.5 Data Validation Edits and Audits

The Contractor's claims processing system shall perform the following validation edits and audits at a minimum but may not be limited to the following:

- i. Service Authorization/Pre-Payment Approval - The system shall determine whether a covered service requires service authorization, and if so, whether the Contractor granted approval.
- ii. Valid Dates of Service - The system shall assure that dates of services are valid dates and not in the future.
- iii. Duplicate Claims - The system shall automatically inform the provider that the current claim is an exact or possible duplicate and deny that claim as appropriate and have override capability.
- iv. Covered Service - The system shall verify that a service is a valid covered service and is eligible for payment under the Department's behavioral health benefit for that eligibility group.
- v. Provider Validation - The system shall approve for payment only those claims received from providers that would have been paid in the absence of other primary insurance coverage for Medicaid/FAMIS plus and FAMIS covered services.
- vi. Eligibility Validation – The system shall confirm the member for whom a service was provided was eligible on the date the service was incurred.
- vii. Quantity of Service - The system shall validate claims to assure that the quantity of services is consistent with Department rules and policy.
- viii. Rejected Claims - The system shall determine whether a claim is acceptable for adjudication and reject claims that are not.
- ix. Managed Care Organizations - The system shall reject claims that should rightly be processed and paid by a member's MCO for any and all physical health treatments.
- x. Other Insurance Coverage – The system shall reject claims that should rightly be processed by a member's primary health care carrier. In addition, the system shall allow for coordination of benefits in accordance with the Medicaid/FAMIS Plus "payer of last resort" rules. The Contractor is responsible for paying deductibles and coinsurance up to the maximum reimbursement amount that would have been paid in the absence of other primary insurance coverage for Medicaid/FAMIS plus and FAMIS covered services.
- xi. Service Limits – The system shall verify that a service is not covered outside of the Department's established service limits, including but not limited to once in a lifetime procedures.

- xii. Correct Payment Amounts – The system shall pay the claim at the lesser of the billed amount or the Department’s allowable amount, other third party payer coverage, etc.

Claims History - The Contractor shall accept 24 months of paid health claims history in an agreeable format to be used for duplicate claims payment verification purposes.

4.18.6 System Flexibility

The Contractor’s claims process system shall be table driven with the capability to handle eligibility and procedure coverage changes and edit and audit changes immediately upon notification by DMAS at no additional charge.

4.18.7 Systems Readiness Review and Access to Contractor’s system

The Contractor will work with the Department to ensure that the Contractor’s processing system satisfies the functional and informational requirements of Virginia’s program requirements. The Contractor shall assist the Department in the analysis and testing of information systems, claims processing and reporting requirements. DMAS expects to test and validate the system through user acceptance testing with ample time prior to production. The Contractor must provide and maintain a test environment and provide eight (8) access/licenses to Department staff allowing access to test the Contractor’s system from DMAS user workstations. DMAS users must be able to access the Contractor’s test and production environments through the life of the contract. The Contractor will provide any software or additional communications network required or special equipment and training for access at the Contractor’s expense. The Contractor shall notify DMAS of available hours and any scheduled downtime prior to its occurrence. When on Contractor’s site, DMAS users must be granted access to system applications when auditing Contractor’s work. The Contractor agrees to actively send and receive test data transmissions prior to implementation until approved and throughout the contract as changes are deemed necessary by Federal, State, or DMAS policy.

4.18.8 Secure Email

The Contractor shall provide SSL secure email access over the Internet between DMAS and the Contractor and any other entity where PHI is communicated. No direct connection of VPNs to DMAS will be used for this purpose nor will DMAS use individual email certificates for its staff. Such secure email will only require DMAS staff to use a 128-bit SSL enabled web browser to access the contractor or send email to the contractor. DMAS will provide no special application server(s) for this purpose. Routing of emails over point-to-point telecommunications circuits between DMAS and the Contractor supports Secure SMTP over Transport Layer Security (TLS) RFC 3207 over the internet. The solution must include a method for secured industry standard email using strong encryption keys (greater than 128 bit) between DMAS and the Contractor throughout the contract term. Bidirectional TLS email encryption must be tested and documented between DMAS and the Contractor’s SMTP server. Otherwise, the Contractor will use the DMAS secure email server encrypted at 128-bits for secure email. DMAS uses Tumbleweed secure email server. DMAS additionally has implemented the new Symantec Mail Security appliances that do point-to-point TLS email encryption.

4.18.9 Risk Management and Security

The Contractor, at a minimum shall meet VITA standards, which may be found on the VITA website at <http://www.vita.virginia.gov> DMAS requires the Contractor to conduct a security risk

analysis and to communicate the results in a Risk Management and Security Plan that is compliant with the most stringent requirements from the standards listed below:

- Section 1902 (a) (7) of the Social Security Act (SSA);
- HIPAA Security Rule, 45 CFR Parts 160, 162, and 164 Health and Insurance Reform; Security Standards: Final Rule (latest version);
- COV ITRM Policy SEC500-02 dates (latest version);
- COV ITRM Standard SEC501-01 (latest version); and
- DMAS policies specifically identified.

The following specific security measures shall be included in a section of the Risk Management and Security Plan:

- Computer hardware controls that ensure acceptance of data from authorized networks only;
- At the Contractor's central facility, placement of software controls that establish separate files for lists of authorized user access and identification codes;
- Manual procedures that provide secure access to the system with minimal risk.
- Multilevel passwords, identification codes or other security procedures that must be used by State agency or Contractor personnel;
- All Contractor database software changes related to the PA program may be subject to the Department's approval prior to implementation; and
- System operation functions must be segregated from systems development duties.

The Risk Management and Security Plan document must be delivered to the Department 30 days before implementation. The Plan will also be made available to appropriate State and Federal agencies as deemed necessary by DMAS.

4.18.10 Disaster Preparedness and Recovery at the Service Authorization Processing Site

The Contractor shall submit a Business Continuity/Disaster Recovery Plan for its processing system prior to implementation. If requested, test results of the plan must be made available to the Department. The plan must be tested before the effective date of the contract and must meet the requirements of any applicable state and federal regulations, and of the Department. The Contractor's Business Continuity/Disaster Recovery Plan must include sufficient information to show that it meets the following requirements:

- Documentation of emergency procedures that include steps to take in the event of a natural disaster by fire, water damage, sabotage, mob action, bomb threats, etc. This documentation must be in the form of a formal Disaster Recovery Plan. The Contractor will apply recognized industry standards governing Disaster Preparedness and Recovery including the ability to continue receiving calls, processing prior authorizations, and other functions required in this RFP in the event that the central site is rendered inoperable. Additionally, the Contractor's disaster plan must include provisions in relation to the processing center telephone number(s);
- Employees at the site must be familiar with the emergency procedures;
- Smoking must be prohibited at the site;
- Heat and smoke detectors must be installed at the site both in the ceiling and under raised floors (if applicable). These devices must alert the local fire department as well as internal personnel;

- Portable fire extinguishers must be located in strategic and accessible areas of the site. They must be vividly marked and periodically tested;
- The site must be protected by an automatic fire suppression system;
- The site must be backed up by an uninterruptible power source system; and
- The system at the disaster recovery site must be tested and verified in accordance with VITA standards.

The Business Continuity/Disaster Recovery Plan document must be delivered to the Department 30 days before implementation.

4.18.11 Continuity of Operations

The Contractor shall be required to provide a Continuity of Operations Plan (COOP) that relates to the services or functions provided by them under this contract. Key information to be included in the Contractor's COOP and used as an example can be found on the VITA website at <http://www.vita.virginia.gov>

The COOP shall be delivered to the Department 30 days before implementation.

4.18.12 Security Training

The Contractor shall be required to provide a Security Training Plan that relates to the services or functions provided by them under this contract.

The Security Training Plan document shall be delivered to the Department 30 days before implementation.

4.19 Electronic Data Submission Including Encounter Claims

The Contractor shall not transmit protected health information (PHI) over the Internet or any other insecure or open communication channel unless such information is encrypted or otherwise safeguarded using procedures no less stringent than those described in 45 CFR § 142.308(d). If the Contractor stores or maintains PHI in encrypted form, the Contractor shall, promptly at the Department's request, provide the Department with the software keys to unlock such information.

4.19.1 Electronic Data Interchange (EDI)

The Contractor shall transmit documents directly or through a third party value added network. Either party may select, or modify a selection of, a Value-Added Network (VAN) with thirty (30) calendar days written notice.

The Contractor shall be solely responsible for the costs of any VAN with which it contracts. The Contractor will be liable to the other for the acts or omissions of its VAN while transmitting, receiving, storing or handling documents. The Contractor is solely responsible for complying with the subscription terms and conditions of the VAN he or she selects, and for any and all financial liabilities resulting from that subscription agreement.

4.19.2 Test Data Transmission

The Contractor agrees to actively send and receive test data transmissions prior to implementation

until approved. The Contractor agrees to receive redundant transmission (e.g. faxed copy and electronic), if required by the Department, for up to thirty (30) calendar days after a successful EDI link is established.

4.19.3 Garbled Transmissions

If the Contractor receives an unintelligible document/file, the Contractor will promptly notify the sending party (if identifiable from the received document/file). If the sending party is identifiable from the document, but the receiving party failed to give notice that the document is unintelligible, the records of the sending party will govern. If the sending party is not identifiable from the document, the records of the party receiving the unintelligible document will govern.

4.19.4 Certification

Any payment information from the Contractor that is used for rate setting purposes (e.g. any encounter data) or any payment related data required by the Department must be certified by the Contractor's Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer of the Contractor. The Contractor shall be responsible for validating submissions from providers and subcontractors.

The Contractor shall use Attachment IV, Certification of Encounter Data, on a monthly basis reflecting prior submissions of encounters; and, Attachment V, Certification of Data, for certification of non-encounter payment related data submissions within one (1) week of the date of submission. Any data not certified within the specified time frames will not be considered as part of the rate setting processes.

4.19.5 Enforceability and Admissibility

Any document properly transmitted pursuant to this Contract shall be deemed for all purposes (1) to be "a writing" or "in writing," and (2) to constitute an "original" when printed from electronic records established and maintained in the ordinary course of business. Any document which is transmitted pursuant to the EDI terms of this Agreement will be as legally sufficient as a written, signed, paper document exchanged between the parties, notwithstanding any legal requirement that the document be in writing or signed. Documents introduced as evidence in any judicial, arbitration, mediation or administrative proceeding will be admissible to the same extent as business records maintained in written form.

4.19.6 Timeliness, Accuracy, and Completeness of Data

The Contractor shall ensure that all electronic data submitted to the Department are timely, accurate and complete. At a minimum, encounter data and provider network reports will be submitted via electronic media in accordance with Department criteria.

In the event that electronic data files are returned to the Contractor due to errors, the Contractor agrees to process incorrect data and resubmit within thirty (30) calendar days. The Contractor agrees to correct encounter claims where appropriate and resubmit corrected encounter claims in accordance with the specifications set forth in this RFP.

The Contractor shall evaluate the completeness of the data from providers on a periodic basis. The Contractor must report the plan/strategy used by the Contractor, including completeness at

start up, when revised, and upon request. Any deficiencies found through the review process must be reported to the Department within 60 calendar day. A corrective action plan to address any deficiencies found must be provided to the Department within 30 calendar days after notification of any deficiencies.

4.19.7 Encounter Claims Data Submission

Approved and denied encounters shall be submitted following the guidelines established by the Encounter Data Submission Manual, including the format, data elements, and data values specified. All encounters must be submitted via Virginia's Medicaid EDI Bulletin Board as described in that guide. The standard for accepting a transmission in its entirety is no more than a five percent (5%) fatal error rate. Fatal errors, when applicable, should be corrected and the encounter adjusted within thirty (30) days of receipt of the propriety error and/or electronic error reports. If the Contractor loses its production privilege due to a high volume of fatal errors, then the Contractor must actively test with DMAS and regain approval for production submissions within thirty (30) days.

All Behavioral Health claim encounters shall be submitted weekly using the X12 5010 Version 837I or 837P with addenda including all required data elements.

Submissions shall be made at least weekly and may be made more frequently with the approval of the Department. Files with HIPAA defined level 1 or level 2 errors in the ISA, GS, GE, or ISE records will be rejected and a negative 997 sent back to the submitter. The entire file must be resubmitted after the problem is fixed. Files with HIPAA defined level 1 or level 2 errors inside a ST-SE loop will have that ST-SE loop rejected and a negative 997 will be sent back to the submitter identifying the loop. Any other ST-SE loops, which do not have level 1 or level 2 errors, will be processed. Only the rejected ST-SE loops should be resubmitted after fixing the problem. Errors on rejected files or ST-SE loops must be corrected and resubmitted within thirty (30) calendar days of the date of rejection.

For the purposes of this Contract, an encounter is any service received by the member and processed by the Contractor. The Contractor shall submit encounters/claims for all claims it receives, with the exception of claims the Contractor has determined to be a duplicate of a previously processed claim/encounter and other exceptions as noted in the Encounter Data Submission Manual. The Contractor is responsible for submission of data from all of its subcontractors to the Department or its agent in the specified format that meets all specifications required by the Department and matches the requirements placed on the Contractor by the Department for encounters. This data shall be submitted and on a timely basis.

At the end of each calendar year, the Department will prepare an Encounter Submission Calendar. The purpose of this calendar is to schedule receipt of encounter records from the Contractor. The Contractor shall adhere to the Department's submission schedule. Files submitted on the scheduled date should only include the normal submission, no backlog, unless agreed to in advance by the Department. Any changes to the submission dates require re-scheduling with the Department. If unable to submit the encounters on the scheduled date, notify the Department within three business days of an alternate submission date.

Except for encounters involving appeals, the Contractor shall submit to the Department ALL electronic encounter claims within thirty (30) calendar days of receipt. Late data will be accepted, but the Department reserves the right to set and adjust timeliness standards as required in order to comply with State and Federal reporting requirements. The Contractor is strongly

encouraged to submit encounter data as received and discouraged from waiting the full time allotted before submitting the encounter data to the Department. The Department reserves the right to require written explanations of all appeals. The Department reserves the right to require more frequent submissions, based on file size/volume and to require more frequent submissions, based on file size/volume.

The Contractor shall be required to pass a testing phase before production encounter data will be accepted. The Contractor shall pass the testing phase within twelve calendar weeks from the effective date of the change.

The Contractor shall submit the test encounter data to the Department's fiscal agent electronically according to the specifications of the HIPAA Implementation and Companion Guidelines.

The Contractor shall be responsible for passing a phased-in test process prior to submitting production encounter data. The Contractor shall utilize production encounter data, systems, tables, and programs when processing encounter test files.

Any additional costs incurred by the Department resulting from the Contractor not submitting encounters within thirty (30) calendar days of receipt will be passed on to the Contractor.

The Department reserves the right to reimburse the Contractor for paid claim dollars based on the encounter claims data submissions. Should the Department opt for this or a similar alternative payment process, the Department shall consider the impact of payments to providers.

4.19.8 Encounter Data Reconciliation

The Contractor shall fully cooperate with all the Department's efforts to monitor the Contractor's compliance with the requirements of encounter data submission including encounter data accuracy, completeness, and timeliness of submission to the Department's Fiscal Agent. The Contractor may comply with all requests related to encounter data monitoring efforts in a timely manner.

4.19.9 Provider Identification Data

Contractor shall maintain a behavioral health provider database. The Department also maintains a copy of this provider file on our own MMIS in order to support encounter processing. The Contractor will submit a weekly Excel file to designated DMAS staff via secure email with new and/or updated provider information. In the event no changes to provider information are needed for the month, the Contractor will inform the Department via email notification. The file layout is defined below:

- a) NPI
- b) Provider Type
- c) Last Name
- d) First Name
- e) Organization Name
- f) Middle Initial
- g) Suffix
- h) Title
- i) Service Address
- j) City

- k) State
- l) Zip(5+4)
- m) Contact Name
- n) Phone(including area code)
- o) Tax ID Number
- p) Provider Begin Date
- q) License Number
- r) License Begin Date
- s) License End Date
- t) Email Address
- u) Specialty
- v) Languages

The Contractor is responsible to ensure that all encounter claims are identified with an active National Provider Identification (NPI) number and the correct provider identification numbers are associated with the appropriate claims and service dates. As of the effective date of mandatory compliance with the CMS NPI Rule, no encounter record will be accepted by DMAS unless the provider has an active NPI record.

4.20 Transition Upon Termination Requirements

At the expiration of this Contract, or if at any time the Department desires a transition of all or any part of the duties and obligations of Contractor to the Department or to another vendor after termination or expiration of the Contract, the Department shall notify the Contractor of the need for transition. Such notice shall be provided at least ninety (90) calendar days prior to the date the Contract will expire, or at the time the Department provides notice of termination to Contractor, as the case may be. The transition process will commence immediately upon such notification and shall, at no additional cost to the Department, continue past the date of contract termination or expiration if, due to the actions or inactions of Contractor, the transition process is not completed before that date. The Offeror shall respond to any appeals or related activities for adverse decisions that were made up to and including the last day of the contract.

If delays in the transition process are due to the actions or inactions of the Department or the Department's newly designated vendor, the Department and Contractor will negotiate in good faith a contract for the conduct of and compensation for transition activities after the termination or expiration of the Contract. In the event that a subsequent Contractor is unable to assume operations on the planned date for transfer, the Contractor will continue to perform MMIS operations on a month-to-month basis for up to six months beyond the planned transfer date. The Department will withhold final payment to the Contractor until transition to the new Contractor is complete.

4.20.1 Close Out and Transition Procedures:

- 4.20.1.a Within ten (10) business days after receipt of written notifications by the Department of the initiation of the transition, Contractor shall provide to the Department a detailed electronic document, containing the following:
 - i. The number of behavioral health claims approved, denied or pending at the time of transition, including the following information: the Member's name and identification number, the

Participating Behavioral health Provider's name and provider number, and the type of service;

- ii. Information on any pending grievances, including Department appeals hearings; and
- iii. The number of service authorizations in process, including the following information: the Member's name and identification number, the Participating behavioral health provider name and provider number and type of behavioral health service.

4.20.1.b Within ten (10) business days after receipt of the detailed document, the Department will provide Contractor with written instructions, which shall include, but not be limited to, the following:

- i. The packaging, documentation, delivery location, and delivery date of all records, data and review information to be transferred. The delivery period shall not exceed thirty (30) calendar days from the date the instructions are issued by the Department.
- ii. The date, time and location of any transition meeting to be held among the Department, Contractor and any incoming Contractor. Contractor shall provide a minimum of two (2) individuals to attend the transition meeting and those individuals shall be proficient in and knowledgeable about the materials to be transferred.

4.20.1.c Within five (5) business days after receipt of the materials from Contractor, the Department will submit to Contractor in writing any questions the Department has with regard to the materials transferred by Contractor. Within five (5) business days after receipt of the questions, Contractor shall provide written answers to the Department.

4.20.1.d All copyright and patent rights to all papers, reports, forms, materials, creations, or inventions created or developed in the performance of this contract shall become the sole property of the Department. On request, the Contractor shall promptly provide an acknowledgment or assignment in a tangible form satisfactory to the Department to evidence the Department's sole ownership of specifically identified intellectual property created or developed in the performance of the contract. This includes but is not limited to the call center telephone number established for Medicaid/FAMIS Plus/FAMIS.

4.20.1.e The Contractor shall be liable for all behavioral health claims incurred up to the date of termination.

4.21 Reporting Requirements

The Contractor shall submit the reports described within this section in a format approved by the Department.

4.21.1 Data Base Requirements

In order to meet information system requirements and to support the timely provision of ad hoc report requests that may be made by the Department, Contractor shall maintain a current database, in a format acceptable to the Department, capable of retrieving data on short notice. At a minimum, the database shall include the following data:

- Member Name;
- Medicaid/FAMIS Plus or FAMIS ID #;
- Member Social Security Number (SSN);
- Member MCO (if applicable);
- Dates of Service;
- Specific service provided by procedure code;
- Servicing Provider Number (Medicaid #);
- Participating Provider Name;
- Payment Status;
- Billed Charge Amount;
- Allowed Amount;
- Payment Amount;
- Received Date;
- Payment Date; and
- Any other data element required by federal or state law.

Data stored in the database shall be current through the prior week.

4.21.2 Claim Activity Reporting Requirements

The Contractor shall provide to the Department a Monthly Behavioral Health Report, as reflected in Attachment VIII, a Detailed Claim Processing and Reconciliation Report as described in Section 6 of this RFP, a Monthly Batch Claim Operations Report, an Encounter Data Report, and a Claims Lag Triangle Report including the data elements and in the format and medium (including electronic) requested by the Department. Record layout and other information about report submission are available through the Department.

The Contractor shall provide an **annual version** of the Monthly Summary Report (shown in Attachment VIII) that captures totals for the contract year, within ninety (90) calendar days of the effective contract date and effective contract renewal date.

4.21.3 Financial Reporting Requirements

4.21.3a Monthly Full Reconciliation Report

The Contractor shall provide to the Department a monthly cumulative account of the financial transactions reconciling the provider claims to the BHSA checking account. Should the contractor stop payment or void any check and not reissue a replacement check, the funds are to be refunded to the Department and the associated claims must be voided in the claims system.

4.21.3b Monthly Bank Statement

The Contractor shall provide to the Department a copy of monthly bank statements with supporting documentation sufficient to verify account credit and debit adjustments. At a

minimum, the monthly bank statement should clearly indicate the date of the statement, bank account name and account numbers to verify transfer of funds.

4.21.3c Stale Dated Check Report

The contractor shall provide to the Department a monthly Stale Dated Check report that includes checks outstanding or uncashed after the 150-day mark for review and potential follow up with the providers. Checks that remain uncashed after 180-days of the issue date are deemed “stale dated” and are to be voided and the funds refunded to the Department on a quarterly basis. All claims associated with the voided 180-day checks are to be voided in the claims system.

4.21.3d Negative Balance Report

The contractor shall provide to the Department a monthly Negative Balance report that lists providers who have outstanding debts with the contractor. The report should also list the claims and/or transactions that generated the negative balance as well as the date the overpayment associated with the negative balance occurred.

4.21.3e Accrued Interest report

The Contractor shall provide to the Department a monthly accrued interest report associated with the BHSA bank account. The Contractor should reimburse the Department quarterly for interest accrued on this account. Interest should accrue based on the daily balance of funds remaining in the BHSA account. The Contractor must notify DMAS via email when the transfer has occurred.

4.21.3f Audited Financial Statements and Income Statements

The Contractor shall provide to the Department copies of its annual audited financial statements no later than ninety (90) calendar days after the end of the calendar year and Quarterly Income Statements no later than thirty (30) calendar days after the end of each calendar quarter.

4.21.4 Call Center Response Time Reports

The Contractor shall maintain records and report to the Department on Call Center Response times weekly for the first 3 months and monthly thereafter. The call center reports are identified in Section 4.3 of the RFP. Monthly reports will be due fifteen (15) calendar days after the end of the calendar month being reported. The Department reserves the right to extend the weekly Call Center reporting or re-establish a weekly reporting schedule as deemed necessary.

4.21.5 Meeting Reports

The Contractor shall submit the minutes of its Utilization Review Committee meetings, and Quality Assurance Committee meetings on a calendar quarter basis, due thirty (30) days after the end of each quarter. If no meetings occurred during the quarter, that fact shall be reported. Peer Review Committee shall be scheduled twice a year and held more frequently if additional case reviews are necessary. The Contractor shall submit the minutes of its Peer Review Committee meetings to the Department within (30) days after the meetings occur.

4.21.6 Satisfaction Surveys

The Contractor shall conduct, at a minimum, an annual Member Satisfaction Survey and an annual Provider Satisfaction Survey. The Contractor shall receive input from stakeholders regarding the survey questions and methodology, which shall be approved by the Department prior to conducting the survey. The Contractor shall submit a report identifying key findings to

the Department annually within ninety (90) days after the survey is closed. The Contractor shall provide an analysis of the key findings and a plan to address any poor ratings.

All returned mail resulting from undeliverable surveys is the responsibility of the Contractor to dispose properly in accordance with all HIPPA regulations. The Contractor shall propose a procedure to identify incorrect member addresses to avoid misdirected future correspondences.

4.21.7 Public Filings

The Contractor shall promptly furnish the Department with copies of all public filings, including correspondence, documents and all attachments on any matter arising out of this RFP.

