Colorado Department of Health Care Policy and Financing

Request for Proposals

RFP # HCPFKQ0906BHOR

Operation of the Colorado Medicaid Community Mental Health Services Program

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I. INTRODUCTION

The Colorado Department of Health Care Policy and Financing (the Department) is soliciting competitive proposals from experienced and financially sound managed care organizations to administer, manage and operate the Colorado Medicaid Community Mental Health Services Program (the Program) and to provide medically necessary covered behavioral health services for five geographic service areas covering the State of Colorado. Contractors will provide a wide range of behavioral health services and programs to children, youth, adults, and older adults. These and other services and responsibilities of the contractors are specifically described in Sections III through VI of this Request for Proposal (RFP).

Offerors must meet federal requirements for a Prepaid Inpatient Hospital Plan (PIHP) as defined in 42 CFR § 438.2. Offerors must have a minimum of three (3) years experience as a managed care organization delivering a broad range of behavioral health services to Medicaid clients, including adults, children/youth, older adults, and individuals with dual eligibility and dual diagnoses, and have demonstrated continuous quality improvement in those services. Offerors must also have experience managing at least one project similar in size and scope to the one described in this RFP.

The Department will select a contractor for each of the five geographic service areas. Offerors may propose to provide services in one or more geographic service areas. A separate, complete, and unlinked proposal must be submitted for each geographic service area.

The word "Member" is used throughout this RFP to indicate an individual who is Medicaid-eligible and enrolled in the Program. The word "client" may be used to indicate a Member who is accessing behavioral health services through the Program.

II. ADMINISTRATIVE INFORMATION

A. ISSUING OFFICE

This RFP #HCPFKQ0906BHOR is issued for the State of Colorado by the Department's Contracts and Purchasing Section, for the benefit of the Medical & CHP+ Administration Office, Benefits Division. The Department Contracts and Purchasing Section is the SOLE point of contact concerning this RFP. All communication must be done through the Department Contracts and Purchasing Section. All inquiries shall be directed to Katherine Quinby. See Paragraph A of the Administrative Information document, published as Attachment Q to this RFP, on inquiries. Please also see Section II.E, Schedule of Activities and Timeline.

B. REQUEST FOR PROPOSALS

The State of Colorado is posting this RFP on the Colorado Bid Information and Distribution System (BIDS) website so that Offerors who have an interest may submit a proposal in accordance with the terms of this RFP. The RFP provides prospective Offerors with sufficient information to enable them to prepare and submit proposals for consideration by the Department to satisfy the need for expert assistance in the completion of the goals of this RFP.

This RFP contains the instructions governing the proposals to be submitted and material to be included therein, mandatory requirements which must be met to be eligible for consideration, and other requirements to be met by each proposal. Please read and be aware of the Administrative Information document published as Attachment Q to this RFP, which contains additional terms governing the solicitation and the solicitation process. The State of Colorado Solicitation Instructions and Terms and Conditions linked through the Colorado BIDS Solicitation Page, govern except as modified or supplemented in these instructions and the Administrative Information document, Attachment Q.

By submitting a proposal, the Offeror accepts the terms and requirements of this RFP without exception, deletion, qualification, contingency, condition or qualification. Any exception, deletion, qualification, contingency, condition or qualification by the Offeror may be cause for a proposal to be rejected. A proposal submitted in response to this RFP shall constitute a binding offer.

Modifications, addenda and responses to inquiries regarding this RFP will be posted on the Colorado BIDS website. It is the Offeror's responsibility to periodically check the website for information, changes or modifications that pertain to this solicitation.

C. PROPOSAL REQUIREMENTS

The Offeror's response must meet all requirements of and respond to all requests for information set forth in this RFP. Requests for information found in this RFP are identified in Sections III - VI in **bold font**. All requests for information must be addressed, with supporting detail, in the Offeror's proposal. Section VII, Offeror's Response Format, contains submission details and additional requirements for the Technical and Cost Proposals. Failure to meet all requirements or to respond to all requests for information may result in the disqualification of the Offeror.

Submit one original hard copy (marked "ORIGINAL") and twelve (12) additional hard copies. The Technical Proposal (which includes the RFP Signature Page, Transmittal Letter, and Executive Summary, along with the Technical Proposal itself) and Cost Proposal must be sealed separately. In addition, submit one electronic copy of the Technical Proposal on a CD and one electronic copy of the Cost Proposal on a CD.