4.21.8 Comprehensive Network Analysis Report

The Contractor shall provide a Comprehensive Network Analysis Report, monthly and annually, as described in Section 4.8.4 that provides a detailed analysis of provider recruitment activities and that tracks provider network changes, and when possible, captures reasons for provider disenrollment.

4.21.9 Grievance and Appeals Reports

The Contractor shall provide grievance and appeal logs and summary reports as described in Sections 4.9.14 and 4.10 of this RFP.

4.21.10 Semi-Annual and Annual Report

The Contractor shall provide and develop in conjunction with the Department a semi annual and an annual report that provide a report card summary for all of the following activities: Claims Activity, Registration/Service Authorization Activity, Network Recruitment/Management, Member Outreach, Call Center, Grievances and Appeals, Member Utilization, and Quality Improvement. The Offeror shall submit sample "annual report card" reports with their RFP Proposal. The Department will approve the final reporting format. The Contractor must modify the final report to the agreed upon specifications at no cost to the Department.

4.21.11 Behavioral Health Utilization Tracking System

The Contractor shall develop and maintain a tracking system with the capability to identify and report the member's current behavioral health utilization status, referrals for treatment, whether treatment was provided, and dates of service for treatment for each member. The Contractor shall report weekly the compliance with service authorization time frames.

4.21.12 Other Reporting Requirements

The Contractor shall also provide such additional monthly and ad hoc reports in relation to the RFP (and resulting contract) requirements in a format as agreed upon by the Department and the Contractor. The Contractor shall assure compliance with future reporting requirements of federal initiatives such as H.R. 2; the Children's Health Insurance Program Reauthorization Act of 2009, or CHIPRA and/or other federal/state health care reform activity as determined by the Department. The Department will incur no expense in the generation of such reports. Additionally, the Contractor shall make revisions in the data elements or format of the reports required in this RFP and resulting contract upon request of the Department and without additional

charge to the Department. The Department will provide written notice of such requested revisions of format changes in a notice of required report revisions. The Contractor will respond to all routine inquiries/requests from the Department within two business days either acknowledging receipt of the Department's request or providing a date that the Contractor will respond. Contractor shall maintain a data gathering and storage system sufficient to meet the requirements of this RFP. The Department may impose liquidated damages or monetary liquidated remedies under Attachment III of the RFP based upon Contractor's failure to timely submit Standard Reports in the required format and medium.

4.21.1.3 Baseline Outcome Measures and Reporting

The Contractor shall, in collaboration with stakeholders, develop outcome measures that reflect member and Contractor outcomes within the first year of the contract, with web-based reporting by providers occurring within the first quarter of the second year of the contract. The Contractor shall submit proposed outcome measures to the Department for review and approval within the third quarter of the contract's first year. Outcome measures must include, at a minimum the following domains:

- access to care ;
- hospital admissions and re-admissions, and emergency department visits;
- member and provider satisfaction;
- network development and management;
- employment or school attendance;
- availability of housing; and
- coordination with medical care.

The Contractor, in collaboration with the Department and stakeholders, will identify at least five (5) outcome measures including the required measures above and others proposed by the Contractor. Web-based reporting by providers on the measures will occur on a quarterly basis when the measures are implemented.

4.22 Virginia Bureau of Insurance Requirements

The Contractor shall demonstrate evidence of its compliance with any applicable Virginia Bureau of Insurance requirements. All financial reports filed with the Department by the Contractor shall demonstrate evidence of compliance with Virginia Bureau of Insurance financial requirements.

4.23 Fraud and Abuse

4.23.1 Prevention/Detection of Provider Fraud and Abuse

The Contractor shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected instances of fraud and abuse. Such policies and procedures must be in accordance with Federal regulations described in 42 CFR Parts 455 and 456. The Contractor shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the Contractor in preventing and detecting potential instances of fraud and abuse.

4.23.2 Fraud and Abuse Compliance Plan

- a The Contractor shall have a written Fraud and Abuse compliance plan. The Contractor's specific internal controls, polices and procedures shall be described

in a comprehensive written plan and be maintained on file with the Contractor for review and approval by the Department and as an annual Contract submission. The Plan must define how the Contractor shall identify and report suspected fraud and abuse by members, by network providers, by subcontractors and by the Contractor. The Plan must be submitted annually and must discuss the monitoring tools and controls used to protect against theft, embezzlement, fraudulent marketing practices, or other types of fraud and program abuse. The Plan must additionally describe the type and frequency of training provided to prepare staff to detect fraud. All fraudulent activities or other program abuses shall be handled subject to the laws and regulations of the Commonwealth of Virginia and/or Federal law and regulation.

The Department shall provide notice of approval, denial, or modification to the Contractor within thirty (30) calendar days of annual submission. The Contractor shall make any requested updates or modifications available for review after modifications are completed as requested by the Department within thirty (30) calendar days of a request. At a minimum the written plan shall:

- i. Ensure that all officers, directors, managers, employees and contractors know and understand the provisions of the Contractor's fraud and abuse compliance plan;
- ii. Contain procedures designed to prevent and detect potential or suspected abuse and fraud in the administration and delivery of services under this contract;
- iii. Include a description of the specific controls in place for prevention and detection of potential or suspected abuse and fraud, such as:
 - a. Claims edits;
 - b. Post-payment review of claims;
 - c. Provider profiling and credentialing;
 - d. Service authorization;
 - e. Utilization management;
 - f. Relevant subcontractor and provider agreement provisions;
 - g. Written provider and member material regarding fraud and abuse referrals.
- iv. Contain provisions for the confidential reporting by members, network providers and subcontractors of plan violations to the designated person as described in item b. below;
- v. Contain provisions for the investigation and follow-up of any compliance plan reports;
- vi. Ensure that the identities of individuals reporting violations of the plan are protected;
- vii. Contain specific and detailed internal procedures for officers, directors, managers, employees and Contractors for detecting, reporting, and investigating fraud and abuse compliance plan violations;

- viii. Require any confirmed or suspected provider or member fraud and abuse under state or federal law to be reported to the Department; and
 - ix. Ensure that no individual who reports plan violations or suspected fraud and abuse is subjected to retaliation.
- b. The Contractor shall designate an officer or director in its organization who has responsibility and authority for carrying out the provisions of the fraud and abuse compliance plan.
 - c. The Contractor shall report incidents of potential or actual fraud and abuse to the Department within two (2) business days of initiation of any investigative action by the Contractor or within two (2) business days of Contractor notification that another entity is conducting such an investigation of the Contractor, subcontractor, its network providers, or its members. All reports shall be sent to the Department in writing and shall include a detailed account of the incident, including names, dates, places, and suspected fraudulent activities. In addition, the Contractor shall provide a comprehensive annual report to the Department of all incidents of potential or actual fraudulent activity and results.
 - d. The Contractor shall cooperate with all fraud and abuse investigation efforts by the Department and other State and Federal entities.
 - e. All cases where fraud is suspected or detected shall be referred to the Department for referral to Medicaid Fraud Control Unit (MFCU) prior to the initiation of any actions or recoupment efforts. The Contractor shall provide support to the MFCU on matters relating to specific cases involving detected or suspected fraud.
 - f. The Contractor shall notify the Department for approval of provider recoupment amounts exceeding \$2,000. For recoupment amounts under \$2,000 the Contractor will notify the Department if a problem is identified with the recoupment.

4.24 Readiness for Implementation

No later than April 1, 2012 the Contractor shall demonstrate, to the Department's satisfaction, that Contractor is fully capable of performing all duties under this Contract, including demonstration of the following:

- Contractor's provider network is adequate in all regions of the Commonwealth to assure that there will be minimal disruptions in service to members and that the Contractor has instructed members and participating behavioral health providers in the basic operation of the new behavioral health system;
- Contractor has thoroughly trained its staff on the specifics of behavioral health service and program policies, and that Contractor's staff has sufficient medical and behavioral health knowledge to make determinations of behavioral health services needs;

- Contractor has trained its staff to handle telephone requests from members and participating behavioral health providers, and has provided to the Department copies of training materials and described the methods used for training and outreach;
- Contractor has the ability to accept, process service authorization and accept, process and pay behavioral health claims from participating behavioral health providers for the provision of covered and behavioral health services;
- Contractor's MIS has successfully completed the requirements listed in Section 4 including that the Contractor has the ability to transmit utilization data to the Department that are accurate and timely and consistent with HIPAA standards;
- Contractor has demonstrated the ability to submit and accept to the Department's satisfaction all required documentation with respect to payments from the Department to the Contractor as described in Section 6; and
- Contractor's QI, member services, and other pertinent components are in place in accordance with requirements described in this RFP;
- Contractor shall test all interfaces with the Department prior to implementation;
- Contractor has submitted an Operational Readiness Plan demonstrating compliance with the terms of the RFP.

The Contractor's inability to demonstrate, to the Department's satisfaction and as provided in this Section, that Contractor is fully capable of performing all duties under this contract no later than May 1, 2012 shall be grounds for the immediate termination of the Contract by the Department pursuant to the Department Special Terms and Conditions, 10.7 Cancellation of Contract rights.

4.25 Implementation

Administration of the behavioral health services by the Contractor shall begin on July 1, 2012 ("Implementation"). Payment to Contractor as provided in Section 6 (Payments to the Contractor) of this Contract shall begin upon implementation. Contractor shall not be compensated for any expenses incurred prior to the implementation date.

The Commonwealth may make such reasonable investigations as deemed proper and necessary to determine the ability of the Offeror to perform the services and the Offeror shall furnish to the Commonwealth all such information and data for this purpose as may be requested. The Commonwealth reserves the right to inspect Contractor's physical facilities, including any located outside of Richmond, prior to award to satisfy questions regarding the Offeror's capabilities. The Commonwealth further reserves the right to reject any proposal if the evidence submitted by, or investigations of, such Offeror fails to satisfy the Commonwealth that such Offeror is properly qualified to carry out the obligations of the contract and to provide the services contemplated therein.

4.26 Internet Site

The Contractor agrees to host and maintain a user friendly Internet site that is owned by DMAS on the Contractor's server. The Contractor, at a minimum will meet VITA standards, which may

be found on the VITA website at <http://www.vita.virginia.gov> . The web site will contain information devoted providers and to members at a 6th grade reading level.. At a minimum, the site shall contain the following.

- i. a link to the Contractor's current provider directory, with provider contact information, and with the capability to locate providers by geographic locations, and type of practice
- ii. an outline of coverage
- iii. other information about the program
- iv. Contractor contact names, telephone numbers, and addresses for individuals to contact with respect to services covered in this RFP
- v. how to obtain program information in non-English languages
- vi. information regarding how to submit grievances and or appeals to the Contractor
- vii. information to assist providers with billing and or service authorization issues, access to the provider manual, frequently asked questions, etc.

The Contractor shall maintain the capability to provide totals of daily, weekly, and monthly numbers of site visits and page views for the month, with information detailing the most viewed page(s).

4.27 Behavioral Health Services Consultation and Support

The Contractor shall consult the Department regarding changes and trends in the behavioral health services industry having the potential to impact the Virginia Medicaid program. The Contractor shall support the Department in responses to stakeholders. The Contractor may also include in this section ideas for innovative improvements to the Medicaid program.

The Contractor shall:

- a. Provide quarterly updates on national, federal and state policy changes and provide recommendations to the Department regarding these changes;
- b. Keep the Department abreast of industry and other similar state Medicaid program trends and changes and provide recommendations to the Department regarding these changes;
- c. Identify new evidence based and informed practices in the behavioral health industry;
- d. Make recommendations to the Department as appropriate on cost savings and quality improvement initiatives and assist with the development of such initiatives;
- e. Be responsive to the Department when it receives requests from the General Assembly and other stakeholders on behavioral health-related issues;
- f. Be responsive to the Department during its development and revisions to Medicaid Memos, Manuals, and other official agency documents, as may be applicable;
- g. Support the Department with other behavioral health-related inquiries as requested;
- h. Inform the Department on a quarterly basis, or sooner, if there is a significant benefit to the program, about Federal or State policy or legislative changes, actual or proposed, and new cost savings initiatives or industry trends that could potentially impact this contract; and
- i. Submit a quarterly report that identifies additional behavioral health service costs savings initiatives for the Department to consider. The report shall provide a summary of each initiative proposed, current and projected utilization data to support proposed savings, and pros and cons of each proposed initiative (e.g. policy, administrative barriers). The report shall contain a brief timeline for implementation.
- j. Acknowledge all routine requests for assistance from the Department within two business days and each acknowledgement must include a planned resolution date. Urgent or emergent issues/requests from the Department will stipulate a specific response due date;
- k. Provide a point of contact when Virginia staff are out of the office or are not available.

1. Assure that monthly quarterly semi annual and annual reports are submitted timely and contain accurate information which reflects the current reporting period. Submissions should include an overall analysis of trends and changes in the data.

4.28 Optional Services

The Department is interested in the Offeror's capabilities and expertise with the following *optional* services (Enhanced Benefits). These services may be implemented at some point within the duration of the contract resulting from this RFP. If the Offeror is interested in operating any of the following initiatives, information in the Offeror's technical proposal must describe the Offeror's abilities, experience, and method(s) for accomplishing the selected services at a reasonable cost to the Commonwealth, which may include implementation of pilot programs. The Offeror's cost shall be submitted in the cost proposal (Attachment X), separate from the technical proposal, for each of these optional services.

Innovative Strategies

The Offeror may describe innovations that can be implemented that would benefit Virginia's behavioral health service delivery system. List all states, specifically state Medicaid programs as well as commercial payers, where these innovations have been implemented and describe the quantitative evidence to support the outcomes and success. This may include real time provider question submission and response via the Internet of clinical questions, provider chat room capability for behavioral health issues, cost savings initiatives, enhanced web/Internet based strategies for claims submission and payment in order to support providers and initiatives.

Health Homes

The Offeror may propose a plan for the development of a health home model in accordance with Section 2703 of the Affordability Care Act (http://www.ssa.gov/OP_Home/ssact/title19/1945.htm) that can be implemented to benefit Virginia's behavioral health service delivery system. This provision is an important opportunity for States to address and receive additional Federal support for the enhanced integration and coordination of primary, acute, behavioral health, and long-term services and supports for persons across the lifespan with chronic illness. The Offeror shall address in its plan the involvement of acute and primary providers in the FFS and/or managed care systems in setting up health home established through this provision.

Quality Improvement

The Offeror may propose additional quality measurement strategies supporting improvements in incidence of behavioral health care and associated treatment beyond requirements set forth in section 4.13. Measurement strategies outlining the effect of any specific program changes implemented may be a part of the submission. Provider chart audits may be included as part of the review process.

Peer Support Services

The Offeror may propose a program for the provision of peer support services. Included with this optional service shall be a network development strategy and timelines which support federal health care reform initiatives. The proposal shall also describe applicable programs and results from Virginia, including consumer run businesses and programs, etc., and how these programs will be incorporated into this service. Pricing shall include a program using current member enrollment and projected increased health reform enrollment for adults.

Respite Services

The Offeror may propose a program for the provision of respite services. Included with this optional service shall be a network development strategy and timelines which support federal health care reform initiatives. The program shall also describe applicable programs and results from other States. Pricing shall include a program using current member enrollment and projected increased health reform enrollment for adults.

Service Authorization

The Offeror may propose additional automated functions to streamline the service authorization process. Automated functions must include the Offeror's solution for necessary interface to other systems. The Offeror's automated function must comply with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. In addition, the Offeror must ensure that any proposed systems and/or business solutions, including files and data transfer format of the Offeror's internal system, will comply with Electronic Data Interchange (EDI), and Security requirements throughout the Contract period.

Intensive Care Coordination

The Offeror may propose a strategy to stratify members into a third levels of care for those individuals with serious behavioral health disorders and who require more intensive interventions than described in Section 4.6.

5. DMAS RESPONSIBILITIES

DMAS will oversee the behavioral health services, including overall program management, determination of policy and monitoring of service. DMAS will work in partnership with the Contractor and other behavioral health stakeholders to develop a quality program. Following are the primary responsibilities of DMAS:

- a) Policy interpretation – DMAS will make the final decision regarding all policy issues;
- b) On-going project oversight and management (to include announced and unannounced site visits to the Contractor) to ensure regulatory compliance. If any aspect of the Contractor's operation is conducted outside of the Commonwealth of Virginia, the Contractor will pay for air travel and lodging (to include meals) for two DMAS staff to conduct site visits annually;
- c) Provide Contractor with all up to date member eligibility information;
- d) Field observations of operations and the call center;
- e) Monitor outreach to members, provider network adequacy, behavioral health utilization and other monitoring;
- f) Review and approve any Contractor written policies, subcontracts and or procedural communications to members, providers and others prior to release;
- g) Attend/observe QI/QA peer review activities; and
- h) Media contact-DMAS is the key representative of the behavioral health program with regard to the media. All questions or other contact from the media must be referred directly to the designated DMAS representative.

6. PAYMENTS TO THE CONTRACTOR

Payment processes described in this Section shall be tested as part of the readiness for implementation review described in Section 4.24. Any changes required to the Contractor's

processes as identified through readiness review activities shall be made by the Contractor prior to implementation. Costs associated with these changes shall be borne by the Contractor.

6.1 Annual Review of Controls

The Contractor shall provide to the Department and the State Treasurer a statement from its external auditor that a review of the Company's internal accounting controls reveals no condition believed to be a material weakness in the proper administration of the Department's Behavioral health Program in accordance with sound business principles. The written statement shall be provided annually each June 15 for the preceding calendar year.

6.2 Payment Methodology

6.2.1 BHSA Payments

The Contractor shall be compensated for BHSA responsibilities based on fixed fee per member per month (PMPM) rates as determined by the RFP negotiations and subsequent contract award for the period of the contract. Each monthly payment to the Contractor shall be equal to the number of members certified by the Department as eligible for services through the BHSA multiplied by the PMPM for the appropriate member category. Medicaid members, who shall be excluded from the BHSA responsibilities, and therefore the BHSA payments, include those who are enrolled or will be enrolled in other care coordination delivery models that include both traditional and non-traditional behavioral health services. This would include members served through models such as the PACE program or those who may participate in a Dual Eligible program covering comprehensive behavioral health services. Additionally, those Medicaid recipients not receiving traditional and/or non-traditional behavioral health services on a fee-for-service basis would be excluded.

Member funding categories shall include Medicaid Children under age 21, Medicaid Expansion or FAMIS Plus (member aid category 94), FAMIS members, and Medicaid adults age 21 and over and shall be reimbursed at the behavioral health PMPM rate of reimbursement. However, for Federal funding, reporting, and tracking purposes the payments must be reported separately, as shown in the table below.

The Contractor's payment shall be based on enrollment reported by the Department to the Contractor in the 834 enrollment report effective the first day of each month of the contract period. Monthly compensation will not be adjusted upward or downward during the month based on fluctuating eligibility. The Department will arrange for payment each month at an agreed upon time by the State Treasurer's office for administrative payments as described herein. For programs or services removed from the contract, DMAS will cease payment for the amount of the program identified in line item cost.

Any increases or decreases in traditional or non-traditional Medicaid behavioral health services volume shall be determined by the Department from DMAS' VaMMIS and shall serve as the final authority for determination of volume.

SFY	Medicaid/FAMIS Plus/FAMIS Children	Medicaid/FAMIS Adults
July 1, 2010 – June 30, 2011	6,644,782	3,564,040
July 1, 2011 – June 30, 2012	6,840,437	3,645,713

*Counts do not include limited-benefit Medicaid enrollees who are not eligible for behavioral health services

The Offeror may also propose a separate PMPM for children and adults who only receive traditional behavioral health services.

6.2.2 Payment Modifications

In the event of an increase or decrease in traditional or non-traditional behavioral health services Medicaid volume in a given contract year of 40 percent or more based on State Fiscal Year 2011 baseline data, the parties may enter into good faith negotiations and agree upon revised payment terms to adjust the Contractor’s compensation for the change(s) in volume. Volume thresholds shall be determined by the number of members receiving behavioral health services.

All costs for service provided in the proposal and resulting contract shall be included in the PMPM and the cost is the sole consideration to be received by Contractor for performance of the contract.

6.2.3 Detailed Claim Processing and Reconciliation Reports

The Contractor shall pay claims only for persons determined to be eligible by the Department. The Contractor shall provide to the Department a weekly electronic Detailed Claim Processing Report. This report must provide detailed data on all claims processed, including any voids or adjustments. As part of the RFP response, the Offeror must provide sample detailed claim-processing reports currently being utilized and the specific data elements captured. The Department will approve the final Detailed Claim Processing Report format. The Contractor must modify the final report to the agreed upon specifications at no cost to the Department.

The final report shall be sorted by member funding category (Medicaid Children under age 21, Medicaid Expansion/FAMIS Plus (member aid category 94), FAMIS members, and Medicaid adults age 21 and over.), and sorted by age category. The report will reflect a subtotal of claims processed by age category for each program category. The report must also reflect a grand total paid for all member categories. The grand total must reconcile to the amount of reimbursement requested by the Contractor. The report must reflect claim data by individual. Individuals must be identified by name, Medicaid/FAMIS Plus or FAMIS ID number, and aid category. All payment related reports shall be submitted using the appropriate Data Certification form as shown in Attachments IV and V in accordance with requirements listed in Section 6.2.4.

The Contractor shall reconcile the net totals on the Detailed Claim Processing Report to the check register and EFT register monthly. A full bank reconciliation report shall be provided to the Department monthly by the 20th of the next month, including monthly bank statements and a list of outstanding checks. A cumulative account of funds is required and the account balance must be carried month to month in the ledger to identify check dates and the length of time checks have

been outstanding. Any interest accrued in the BHSA bank account should be returned to the Department through an established process approved by the Department.

6.2.4 Pass-Through Payment to the Contractor for Claims Paid on Behalf of the Department

Should the Department not reimburse the Contractor for paid claim dollars based on the encounter claims data submissions, the Contractor shall provide to the Department a weekly request for reimbursement with the Detailed Claim Processing Report (where the total monies requested matches the total claim monies paid) in the agreed upon format, by member funding category by 5:00PM EST on Wednesday prior to the Friday evening VaMMIS payment processing cycle. The Contractor shall ensure that its requests for reimbursement from the Department are made timely, such that claims are paid in accordance with prompt-pay requirements, as described in Section 4.14.3 of this RFP. The Contractor shall be reimbursed by the VaMMIS either by check or electronic funds transfer(s), as agreed to by the Contractor. For submissions received prior to the Friday VaMMIS payment processing cycle, reimbursement by check would reflect the date of the Friday occurring one week after the Friday VaMMIS payment processing cycle. Reimbursement by electronic funds transfer payment would reflect the date of the Monday occurring one week after the Friday VaMMIS payment processing cycle. For reconciliation purposes, the Contractor's payment to the provider should be dated/handled such that the funding by the Department, the Contractor's behavioral health encounter data, remittance advice records and checks issued would consistently represent payments processed during the same week and month.

Pass-through payment funds shall be maintained in a separate account, referred to herein as the **Virginia Behavioral Health Services Administrator** claim payment account, from the Contractor's ASO payment funds. The Contractor shall list the Department on the bank signature card. Funds in the **Virginia Behavioral Health Services Administrator** claims payment account can only be used for paying claims under this Contract pursuant to Section 4.14, and cannot be pledged by Contractor or used to secure a loan, guaranty, debt or other obligation of the Contractor. The Department will not be liable for over-draft charges or any other banking related charges assessed on the **Virginia Behavioral Health Services Administrator** claim payment account. Contractor shall be responsible for submitting claims information to the Department within the time frame necessary to meet its obligations to pay provider claims within the prompt-pay claims processing requirements described in Section 4.13.3. Additionally, any monetary charges for claims not paid by the Contractor within prompt-pay claims processing requirements, as described in Section 4.14.3 of this RFP, shall be borne by and the sole obligation of the Contractor and at no expense to the Department.

The Department reserves the right to reimburse the Contractor for paid claim dollars based on the encounter claims data submissions. Should the Department opt for this or a similar alternative payment process, the Department shall consider the impact of payments to providers.

6.2.5 Encounter Claims Submission and Reconciliation

The Contractor's encounter data shall be in the X12-410A format for behavioral health services (reference Section 4.18). Encounters received shall reflect all adjudicated claims (i.e., claims paid, denied, voids, adjustments, etc.). Encounters must be submitted to the fiscal agent within ninety (90) days of claims processing. All fatal errors must be corrected within thirty (30) days of receipt of the error report and the Contractor must notify the Department of the resubmissions.

The Contractor shall submit the Data Certification form shown in Attachment IV within one month of the date of the encounter submission.

The encounter data shall reconcile to the Detailed Claim Processing Report within six (6) months of receipt of the Detailed Claim Processing Report. Any claim reflected on the Detailed Claim Processing Report but is not validated by an encounter submission must be refunded to the Department. The Department will advise the Contractor of any discrepancies. The Contractor shall have thirty (30) days to justify and correct the discrepancy or reimburse the Department of any overpayments, if any.

6.2.6 Interest Monies

Interest monies generated from the deposit of funds into the **BHSA** claim payment account shall be the property of the Department. The Contractor shall report on a monthly basis any interest earned on provider payment funds to the Department. The Contractor shall refund interest payments to the Department quarterly, through a repayment method to be agreed upon prior to implementation.

6.2.7 Stale Dated Checks

If a check written from the BHSA bank account has not been cashed after 180 days, the funds shall be returned to the Department. All claims associated with stale dated checks are to be voided in the claims system. The Contractor shall return funds to the Department through a repayment method to be agreed upon prior to implementation.

6.2.8 Deductions

The Department reserves the right to deduct from amounts which are or shall become due and payable to the Contractor under this or any contract between the Contractor and the Commonwealth of Virginia, including but not limited to interest earned on provider payments, claims not validated in encounter submissions (as described in Section 6.2.4) and liquidated damages assessed as described in Attachment III to this RFP.

The Contractor shall be reimbursed based on a per-member-per-month (PMPM) calculation. PMPM payments will be made monthly for the previous month and may include members whose eligibility for the prior three (3) months has changed retroactively. DMAS may retroactively adjust each member's capitation payment up to a maximum of three (3) months after the initial monthly PMPM determination. Retroactive adjustments can include eligibility additions, terminations/retractions, and/or rate changes. DMAS will provide the Contractor with a monthly detail report listing the PMPM adjustment amounts and reasons.

The Contractor shall have procedures in place to pay behavioral health claims for individuals who have applied for Medicaid but whose eligibility is pending. The Offeror must explain how these services will be authorized and how claims from providers will be paid.

The Contractor will have procedures in place to receive monthly information from DMAS' contracted managed care organizations for their coverage of services previously scheduled for members who transition from managed care to fee-for-service. The Contractor must honor prior authorized services using either the provider already scheduled or one under contract to the Contractor. If the service provider is changed, the Contractor shall notify the member and scheduled provider in advance. In the event of a retroactive disenrollment of an MCO member,

the MCO will recover the payments made to service providers for pre-authorized services during the period of time covered by the retroactive disenrollment. The Contractor shall reimburse the service provider for the amount recovered by the MCO.

The Offeror shall submit a Cost Proposal that will form the basis of the payment arrangement. Cost Proposals shall be structured to reflect monthly payments by population group, as defined in Attachment X, for each year of the three years of the ASO contract period. The monthly cost proposal for each population group shall be broken out into two components. One component shall include administrative costs, including corporate overhead and profit. Administrative costs may not include the following:

- Related party management fees in excess of actual cost,
- Lobbying expenses,
- Contributions,
- State and Federal income taxes,
- Administrative fees for services provided by a parent organization, which did not represent a pass through of actual costs,
- Management fees relating to non-Virginia operations,
- Management fees paid for the sole purpose of securing an exclusive arrangement for the provision of services for specific members,
- Administrative fee/royalty licensing agreements for services provided by a parent organization, which did not represent a pass through of actual costs,
- Accruals for future losses,
- Reserves based on estimates for bankrupt providers,
- Unsupported expenses, and
- Expenses related to the preparation of the proposal.

The PMPM rate does not include start-up costs. DMAS may reimburse start-up costs, but start-up costs must be submitted separately on Attachment X as part of the Offeror's cost proposal.

6.3 Travel Compensation

The Contractor shall not be compensated or reimbursed for travel, meals, or lodging.

6.4 Payment of Invoice

The payment of the invoice by the Department will not prejudice the Department's right to object to or question any invoice or matter in relation thereto. Such payment by the Department will neither be construed as acceptance of any part of the work or service provided nor as an approval of any of the amounts invoiced therein.

6.5 Invoice Reductions

The Contractor's invoice shall be subject to reduction for amounts included in any invoice or payment theretofore made which are determined by the Department, on the basis of audits conducted in accordance with the terms of this contract, not to constitute proper remuneration for compensable services.

7. PROPOSAL PREPARATION AND SUBMISSION REQUIREMENTS

Each Offeror shall submit a separate Technical Proposal and a Cost Proposal in relation to the requirements described in this RFP. The following describes the general requirements for each proposal and the specific requirements for the Technical Proposal and the Cost Proposal.

General Requirements for Technical Proposals and Cost Proposals

7.1. Overview

Both the Technical Proposal and the Cost Proposal shall be developed and submitted in accordance with the instructions outlined in this section. The Offeror's proposals shall be prepared simply and economically, and they shall include a straightforward, concise description of the Offeror's capabilities that satisfy the requirements of the RFP. Although concise, the proposals should be thorough and detailed so that DMAS may properly evaluate the Offeror's capacity to provide the required services. All descriptions of services should include an explanation of proposed methodology, where applicable. The proposals may include additional information that the Offeror considers relevant to this RFP.

The proposals shall be organized in the order specified in this RFP. A proposal that is not organized in this manner risks elimination from consideration if the evaluators, at their sole discretion, are unable to find where the RFP requirements are specifically addressed. Failure to provide information required by this RFP may result in rejection of the proposal.

7.1.1 Critical Elements of the Technical Proposal

The Offeror must cross reference its Technical proposal with each requirement listed in Section 4 of this RFP. In addition, the Offeror must assure that the following documentation is included in the proposal:

Implementation Plan: Submit a detailed implementation plan demonstrating the Offeror's proposed schedule to implement the behavioral health program no later than July 1, 2012. The plan shall be mutually agreed to by the Contractor and the Department.

Implementation Schedule: The Contractor shall implement the behavioral health program described in this RFP no later than July 1, 2012. The Contractor shall provide a detailed implementation work plan, including deliverables and timelines, as part of the proposal. A comprehensive report on the status of each subtask, tasks, and deliverables in the work plan will be provided to the Department by the Contractor every week during implementation. The Contractor shall submit, no later than 30 days after the award of the contract, a detailed implementation plan demonstrating the Contractor's proposed schedule to implement the behavioral health benefits program no later than July 1, 2012. The plan must include a pre-testing of all programs. A comprehensive report on the status of each subtask, tasks, and deliverables, in the work plan will be provided to the Department every week during the implementation. The implementation shall be prepared in Microsoft MS Excel and shall delineate each task, with milestones, and dates through the end of the first contract year. The Contractor and the Department will work together during the initial contract start-up to establish a schedule for key activities and define expectations for the content and format of Contract Deliverable for at least the first fiscal year. The Department may make such reasonable investigations as deemed proper and necessary to determine the ability of the Offeror to perform the services and the Offeror shall furnish to the Department all such information and data for this purpose as may be requested. The Department reserves the right to inspect Offeror's physical facilities, including any located

outside of Richmond, prior to award to satisfy questions regarding the Offeror's capabilities. The Department further reserves the right to reject any proposal if the evidence submitted by, or investigations of, such Offeror fails to satisfy the Department that such Offeror is properly qualified to carry out the obligations of the contract and to provide the services contemplated therein.

Network Development and Maintenance: Submit a detailed description with complete information on the Offeror's intent to ensure that its behavioral health services delivery system shall provide available, accessible and adequate numbers of behavioral health providers, and appropriate locations for the provision of covered services. The description shall include 1) how the delivery system will be established, taking into account requirements established in Section 4.9; and 2) the planned behavioral health access capacity as of the anticipated start date of the contract with DMAS. The Offeror may submit Letters of Intent (LOIs) and contracts from behavioral health providers with whom the Contractor intends to negotiate a contract for behavioral health services prior to implementation of this RFP. In lieu of LOIs the Offeror may provide a detailed strategy describing its provider network development and maintenance activities. The Contractor's strategy should include a quantitative analysis of the planned activities and expected results based upon the Offeror's prior experience or related research analysis. Thirty days prior to the program implementation date, Contractor shall supply the Department with a final provider network for evaluation and analysis and must include requirements for transition of the current network while maintaining high provider satisfaction ratings. The Contractor shall assure that its submitted network includes providers currently licensed to provide services as described in Section 4.10.5 of this RFP.

Education: Submit a detailed description of the Offeror's plan to educate Virginia Medicaid/FAMIS Plus/FAMIS members, providers, and others with an interest in behavioral health services covered in this RFP. The Offeror must recommend education and notification processes and methods to the Department to increase compliance rates and minimize transition disruptions. The plan must include education activities prior to and after implementation.

Service Authorization Process: Submit a detailed description of any proposed service authorization approval and appeals process for behavioral health services authorizations. The Offeror must address how it will use automation, and what specific steps will be taken to make the service authorization process consumer/provider friendly.

Claims Processing: Submit a detailed description of the Offeror's claim processing policies, procedures, and systems. Contractors must include documentation describing their performance track record in relation to claim processing time frames.

Call Center: Submit a detailed description of how the Offeror will staff and operate a 24 hour, 7 days per week toll-free Call Center. The plan must describe the information and assistance that will be provided by Call Center Representatives.

QI/QM Process: Submit a detailed description of any proposed QI/QM process. The Offeror must address how it will use automation, and what specific steps will be taken to make the QI/QM process consumer/provider friendly.

Staffing: The Offeror must submit a detailed description of the staffing plan, which describes the types of personnel who shall be hired, how staff shall be compensated (hourly, wage, temporary), and how the staff shall be supervised. This section shall also include a description of the Offeror's

plan for staff training, including components and length of training curriculum, a plan for on-going training, and a proposal of a Training Guide or Procedures Manual.

Auditing: Submit a description of how all activities will be audited and how processing center responses will be monitored to ensure accuracy of information provided to callers. This section must also describe a plan to ensure confidentiality of records.

Transition of Care: Submit a detailed description of how the Offeror shall minimize disruption to members and providers particularly in relation to start-up transition of care issues as described in Section 4. The transition plan shall include at a minimum the following: Within ten (10) days from the award of contract, the Contractor shall schedule and attend a meeting (entrance conference) at DMAS to discuss all pertinent items relative to the contract. The Contractor will work closely with DMAS to define project management, status reporting standards, and communication protocols. DMAS shall:

- Coordinate communications and act as a liaison between the new Contractor and the incumbent Contractor;
- Coordinate the transfer of files and applications from the incumbent Contractor to the new Contractor on a schedule outlined in the approved work plan;
- Provide all available relevant documentation on operations currently performed by the incumbent Contractor and DMAS;
- Establish protocols for problem reporting and controls for the transfer of data or information from the incumbent Contractor to the new Contractor;
- Work with the Contractor to review and finalize the project work plan for the Transition Phase;
- Assign a DMAS' liaison to participate in Contractor work groups;
- Review and approve procedure and protocols defined by the work groups; and
- Monitor progress through periodic status reports, weekly meetings, and work plan updates.

The new Contractor shall:

- Finalize the implementation plan, including the Transition Phase activities and submit it to DMAS for approval;
- Work with DMAS to establish communication protocols between the new Contractor and DMAS;
- Weekly meetings will be held throughout the Transition Phase to discuss and resolve transition issues, establish procedures and protocols to support operations, and promote communications among all parties;
- Work with DMAS to establish project management and reporting standards;
- Submit periodic written status reports on the progress of tasks against the approved work plan; and
- Conduct periodic status meetings with DMAS. The new Contractor is responsible for preparing the agenda for the meetings and preparing and distributing minutes, to include action items, from each meeting

Quality Management: The Contractor must submit a detailed description of the process and program, including submission of standard and proposed reporting packages.

7.2 Binding of Proposal

The Technical Proposal shall be clearly labeled “RFP 2012-08 Technical Proposal” on the front cover. The Cost Proposal shall be clearly labeled “RFP 2011-08 Cost Proposal” on the front cover. The legal name of the organization submitting the proposal shall also appear on the covers of both the Technical Proposal and the Cost Proposal.

The proposals shall be typed, bound, page-numbered, single-spaced with a 12-point font on 8 1/2” x 11” paper with 1” margins and printed on one side only. It shall be acceptable for Offerors to use a larger size font for section headings or a smaller font size for footers, tables, graphics, exhibits, or similar sections. Larger graphics, exhibits, org charts, network diagrams may also be printed on larger paper as a foldout if 8 1/2” x 11” paper is not practical. Each copy of the Technical Proposal and each copy of the Cost Proposal and all documentation submitted shall be contained in single three-ring binder volumes where practical. A tab sheet keyed to the Table of Contents shall separate each major section. The title of each major section shall appear on the tab sheet.

The Offeror shall submit one original and five (5) copies of the Technical Proposal and one original of the Cost Proposal by the response date and time specified in this RFP. Each copy of the proposal shall be bound separately. This submission shall be in a sealed envelope or sealed box clearly marked “RFP 2011-08 Technical Proposal”. In addition, the original of the Cost Proposal shall be sealed separately and clearly marked “RFP 2011-08 Cost Proposal” and submitted by the response date and time specified in this RFP. The Cost Proposal forms in Attachment X shall be used. The Offeror shall also submit one electronic copy (compact disc preferred) of their Technical Proposal in MS Word format (Microsoft Word 2003 or compatible format) and of their Cost Proposal in MS Excel format (Microsoft Word 2003 or compatible format). In addition, the Offeror shall submit a redacted (proprietary and confidential information removed) electronic copy in PDF format of their Technical Proposal and their Cost Proposal.

7.3 Table of Contents

The proposals shall contain a Table of Contents that cross-references the RFP submittal requirements in Section 4: “Technical Proposal Requirements.” Each section of the Technical Proposal shall be cross-referenced to the appropriate section of the RFP that is being addressed. This will assist DMAS in determining uniform compliance with specific RFP requirements.

7.4 Submission Requirements

All information requested in this RFP shall be submitted in the Offeror’s proposals. A Technical Proposal shall be submitted and a Cost Proposal shall be submitted in the Offeror’s collective response. The proposals will be evaluated separately. By submitting a proposal in response to this RFP, the Offeror certifies that all of the information provided is true and accurate.

All data, materials and documentation originated and prepared for the Commonwealth pursuant to this RFP belong exclusively to the Commonwealth and shall be subject to public inspection in accordance with the Virginia Freedom of Information Act. Confidential information shall be clearly marked in the proposal and reasons the information should be confidential shall be clearly stated.

Trade secrets or proprietary information submitted by an Offeror are not subject to public disclosure under the Virginia Freedom of Information Act; however, the Offeror shall invoke the protections of §2.2-4342(F) of the Code of Virginia, in writing, either before or at the time the

data is submitted. The written notice shall specifically identify the data or materials to be protected and state the reasons why protection is necessary.

The proprietary or trade secret materials submitted shall be identified by some distinct method such as highlighting or underlining and shall indicate only the specific words, figures, or paragraphs that constitute trade secret or proprietary information. The classification of an entire proposal document, line item prices and/or total proposal prices as proprietary or trade secrets is not acceptable and, in the sole discretion of DMAS, may result in rejection and return of the proposal. **Attachment XVIII of this RFP shall be used for the identification of proprietary or confidential information and submitted with the technical proposal.**

All information requested by this RFP on ownership, utilization and planned involvement of small businesses, women-owned businesses and minority-owned business (Attachment XI) **shall be submitted with the Offeror's Cost Proposal.**

7.5 Transmittal Letter

The transmittal letter shall be on official organization letterhead and signed by the individual authorized to legally bind the Offeror to contract agreements and the terms and conditions contained in this RFP. The organization official who signs the proposal transmittal letter shall be the same person who signs the cover page of the RFP and Addenda (if issued).

At a minimum, the transmittal letter shall contain the following:

1. A statement that the Offeror meets the required conditions to be an eligible candidate for the contract award including:
 - a) The Offeror must identify any contracts or agreements they have with any state or local government entity that is a Medicaid and/or Title XXI State Child Health Insurance Program provider or Contractor and the general circumstances of the contract or agreement. This information will be reviewed by DMAS to ensure there are no potential conflicts of interest;
 - b) Offeror must be able to present sufficient assurances to the state that the award of the contract to the Contractor will not create a conflict of interest between the Contractor, the Department, and its subcontractors; and
 - c) The Offeror must be licensed to conduct business in the Commonwealth of Virginia.
2. A statement that the Offeror has read, understands and agrees to perform all of the Contractor responsibilities and comply with all of the requirements and terms set forth in this RFP, any modifications of this RFP, the Contract and Addenda;
3. The Offeror's general information, including the address, telephone number, and facsimile transmission number;
4. Designation of an individual, to include their e-mail and telephone number, as the authorized representative of the organization who will interact with DMAS on any matters pertaining to this RFP and the resultant Contract; and
5. A statement agreeing that the Offeror's proposal shall be valid for a minimum of 180 days from its submission to DMAS.

7.6 Signed Cover Page of the RFP and Addenda

To attest to all RFP terms and conditions, the authorized representative of the Offeror shall sign the cover page of this RFP, as well as the cover page of the Addenda, (if issued), to the RFP; the Certification of Compliance with Prohibition of Political Contributions and Gifts during the Procurement Process” form (Attachment XV); and The State Corporate Commission form (Attachment XVX) and submit them along with its Technical Proposal.

7.7 Procurement Contact

The principal point of contact for this procurement in DMAS shall be:

Sandra R. Brown
Policy and Research Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219
Email: RFP2012-08@dmass.virginia.gov

All communications with DMAS regarding this RFP should be directed to the principal point of contact or the DMAS Contract Management Officer named in the cover memo. All RFP content-related questions shall be in writing to the principal point of contact. An Offeror who communicates with any other employees or Contractors of DMAS concerning this RFP after issuance of the RFP may be disqualified from this procurement.

7.8 Submission and Acceptance of Proposals

The proposals, whether mailed or hand delivered, shall arrive at DMAS no later than 10:00 A.M. EST on January 27, 2012. DMAS shall be the sole determining party in establishing the time of arrival of proposals. Late proposals shall not be accepted and shall be automatically rejected from further consideration. The address for delivery is:

Proposals may be sent by US mail, Federal Express, UPS, etc. to:

Attention: Christopher Banaszak
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Hand Delivery or Courier to:

Attention: Christopher Banaszak
Department of Medical Assistance Services
7th Floor DMAS Receptionist
600 East Broad Street
Richmond, VA 23219

DMAS reserves the right to reject all proposals. DMAS reserves the right to delay implementation of the RFP if a satisfactory Contractor is not identified or if DMAS determines a delay is necessary to ensure implementation goes smoothly without service interruption.

Information will be posted on the DMAS web site, http://dmasva.dmas.virginia.gov/Content_pgs/rfp-home.aspx and the eVA Web-site at <http://www.eVA.virginia.gov>. It is the responsibility of the Offeror to check these sites for updates and notices.

7.9 Oral Presentation and Site Visit

At any point in the evaluation process, DMAS may employ any or all of the following means of evaluation:

- Reviewing Industry Research
- Offeror Presentations
- Site Visits
- Contacting Offerors References
- Product Demonstrations/Pilot Tests
- Requesting Offeror to elaborate on or clarify specific portions of their proposals.

No Offeror is guaranteed an opportunity to explain, supplement or amend its initial proposal. Offeror must not submit a proposal assuming that there will be an opportunity to negotiate, amend or clarify any aspect of their submitted proposals. Therefore, each Offeror is encouraged to ensure that its initial proposal contains and represents its best offering.

Offerors should be prepared to conduct product demonstrations, pilot tests, presentations or site visits at the time, date and location of DMAS' choice, should DMAS so request.

DMAS may make one or more on-site visits to see the Offeror's operation of another contract. DMAS shall be solely responsible for its own expenses for travel, food and lodging.

7.10 Technical Proposal

The following describes the required format, content and sequence of presentations for the Technical Proposal:

7.10.1 Chapter One: Executive Summary

The Executive Summary Chapter shall highlight the Offeror's:

1. Understanding of the project requirements.
2. Qualifications to serve as the DMAS Contractor for the project.
3. Overall Approach to the project and a summary of the contents of the proposal.

7.10.2 Chapter Two: Corporate Qualifications and Experience

Chapter Two shall present the Offeror's qualifications and experience to serve as the Contractor. Specifically, the Offeror shall describe its:

1. Organization Status:

- a) Name of Project Director for this Contract;
- b) Name, address, telephone number, fax number, and e-mail address of the legal entity with whom the contract is to be written;
- c) Federal employer ID number;
- d) Name, address, telephone numbers of principal officers (president, vice-president, treasurer, chair of the board of directors, and other executive officers);

- e) Name of the parent organization and major subsidiaries;
- f) Major business services;
- g) Legal status and whether it is a for-profit or a not-for-profit company;
- h) A list of board members and their organizational affiliations;
- i) Current organization chart; and
- j) Any specific licenses and accreditation held by the Offeror.

2. Corporate Experience:

- a) Offeror's overall qualifications to carry out a project of this nature and scope.
- b) The Offeror shall describe the background and success of the Offeror's organization and experience in performing as a behavioral health service administrator, specifically implementing state, local or regional programs.
- c) The Offeror's knowledge of the Medicaid/FAMIS Plus and/or FAMIS member populations and the communities.
- d) For each experience with operating, managing, or contracting for the provision of service authorization services or other human services, the Offeror shall indicate the contract or project title, dates of performance, scope and complexity of contract, and customer references (see below).
- e) Any other related experience the Offeror feels is relevant shall be included.
- f) The Offeror shall indicate whether the Offeror has had a contract terminated for any reason within the last five years.
- g) The Offeror also shall indicate if a claim was made on a payment or performance bond. If so, the Offeror shall submit full details of the termination and the bonds including the other party's name, address, and telephone number.

3. References:

- a) Two customers or members who will substantiate the Offeror's qualifications and capabilities to perform the services required by the RFP.
- b) Two customers or members who can attest to the Offeror's experience with interface files for data loads.
- c) Contact information for all service authorization contracts for Medicaid/FAMIS Plus or FAMIS products and any Virginia based non-Medicaid groups the Contractor chooses to include, held by the Offeror at any time since January 1, 2004.

The Offeror shall complete the Reference Form in Attachment IX for each reference and contract, which includes the contract name, address, telephone number, contact person, and periods of work performance.

4. Financial Stability:

The Offeror shall submit evidence of financial stability. The Offeror should submit one of the following financial reports:

- a) For a publicly held corporation, a copy of the most recent three years of audited financial reports and financial statements with the name, address, and telephone number of a responsible person in the Offeror's principal financial or banking organization, or
- b) For a privately held corporation, proprietorship, or partnership, financial information for the past three years, similar to that included in an annual report, to include, at a minimum, an income statement, a statement of cash flows, a balance sheet, and number of years in business, as well as the name, address, and telephone number of a

contact in the Offeror's principal financial or banking organization and its auditor.

7.10.3 Chapter Three: Tasks and Technical Approach

The Offeror shall fully describe how it intends to meet all of the tasks required in Section 3 of the RFP and technical proposal requirements listed in Section 4 of this RFP. DMAS does not want a "re-write" of the RFP requirements. Specifically, the Offeror shall describe in detail its proposed approach for each of the required tasks listed in Section 3 and technical proposal requirements in Section 4 including any staff, systems, procedures, or materials that will be used to perform these tasks. This includes how each task will be performed, what problems need to be overcome, what functions the staff will perform, and what assistance will be needed from DMAS, if any.

Note: DMAS welcomes new and innovative approaches to behavioral health services. While fully addressing the objectives in Sections 3 and 4 of this RFP, the Offeror may also include alternate approaches for DMAS consideration. Additional services can be addressed as long as a separate line item for the associated costs is submitted with the proposal. (refer to Attachment X – Enhanced Benefits)

7.10.4 Chapter Four: Staffing

The proposal shall describe the following:

1. Staffing Plan: The Offeror shall provide a functional organizational chart of the proposed project structure and organization, indicating the lines of authority for proposed staff directly involved in performance of this contract and relationships of the staff to each function of the organization. The staffing plan shall indicate the number of proposed FTEs by position and an estimate of hours to be committed to the project by each staff position. The plan shall also show the number of staff to be employed by the Contractor and staff to be obtained through subcontracting arrangements. Contact information must be provided for all key staff involved in the implementation and ongoing management of the program.

Offerors must submit two (2) references for each proposed key staff member, showing work for previous participants who have received similar services to those proposed by the Offeror for this contract. Each reference must include the name of the contact person, address, telephone number and description of services provided.

2. Staff Qualifications and Resumes: Job descriptions for all key staff on the project including qualifications, experience and/or expertise required should be included. Resumes limited to two pages must be included for key staff. The resumes of personnel proposed must include qualifications, experience, and relevant education, professional certifications and training for the position they will fill.
3. Office Location: A description of the geographical location of the central business office, the billing office, the processing center and satellite offices, if applicable, shall be included. In addition, the hours of operation should be noted for each office as applicable to this contract.

7.10.5 Chapter Five: Project Work Plan

The proposal shall describe the following:

Work Plan and Project Management: The proposal shall include a work plan (Microsoft Word or Excel 2003 or compatible version) detailing the sequence of events and the time required to implement this project no later than July 1, 2012. The relationship between key staff and the specific tasks and assignments proposed to accomplish the scope of work shall also be included. A PERT, Gantt, or Bar Chart that clearly outlines the project timetable from beginning to end shall be included in the proposal. Key dates and key events relative to the project shall be clearly described on the chart including critical path of tasks. The Offeror shall describe its management approach and how its proposed work plan will be executed.

Progress Reports: Upon award of a contract, the Contractor must prepare a written progress report, as well as telephonic meetings, every week or more frequently as necessary and present this report to the Director, Division of Policy and Research or her designee. The report must include:

1. Status of major activities and tasks in relation to the Contractor's work plan, including specific tasks completed for each part of the project.
2. Target dates for completion of remaining or upcoming tasks/activities.
3. Any potential delays or problems anticipated or encountered in reaching target dates and the reason for such delays.
4. Any revisions to the overall work schedule.

7.10.6 Chapter Six: Required Forms:

This chapter shall contain the signatory documents as outlined in the RFP. These include the following:

1. RFP Cover Sheet
2. RFP Addenda (if issued).
3. Offerors Transmittal Letter
4. Certification of Compliance with Prohibition of Political Contributions and Gifts During the Procurement Process" (Attachment XV)
5. Proprietary/Confidential Information Identification Form (Attachment XVIII)
6. State Corporation Commission Form (Attachment XVX)

8. PROPOSAL EVALUATIONS

DMAS will conduct a comprehensive, fair, and impartial evaluation of the Technical and Cost Proposals received in response to this RFP. The Evaluation Team will be responsible for the review and scoring of all Technical Proposals and the Office of Budget and Contract Management will review and score the Cost Proposals and Small Business Subcontracting Plans. This group will be responsible for the recommendation to the DMAS Director.

8.1 Evaluation of Minimum Requirements

DMAS will initially determine if each proposal addresses the minimum RFP requirements to permit a complete evaluation of the Technical and Cost Proposals. Proposals shall comply with the instructions to Offerors contained throughout this RFP. Failure to comply with the instructions shall deem the proposal non-responsive and subject to disqualification without further consideration. DMAS reserves the right to waive minor irregularities.

The minimum requirements for a proposal to be given consideration are:

RFP Cover Sheet, Addenda (if issued), Transmittal Letter and Certification of Compliance with Prohibition of Political Contributions and Gifts During the Procurement Process” (Attachment XV), Proprietary/Confidential Information Identification Form (Attachment XVIII), and State Corporation Commission Form (Attachment XVX):: These shall be completed and properly signed by the authorized representative of the organization.

Closing Date: The proposal shall have been received, as provided in Section 7.8, before the closing of acceptance of proposals in the number of copies specified.

Compliance: The proposal shall comply with the entire format requirements described in Section 4 and the Technical Proposal and Cost Proposal requirements described in Section 7.

Mandatory Conditions: All mandatory General and Specific Terms and Conditions contained in Sections 9 and 10 shall be accepted.

Small Business Subcontracting Plan – Summarize the planned utilization of DMBE certified small businesses and small businesses owned by women and minorities under the contract to be awarded as a result of this solicitation. (Attachment XI) The **Small Business Subcontracting Plan, is a scored criteria and, if applicable, documents the Offeror and/or their planned subcontractors as either a small business, small women-owned or small minority-owned business as certified by the Department of Minority Business Enterprises (DMBE). Offerors are encouraged to populate the table with their plans to utilize small businesses from joint ventures, partnerships, suppliers, etc. Regardless of planned Small Business utilization, all proposals must have this attachment included in their Cost Proposal.**

8.2 Proposal Evaluation Criteria

The broad criteria for evaluating proposals include, but are not limited to, the elements below:

Criteria	Weights
1. Experience of the Offeror in performing behavioral health benefits administration services in rural and urban areas.	15%
a) Experience of the Offeror in working with indigent populations, particularly Medicaid/FAMIS Plus and FAMIS populations.	
b) Experience in managing a diverse provider network.	
c) Experience of the Offeror in developing productive relationships with public, private and not-for-profit community organizations regarding behavioral health provider issues.	
2. Technical Proposal - Demonstration in the written proposal of the Offeror’s ability, facilities and capacity to provide all required services in a timely, efficient and professional manner.	35%
a) Clarity and thoroughness of the Offeror’s proposal in addressing the components of the RFP and implementing them as described and on schedule.	
b) Proposed project management of the resources available to the Offeror for meeting the requirements of the RFP.	
3. Staffing - Experience and expertise of specific staff assigned to the contract.	10%
a) Prior experience of staff with similar projects.	
b) Qualifications of staff.	
c) Appropriateness of the relationship between staff qualifications and assigned responsibilities.	

4. Quality of References	5%
a) References who clearly address the nature of the work performed by the Offeror.	
b) References who exhibit satisfaction with the work performed by the Offeror.	
c) Contacts for other contracts who exhibit satisfaction with the work performed by the Offeror.	
5. Small Business Subcontracting Plan (Attachment XI)	20%
6. Cost Proposal	15%
a) The PMPM cost proposal – see Attachment X. For purposes of evaluation, each Offeror’s PMPM cost by member program category shall be multiplied by the average monthly enrollment for each eligibility category. The Offeror with the lowest cost proposal shall be identified, and all other Offeror costs shall be evaluated in comparison to this price bid.	

The cost proposal shall be evaluated and weighted but is not the sole deciding factor for the RFP. The lowest cost proposal shall be scored the maximum number of evaluation points for cost. All other cost proposals shall be evaluated and assigned points for cost in relation to the lowest cost proposal. Although cost proposals are evaluated and weighted, they are not the sole deciding factor for the RFP.

9. GENERAL TERMS AND CONDITIONS

9.1 Vendors Manual

This solicitation is subject to the provisions of the Commonwealth of Virginia *Vendors Manual* and any changes or revisions thereto, which are hereby incorporated into this contract in their entirety. The procedure for filing contractual claims is in section 7.19 of the *Vendors Manual*. A copy of the manual is normally available for review at the purchasing office and is accessible on the Internet at <http://www.eva.virginia.gov/learn-about-eva/vendors-manual.htm> .

9.2 Applicable Laws and Courts

This solicitation and any resulting contract shall be governed in all respects by the laws of the Commonwealth of Virginia and any litigation with respect thereto shall be brought in the courts of the Commonwealth. The agency and the Contractor are encouraged to resolve any issues in controversy arising from the award of the contract or any contractual dispute using Alternative Dispute Resolution (ADR) procedures (*Code of Virginia*, §2.2-4366). ADR procedures are described in Chapter 9 of the *Vendors Manual*. The Contractor shall comply with all applicable federal, state and local laws, rules and regulations.

9.3 Anti-Discrimination

By submitting their proposals, Offerors certify to the Commonwealth that they will conform to the provisions of the Federal Civil Rights Act of 1964, as amended, as well as the Virginia Fair Employment Contracting Act of 1975, as amended, where applicable, the Virginians With Disabilities Act, the Americans With Disabilities Act and §2.2-4311 of the Virginia Public Procurement Act (VPPA), and any other applicable laws. If the award is made to a faith-based organization, the organization shall not discriminate against any member of goods, services, or disbursements made pursuant to the contract on the basis of the member’s religion, religious belief, refusal to participate in a religious practice, or on the basis of race, age, color, gender or

national origin and shall be subject to the same rules as other organizations that contract with public bodies to account for the use of the funds provided; however, if the faith-based organization segregates public funds into separate accounts, only the accounts and programs funded with public funds shall be subject to audit by the public body. (*Code of Virginia*, § 2.2-4343.1 E).

In every contract over \$10,000, the provisions in Sections 9.3.1 and 9.3.2. below apply:

9.3.1. During the performance of this contract, the Contractor agrees as follows:

- a) The Contractor will not discriminate against any employee or applicant for employment because of race, religion, color, sex, national origin, age, disability, or any other basis prohibited by state law relating to discrimination in employment, except where there is a bona fide occupational qualification reasonably necessary to the normal operation of the Contractor. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this nondiscrimination clause.
- b) The Contractor, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, will state that such Contractor is an equal opportunity employer.
- c) Notices, advertisements and solicitations placed in accordance with federal law, rule or regulation shall be deemed sufficient for the purpose of meeting these requirements.

9.3.2. The Contractor will include the provisions of 9.3.1 above in every subcontract or purchase order over \$10,000, so that the provisions will be binding upon each subcontractor or vendor.

9.4 Ethics in Public Contracting

By submitting their proposals, Offerors certify that their proposals are made without collusion or fraud and that they have not offered or received any kickbacks or inducements from any other Offeror, supplier, manufacturer or subcontractor in connection with their proposal, and that they have not conferred on any public employee having official responsibility for this procurement transaction any payment, loan, subscription, advance, deposit of money, services or anything of more than nominal value, present or promised, unless consideration of substantially equal or greater value was exchanged.

9.5 Immigration Reform and Control Act Of 1986

By entering into a written contract with the Commonwealth of Virginia (COV), the Contractor certifies that the Contractor does not, and shall not during the performance of the contract for goods and services in the Commonwealth, knowingly employ an unauthorized alien as defined in the federal Immigration Reform and Control Act of 1986.

9.6 Debarment Status

By submitting their proposals, Offerors certify that they are not currently debarred by the Commonwealth of Virginia or any other federal, state or local government from submitting bids

or proposals on any type of contract, nor are they an agent of any person or entity that is currently so debarred.

9.7 Antitrust

By entering into a contract, the Contractor conveys, sells, assigns, and transfers to the Commonwealth of Virginia all rights, title and interest in and to all causes of action it may now have or hereafter acquire under the antitrust laws of the United States and the Commonwealth of Virginia, relating to the particular goods or services purchased or acquired by the Commonwealth of Virginia under said contract.

9.8 Mandatory Use of State Form and Terms and Conditions

Failure to submit a proposal on the official State form, in this case the completed and signed RFP Cover Sheet, may be a cause for rejection of the proposal. Modification of or additions to the General Terms and Conditions of the solicitation may be cause for rejection of the proposal; however, the Commonwealth reserves the right to decide, on a case by case basis, in its sole discretion, whether to reject such a proposal.

9.9 Clarification of Terms

If any prospective Offeror has questions about the specifications or other solicitation documents, the prospective Offeror should contact Sandra Brown (RFP2012-08@dmass.virginia.gov) no later than 2:00 P.M. EST on December 29, 2011. Any revisions to the solicitation will be made only by addendum issued by the buyer.

9.10 Payment

1. To Prime Contractor:
 - a. Invoices for items ordered, delivered and accepted shall be submitted by the Contractor directly to the payment address shown on the purchase order/contract. All invoices shall show the state contract number and/or purchase order number; social security number (for individual contractors) or the federal employer identification number (for proprietorships, partnerships, and corporations).
 - b. Any payment terms requiring payment in less than 30 days will be regarded as requiring payment 30 days after invoice or delivery, whichever occurs last. This shall not affect offers of discounts for payment in less than 30 days, however.
 - c. All goods or services provided under this contract or purchase order, that are to be paid for with public funds, shall be billed by the Contractor at the contract price, regardless of which public agency is being billed.
 - d. The following shall be deemed to be the date of payment: the date of postmark in all cases where payment is made by mail, or the date of offset when offset proceedings have been instituted as authorized under the Virginia Debt Collection Act.
 - e. Unreasonable Charges: Under certain emergency procurements and for most time and material purchases, final job costs cannot be accurately determined at the time orders are placed. In such cases, Contractors should be put on notice that final payment in full is contingent on a determination of reasonableness with respect to all invoiced charges. Charges that appear to be unreasonable will be researched and challenged, and that portion of the invoice held in abeyance until a settlement can be reached. Upon determining that invoiced charges are not reasonable, the Commonwealth shall promptly notify the Contractor, in writing, as to those charges

which it considers unreasonable and the basis for the determination. A Contractor may not institute legal action unless a settlement cannot be reached within thirty (30) days of notification. The provisions of this section do not relieve an agency of its prompt payment obligations with respect to those charges that are not in dispute (*Code of Virginia*, § 2.2-4363).

2. To Subcontractors:

- a. A Contractor awarded a contract under this solicitation is hereby obligated:
 - (1) To pay the subcontractor(s) within seven (7) days of the Contractor's receipt of payment from the Commonwealth for the proportionate share of the payment received for work performed by the subcontractor(s) under the contract; or
 - (2) To notify the agency and the subcontractor(s), in writing, of the Contractor's intention to withhold payment and the reason.
- b. The Contractor is obligated to pay the subcontractor(s) interest at the rate of one percent per month (unless otherwise provided under the terms of the contract) on all amounts owed by the Contractor that remain unpaid seven (7) days following receipt of payment from the Commonwealth, except for amounts withheld as stated in (2) above. The date of mailing of any payment by U. S. Mail is deemed to be payment to the addressee. These provisions apply to each sub-tier Contractor performing under the primary contract. A Contractor's obligation to pay an interest charge to a subcontractor may not be construed to be an obligation of the Commonwealth.

3. Each prime Contractor who wins an award in which provision of a SWAM procurement plan is a condition to the award, shall deliver to the contracting agency or institution, on or before request for final payment, evidence and certification of compliance (subject only to insubstantial shortfalls and to shortfalls arising from subcontractor default) with the SWAM procurement plan. Final payment under the contract in question may be withheld until such certification is delivered and, if necessary, confirmed by the agency or institution, or other appropriate penalties may be assessed in lieu of withholding such payment.

4. The COV encourages Contractors and subcontractors to accept electronic and credit card payments.

9.11 Precedence of Terms

The following General Terms and Conditions: *VENDORS MANUAL*, APPLICABLE LAWS AND COURTS, ANTI-DISCRIMINATION, ETHICS IN PUBLIC CONTRACTING, IMMIGRATION REFORM AND CONTROL ACT OF 1986, DEBARMENT STATUS, ANTITRUST, MANDATORY USE OF STATE FORM AND TERMS AND CONDITIONS, CLARIFICATION OF TERMS, PAYMENT shall apply in all instances. In the event there is a conflict between any of the other General Terms and Conditions and any Special Terms and Conditions in this solicitation, the Special Terms and Conditions shall apply.

9.12 Qualifications of Offerors

The Commonwealth may make such reasonable investigations as deemed proper and necessary to determine the ability of the Offeror to perform the services/furnish the goods and the Offeror shall furnish to the Commonwealth all such information and data for this purpose as may be requested.

The Commonwealth reserves the right to inspect Offeror's physical facilities prior to award to satisfy questions regarding the Offeror's capabilities. The Commonwealth further reserves the right to reject any proposal if the evidence submitted by, or investigations of, such Offeror fails to satisfy the Commonwealth that such Offeror is properly qualified to carry out the obligations of the Contract and to provide the services and/or furnish the goods contemplated therein.

9.13 Testing And Inspection

The Commonwealth reserves the right to conduct any test/inspection it may deem advisable to ensure goods and services conform to the specifications.

9.14 Assignment of Contract

A contract shall not be assignable by the Contractor in whole or in part without the written consent of the Commonwealth. Any assignment made in violation of this section will be void.

9.15 Changes To The Contract

Changes can be made to the contract in any of the following ways:

1. The parties may agree in writing to modify the scope of the contract. An increase or decrease in the price of the contract resulting from such modification shall be agreed to by the parties as a part of their written agreement to modify the scope of the contract. **In any such change to the resulting contract, no increase to the contract price shall be permitted without adequate consideration, and no waiver of any contract requirement that results in savings to the Contractor shall be permitted without adequate consideration. Pursuant to Virginia Code § 2.2-4309, the value of any fixed-price contract shall not be increased via modification by more than 25% without the prior approval of the Division of Purchases and Supply of the Virginia Department of General Services.**
2. The Department may order changes within the general scope of the contract at any time by written notice to the Contractor. Changes within the scope of the contract include, but are not limited to, things such as services to be performed or changes in programs, policies, legislation or operations. The Contractor shall comply with the notice upon receipt. The Contractor shall be compensated for any additional costs incurred as the result of such order and shall give the Department a credit for any savings. Said compensation shall be determined by one of the following methods:
 - a. By mutual agreement between the parties in writing; or
 - b. By agreeing upon a unit price or using a unit price set forth in the contract, if the work to be done can be expressed in units, and the Contractor accounts for the number of units of work performed, subject to the Department's right to audit the Contractor's records and/or to determine the correct number of units independently; or
 - c. By ordering the Contractor to proceed with the work and keep a record of all costs incurred and savings realized. A markup for overhead and profit may be allowed if provided by the contract. The same markup shall be used for determining a decrease in price as the result of savings realized. The Contractor shall present the Department with all vouchers and records of expenses incurred and savings realized. The

Department will have the right to audit the records of the Contractor as it deems necessary to determine costs or savings. Any claim for an adjustment in price under this provision must be asserted by written notice to the Department within thirty (30) days from the date of receipt of the written order from the Department. If the parties fail to agree on an amount of adjustment, the question of an increase or decrease in the contract price or time for performance shall be resolved in accordance with the procedures for resolving disputes provided by the Disputes Clause of this contract or, if there is none, in accordance with the disputes provisions of the Commonwealth of Virginia *Vendors Manual*. Neither the existence of a claim nor a dispute resolution process, litigation or any other provision of this contract shall excuse the Contractor from promptly complying with the changes ordered by the Department or with the performance of the contract generally.

9.16 Default

In case of failure to deliver goods or services in accordance with the contract terms and conditions, the Commonwealth, after due oral or written notice, may procure them from other sources and hold the Contractor responsible for any resulting additional purchase and administrative costs. This remedy shall be in addition to any other remedies, which the Commonwealth may have.

9.17 Insurance

By signing and submitting a bid or proposal under this solicitation, the Offeror certifies that if awarded the contract, it will have the following insurance coverage at the time the contract is awarded. For construction contracts, if any subcontractors are involved, the subcontractor will have workers' compensation insurance in accordance with §§ 2.2-4332 and 65.2-800 et seq. of the *Code of Virginia*. The Offeror further certifies that the Contractor and any subcontractors will maintain this insurance coverage during the entire term of the contract and that all insurance coverage will be provided by insurance companies authorized to sell insurance in Virginia by the Virginia State Corporation Commission.

MINIMUM INSURANCE COVERAGES AND LIMITS REQUIRED FOR MOST CONTRACTS:

1. Workers' Compensation: Statutory requirements and benefits: Coverage is compulsory for employers of three or more employees, to include the employer. Contractors who fail to notify the Commonwealth of increases in the number of employees that change their workers' compensation requirements under the *Code of Virginia* during the course of the contract shall be in noncompliance with the contract.
2. Employer's Liability: \$100,000.
3. Commercial General Liability: \$1,000,000 per occurrence. Commercial General Liability is to include bodily injury and property damage, personal injury and advertising injury, products and completed operations coverage. The Commonwealth of Virginia must be named as an additional insured and so endorsed on the policy.
4. Automobile Liability: \$1,000,000 per occurrence. (Only used if motor vehicle is to be used in the contract.)

9.18 Announcement of Award

Upon the award or the announcement of the decision to award a contract as a result of this solicitation, the Department will publicly post such notice on the DGS/DPS eVA VBO (www.eva.virginia.gov) for a minimum of 10 days.

9.19 Drug-Free Workplace

During the performance of this contract, the Contractor agrees to:

1. Provide a drug-free workplace for the Contractor's employees;
2. Post in conspicuous places, available to employees and applicants for employment, a statement notifying employees that the unlawful manufacture, sale, distribution, dispensation, possession, or use of a controlled substance or marijuana is prohibited in the Contractor's workplace and specifying the actions that will be taken against employees for violations of such prohibition;
3. State in all solicitations or advertisements for employees placed by or on behalf of the Contractor that the Contractor maintains a drug-free workplace; and
4. Include the provisions of the foregoing clauses in every subcontract or purchase order of over \$10,000, so that the provisions will be binding upon each subcontractor or vendor.

For the purposes of this section, “*drug-free workplace*” means a site for the performance of work done in connection with a specific contract awarded to a Contractor, the employees of whom are prohibited from engaging in the unlawful manufacture, sale, distribution, dispensation, possession or use of any controlled substance or marijuana during the performance of the contract.

9.20 Nondiscrimination of Contractors

A Bidder, Offeror, or Contractor shall not be discriminated against in the solicitation or award of this contract because of race, religion, color, sex, national origin, age, disability, faith-based organizational status, any other basis prohibited by state law relating to discrimination in employment or because the bidder or Offeror employs ex-offenders unless the state agency, department or institution has made a written determination that employing ex-offenders on the specific contract is not in its best interest. If the award of this contract is made to a faith-based organization and an individual, who applies for or receives goods, services, or disbursements provided pursuant to this contract objects to the religious character of the faith-based organization from which the individual receives or would receive the goods, services, or disbursements, the public body shall offer the individual, within a reasonable period of time after the date of his objection, access to equivalent goods, services, or disbursements from an alternative provider.

9.21 eVA Business-To-Government Vendor Registration

The eVA Internet electronic procurement solution, Web-site portal www.eva.virginia.gov, streamlines and automates government purchasing activities in the Commonwealth. The eVA portal is the gateway for vendors to conduct business with state agencies and public bodies. All vendors desiring to provide goods and/or services to the Commonwealth shall participate in the eVA Internet e-procurement solution either through the eVA Basic Vendor Registration Service or

eVA Premium Vendor Registration Service. All Offerors must register in eVA and pay the Vendor Transaction Fees specified below; failure to register shall result in the proposal being rejected.

Effective July 1, 2011, vendor registration and registration-renewal fees have been discontinued. Registration options are as follows:

- a. eVA Basic Vendor Registration Service: eVA Basic Vendor Registration Service includes electronic order receipt, vendor catalog posting, on-line registration, electronic bidding, and the ability to research historical procurement data available in the eVA purchase transaction data warehouse.
- b. eVA Premium Vendor Registration Service: eVA Premium Vendor Registration Service includes all benefits of the eVA Basic Vendor Registration Service plus automatic email or fax notification of solicitations and amendments.

Vendor transaction fees are determined by the date the original purchase order is issued and are as follows:

- a. For orders issued prior to August 16, 2006, the Vendor Transaction Fee is 1%, capped at a maximum of \$500 per order.
- b. For orders issued August 16, 2006 thru June 30, 2011, the Vendor Transaction Fee is:
 - (i) DMBE-certified Small Businesses: 1%, capped at \$500 per order.
 - (ii) Businesses that are not DMBE-certified Small Businesses: 1%, capped at \$1,500 per order.
- c. For orders issued July 1, 2011 thru June 30, 2012, the Vendor Transaction Fee is:
 - (i) DMBE-certified Small Businesses: 0.75%, capped at \$500 per order.
 - (ii) Businesses that are not DMBE-certified Small Businesses: 0.75%, capped at \$1,500 per order.
- d. For orders issued July 1, 2012 and after, the Vendor Transaction Fee is:
 - (i) DMBE-certified Small Businesses: 1%, capped at \$500 per order.
 - (ii) Businesses that are not DMBE-certified Small Businesses: 1%, capped at \$1,500 per order.

The specified vendor transaction fee will be invoiced, by the Commonwealth of Virginia Department of General Services, approximately 30 days after the corresponding purchase order is issued and payable 30 days after the invoice date. Any adjustments (increases/decreases) will be handled through purchase order changes.

9.22 Availability of Funds

It is understood and agreed between the parties herein that the agency shall be bound hereunder only to the extent of the funds available or which may hereafter become available for the purpose of this agreement.

9.23 Set-Asides

This solicitation is set-aside for DMBE-certified small business participation only when designated “SET-ASIDE FOR SMALL BUSINESSES” in the solicitation. DMBE-certified small businesses are those businesses that hold current small business certification from the Virginia Department of Minority Business Enterprise. This shall not exclude DMBE-certified women-owned and minority-owned businesses when they have received the DMBE small business certification. For purposes of award, Offerors shall be deemed small businesses if and only if they are certified as such by DMBE on the due date for receipt of proposals.

9.24 Bid Price Currency

Unless stated otherwise in the solicitation, Offerors shall state offer prices in US dollars.

9.25 Authorization To Conduct Business In the Commonwealth

The Contractor as a stock or non-stock corporation, limited liability company, business trust, or limited partnership or registered as a registered limited liability partnership shall be authorized to transact business in the Commonwealth as a domestic or foreign business entity if so required by Title 13.1 or Title 50 of the *Code of Virginia* or as otherwise required by law. Any business entity described above that enters into a contract with a public body pursuant to the *Virginia Public Procurement Act* shall not allow its existence to lapse or its certificate of authority or registration to transact business in the Commonwealth, if so required under Title 13.1 or Title 50, to be revoked or cancelled at any time during the term of the contract. A public body may void any contract with a business entity if the business entity fails to remain in compliance with the provisions of this section

10. SPECIAL TERMS AND CONDITIONS

10.1 Access To Premises

The Contractor shall allow duly authorized agents or representatives of the State or Federal Government, during normal business hours, access to Contractor’s and subcontractors’ premises, to inspect, audit, monitor or otherwise evaluate the performance of the Contractor’s and subcontractor’s contractual activities and shall forthwith produce all records requested as part of such review or audit. In the event right of access is requested under this section, the Contractor and subcontractor shall, upon request, provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the State or Federal personnel conducting the audit or inspection effort. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of Contractor or subcontractor’s activities. The Contractor will be given thirty (30) calendar days to respond to any preliminary findings of an audit before the Department shall finalize its findings. All information so obtained will be accorded confidential treatment as provided under applicable law. The Department, the Office of the Attorney General of the Commonwealth of Virginia, the federal Department of Health and Human Services, and/or their duly authorized representatives shall be allowed access to evaluate through inspection or other means, the quality, appropriateness, and timeliness of services performed under this Contract.

10.2 Access To and Retention of Records

In addition to the requirements outlined below, the Contractor must comply, and must require compliance by its subcontractors with the security and confidentiality of records standards.

10.2.1 Access to Records

The Department, the Centers for Medicare and Medicaid Services, State and Federal auditors, or any of their duly authorized representatives shall have access to any books, fee schedules, documents, papers, and records of the Contractor and any of its subcontractors.

The Department, the Centers for Medicare and Medicaid Services, State and Federal auditors, or any of their duly authorized representatives, shall be allowed to inspect, copy, and audit any of the above documents, including, medical and/or financial records of the Contractor and its subcontractors.

10.2.2 Retention of Records

The Contractor shall retain all records and reports relating to this Contract for a period of six (6) years after final payment is made under this Contract or in the event that this Contract is renewed six (6) years after the renewal date. When an audit, litigation, or other action involving records is initiated prior to the end of said period, however, records shall be maintained for a period of six (6) years following resolution of such action or longer if such action is still ongoing. Copies on microfilm or other appropriate media of the documents contemplated herein may be substituted for the originals provided that the microfilming or other duplicating procedures are reliable and are supported by an effective retrieval system which meets legal requirements to support litigation, and to be admissible into evidence in any court of law.

10.2.3 Confidentiality Of Personally Identifiable Information

The Contractor assures that information and data obtained as to personal facts and circumstances related to patients or members will be collected and held confidential, during and following the term of this agreement, and will not be divulged without the individual's and the agency's written consent and only in accordance with federal law or the Code of Virginia. Contractors who utilize, access, or store personally identifiable information as part of the performance of a contract are required to safeguard this information and immediately notify the agency of any breach or suspected breach in the security of such information. Contractors shall allow the agency to both participate in the investigation of incidents and exercise control over decisions regarding external reporting. Contractors and their employees working on this project may be required to sign a confidentiality statement. The Contractor shall maintain the confidentiality of Medicaid client information. The Contractor shall ensure that access to this information will be limited to the Contractor. The Contractor shall take measures to prudently safeguard and protect unauthorized disclosure of the Medicaid client information in its possession. The Contractor shall establish internal policies to ensure compliance with Federal and State laws and regulations regarding confidentiality including, but not limited to, 42 CFR § 431, Subpart F, and Virginia Code § 2.2-3800, et. seq. In no event may the Contractor provide, grant, allow, or otherwise give, access to Medicaid client information to anyone without the express written permission of DMAS. The Contractor shall assume all liabilities under both State and Federal law in the event that the information is disclosed in any manner. Upon the Contractor's receiving any requests for Medicaid client information from any individual, entity, corporation, partnership or otherwise, the Contractor shall notify DMAS within twenty-four (24) hours or on the next business day. In cases where the information requested by outside sources is releasable under the Freedom of Information Act (FOIA), as determined by DMAS, the Contractor shall provide support for copying and invoicing such documents at the Contractor's expense.

Protected Health Information (PHI)

The Contractor shall comply with all federal and state laws and regulations with regard to handling, processing, and using health care data. The Contractor must keep abreast of the regulations and be able to reach full compliance within the specified timeframes. Since HIPAA is federal law and its enacting regulations apply to all health care information, the Contractor must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations at no additional cost to DMAS. The DMAS and the Contractor, as defined in section 160.103 of the Final HIPAA Privacy Rule, will enter into this Business Associate Agreement to comply with the HIPAA Privacy regulation requirements.

- a. The Contractor shall not use Protected Health Information (PHI) otherwise than as expressly permitted, or as required by law.
- b. The Contractor shall ensure that any agents and subcontractors to whom it provides PHI received from DMAS agree in writing to the same restrictions, terms, and conditions relating to PHI that apply to the Contractor.
- c. The Contractor shall report to DMAS within thirty (30) days of discovery, any use or disclosure of PHI made in violation of agreement or any law. The Contractor shall implement and maintain liquidated remedies for any employee, subcontractor, or agent who violates the requirements of agreement or the HIPAA privacy regulations.
- d. The Contractor shall make an individual's PHI available to DMAS within thirty (30) days of an individual's request for such information as notified by DMAS.
- e. The Contractor shall make PHI available for amendment and correction and shall incorporate any amendments or corrections to PHI within thirty (30) days of notification by DMAS.
- f. DMAS may immediately terminate a Business Associate agreement with the Contractor if DMAS determines that the Contractor has violated a material term of the agreement.
- g. The Contractor shall develop a written Business Associate Data Security Plan that shall be available upon request, within thirty (30) days of the execution of a Business Associate Agreement. The Business Associate Data Security Plan shall describe the manner in which the Contractor will use DMAS' data and the procedures the Contractor will employ to secure the data.

10.3 Advertising

In the event a contract is awarded for services resulting from this proposal, no indication of such sales or services to DMAS will be used in product literature or advertising without prior written permission from DMAS. The Contractor shall not state in any of its advertising or product literature that the Commonwealth of Virginia or any agency or institution of the Commonwealth has purchased or uses its products or services without prior written permission from DMAS. DMAS must approve any advertising, marketing or press release connected with this contract.

10.4 Audit

The Contractor shall retain all books, records, and other documents relative to this contract for six (6) years after final payment, or longer if audited by the Commonwealth of Virginia, whichever is sooner. The agency, its authorized agents (to include the Office of Comprehensive Services),

and/or state auditors shall have full access to and the right to examine any of said materials during said period.

10.5 Award

Selection shall be made of one or more Offerors deemed to be fully qualified and best suited among those *submitting proposals on the* basis of the evaluation factors included in the Request for Proposals, including price, if so stated in the Request for Proposals. Negotiations shall be conducted with the Offeror(s) so selected. Price shall be considered, but need not be the sole determining factor. After negotiations have been conducted with each Offeror so selected, the agency shall select the Offeror which, in its opinion, has made the best proposal, and shall award the contract to that Offeror. The Commonwealth may cancel this Request for Proposals or reject proposals at any time prior to an award, and is not required to furnish a statement of the reasons why a particular proposal was not deemed to be the most advantageous (*Code of Virginia, § 2.2-4359D*). Should the Commonwealth determine in writing and in its sole discretion that only one Offeror is fully qualified, or that one Offeror is clearly more highly qualified than the others under consideration, a contract may be negotiated and awarded to that Offeror. The award document will be a contract incorporating by reference all the requirements, terms and conditions of the solicitation and the Contractor's proposal as negotiated.

10.6 Cancellation of Contract

The Department reserves the right to cancel and terminate any resulting contract, in part or in whole, without penalty, upon 90 days written notice to the Contractor. Any contract cancellation notice shall not relieve the Contractor of the obligation to deliver and/or perform on all outstanding services issued prior to the effective date of cancellation.

10.7 Termination

This Contract may be terminated in whole or in part:

- a. By the Department, for convenience, with not less than ninety (90) days prior written notice, which notice shall specify the effective date of the termination,
- b. By the Department, in whole or in part, if funding from Federal, State, or other sources is withdrawn, reduced, or limited;
- c. By the Department if the Department determines that the instability of the Contractor's financial condition threatens delivery of services and continued performance of the Contractor's responsibilities; or
- d. By the Department if the Department determines that the Contractor has failed to satisfactorily perform its contracted duties and responsibilities.

The Contractor shall not terminate this contract in part.

Each of these conditions for contract termination is described in the following paragraphs.

10.7.a Termination for Convenience

- a. The Department may terminate this contract at any time without cause, in whole or in part, upon giving the contractor notice of such termination. Upon such termination, the contractor shall immediately cease work and remove from the project site all of its labor forces and such of its materials as owner elects not to purchase or to assume in the manner hereinafter

provided. Upon such termination, the contractor shall take such steps as owner may require to assign to the owner the contractor's interest in all subcontracts and purchase orders designated by owner. After all such steps have been taken to owner's satisfaction; the contractor shall receive as full compensation for termination and assignment the following:

- (1) All amounts then otherwise due under the terms of this contract,
- (2) Amounts due for work performed subsequent to the latest Request for Payment through the date of termination,
- (3) Reasonable compensation for the actual cost of demobilization incurred by the contractor as a direct result of such termination. The contractor shall not be entitled to any compensation for lost profits or for any other type of contractual compensation or damage other than those provided by the preceding sentence. Upon payment of the forgoing, owner shall have no further obligations to the contractor of any nature.

- b. In no event shall termination for the convenience of the owner terminate the obligations of the contractor's surety on its payment and performance bonds.

10.7.b Termination for Unavailable Funds

The Contractor understands and agrees that the Department will be bound only to the extent of the funds available or which may become available for the purpose of this resulting Contract. When the Department makes a written determination that funds are not adequately appropriated or otherwise unavailable to support continuance of performance of this Contract, the Department will, in whole or in part, cancel or terminate this Contract.

The Department's payment of funds for purposes of this Contract is subject to and conditioned upon the availability of funds for such purposes, whether Federal and/or State funds. The Department may terminate this Contract upon written notice to the Contractor at any time prior to the completion of this Contract, if, in the sole opinion of the Department, funding becomes unavailable for these services or such funds are restricted or reduced. In the event that funds are restricted or reduced, it is agreed by both parties that, at the sole discretion of the Department, this Contract may be amended. If the Contractor shall be unable or unwilling to provide covered services at reduced rates, the Contract shall be terminated.

No damages, losses, or expenses may be sought by the Contractor against the Department, if, in the sole determination of the Department, funds become unavailable before or after this Contract between the parties is executed. A determination by the Department that funds are not appropriated or are otherwise inadequate or unavailable to support the continuance of this Contract shall be final and conclusive.

10.7.c Termination Because of Financial Instability

If DMAS determines that there are verifiable indicators that the Contractor will become financially unstable to the point of threatening the ability of the Department to obtain the services provided for under the Contract, DMAS will require verification of the Contractor's financial situation. If from the information DMAS determines the Contractor will inevitably become financially unstable, DMAS may terminate the contract before this occurs. If the Contractor ceases to conduct business in the normal course, makes a general assignment for the benefit of creditors, or suffers or permits the appointment of a

receiver for its business or assets, DMAS may, at its option, immediately terminate this Contract effective at the close of business on a date specified by the Department. In the event the

Department elects to terminate the Contract under this provision, the Contractor shall be notified in writing, by either certified or registered mail, specifying the date of termination. The Contractor shall submit a written waiver of the licensee's rights under the Federal bankruptcy laws.

In the event of the filing of a petition in bankruptcy by a principal network provider or subcontractor, the Contractor shall immediately so advise the Department. The Contractor shall ensure that all tasks that have been delegated to its subcontractor(s) are performed in accordance with the terms of this Contract.

10.7.d Termination for Default

The Department may terminate the Contract, in whole or in part, if the Department determines that the Contractor has failed to satisfactorily perform its duties and responsibilities under this Contract and is unable to cure such failure within a reasonable period of time as specified in writing by the Department, taking into consideration the gravity and nature of the default. Such termination shall be referred to herein as "Termination for Default."

Upon determination by the Department that the Contractor has failed to satisfactorily perform its duties and responsibilities under this Contract, the Contractor shall be notified in writing, by either certified or registered mail, of the failure and of the time period which has been established to cure such failure. If the Contractor is unable to cure the failure within the specified time period, the Department can notify the Contractor in writing within thirty (30) calendar days of the last day of the specified time period that the Contract, has been terminated in full or in part, for default. This written notice will identify all of the Contractor's responsibilities in the case of the termination, including responsibilities related to member notification, network provider notification, refunds of advance payments, return or destruction of Department data and liability for medical claims.

In the event that DMAS determines that the Contractor's failure to perform its duties and responsibilities under this contract results in a substantial risk to the health and safety of Medicaid/FAMIS Plus or FAMIS members, DMAS may terminate this contract immediately without notice.

If, after notice of termination for default, it is determined by the Department or by a court of law that the Contractor was not in default or that the Contractor's failure to perform or make progress in performance was due to causes beyond the control of and without error or negligence on the part of the Contractor or any of its subcontractors, the notice of termination shall be deemed to have been issued as a termination for the convenience of the Department, and the rights and obligations of the parties shall be governed accordingly.

In the event of termination for default, in full or in part, as provided for under this clause, the Department may procure or contract from other sources, upon such terms and in such manner as is deemed appropriate by the Department, supplies or services similar to those terminated, and the Contractor shall be liable for any costs for such similar supplies and services and all other damages allowed by law. In addition, the Contractor shall be liable to the Department for administrative costs incurred to procure such similar supplies or services as are needed to continue operations. In the event of a termination for default prior to the start of operations, any claim the Contractor may assert shall be governed by the procedures defined by the Department for handling contract termination. Nothing herein shall be construed as limiting any other remedies that may be available to the Department.

In the event of a termination for default during ongoing operations, the Contractor shall be paid for any outstanding payments due less any assessed damages.

10.8 Remedies for Violation, Breach, or Non-Performance of Contract

Upon receipt by the Department of evidence of substantial non-compliance by the Contractor with any of the provisions of this Contract or with State or federal laws or regulations the following remedies may be imposed.

10.8.1 Procedure for Contractor Noncompliance Notification

In the event that the Department identifies or learns of noncompliance with the terms of this contract, the Department will notify the Contractor in writing of the nature of the noncompliance. The Contractor must remedy the noncompliance within a time period established by the Department and the Department will designate a period of time, not less than ten (10) calendar days, in which the Contractor must provide a written response to the notification. The Department may develop or may require the Contractor to develop procedures with which the Contractor must comply to eliminate or prevent the imposition of specific remedies.

10.8.2 Remedies Available To the Department

The Department reserves the right to employ, at the Department's sole discretion, any and all remedies available at law or equity including but not limited to, payment withholds and/or termination of the contract.

10.9 Performance and Payment Bonds

The Contractor shall deliver to the Department purchasing office an executed performance bond, in a form acceptable to the Department, in the amount of one month of the estimated annual administrative (PMPM) contract amount, with the Department as obliged. In addition, the Contractor shall deliver to the Department purchasing office and executed payment bond, in a form acceptable to the Department, in the amount of one month of the estimated annual behavioral health services payments amount, with the Department as obliged. The surety shall be a surety company or companies approved by the State Corporation Commission to transact business in the Commonwealth of Virginia. No payment shall be due and payable to the Contractor, even if the contract has been performed in whole or in part, until the bonds have been delivered to and approved by the Department.

10.10 Payment

The Contractor shall be prepared to provide the full range of services requested under this RFP and resultant contract, on site and operationally ready to begin work by the implementation date established by DMAS. DMAS will provide adequate prior notice of at least 120 days of the implementation date. Upon approval of the Contractor's operational readiness and a determined start date, DMAS shall make payments as described in Section 6.

Each invoice submitted by the Contractor shall be subject to DMAS approval based on satisfactory performance of contracted services and compliance with all contract terms. The invoice shall contain the Federal tax identification number, the contract number and any other information subsequently required by DMAS.

10.11 Identification of Proposal Envelope

If a special envelope is not furnished, or if return in the special envelope is not possible, the signed bid/proposal should be returned in a separate envelope or package, sealed and identified as follows:

From: _____	_____
Name of Contractor	Due Date /Time
_____	_____
Street or Box Number	City, State, Zip Code

RFP Number	

Name of Contract/Purchase Officer:

The envelope should be addressed as directed on Page 1 of the solicitation.

If a proposal not contained in the special envelope is mailed, the Offeror takes the risk that the envelope, even if marked as described above, may be inadvertently opened and the information compromised which may cause the proposal to be disqualified. Proposals may be hand delivered to the designated location in the office issuing the solicitation. No other correspondence or other proposals should be placed in the envelope.

10.12 Indemnification

Contractor agrees to indemnify, defend and hold harmless the Commonwealth of Virginia, its officers, agents, and employees from any claims, damages and actions of any kind or nature, whether at law or in equity, arising from or caused by the use of any materials, goods, or equipment of any kind or nature furnished by the Contractor/any services of any kind or nature furnished by the Contractor, provided that such liability is not attributable to the sole negligence of the using agency or to failure of the using agency to use the materials, goods, or equipment in the manner already and permanently described by the Contractor on the materials, goods or equipment delivered.

10.13 SMALL Businesses Subcontracting and Evidence of Compliance

- A. It is the goal of the Commonwealth that 40% of its purchases be made from small businesses. This includes discretionary spending in prime contracts and subcontracts. All potential Offerors are required to submit a Small Business Subcontracting Plan. Unless the Offeror is registered as a DMBE-certified small business and where it is practicable for any portion of the awarded contract to be subcontracted to other suppliers, the contractor is encouraged to offer such subcontracting opportunities to DMBE-certified small businesses. This shall not exclude DMBE-certified women-owned and minority-owned businesses when they have received DMBE small business certification. No Offeror or subcontractor shall be considered a Small Business, a Women-Owned Business or a Minority-Owned Business unless certified as such by the Department of Minority Business Enterprise (DMBE) by the due date for receipt of proposals. If small business subcontractors are used,

the prime contractor agrees to report the use of small business subcontractors by providing the purchasing office at a minimum the following information: name of small business with the DMBE certification number, phone number, total dollar amount subcontracted, category type (small, women-owned, or minority-owned), and type of product/service provided.

- B. Each prime contractor who wins an award in which provision of a small business subcontracting plan is a condition of the award, shall deliver to the contracting agency or institution on a quarterly basis, evidence of compliance (subject only to insubstantial shortfalls and to shortfalls arising from subcontractor default) with the small business subcontracting plan. When such business has been subcontracted to these firms and upon completion of the contract, the contractor agrees to furnish the purchasing office at a minimum the following information: name of firm with the DMBE certification number, phone number, total dollar amount subcontracted, category type (small, women-owned, or minority-owned), and type of product or service provided. Payment(s) may be withheld until compliance with the plan is received and confirmed by the agency or institution. The agency or institution reserves the right to pursue other appropriate remedies to include, but not be limited to, termination for default.
- C. Each prime contractor who wins an award valued over \$200,000 shall deliver to the contracting agency or institution on a quarterly basis, information on use of subcontractors that are not DMBE-certified small businesses. When such business has been subcontracted to these firms and upon completion of the contract, the contractor agrees to furnish the purchasing office at a minimum the following information: name of firm, phone number, total dollar amount subcontracted, and type of product or service provided.

10.14 Prime Contractor Responsibilities

The Contractor shall be responsible for completely supervising and directing the work under this contract and all subcontractors that it may utilize, using its best skill and attention. Subcontractors who perform work under this contract shall be responsible to the prime Contractor. The Contractor agrees that it is as fully responsible for the acts and omissions of its subcontractors and of persons employed by it as it is for the acts and omissions of its own employees.

10.15 Renewal of Contract

This contract may be renewed by the Commonwealth for two successive one year periods under the terms and conditions of the original contract except as stated in 1. and 2. below. Price increases may be negotiated only at the time of renewal. Written notice of the Commonwealth's intention to renew shall be given approximately 90 days prior to the expiration date of each contract period.

1. If the Commonwealth elects to exercise the option to renew the contract for an additional one-year period, the contract price(s) for the additional one year shall not exceed the contract price(s) of the original contract, **in addition to any modifications**, increased/decreased by more than the percentage increase/decrease of the Services category under the Commodity and Services Group of the CPI-W section of the Consumer Price Index of the United States Bureau of Labor Statistics for the latest twelve months for which statistics are available.
2. If during any subsequent renewal periods, the Commonwealth elects to exercise the option to renew the contract, the contract price(s) for the subsequent renewal period shall not

exceed the contract price(s) of the previous renewal periods, in addition to any modifications, increased/decreased by more than the percentage increase/decrease of the Services category under the Commodity and Services Group of the CPI-W section of the Consumer Price Index of the United States Bureau of Labor Statistics for the latest twelve months for which statistics are available.

10.16 Confidentiality of Information

By submitting a proposal, the Contractor agrees that information or data obtained by the Contractor from DMAS during the course of determining and/or preparing a response to this RFP may not be used for any other purpose than determining and/or preparing the Contractor's response. Such information or data may not be disseminated or discussed for any reasons not directly related to the determination or preparation of the Contractor's response to this RFP.

10.17 HIPAA Compliance

The Contractor shall comply, and shall ensure that any and all subcontractors comply, with all State and Federal laws and Regulations with regards to handling, processing, or using Health Care Data. This includes but is not limited to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations as it pertains to this agreement, and the Contractor shall keep abreast of the regulations. Since this is a federal law and the regulations apply to all health care information, the Contractor shall comply with the HIPAA regulations at no additional cost to DMAS. The Contractor will also be required to enter into a DMAS-supplied HIPAA Business Associate Agreement with DMAS to comply with the regulations protecting Health Care Data. A template of this Agreement is available on the DMAS Internet Site at http://dmasva.dmas.virginia.gov/Content_pgs/ab-ocs.aspx

10.18 Obligation of Contractor

By submitting a proposal, the Contractor covenants and agrees that it has satisfied itself of the conditions to be met, and fully understands its obligations, and that it will have no right to cancel its proposal or to relief of any other nature because of its misunderstanding or lack of information.

10.19 Independent Contractor

Any Contractor awarded a contract under this RFP will be considered an independent Contractor, and neither the Contractor, nor personnel employed by the Contractor, is to be considered an employee or agent of DMAS.

10.20 Ownership of Intellectual Property

All copyright and patent rights to all papers, reports, forms, materials, creations, or inventions created or developed in the performance specific to this contract shall become the sole property of the Commonwealth. DMAS shall have open access to the above. On request, the Contractor shall promptly provide an acknowledgement or assignment in a tangible form satisfactory to the Commonwealth to evidence the Commonwealth's sole ownership of specifically identified intellectual property created or developed in the performance of the contract.

10.21 Subsidiary-Parent Relationship

In the event the Offeror is a subsidiary or division of a parent organization, the Offeror must include in the proposal, a signed statement by the chief executive officer of the parent organization pledging the full resources of the parent organization to meet the responsibilities of the subsidiary organization under contract to the Department. DMAS must be notified within 10 days of any change in ownership as well as a letter explaining how the changes affect the Contractor's relationship with the Department. Any change in ownership will not relieve the original parent of its obligation of pledging its full resources to meet the obligations of the contract with DMAS without the expressed written consent of the DMAS Director.

10.22 Business Transactions Reporting

The Contractor shall notify the Department within five (5) calendar days after any publicly announced acquisition agreement, pre-merger agreement, or pre-sale agreement impacting the Contractor's ownership. Business transactions to be disclosed include, but are not limited to:

- a. Any sale, exchange, or lease of any property between the Contractor and a Party in Interest;**
- b. Any lending of money or other extension of credit between the Contractor and a Party in Interest; and**
- c. Any furnishing for consideration of goods, services (including management services) or facilities between the Contractor and a Party in Interest. Business transactions for purposes of this section do not include salaries paid to employees for services provided in the normal course of employment by the Contractor.**

The Contractor shall advise the Department, in writing, within five (5) business days of any organizational change or major decision affecting its Medicaid business in Virginia or other states. This includes but is not limited to sale of existing business to other entities or a complete exit from the Medicaid market in another state or jurisdiction.

10.23 eVA Business-To-Government Contracts and Orders

The solicitation/contract will result in 1 purchase order(s) with the eVA transaction fee specified below assessed for each order.

- a. For orders issued prior to August 16, 2006, the Vendor Transaction Fee is 1%, capped at a maximum of \$500 per order.
- b. For orders issued August 16, 2006 thru June 30, 2011, the Vendor Transaction Fee is:
 - (i) DMBE-certified Small Businesses: 1%, Capped at \$500 per order.
 - (ii) Businesses that are not DMBE-certified Small Businesses: 1%, Capped at \$1,500 per order.
- c. For orders issued July 1, 2011 thru June 30, 2012, the Vendor Transaction Fee is:
 - (i) DMBE-certified Small Businesses: 0.75%, Capped at \$500 per order.
 - (ii) Businesses that are not DMBE-certified Small Businesses: 0.75%, Capped at \$1,500 per order.
- d. For orders issued July 1, 2012, and after, the Vendor Transaction Fee is:
 - (i) DMBE-certified Small Businesses: 1%, Capped at \$500 per order.
 - (ii) Businesses that are not DMBE-certified Small Businesses: 1%, Capped at \$1,500 per order.

The specified vendor transaction fee will be invoiced, by the Commonwealth of Virginia Department of General Services, approximately 30 days after the corresponding purchase order is issued and payable 30 days after the invoice date. Any adjustments (increases/decreases) will be handled through purchase order changes.

Internet electronic procurement solution, website portal www.eVA.virginia.gov, streamlines and automates government purchasing activities in the Commonwealth. The portal is the gateway for vendors to conduct business with state agencies and public bodies.

Vendors desiring to provide goods and/or services to the Commonwealth shall participate in the eVA Internet e-procurement solution and agree to comply with the following: If this solicitation is for a term contract, failure to provide an electronic catalog (price list) or index page catalog for items awarded will be just cause for the Commonwealth to reject your bid/offer or terminate this contract for default. The format of this electronic catalog shall conform to the eVA Catalog Interchange Format (CIF) Specification that can be accessed and downloaded from www.eVA.virginia.gov. Contractors should e-mail Catalog or Index Page information to eVA-catalog-manager@dgs.virginia.gov

10.24 Compliance with Virginia Information Technology Accessibility Standard

The Contractor shall comply with all State laws and Regulations with regards to accessibility to information technology equipment, software, networks, and web sites used by blind and visually impaired individuals. This accessibility standards are State law see § 2.2-3502 and § 2.2-3503 of The Code of Virginia. Since this is a State law and the regulations apply to accessibility to information technology equipment, software, networks, and web sites used by blind and visually impaired individuals, the Contractor shall comply with the Accessibility Standards at no additional cost to the Department. The Contractor must also keep abreast of any future changes to The Virginia Code as well as any subsequent revisions to the Virginia Information Technology Standards. The current Virginia Information Technology Accessibility Standards are published on the Internet at <http://www.vita.virginia.gov/library/default.aspx?id=663>

10.25 Continuity of Services

- a) The Contractor recognizes that the services under this contract are vital to the Agency and must be continued without interruption and that, upon contract expiration, a successor, either the Agency or another contractor, may continue them. The Contractor agrees:
 - (i.) To exercise its best efforts and cooperation to effect an orderly and efficient transition to a successor;
 - (ii.) To make all Agency owned facilities, equipment, and data available to any successor at an appropriate time prior to the expiration of the contract to facilitate transition to successor; and
 - (iii.) That the Agency Contracting Officer shall have final authority to resolve disputes related to the transition of the contract from the Contractor to its successor.
- b) The Contractor shall, upon written notice from the Contract Officer, furnish phase-in/phase-out services for up to ninety (90) days after this contract expires and shall

negotiate in good faith a plan with the successor to execute the phase-in/phase-out services. This plan shall be subject to the Contract Officer's approval.

- c) The Contractor shall be reimbursed for all reasonable, pre-approved phase-in/phase-out costs (i.e., costs incurred within the agreed period after contract expiration that result from phase-in, phase-out operations) and a fee (profit) not to exceed a pro rata portion of the fee (profit) under this contract. All phase-in/phase-out work fees must be approved by the Contract Officer in writing prior to commencement of said work.

10.26 STATE CORPORATION COMMISSION IDENTIFICATION NUMBER:

Pursuant to Code of Virginia, §2.2-4311.2 subsection B, a bidder or Offeror organized or authorized to transact business in the Commonwealth pursuant to Title 13.1 or Title 50 is required to include in its bid or proposal the identification number issued to it by the State Corporation Commission (SCC). Any bidder or Offeror that is not required to be authorized to transact business in the Commonwealth as a foreign business entity under Title 13.1 or Title 50 or as otherwise required by law is required to include in its bid or proposal a statement describing why the bidder or Offeror is not required to be so authorized.

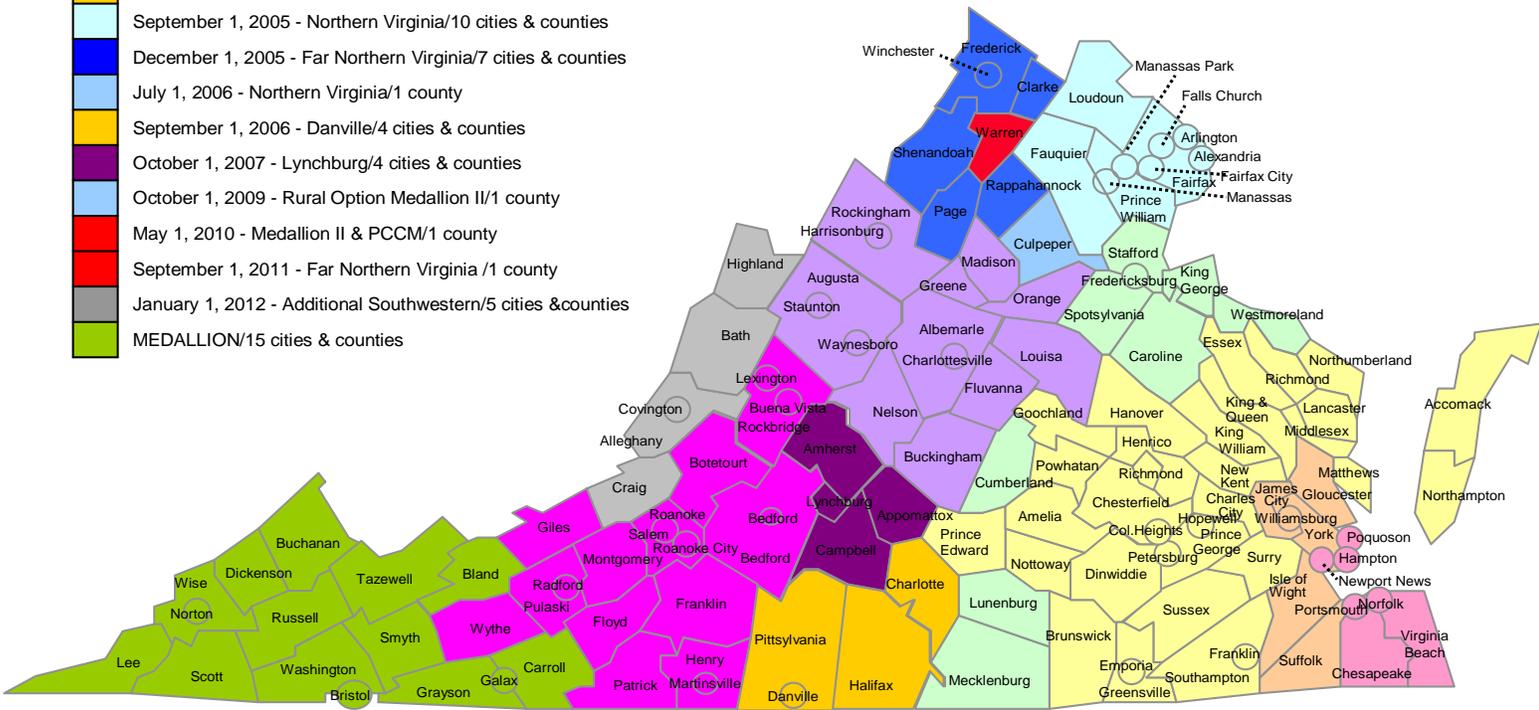
10.27 Subcontracts

No portion of the work shall be subcontracted without prior written consent of the purchasing agency. In the event that the contractor desires to subcontract some part of the work specified herein, the contractor shall furnish the purchasing agency the names, qualifications and experience of their proposed subcontractors. The contractor shall, however, remain fully liable and responsible for the work to be done by its subcontractor(s) and shall assure compliance with all requirements of the contract.

ATTACHMENT Ib – MANAGED CARE CONVERSION MAP

Managed Care Conversions

- January 1, 1996 - Tidewater/7 cities & counties
- November 1, 1997 - Adjacent Tidewater/6 cities & counties
- April 1, 1999 - Central Virginia/33 cities & counties
- October 1, 2000 - Areas Adjacent to CVA/9 cities & counties
- December 1, 2001 - Northern Virginia/10 cities & counties
- December 1, 2001 - Northern Virginia/1 county
- December 1, 2001 - Western Virginia/14 cities & counties
- December 1, 2001 - Southwestern Virginia/19 cities & counties
- December 1, 2001 - Danville/4 cities & counties
- September 1, 2005 - Northern Virginia/10 cities & counties
- December 1, 2005 - Far Northern Virginia/7 cities & counties
- July 1, 2006 - Northern Virginia/1 county
- September 1, 2006 - Danville/4 cities & counties
- October 1, 2007 - Lynchburg/4 cities & counties
- October 1, 2009 - Rural Option Medallion II/1 county
- May 1, 2010 - Medallion II & PCCM/1 county
- September 1, 2011 - Far Northern Virginia /1 county
- January 1, 2012 - Additional Southwestern/5 cities & counties
- MEDALLION/15 cities & counties



Update: 06/07/2011

ATTACHMENT II a- BEHAVIORAL HEALTH SERVICES BENEFITS
 (A copy of this attachment is also available on the DMAS website
http://dmasva.dmas.virginia.gov/Content_pgs/obh-home.aspx)

ATTACHMENT II a - BEHAVIORAL HEALTH SERVICES BENEFITS

RFP#	DESCRIPTION	CLAIM TYPE	PROVIDER CLASS	DIAGNOSIS CODE	PROCEDURE CODE	PROCEDURE MODIFIER	PROCEDURE MODIFIER	REVIEW REQUIREMENT	SA CATEGORY	
A.1	Crisis Intervention				H0098			Registration		
A.2	Crisis Stabilization				H2079			Registration		
A.3	Day Treatment/Partial Hospitalization Services for Adults	Provider Service Assessment			H0032	J7	HB	Registration		
		Service			H0035		HB	Service Authorization	0650	
A.4	Intensive Community Treatment	Provider Service Assessment			H0032	J9		Registration		
		Service			H0039			Service Authorization	0650	
A.5	Intensive In Home Services	Provider Service Assessment			H0031			Registration		
		Service			H2072			Service Authorization	0650	
A.6	Mental Health Case Management	Service			H0023			Service Authorization	0650	
		Provider Service Assessment			H0032	J8		Registration		
A.7	Mental Health Support Services	Service			H0046			Service Authorization	0650	
		Service			H0020	HMHNHO		Registration		
A.8	Opioid Treatment	Provider Service Assessment			H0032	J8		Registration		
		Service			H2077			Service Authorization	0650	
A.9	Psychosocial Rehabilitation				H0018	HD		Registration		
A.10	Residential Substance Abuse Treatment for Pregnant & Post Partum Women				H0006	HO		Registration		
A.11	Substance Abuse Case Management				H0050	HQHO		Registration		
A.12	Substance Abuse Crisis Intervention				H0047	HMHNHO		Registration		
A.13	Substance Abuse Day Treatment				H0015	HD		Registration		
A.14	Substance Abuse Day Treatment or Pregnant & Post Partum Women				H2016	HMHNHO		Registration		
A.15	Substance Abuse Intensive Outpatient Treatment				H0032	J7	HA	Registration		
A.16	Therapeutic Day Treatment for Children & Adolescents	Provider Service Assessment			H0035		HA	Service Authorization	0650	
		Service			H2022	HWHR		Service Authorization	0752	
B.1	Community-Based Residential Level A				H2020	HWHR		Service Authorization	0753	
B.2	Community-Based Residential Level B							Service Authorization	0750 & 0751	
B.3	Residential Treatment Facility Level C	01	077					Service Authorization	0700	
C	Treatment Foster Care Case Management		022		T1016			Service Authorization	0401	
D.1	Inpatient Psychiatric Hospital Services - General Acute Care Hospital	01	001 001	290-319				Service Authorization	0063	
D.2	Inpatient Psychiatric Hospital Services - Freestanding Psychiatric Hospital	01	003 007	290-319				Service Authorization		
E	Outpatient Psychiatric Services				00801-00802, 00862			Registration		
					00816-00820			Registration		
					00804-00815, 00870			Service Authorization	0050	
					00845-00857			Service Authorization	0050	
					00150-00152			Registration		
					00101-00104			Registration		
				056	00772, 00372			Registration		
				03	001 001	290-319			Registration	
							00801-00802, 00862	HF	Registration	
							00816-00820	HF	Registration	
F	Outpatient Substance Abuse Services				00804-00815, 00870	HF		Service Authorization	0051	
					00845-00857	HF		Service Authorization	0051	
					00150-00152	HF		Registration		
					00101-00104	HF		Registration		
				056	00772, 00372	HF		Registration		
					00408, 00409			Registration		
					80100			Registration		
								Registration		
								Registration		
							H2033		Service Authorization	0068
G	Multisystemic Therapies In-Home Behavioral Therapies							Service Authorization		

ATTACHMENT II b– EPSDT BEHAVIORAL THERAPY CRITERIA

EPSDT BEHAVIORAL THERAPY

The Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit is Medicaid's comprehensive and preventive child health program for children under the age of 21. Federal law (42 CFR § 441.50 et seq) requires a broad range of outreach, coordination, and health services under EPSDT distinct from general state Medicaid program requirements. EPSDT is geared to the early assessment of children's health care needs through periodic screenings. The goal of EPSDT is to assure that health problems are diagnosed and treated as early as possible, before the problem becomes complex and treatment more costly. Examination and treatment services are provided at no cost to the individual.

Any treatment service which is not otherwise covered under the State's Plan for Medical Assistance can be covered for a child through EPSDT as long as the service is allowable under the Social Security Act Section 1905(a) and the service is determined by the Department of Medical Assistance Services (DMAS) or its agent as medically necessary.

SERVICE DESCRIPTION

The EPSDT Behavioral Therapy Program allows reimbursement for systematic treatment interventions provided typically in the home of an individual. Services are designed to enhance communication skills and decrease maladaptive behaviors which, if left untreated, would lead to significant long term impairments in adaptive functioning.

The behavioral therapy must be coordinated with other medical services to effectively increase adaptive functioning. Services such as speech therapy, occupational therapy or psychiatric care must be coordinated with and integrated into the behavioral therapy plan for each individual. All services must be evidence based, measureable and medically necessary to specifically improve components of adaptive functioning.

The intent of the behavioral therapy services should be to improve the functional behaviors of the individual by integrating multi disciplinary clinical and medical services with the behavioral therapy protocol. Family training and counseling related to the implementation of the behavioral therapy is included as part of the service. The service goal is to ensure that the individual's family is trained to successfully manage clinically designed behavioral modification strategies in the home setting. The family involvement in therapy is meant to increase the child's adaptive functioning by training the family in effective methods of behavioral modification strategies. Family members do not have to be present during all hours of therapy; however, family members must be active participants with the treatment plan objectives.

PROVIDERS-

All providers must be an agency licensed by the Department of Behavioral Health and Developmental Services. Behavioral therapy may be provided by provider agencies licensed as an Intensive In Home agency, Day Treatment Agency an Outpatient Clinic or an Outpatient Clinic licensed with a specialty track of Applied Behavioral Analysis. Individuals providing clinical services and clinical direction must be a Licensed Mental Health Provider or a Board Certified Behavioral Analyst. Direct therapy staff must have a undergraduate degree in a related field of study and are recognized as Qualified Mental Health Providers by the Department of Behavioral Health and Developmental Services Office of Licensure. Qualified Mental Health Providers receive ongoing clinical supervision by the clinical directors in the program.

ELIGIBILITY-

Children under the age of 21 enrolled in FAMIS Plus, Fee for Service Medicaid and those under the age of 19 enrolled in FAMIS Fee for Service are eligible for the services if deemed medically necessary.

Behavioral therapy may be provided to persons with developmental delays such as autism and intellectual disabilities. Children must exhibit intensive behavioral challenges to be authorized for services. Children who have attained behavioral control and who require services such as social skills enhancement are not appropriate for the service. Children with severe emotional disturbances and traditional psychiatric care needs who meet the eligibility requirements under the Community Mental Health Rehabilitation programs are not eligible for EPSDT Behavioral Therapy services.

CRITERIA

The following requirements must be met in order for an individual to receive EPSDT Behavioral Therapy:

- *The interventions needed require the expertise of a Licensed Mental Health Provider or a Board Certified Behavioral Analyst;*
- The family and caregivers are not able to effectively manage the behaviors in the home environment without the intervention of Behavioral Therapy.
- Each individual who requests services must have clinical necessity documented by their physician and the therapy provider's clinical director; and
- Individuals must require treatment services that cannot be provided by another DMAS program or a lower level of care.

Medical Necessity

Individuals must have a current, valid psychiatric diagnosis and be clinically stable to benefit from treatment at this level of care. Individuals must meet the criteria as listed under Clinical Indications, Symptoms and Behavior and the support System areas to be approved for EPSDT Behavioral Therapy.

Clinical Indications

A minimum of **one** indicator within the clinical indications below is required:

- The individual is expected to demonstrate improvement in behavioral symptoms
- The individual must be medically or clinically stable so that treatment benefits are maintained and improvements are not lost due to deteriorating psychiatric conditions or inpatient acute care is not necessary to stabilize behaviors.

Symptoms and Behavior

A minimum of **one** indicator **in each** behavioral area is required.

1. Behaviors

- Self Injurious
- Runaway/Elopement (need to define)
- Sexually inappropriate/aggressive/abusive
- Functional Communication Impairment that causes disruptive behaviors

2. Behaviors, Unmanageable

- Angry outbursts/aggression
- Psychotic symptoms
- Impulsive Behavior/Tics/Inattention/Hyperactivity
- Encopresis, Enuresis and/or fecal smearing
- Pica
- Disruptive behaviors: obsessive, repetitive or ritualized behaviors with significant frequency, duration and intensity

Support System (as described within the past 30 days)

Both of the following indicators in the Support System area are required.

- Willing to participate in treatment; AND
- Individual is unable to benefit from less-intensive modes of therapy.

DISCHARGE CRITERIA:

One of the following criteria must be met to satisfy the criteria for discharge.

- A.** No meaningful*, measurable improvement has been documented in the individual's behavior(s) after receiving services, and there is no reasonable expectation that termination of the current level of services would result in decompensation or the recurrence of the signs and symptoms that necessitated treatment;
 - *For changes to be "meaningful" they must be durable over time beyond the end of the actual treatment session, and treatment results must be documented to indicate a generalized ability to maintain the targeted functioning outside of the treatment setting in the patient's residence and the larger community within which the individual resides.
- B.** Treatment is making the symptoms persistently worse;
- C.** The patient has achieved adequate stabilization of the challenging behavior and less-intensive modes of therapy are appropriate; or
- D.** The patient demonstrates an inability to maintain long-term gains from the proposed plan of treatment.

ATTACHMENT III - LIQUIDATED DAMAGES AND LIQUIDATED REMEDIES

LIQUIDATED DAMAGES

The Department may impose any or all of the liquidated damages below upon reasonable determination that the Contractor fails to comply with any corrective action plan (CAP) or is otherwise deficient in the performance of its obligations under the RFP, provided, however, that the Department only imposes those damages it determines to be appropriate for the deficiencies identified. The Department may impose intermediate damages on the Contractor simultaneously with the development and implementation of a corrective action plan if the deficiencies are severe or numerous.

A Reports and Deliverables:

For each day that an agreed upon report or deliverable is late, incorrect, or deficient, the Contractor shall be liable to the Department for liquidated damages in the amount of \$100 per work day per report or deliverable, except that if the delivery be delayed by any act, negligence, or default on the part of the Commonwealth, public enemy, war, embargo, fire, or explosion not caused by the negligence or intentional act of the contractor or his supplier(s), or by riot, sabotage, or labor trouble that results from a cause or causes entirely beyond the control or fault of the contractor or his supplier(s), a reasonable extension of time as the procuring public body deems appropriate may be granted. Upon receipt of a written request and justification for any extension from the contractor, the purchasing office may extend the time for performance of the contract or delivery of goods herein specified, at the purchasing office's sole discretion, for good cause shown.

Liquidated damages for late reports shall begin on the first day the report is late. Liquidated damages for incorrect reports (except ad hoc or on-request reports), or deficient deliverables shall begin on the sixteenth day after notice is provided from the Department to the Contractor that the report remains incorrect or the deliverables remain deficient; provided, however, that it is reasonable to correct the report or deliverable within fifteen (15) calendar days. For the purposes of determining liquidated damages in accordance with this Section, reports or deliverables are due in accordance with the following schedule, unless otherwise specified elsewhere in this RFP:

<u>DELIVERABLES</u>	<u>DATE AGREED UPON BY THE PARTIES</u>
Weekly Reports	Tuesday after the end of the week ending on Friday
Monthly Reports	15th day of month for prior month reporting.
Quarterly Reports	30 calendar days after the end of each quarter.
Annual Reports	Within ninety (90) calendar days of the effective contract date. (contract date)
Ad Hoc	Within ten (10) working days from the date of the request, or agreed upon date, when reasonable unless otherwise specified by Department.

B Program Issues

Liquidated damages for failure to perform specific responsibilities as described in this RFP are shown below

<u>PROGRAM ISSUES</u>	<u>DAMAGE</u>
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	<u>PROGRAM ISSUES</u>	<u>DAMAGE</u>
1.	Failure to comply with Appeals notice requirements of the Department's rules and regulations or any subsequent amendments thereto and all court orders governing appeal procedures, as they become effective. This includes notice of the right to appeal, appeals summaries, and timeliness requirements.	\$500 per calendar day for each day beyond the required time frame that the appeal is unanswered in each and every aspect and/or each day the appeal is not handled according to the provisions set forth by this RFP or required by the Department
2.	Failure to forward an expedited appeal to the Department in twenty-four (24) hours or a standard appeal in five (5) days.	\$500 per calendar day.
3.	Failure to submit provider appeals summaries shall result in the Contractor being liable for any costs that DMAS incurs as a result of the contractor's noncompliance.	Costs that DMAS incurs as a result of the Contractor's noncompliance.
4.	Failure to attend or defend the Contractor's decisions at provider appeal hearings or conferences shall result in the Contractor being liable for any costs that DMAS incurs as a result of the contractor's noncompliance.	Costs that DMAS incurs as a result of the Contractor's noncompliance.
5.	Failure to submit enrollee appeals summaries shall result in the Contractor being liable for a liquidated damage of \$100 per calendar day for each day that the appeal summary is late.	\$100 per calendar day for each day that the appeal summary is late.
6.	Failure to attend or defend the Contractor's decisions at enrollee appeal hearings or conferences shall result in the Contractor being liable for a liquidated damage of \$100 per calendar day for each day that the hearing or conference is delayed as a result of the contractor's noncompliance.	\$100 per calendar day for each day that the hearing or conference is delayed as a result of the contractor's noncompliance.
7.	Failure to complete or comply with corrective action plans as required by the Department.	\$500 per calendar day for each day the corrective action is not completed or complied with as required.
8.	Employment of licensed personnel.	\$250 per calendar day for each day that personnel are not licensed as required by applicable state law, regulations, and/or this contract.
9.	Failure to comply in any way with staffing requirements as described in	\$250 per calendar day.

	<u>PROGRAM ISSUES</u>	<u>DAMAGE</u>
	this RFP.	
10.	Failure to comply in any way with Member Material and Communication Requirements in Section 4.2. Requirements include the design, production and distribution (including all distribution costs such as postage) of member materials, including but not limited to brochures, provider directories, fact sheets, notices, or any other material necessary to provide information to members.	\$250 per calendar day.
11.	Failure to comply in any way with Outreach Activities in Section 4.7. Outreach activities include activities to increase utilization, appointment assistance, correcting non-compliant members, coordination with public health and other community organizations and as determined by the Department.	\$250 per calendar day.
12.	Failure to comply in any way Notification of Subcontractor Terminations in Section 4.11.4. When a subcontract that relates to the provision of services to members or claims processing services is being terminated between the Contractor and a subcontractor, the Contractor shall give at least thirty (30) days prior written notice of the termination to the Department. Such notice shall include, at a minimum, a Contractor's intent to change to a new subcontractor for the provision of said services, an effective date for termination and/or change, as well as any other pertinent information that may be needed. In addition to prior written notice, the Contractor shall also provide the Department with a transition plan, when requested, which shall include, at a minimum, information regarding how service authorization requests will be handled during and after the transition, and how continuity of care will be maintained for the members. The	\$500 per calendar day.

	<u>PROGRAM ISSUES</u>	<u>DAMAGE</u>
	Contractor's transition plan shall also include provisions to notify impacted or potentially impacted providers and members of the change.	
13.	Failure to comply in any way with Deductions in Section 6.2.7. Deductions include adjustments for interest earned on provider payments, claims not validated in encounter submissions (as described in Section 6.2.4) and liquidated damages.	\$100 per calendar day.
14.	Failure to comply in any way with Timeliness and Accuracy of Payment in Section 4.13 and 42 CFR §447.45. Timeliness and accuracy of payment require that the Contractor shall have in place an automated claims processing system, an electronic data processing system, the ability to reimburse and Medicaid established rates, and HIPAA compliance. The Contractor shall ensure that ninety percent (90%) of clean claims for payment of services delivered to members (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) calendar days of receipt of such claims. The Contractor shall process, and, if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all provider claims for services delivered.	\$1000 per calendar day.
15.	Failure to comply in any way with Other Reporting Requirements in Section 4.20.15 or any other terms in this RFP. Reports include monthly and ad hoc reports requested by the Department. The Contractor will assure compliance with CHIPRA and state/federal health reform initiatives.	\$100 per calendar day.

C Payment of Liquidated Damages

It is further agreed by the Department and the Contractor that any liquidated damages assessed by the Department shall be due and payable to the Department within thirty (30) calendar days after Contractor's receipt of the notice of damages and if payment is not made by the due date, the amount of said liquidated damages may be withheld from future payments by the Department without further notice. It is agreed by the Department and the Contractor that the collection of liquidated damages by the Department shall be made without regard to any appeal rights the Contractor may have pursuant to this RFP; however, in the event an appeal by the Contractor results in a decision in favor of the Contractor, any such funds withheld by the Department will be immediately returned to the Contractor. The due dates mentioned above may be delayed if the Contractor can show good cause as to why a delay should be granted. The Department has sole discretion in determining whether good cause exists for delaying the due dates.

The Contractor shall be liable for all liquidated damages imposed by DMAS. Any dispute between the Contractor and any provider/subcontractor regarding responsibility for any events giving rise to the imposition of liquidated damages shall not relieve the Contractor of their liability for said damages.

All liquidated damages imposed pursuant to this RFP, whether paid or due, shall be paid by the Contractor out of administrative and management costs and profits.

ATTACHMENT IV- CERTIFICATION OF ENCOUNTER DATA

CERTIFICATION

Pursuant to the contract(s) between Virginia and the (enter name of business entity) behavioral health services administrator (BHSA), the BHSA certifies that: the business entity named on this form is a qualified provider enrolled with and authorized to participate in the Virginia Medical Assistance Program as a BHSA Plan, (insert Plan identification number(s) here). The (enter name of business) BHSA acknowledges that if payment is based on encounter data, Federal regulations at 42 CFR 438.600 (et. al.) require that the data submitted must be certified by a Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

The BHSA hereby requests payment from the Virginia Medical Assistance Program under contracts based on encounter data submitted and in so doing makes the following certification to Virginia as required by the Federal regulations at 42 CFR 438.600 (et. al.).

The (enter name of business) BHSA has reported to Virginia for the month of (indicate month and year) all new encounters (indicate type of data such as – Professional, Mental Health – Institutional). The (enter name of business) BHSA has reviewed the encounter data for the month of (indicate month and year) and I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly To And Who Is Authorized To Sign For Chief Financial Officer, Chief Executive Officer) attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to Virginia in this report is accurate, complete, and truthful.

NO MATERIAL FACT HAS BEEN OMITTED FROM THIS FORM. I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly To And Who Is Authorized To Sign For Chief Financial Officer, Chief Executive Officer) ACKNOWLEDGE THAT THE INFORMATION DESCRIBED ABOVE MAY DIRECTLY AFFECT THE CALCULATION OF PAYMENTS TO THE (Enter Name of Business) BHSA. I UNDERSTAND THAT I MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT.

Furthermore, by signing below, the BHSA attests that the paid claim amount is a proprietary field to be held as such by the Department of Medical Assistance Services. The BHSA states the following as to why _____ protection is necessary: _____

_____. This information shall not be released, pursuant to the authority of the COV sec. 2.2-4342(F) 2.23705.6, except as required for purposes of the administration of the Title XIX State Plan for Medical Assistance.

**(INDICATE NAME AND TITLE (CFO, CEO, OR DELEGATE)
on behalf of**

(INDICATE NAME OF BUSINESS ENTITY)

DATE

ATTACHMENT V - CERTIFICATION OF DATA (NON-ENCOUNTER)

CERTIFICATION

Pursuant to the contract(s) between Virginia and the (enter name of business entity) managed care organization (BHSA), the BHSA certifies that: the business entity named on this form is a qualified provider enrolled with and authorized to participate in the Virginia Medical Assistance Program as a BHSA Plan, (insert Plan identification number(s) here). The (enter name of business) BHSA acknowledges that if payment is based on any information required by the State and contained in contracts, proposals, and related documents, Federal regulations at 42 CFR 438.600 (et. al.) require that the data submitted must be certified by a Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

The BHSA hereby requests payment from the Virginia Medical Assistance Program under contracts based on any information required by the Department and contained in contracts, proposals, and related documents submitted and in so doing makes the following certification to Virginia as required by the Federal regulations at 42 CFR 438.600 (et. al.).

The (enter name of business) BHSA has reported to Virginia for the period of (indicate dates) all information required by the Department and contained in contracts, proposals, and related documents submitted. The (enter name of business) BHSA has reviewed the information submitted for the period of (indicate dates) and I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly To And Who Is Authorized To Sign For Chief Financial Officer, Chief Executive Officer) attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to Virginia is accurate, complete, and truthful.

NO MATERIAL FACT HAS BEEN OMITTED FROM THIS FORM. I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly To And Who Is Authorized To Sign For Chief Financial Officer, Chief Executive Officer) ACKNOWLEDGE THAT THE INFORMATION DESCRIBED ABOVE MAY DIRECTLY AFFECT THE CALCULATION OF PAYMENTS TO THE (Enter Name of Business) BHSA. I UNDERSTAND THAT I MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT.

Furthermore, by signing below, the BHSA attests that the paid claim amount is a proprietary field to be held as such by the Department of Medical Assistance Services. The BHSA states the following as to why protection is necessary: _____

_____. This information shall not be released, pursuant to the authority of the COV sec. 2.2-4342(F) and 2.2-3705.6, except as required for purposes of the administration of the Title XIX State Plan for Medical Assistance.

**(INDICATE NAME AND TITLE
(CFO, CEO, OR DELEGATE)
on behalf of**

**(INDICATE NAME OF BUSINESS)
DATE**

**ATTACHMENT VI – ACCIDENT/TRAUMA, WORKERS COMPENSATION, AND TPL
COVERAGE**

EXCEL SPREADSHEET REPORTING FORMAT

IDENTIFIED ACCIDENT / TRAUMA CLAIM INFORMATION

MEMBER IDENTIFICATION NUMBER
MEMBER NAME
BIRTHDATE
PROVIDER OF SERVICE NAME
DIAGNOSIS CODE
PROCEDURE CODE
DATE OF ACCIDENT
DATE OF SERVICE
AMOUNT BILLED
AMOUNT PAID

IDENTIFIED WORKERS COMPENSATION CLAIM INFORMATION

MEMBER IDENTIFICATION NUMBER
MEMBER NAME
BIRTHDATE
PROVIDER OF SERVICE NAME
WORK RELATED DIAGNOSIS
PROCEDURE CODE
DATE OF ACCIDENT
DATE OF SERVICE
AMOUNT BILLED
AMOUNT PAID

IDENTIFIED HEALTH INSURANCE INFORMATION

MEMBER ID	MEMBER NAME	BIRTHDATE	OTHER INSURER POLICY ID	OTHER INSURER NAME (OI)	(OI) ADDRESS1	(OI) ADDRESS2	(OI) CITY	(OI) ST	(OI) ZIP	(OI) ZIP+4	POLICY #	POLICY EFFECTIVE DATE

ATTACHMENT VII - THE 2011 APPROPRIATIONS ACT

2011 Acts of Assembly, Chapter 890, Item 297 MMMM

MMMM.1. The Department of Medical Assistance Services shall seek federal authority through the necessary waiver(s) and/or State Plan authorization under Titles XIX and XXI of the Social Security Act to expand principles of care coordination to all geographic areas, populations, and services under programs administered by the department. The expansion of care coordination shall be based on the principles of shared financial risk such as shared savings, performance benchmarks or risk and improving the value of care delivered by measuring outcomes, enhancing quality, and monitoring expenditures. The department will engage stakeholders, including beneficiaries, advocates, providers, and health plans, during the development and implementation of the care coordination projects. Implementation shall include specific requirements for data collection to ensure the ability to monitor utilization, quality of care, outcomes, costs, and cost savings. The department shall report by November 1 of each year to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees detailing implementation progress including, but not limited to, the number of individuals enrolled in care coordination, the geographic areas, populations and services affected and cost savings achieved. Unless otherwise delineated, the department will have authority to implement necessary changes upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change. The intent of this Item may be achieved through several steps, including, but not limited to, the following:

a. In fulfillment of this Item, the department may seek any necessary federal authority through amendment to the State Plans under Title XIX and XXI of the Social Security Act, and appropriate waivers to such, to expand the current managed care program, Medallion II, to the Roanoke/Alleghany area by January 1, 2012, and far Southwest Virginia by July 1, 2012. The department will have authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act.

b. In fulfillment of this Item, the department may seek federal authority through amendments to the State Plans under Title XIX and XXI of the Social Security Act, and appropriate waivers to such, to allow, on a pilot basis, foster care children, under the custody of the City of Richmond Department of Social Services, to be enrolled in Medicaid managed care (Medallion II) effective July 1, 2011. The department will have the authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment date of this act.

c. In fulfillment of this item, the department will seek federal authority to implement a care coordination program for Elderly or Disabled with Consumer Direction (EDCD) waiver participants effective October 1, 2011. This service would be provided to adult ED CD waiver participants on a mandatory basis. The department will have authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act.

d. In fulfillment of this item, the department will seek federal authority through amendments to the State Plan under Title XIX of the Social Security Act, and any necessary waivers, to allow individuals enrolled in Home and Community Based Care (HCBC) waivers to also be enrolled in contracted Medallion II managed care organizations for the purposes of receiving acute and medical care services effective January 1, 2012. The department will have authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act.

e. In fulfillment of this item, the department and the Department of Behavioral Health and Developmental Services, in collaboration with the Community Services Boards and in consultation with appropriate

stakeholders, shall develop a blueprint for the development and implementation of a care coordination model for individuals in need of behavioral health services not currently provided through a managed care organization. The overall goal of the project is to improve the value of behavioral health services purchased by the Commonwealth of Virginia without compromising access to behavioral health services for vulnerable populations. Targeted case management services will continue to be the responsibility of the Community Services Boards. The blueprint shall: (i) describe the steps for development and implementation of the program model(s) including funding, populations served, services provided, timeframe for program implementation, and education of clients and providers; (ii) set the criteria for medical necessity for community mental health rehabilitation services; and (iii) include the following principles:

1. Improves value so that there is better access to care while improving equity.
2. Engages consumers as informed and responsible partners from enrollment to care delivery.
3. Provides consumer protections with respect to choice of providers and plans of care.
4. Improves satisfaction among providers and provides technical assistance and incentives for quality improvement.
5. Improves satisfaction among consumers by including consumer representatives on provider panels for the development of policy and planning decisions.
6. Improves quality, individual safety, health outcomes, and efficiency.
7. Develops direct linkages between medical and behavioral services in order to make it easier for consumers to obtain timely access to care and services, which could include up to full integration.
8. Builds upon current best practices in the delivery of behavioral health services.
9. Accounts for local circumstances and reflects familiarity with the community where services are provided.
10. Develops service capacity and a payment system that reduces the need for involuntary commitments and prevents default (or diversion) to state hospitals.
11. Reduces and improves the interface of vulnerable populations with local law enforcement, courts, jails, and detention centers.
12. Supports the responsibilities defined in the Code of Virginia relating to Community Services Boards and Behavioral Health Authorities.
13. Promotes availability of access to vital supports such as housing and supported employment.
14. Achieves cost savings through decreasing avoidable episodes of care and hospitalizations, strengthening the discharge planning process, improving adherence to medication regimens, and utilizing community alternatives to hospitalizations and institutionalization.
15. Simplifies the administration of acute psychiatric, community mental health rehabilitation, and medical health services for the coordinating entity, providers, and consumers.

16. Requires standardized data collection, outcome measures, customer satisfaction surveys, and reports to track costs, utilization of services, and outcomes. Performance data should be explicit, benchmarked, standardized, publicly available, and validated.

17. Provides actionable data and feedback to providers.

18. In accordance with federal and state regulations, includes provisions for effective and timely grievances and appeals for consumers.

f. The department will seek the necessary waiver(s) and/or State Plan authorization under Titles XIX and XXI of the Social Security Act to develop and implement a care coordination model, that is consistent with the principles in Paragraph e, for individuals in need of behavioral health services not currently provided through managed care to be effective July 1, 2012. This model may be applied to individuals on a mandatory basis. The department will have authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment date of this act.

g. The department will seek the necessary waiver(s) and/or State Plan authorization under Title XIX of the Social Security Act to develop and implement a care coordination model for individuals dually eligible for services under both Medicare and Medicaid to be effective April 1, 2012. The department will have authority to implement necessary changes upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change.

h. In fulfillment of this item, the department will seek the federal authority through amendment to the State Plan under Title XIX of the Social Security Act, and any necessary waivers, to allow for the implementation of a Health Home Program for Chronic Kidney Disease utilizing available funding included in the Patient Protection and Affordable Care Act of 2010 to be effective May 1, 2012. The department will have authority to implement necessary changes upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change.

ATTACHMENT VIII – BEHAVIORAL HEALTH MONTHLY SUMMARY REPORT (MM-CCYY)

ENROLLEES	NUMBER	
NUMBER OF ACTIVE ENROLLEES FOR THE MONTH		
CLAIMS VOLUME	NUMBER	
MONTH BEGIN INVENTORY		
RECEIVED THIS MONTH		
PROCESSED THIS MONTH		
MONTH END INVENTORY		
SERVICES PROCESSED FOR THE MONTH	NUMBER	PERCENT
NUMBER PAID THIS MONTH		
NUMBER DENIED THIS MONTH		
NUMBER PENDED THIS MONTH		
TOTAL:		
PROCESSING TIME FOR CLEAN CLAIMS	NUMBER	PERCENT
PERCENT PROCESSED WITHIN 30 DAYS		
TOTAL:		
BEHAVIORAL HEALTH AUTHORIZATIONS	NUMBER	PERCENT
NUMBER OF REGISTRATIONS		
NUMBER OF PRIOR AUTHORIZATIONS		
NUMBER APPROVED		
NUMBER ADMINISTRATIVE DENIALS		
NUMBER CLINICAL DENIALS		
PRIOR AUTHORIZATIONS - TURNAROUND TIME (DAYS)		
BEHAVIORAL HEALTH UTILIZATION	NUMBER	PERCENT
MEDICAID/FAMIS PLUS CHILDREN UNDER AGE 21		
FAMIS CHILDREN		
ADULTS		
TOTAL ENROLLEES SERVED		
BEHAVIORAL PROVIDERS	NUMBER	PERCENT
NUMBER WITH OPEN PANELS		
NUMBER WITH RESTRICTED PANELS (EPO ONLY)		
TOTAL		
MEMBER SERVICES	NUMBER	
NUMBER OF MEMBER GRIEVANCES		
NUMBER OF PROVIDER GRIEVANCES		
NUMBER OF STATE GRIEVANCES		
NUMBER OF APPEALS		

ATTACHMENT IX - REFERENCES

RFP 2012-08

Reference Form:

Contract Name:	
Customer name and address:	
Customer contact and title:	
Contact Phone number:	
Scope of Services of Contract:	
Contract Type (fixed price, fee for service, capitation, etc)	
Contract Size (# of members eligible, # of members served, etc):	
Contract Period	
Number of Contractor staff assigned to contract:	
Annual Value of Contract:	

**ATTACHMENT X - COST PROPOSAL
OFFEROR'S COST DETAILS FOR PRICING
(Reference RFP Section 6.2)
Schedule A-1: Total Price**

Item	Subtotal	Price
Start-up/Implementation cost: For period between date of signing contract with DMAS and date of start of operations.		\$
Average annual cost for Pediatric Behavioral Health (Total from Schedule B)	\$	
Average cost for Pediatric Behavioral Health for initial 3 year contract. (Annual Cost x 3 years)		\$
Average annual cost for Adult Behavioral Health (Total from Schedule B)	\$	
Average cost for Adult Behavioral Health for initial 3 year contract. (Annual Cost x 3 years)		\$
Total Contract Cost (Add amounts in right hand column)		\$
<i>Note: The Total Cost Proposal dollar amount will also be used for RFP 2012-08 Small Business Subcontracting Plan Scoring purposes.</i>		

Schedule B-1: PMPM Calculation Chart

<u>PMPM Category</u>	<u>Per Member Per Month (PMPM) Cost</u>	<u>Average Monthly Enrollment Volumes¹</u>	<u>Average Monthly Cost</u> (PMPM x Avg. Monthly Enrollment)	<u>Average Annual Cost³</u> (Average Monthly Cost x 12 months)
Pediatric Behavioral health PMPM²	\$	570,036	\$	\$
Adult Behavioral health PMPM	\$	303,809	\$	\$
<p>Note 1: Average Monthly Enrollment Volumes based on numbers provided in RFP section 6.2 and divided by 12 months.</p> <p>Note 2: Pediatric Behavioral health PMPM includes eligible members in the Medicaid Children, Medicaid Expansion, and FAMIS member categories. Reference RFP Section 6.2 for details.</p> <p>Note 3: Average annual cost calculated by the Offeror in this table does not represent the actual amounts to be paid in the performance of the contract. Amount paid to the winning Offeror in the performance of the contract will be based on their proposed PMPM and the actual monthly enrollments for each category.</p>				

Schedule C-1: Optional Enhanced Benefits

<u>PMPM Category¹</u> <u>(Description of Services)</u>	<u>Additional Per Member Per Month (PMPM) Cost</u>	<u>Estimated Average Monthly Enrollment Volumes²</u>	<u>Average Monthly Cost (PMPM x Avg. Monthly Enrollment)</u>	<u>Average Annual Cost (Average Monthly Cost x 12 months)</u>
	\$		\$	\$
	\$		\$	\$
<p>Note 1: Optional PMPM Category/Enhanced Benefits must also be detailed in the Offeror's Technical Proposal</p> <p>Note 2: Offeror shall also detail how estimated average monthly enrollment volumes were determined in their Technical Proposal.</p>				

Signature

Printed Name & Title

Company

Date

ATTACHMENT XI - SMALL BUSINESS AND SUBCONTRACTING PLAN

Small Business Subcontracting Plan

This form shall be submitted with Offerors Cost Proposal

Definitions

Small Business: "Small business " means an independently owned and operated business which, together with affiliates, has 250 or fewer employees, or average annual gross receipts of \$10 million or less averaged over the previous three years. Note: This shall not exclude DMBE-certified women- and minority-owned businesses when they have received DMBE small business certification.

Women-Owned Business: Women-owned business means a business concern that is at least 51% owned by one or more women who are citizens of the United States or non-citizens who are in full compliance with United States immigration law, or in the case of a corporation, partnership or limited liability company or other entity, at least 51% of the equity ownership interest is owned by one or more women who are citizens of the United States or non-citizens who are in full compliance with United States immigration law, and both the management and daily business operations are controlled by one or more women who are citizens of the United States or non-citizens who are in full compliance with the United States immigration law.

Minority-Owned Business: Minority-owned business means a business concern that is at least 51% owned by one or more minority individuals or in the case of a corporation, partnership or limited liability company or other entity, at least 51% of the equity ownership interest in the corporation, partnership, or limited liability company or other entity is owned by one or more minority individuals and both the management and daily business operations are controlled by one or more minority individuals.

All small businesses must be certified by the Commonwealth of Virginia, Department of Minority Business Enterprise (DMBE) by the due date of the solicitation to participate in the SWAM program. Certification applications are available through DMBE online at www.dmbv.virginia.gov (Customer Service).

Offeror Name: _____

Preparer Name: _____ **Date:** _____

Instructions

- A. If you are certified by the Department of Minority Business Enterprise (DMBE) as a small business, complete only Section A of this form. This shall not exclude DMBE-certified women-owned and minority-owned businesses when they have received DMBE small business certification.
- B. If you are not a DMBE-certified small business, complete Section B of this form. For the Offeror to receive credit for the small business subcontracting plan evaluation criteria, the Offeror shall identify the portions of the contract that will be subcontracted to DMBE-certified small business in this section. Points will be assigned based on each Offeror proposed subcontracting expenditures with DMBE certified small businesses for the initial contract period as indicated in Section B in relation to the Offeror's total price.

ATTACHMENT XII – CALL CENTER RESPONSE REPORT FORMAT

Monthly Provider Call Center Response Time	Month	Total of Hours of Daily Call Center Access Provided	Total Agents Available	Total Calls Received	Total Calls Answered	ASA	Total Number Abandoned	Rate	% Answered	Hours Downtime Experienced	Reason	Calls with Average Wait Time of 3 Minutes or Less	Calls with Average Wait Time of 3 Minutes or More	% of Calls with Average Wait Time of 3 Minutes or Less	Avg. Time Prior to Abandonment	Avg. Talk Time
Provider																
Provider																
Provider																
Provider																
Provider																
Provider																
Provider																
Provider																
Provider																
Provider																
Provider																
Provider																
		Annual Total		Annual Total	Annual Total		Annual Total	Annual Average	Annual Average	Annual Total		Annual Total	Annual Average	Annual Average	Annual Average	Annual Average

ATTACHMENT XIII – 834 VERSION 5010 COMPANION GUIDE

The 834 Companion Guide is posted on the DMAS website at the following location:

<https://www.viriniamedicaid.dmas.virginia.gov/wps/portal/EDICompanionGuides>

ATTACHMENT XIV – 837 VERSION 5010 COMPANION GUIDE

<https://www.viriniamedicaid.dmas.virginia.gov/wps/portal/EDICompanionGuides>

**ATTACHMENT XV - CERTIFICATION OF COMPLIANCE
WITH PROHIBITION OF POLITICAL CONTRIBUTIONS AND GIFTS DURING THE
PROCUREMENT PROCESS**

For contracts with a stated or expected value of \$5 million or more except those awarded as the result of
competitive sealed bidding

To Be Completed By Offeror and Returned With Your Technical Proposal

I, _____, a representative of _____,
Please Print Name *Name of Bidder/Offeror*

am submitting a bid/proposal to _____ in response to
Name of Agency/Institution

_____, a solicitation where stated or expected contract value is
Solicitation/Contract #

\$5 million or more which is being solicited by a method of procurement other than competitive sealed
bidding as defined in § 2.2-4301 of the *Code of Virginia*.

I hereby certify the following statements to be true with respect to the provisions of §2.2-4376.1 of the
Code of Virginia. I further state that I have the authority to make the following representation on behalf of myself
and the business entity:

1. The bidder/offeror shall not knowingly provide a contribution, gift, or other item with a value greater than \$50 or make an express or implied promise to make such a contribution or gift to the Governor, his political action committee, or the Governor's Secretaries, if the Secretary is responsible to the Governor for an agency with jurisdiction over the matters at issue, during the period between the submission of the bid/proposal and the award of the contract.
2. No individual who is an officer or director of the bidder/offeror, shall knowingly provide a contribution, gift, or other item with a value greater than \$50 or make an express or implied promise to make such a contribution or gift to the Governor, his political action committee, or the Governor's Secretaries, if the Secretary is responsible to the Governor for an agency with jurisdiction over the matters at issue, during the period between the submission of the bid/proposal and the award of the contract.
3. I understand that any person who violates § 2.2-4376.1 of the *Code of Virginia* shall be subject to a civil penalty of \$500 or up to two times the amount of the contribution or gift, whichever is greater.

Signature

Title

Date

Contractor’s Processing Timeframes for Behavioral Health Services:

Inpatient Psychiatric Hospital Services (Service Type 0401)

Freestanding Psychiatric Hospital Services (Service Type 0093)

Initial/Concurrent Review Request - Turn around time begins from the date provider submits a current review request (via fax, phone, mail, and/or data entry) to SA date in VaMMIS. Timeframe does not include pend requests for additional information:

One business day

Retrospective Review Request - Turn around time from date provider submits a retrospective review request (via fax, phone, mail, and/or data entry) to SA date in VaMMIS (timeframe to include requests for pended for additional information and/or physician/administrative reconsideration referrals): **Twenty business days**

Request Pended for Additional Information - Turn around time from date provider responds to a pend for additional information request, (regardless of the pended timeframe allowed for the provider to respond) to SA date in VaMMIS: **One business day**

*** For these services providers are allowed one business day to respond to a pended request. Providers may submit additional information earlier than the pended timeframe allowed. Should the provider submit additional information earlier than the allowed timeframe, the Contractor must review and process within one business day from the date the provider responded to the pend. Should the pended timeframe expire without a provider response, the Contractor’s processing timeframe will start the next business day.**

Physician/Psychologist Reconsideration Review – turn around time from the date referred for reconsideration to the decision made available to the provider: **One business day**

*Total processing time to include SA in VaMMIS should not exceed 3 business days.

Administrative Reconsideration Review - turn around time from the date referred for reconsideration to the decision made available to the provider: **One business day**

*Total processing time to include in SA in VaMMIS should not exec 3 business days

Contractor’s Processing Timeframes for Behavioral Health Services:

Outpatient Psychiatric Services (Service Type 0050)

Outpatient Substance Abuse Services (Service Type 0051)

Psychiatric Residential Treatment Facility Services (Service Type 0750, 0751)

Treatment Foster Care Case Management Services (Service Type 0700)

Intensive In-Home Services (Service Type 0650)

**Community Based Residential Services for Children and Adolescent under age 21-
Level A and Therapeutic Behavioral Services-Level B (Service Type 0752, 0753)**

Psychosocial Rehabilitation (Service Type 0650)

Therapeutic Day Treatment for Children and Adolescents (Service Type 0650)

Day Treatment/Partial Hospitalization for Adults (Service Type 0650)

Intensive Community Treatment (Service Type 0650)

Mental Health Support Services (Service Type 0650)

Mental Health Case Management (Service Type 0650)

Initial//Concurrent/Retro/Change/Transfer/Discharge Review Requests - Turn around time begins from the date provider submits a current review request (via fax, phone, mail,

and/or data entry) to SA date in VaMMIS. Timeframe does not include pend requests for additional information: **Three business days**

Request Pended for Additional Information - Turn around time from date provider responds to a pend for additional information request, (regardless of the pended timeframe allowed for the provider to respond) to SA date in VaMMIS: **One business day**

*** For these services providers are allowed three business days to respond to a pended request. Providers may submit additional information earlier than the pended timeframe allowed. Should the provider submit additional information earlier than the allowed timeframe, the Contractor must review and process within one business day from the date the provider responded to the pend. Should the pended timeframe expire without a provider response, the Contractor's processing timeframe will start the next business day.**

Physician/Psychologist Reconsideration Review – turn around time from the date referred for reconsideration to the decision made available to the provider: **One business day**

*Total processing time to include SA in VaMMIS should not exceed 3 business days.

Administrative Reconsideration Review - turn around time from the date referred for reconsideration to the decision made available to the provider: **One business day**

*Total processing time to include SA in VaMMIS should not exceed 3 business days.

For a more detail regarding the business rules for each service, please go to:

http://dmasva.dmas.virginia.gov/Content_pgs/obh-home.aspx

ATTACHMENT XVII – BHO RFP Statistics

(A copy of this attachment is also available on the DMAS website http://dmasva.dmas.virginia.gov/Content_pgs/obh-home.aspx)

BHO RFP Statistics

RFP#	DESCRIPTION	Annual Expenditures			Reimbursed Billing Providers			Annual Unduplicated Recipients		
		FY09	FY10	FY11	FY09	FY10	FY11	FY09	FY10	FY11
A.1	Crisis Intervention	\$2,724,480	\$3,287,999	\$3,614,128	48	50	50	8,891	9,088	10,208
A.2	Crisis Stabilization	\$8,004,090	\$8,880,391	\$10,055,992	25	33	35	1,201	1,227	1,742
A.3	Day Treatment/Partial Hospitalization Services for Adults	\$1,028,380	\$1,027,733	\$1,313,025	8	14	22	288	357	287
A.4	Intensive Community Treatment	\$10,829,287	\$10,448,902	\$10,420,171	20	26	25	1,073	1,288	1,249
A.5	Intensive In Home Services	\$1,48,038,918	\$178,517,090	\$129,337,031	215	282	315	20,088	24,273	20,049
A.6	Mental Health Case Management	\$67,238,380	\$94,317,293	\$101,145,830	42	43	43	35,255	37,743	40,250
A.7	Mental Health Support Services	\$65,808,284	\$92,829,548	\$108,190,835	119	185	228	8,872	12,109	15,447
A.8	Opioid Treatment	\$9,583	\$33,027	\$70,898	1	1	1	55	64	88
A.9	Psychosocial Rehabilitation	\$28,782,379	\$28,784,797	\$28,182,728	49	54	55	4,501	4,954	4,889
A.10	Residential Substance Abuse Treatment for Pregnant & Post-Partum Women	\$689,640	\$582,990	\$666,950	3	3	3	72	68	70
A.11	Substance Abuse Case Management	\$237,031	\$288,751	\$342,742	19	23	22	853	828	872
A.12	Substance Abuse Crisis Intervention	\$18,990	\$29,875	\$45,895	6	8	12	80	127	254
A.13	Substance Abuse Day Treatment	\$34,891	\$89,091	\$12,944	2	4	5	37	57	87
A.14	Substance Abuse Day Treatment for Pregnant & Post-Partum Women	\$37,020	\$2,520	\$5,990	2	1	1	14	3	2
A.15	Substance Abuse Intensive Outpatient Treatment	\$120,373	\$190,951	\$276,375	15	15	16	289	382	470
A.16	Therapeutic Day Treatment for Children & Adolescents	\$111,833,283	\$143,889,808	\$184,789,402	290	332	377	12,189	16,921	18,843
B.1	Community-Based Residential Level A	\$4,358,028	\$5,016,734	\$4,721,835	48	38	32	287	298	294
B.2	Community-Based Residential Level B	\$16,858,273	\$17,287,993	\$14,088,756	90	88	77	808	828	718
B.3	Residential Treatment Facility	\$89,722,048	\$87,424,058	\$82,488,890	27	29	30	1,732	1,738	1,897
C	Treatment Foster Care Case Management	\$3,287,815	\$3,577,015	\$3,318,328	81	84	88	1,473	1,441	1,393
D.1	Inpatient Psychiatric Hospital Services - General Acute Hospital	\$24,817,398	\$22,398,384	\$24,300,996	77	72	75	6,819	6,726	7,145
D.2	Inpatient Psychiatric Hospital Services - Freestanding Psych Hospital	\$3,851,984	\$3,576,885	\$3,828,900	11	11	9	728	893	1,008
E	Outpatient Psychiatric Services	\$18,798,858	\$17,186,934	\$18,934,440	1,188	1,143	1,158	38,307	40,434	43,589
F	Outpatient Substance Abuse Services	\$79,238	\$127,313	\$111,318	31	37	46	390	533	628
G	Multisystemic Therapies	\$71,759	\$140,050	\$2,414,951	3	14	33	3	59	309
		\$620,420,447	\$713,627,794	\$742,215,904	1,780	1,880	1,971	85,836	107,128	111,973

Notes:

Total lines for A.3 are interpolated based on percentage.

Indicates SA not currently required so information not available

*Included with combined figure reported for A.4-A.7

n/a - not available

**Included in figure reported for A.18

BHO RFP Statistics

		Claims Processed									
RFP#	DESCRIPTION	FY10					FY11				
		Original Paid	Adjustments	Void	Denials	Total Processed	Original Paid	Adjustments	Void	Denials	Total Processed
A.1	Crisis Intervention	17,738	529	125	1,670	20,062	21,579	504	127	1,845	24,155
A.2	Crisis Stabilization	6,278	185	46	1,145	7,654	10,624	199	57	1,519	12,999
A.3	Day Treatment/Partial Hospitalization Services for Adults	1,311	9	62	131	1,513	1,975	16	11	215	1,819
A.4	Intensive Community Treatment	10,058	620	26	1,448	12,150	10,623	499	35	2,244	13,401
A.5	Intensive In Home Services	345,622	15,454	2,539	111,890	477,715	316,665	4,206	27,419	66,624	426,905
A.6	Mental Health Case Management	269,743	994	762	20,271	311,770	310,941	228	642	26,602	338,413
A.7	Mental Health Support Services	382,478	26,064	515	54,347	474,325	585,714	9,733	612	53,647	649,906
A.8	Opisid Treatment	623	-	-	20	643	1,190	-	-	52	1,242
A.9	Psychosocial Rehabilitation	172,643	1,612	370	15,000	189,625	211,462	374	340	18,128	229,904
A.10	Residential Substance Abuse Treatment for Pregnant & Post Partum Women	214	-	-	10	224	245	1	-	40	287
A.11	Substance Abuse Case Management	4,902	77	24	1,630	6,633	5,770	102	31	1,698	7,561
A.12	Substance Abuse Crisis Intervention	169	9	1	99	274	280	22	-	124	426
A.13	Substance Abuse Day Treatment	758	9	6	56	827	530	668	12	84	1,294
A.14	Substance Abuse Day Treatment or Pregnant & Post Partum Women	3	-	-	-	3	4	-	-	2	6
A.15	Substance Abuse Intensive Outpatient Treatment	3,953	94	41	735	4,423	4,656	596	469	465	6,186
A.16	Therapeutic Day Treatment for Children & Adolescents	519,299	3,634	674	60,452	584,059	623,003	2,449	661	61,626	687,729
B.1	Community-Based Residential Level A	3,953	38	59	1,178	5,228	3,756	53	12	835	4,656
B.2	Community-Based Residential Level B	12,107	103	13	4,268	16,591	10,919	75	25	2,847	13,476
B.3	Residential Treatment Facility	13,919	1,190	221	3,629	19,759	13,957	1,143	274	4,969	19,943
C	Treatment Foster Care Case Management	11,040	5	50	2,181	13,276	10,231	56	29	1,287	11,603
D.1	Inpatient Psychiatric Hospital Services - General Acute Hospital	6,366	142	248	3,600	12,376	9,122	156	245	4,831	14,354
D.2	Inpatient Psychiatric Hospital Services - Free-standing Psych Hospital	1,575	12	22	588	2,197	1,653	19	36	484	2,202
E	Outpatient Psychiatric Services	368,214	631	5,362	156,086	530,293	391,646	661	7,414	148,680	548,997
F	Outpatient Substance Abuse Services	7,007	9	74	4,678	11,768	4,491	4	227	1,585	6,287
G	Multisystemic Therapies	270	6	4	56	336	2,034	25	1	689	2,729
		2,192,655	-51,551	11,267	-447,906	2,709,263	2,581,605	31,777	39,079	430,620	3,033,643

Notes:

Total lines for A.3 are interpolated based on percentages.

Indicates SA not currently required so information not available

*Included with combined figure reported for A.4-A.7

n/a - not available

**Included in figure reported for A.16

BHO RFP Statistics

		Total Service Authorization Lines				Rejection Percentage
RFP#	DESCRIPTION	FY08	FY09	FY10	FY11	FY11
A.1	Crisis Intervention					
A.2	Crisis Stabilization					
A.3	Day Treatment/Partial Hospitalization Services for Adults			398	178	7%
A.4	Intensive Community Treatment			2,633	1,048	3%
A.5	Intensive In Home Services		24,855	48,520	30,859	3%
A.6	Mental Health Case Management			41,249	19,881	3%
A.7	Mental Health Support Services			27,469	14,858	3%
A.8	Opioid Treatment					
A.9	Psychosocial Rehabilitation			11,473	4,250	3%
A.10	Residential Substance Abuse Treatment for Pregnant & Post Partum Women					
A.11	Substance Abuse Case Management					
A.12	Substance Abuse Crisis Intervention					
A.13	Substance Abuse Day Treatment					
A.14	Substance Abuse Day Treatment or Pregnant & Post Partum Women					
A.15	Substance Abuse Intensive Outpatient Treatment					
A.16	Therapeutic Day Treatment for Children & Adolescents			30,074	19,624	2%
B.1	Community-Based Residential Level A		830	580	389	4%
B.2	Community-Based Residential Level B		1,709	1,388	847	3%
B.3	Residential Treatment Facility	10,487	12,032	11,332	9,913	7%
C	Treatment Foster Care Case Management	2,487	2,431	1,797	1,542	3%
D.1	Inpatient Psychiatric Hospital Services - General Acute Hospital	7,050	7,303	8,398	9,762	4%
D.2	Inpatient Psychiatric Hospital Services - Freestanding Psych Hospital	2,902	1,992	2,410	2,548	7%
E	Outpatient Psychiatric Services	16,752	20,455	19,062	16,570	10%
F	Outpatient Substance Abuse Services	4	20	33	37	16%
G	Multisystemic Therapies	n/a	n/a	n/a	n/a	n/a

Notes:

Total lines for A.3 are interpolated based on percentage.

Indicates SA not currently required so information not available

*Included with combined figures reported for A.4-A.7

n/a - not available

**Included in figures reported for A.16

BHO RFP Statistics

Approved & Denied Service Authorization Lines

RFP#	DESCRIPTION					YR1	YR2	YR3	YR4
		FY08	FY09	FY10	FY11	FY12	FY13	FY14	FY15
A.1	Crisis Intervention								
A.2	Crisis Stabilization								
A.3	Day Treatment/Partial Hospitalization Services for Adults			388	158	158	158	158	158
A.4	Intensive Community Treatment			2,741	1,018	1,018	1,018	1,018	1,018
A.5	Intensive In Home Services		23,845	45,802	30,037	30,037	30,037	30,037	30,037
A.6	Mental Health Case Management			40,270	19,372	19,372	19,372	19,372	19,372
A.7	Mental Health Support Services			28,744	14,409	14,409	14,409	14,409	14,409
A.8	Opioid Treatment								
A.9	Psychosocial Rehabilitation			11,287	4,132	4,132	4,132	4,132	4,132
A.10	Residential Substance Abuse Treatment for Pregnant & Post Partum Women								
A.11	Substance Abuse Case Management								
A.12	Substance Abuse Crisis Intervention								
A.13	Substance Abuse Day Treatment								
A.14	Substance Abuse Day Treatment or Pregnant & Post Partum Women								
A.15	Substance Abuse Intensive Outpatient Treatment								
A.16	Therapeutic Day Treatment for Children & Adolescents			29,250	19,167	19,167	19,167	19,167	19,167
B.1	Community-Based Residential Level A		934	959	379	379	379	379	379
B.2	Community-Based Residential Level B		1,442	1,327	829	829	829	829	829
B.3	Residential Treatment Facility	9,387	11,177	10,520	9,166	9,166	9,166	9,166	9,166
C	Treatment Foster Care Case Management	2,328	2,389	1,730	1,494	1,494	1,494	1,494	1,494
D.1	Inpatient Psychiatric Hospital Services - General Acute Hospital	8,505	8,965	8,087	9,365	10,863	11,381	12,279	14,575
D.2	Inpatient Psychiatric Hospital Services - Freestanding Psych Hospital	2,317	1,985	2,293	2,842	2,991	3,340	3,859	4,038
E	Outpatient Psychiatric Services	19,020	18,414	17,080	16,918	16,918	16,918	16,918	16,918
F	Outpatient Substance Abuse Services	2	19	23	31	39	47	58	71
G	Multisystemic Therapies	n/a							

Notes:

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n/a - not available

**Included in figure reported for A.16

BHO RFP Statistics

RFP#	DESCRIPTION	Physician Decisions		Dentals								Appeals			
		FY08	FY10	Number				Percentage				FY08	FY10		
				FY08	FY09	FY10	FY11	FY08	FY09	FY10	FY11				
A.1	Crisis Intervention														
A.2	Crisis Stabilization														
A.3	Day Treatment/Partial Hospitalization Services for Adults					**	**			**	**	**	**		
A.4	Intensive Community Treatment					24	15			1%	1%	0	7		
A.5	Intensive In Home Services	313	8,094		1,633	7,184	3,685			8%	16%	13%	87	0	
A.6	Mental Health Case Management					318	278			1%	1%	0	3		
A.7	Mental Health Support Services					374	505			1%	4%	0	13		
A.8	Opioid Treatment														
A.9	Psychosocial Rehabilitation	*	*			78	42			1%	1%	0	1		
A.10	Residential Substance Abuse Treatment for Pregnant & Post Partum Women														
A.11	Substance Abuse Case Management														
A.12	Substance Abuse Crisis Intervention														
A.13	Substance Abuse Day Treatment														
A.14	Substance Abuse Day Treatment of Pregnant & Post Partum Women														
A.15	Substance Abuse Intensive Outpatient Treatment														
A.16	Therapeutic Day Treatment for Children & Adolescents	*	*			2,918	2,525				10%	13%	0	108	
B.1	Community-Based Residential Level A	56	41		138	140	105			25%	25%	29%	29	28	
B.2	Community-Based Residential Level B	70	102		215	212	122			15%	16%	15%	40	73	
B.3	Residential Treatment Facility	244	578		484	328	591	504		5%	3%	8%	5%	213	398
C	Treatment Foster Care Case Management	260	210		741	731	641	703		32%	31%	37%	47%	90	91
D.1	Inpatient Psychiatric Hospital Services - General Acute Hospital	1,547	1,841		980	1,188	1,384	1,132		15%	17%	17%	12%	188	321
D.2	Inpatient Psychiatric Hospital Services - Freestanding Psych Hospital	805	568		484	408	392	444		20%	21%	17%	17%	20	15
E	Outpatient Psychiatric Services	1,579	504		2,108	2,190	1,559	1,688		14%	12%	9%	10%	85	38
F	Outpatient Substance Abuse Services	*	*		1	1	7	9		50%	5%	30%	29%	2	-
G	Multisystemic Therapies	n/a	n/a											n/a	n/a

Notes:

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n/a - not available

**Included in figures reported for A.18

BHO RFP Statistics

RFP#	DESCRIPTION	Method of Submission							
		FY09				FY10			
		DCE	FAX	PHONE	U.S. MAIL	DCE	FAX	PHONE	U.S. MAIL
A.1	Crisis Intervention								
A.2	Crisis Stabilization								
A.3	Day Treatment/Partial Hospitalization Services for Adults								
A.4	Intensive Community Treatment								
A.5	Intensive In Home Services	47%	52%	1%	0%	68%	30%	1%	0%
A.6	Mental Health Case Management								
A.7	Mental Health Support Services								
A.8	Opioid Treatment								
A.9	Psychosocial Rehabilitation	*	*	*	*	*	*	*	*
A.10	Residential Substance Abuse Treatment for Pregnant & Post Partum Women								
A.11	Substance Abuse Case Management								
A.12	Substance Abuse Crisis Intervention								
A.13	Substance Abuse Day Treatment								
A.14	Substance Abuse Day Treatment or Pregnant & Post Partum Women								
A.15	Substance Abuse Intensive Outpatient Treatment								
A.16	Therapeutic Day Treatment for Children & Adolescents	*	*	*	*	*	*	*	*
B.1	Community-Based Residential Level A	11%	65%	2%	1%	38%	62%	2%	0%
B.2	Community-Based Residential Level B	9%	68%	3%	0%	48%	52%	2%	0%
B.3	Residential Treatment Facility	14%	63%	3%	0%	22%	75%	2%	0%
C	Treatment Foster Care Case Management	11%	68%	1%	0%	38%	61%	1%	0%
D.1	Inpatient Psychiatric Hospital Services - General Acute Hospital	67%	20%	13%	0%	74%	13%	12%	0%
D.2	Inpatient Psychiatric Hospital Services - Free-standing Psych Hospital	52%	45%	3%	1%	60%	36%	2%	0%
E	Outpatient Psychiatric Services	35%	59%	6%	0%	54%	41%	5%	0%
F	Outpatient Substance Abuse Services	52%	44%	5%	0%	68%	30%	2%	0%
G	Multisystemic Therapies	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Notes:

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**Included with combined figure reported for A.4-A.7

n/a - not available

**Included in figure reported for A.18

Attachment XVIII - Proprietary/Confidential Information Identification Form
To Be Completed By Offeror and Returned With Your Technical Proposal

Trade secrets or proprietary information submitted by an Offeror shall not be subject to public disclosure under the Virginia Freedom of Information Act; however, the Offeror must invoke the protections of §2.2-4342F of the *Code of Virginia*, in writing, either before or at the time the data or other material is submitted. The written notice must specifically identify the data or materials to be protected including the section of the proposal in which it is contained and the page numbers, and state the reasons why protection is necessary. The proprietary or trade secret material submitted must be identified by some distinct method such as highlighting or underlining and must indicate only the specific words, figures, or paragraphs that constitute trade secret or proprietary information. In addition, a summary of proprietary information submitted shall be submitted on this form. The classification of an entire proposal document, line item prices, and/or total proposal prices as proprietary or trade secrets is not acceptable. If, after being given reasonable time, the Offeror refuses to withdraw such a classification designation, the proposal will be rejected.

Name of Firm/Offeror: _____, invokes the protections of § 2.2-4342F of the *Code of Virginia* for the following portions of my proposal submitted on _____.

Date

Signature: _____ Title: _____

DATA/MATERIAL TO BE PROTECTED	SECTION NO., & PAGE NO.	REASON WHY PROTECTION IS NECESSARY

Attachment XVX - State Corporation Commission Form

Virginia State Corporation Commission (SCC) registration information. The Offeror:

- is a corporation or other business entity with the following SCC identification number: _____ **-OR-**
- is not a corporation, limited liability company, limited partnership, registered limited liability partnership, or business trust **-OR-**
- is an out-of-state business entity that does not regularly and continuously maintain as part of its ordinary and customary business any employees, agents, offices, facilities, or inventories in Virginia (not counting any employees or agents in Virginia who merely solicit orders that require acceptance outside Virginia before they become contracts, and not counting any incidental presence of the Offeror in Virginia that is needed in order to assemble, maintain, and repair goods in accordance with the contracts by which such goods were sold and shipped into Virginia from Offeror's out-of-state location) **-OR-**
- is an out-of-state business entity that is including with this proposal an opinion of legal counsel which accurately and completely discloses the undersigned Offeror's current contacts with Virginia and describes why those contacts do not constitute the transaction of business in Virginia within the meaning of § 13.1-757 or other similar provisions in Titles 13.1 or 50 of the Code of Virginia.

****NOTE**** >> Check the following box if you have not completed any of the foregoing options but currently have pending before the SCC an application for authority to transact business in the Commonwealth of Virginia and wish to be considered for a waiver to allow you to submit the SCC identification number after the due date for proposals (the Commonwealth reserves the right to determine in its sole discretion whether to allow such waiver):

To Be Completed by Offeror and Returned with Your Technical Proposal

Signature

Title

Date