Offerors may submit a proposal to provide services in one or more geographic service areas, but must submit separate, complete and unlinked proposals for each geographic service area. The Offeror's response shall describe how the Offeror proposes to meet the requirements in the RFP. Each proposal shall describe a comprehensive, quality package of services and programs the Offeror agrees to provide, and demonstrate the Offeror's ability as a managed care company.

D. DISCLAIMER

All statistical and fiscal information contained within this RFP, and any amendments and modifications thereto, reflect the best and most accurate information available to the Department at the time of RFP preparation. No inaccuracies in such data shall constitute a basis for legal recovery of damages or protests, either real or punitive, except to the extent that any such inaccuracy was a result of intentional misrepresentation by the Department.

E. SCHEDULE OF ACTIVITIES AND TIMELINE

The following table summarizes the schedule of key activities for this RFP:

		TIME (Mountain Time)	**DATE**
1.	RFP PUBLISHED ON BIDS WEB PAGE www.gssa.state.co.us/VenSols		12/12/08
2.	PROSPECTIVE OFFERORS WRITTEN INQUIRY DEADLINE - NO QUESTIONS ACCEPTED AFTER THIS DATE. See the Administrative Information, Section A, for inquiry details. E-mail is the preferred method of inquiry. Please send questions to: Katherine Quinby.	11:59 PM Mountain Time	1/8/09
3.	PROPOSAL SUBMISSION DEADLINE See Section VII for submission details.	3:00 PM Mountain Time	2/18/09
4.	PROPOSAL SELECTION – Estimated the week of:		3/23/09
5.	CONTRACT FINALIZED – Estimated the week of:		5/1/09
6.	CONTRACT PERIOD: July 1, 2009 through June 30, 2010		

The Department reserves the right to revise the dates in this schedule. Any such revisions will be made via a modification to the RFP posted on the Colorado BIDS website, except for items #4 through #6. Dates for items #4 through #6 are estimates only and revisions will not be made by modification.

F. PERFORMANCE PERIOD AND FUNDING

The anticipated initial term of the resulting contracts for performance of the services is July 1, 2009, or upon final execution of the contract, through June 30, 2010, contingent upon funds being appropriated, budgeted and otherwise made available, and other contractual requirements, if applicable, being satisfied. Final execution of contracts may not occur until the State Long Bill is signed, which appropriates state funds. For new contractors, there will be a transition period commencing upon the final execution of the contract to ensure that a new contractor will be ready to perform on July 1, 2009. At this time, funding has not been appropriated for a new contractor transition period and there will not be any compensation of contractors during the transition period. The resulting contracts may be renewed for up to four (4) additional one (1)

year periods, at the sole discretion of the Department, contingent upon funds being appropriated, budgeted and otherwise made available, and other contractual requirements, if applicable, being satisfied.

Funding for the three options for new benefit/services for the initial contract term (July 1, 2009 through June 30, 2010) appears extremely unlikely. The Department plans to request funding for subsequent state fiscal years.

The resulting contracts are subject to and contingent upon the continuing availability of federal funds for the purpose hereof. The Offeror recognizes that it is to be paid, reimbursed or otherwise compensated with funds provided to the Department by the state and federal governments for the purpose of contracting for the services provided herein. The Offeror expressly understands and agrees that all its rights, demands and claims to compensation arising under the resulting contracts are contingent upon receipt of such funds by the Department. In the event that the Department does not receive such funds or any part thereof, the Department may immediately terminate the resulting contracts without liability, including liability for termination cost.

The rates identified for this procurement are developed using actuarially sound principles and in compliance with the Financial Review Documentation for At-Risk Capitated Contracts Rate Setting Checklist (42 C.F.R. 438.6(c)) issued by the Centers for Medicare and Medicaid Services (CMS), the federal agency which supervises the administration of the Medicaid program. The rates included in the RFP are contingent upon approval by CMS.

G. MUTIPLE AWARDS

The Department reserves the right to make an award for each of the geographic service areas as the result of this RFP.

If the Department does not receive any qualified proposals for a geographic service area or if after award the successful Offeror is unable to meet the requirements for contracting identified in this RFP, the Department will consider it a failed procurement for that geographic service area. If there is a failed procurement in a geographic service area, the Department shall contract with the Offeror that has submitted the next qualified proposal or the most qualified Offeror in another geographic service area.

H. DRAFT CONTRACT

The contracts resulting from this RFP will be substantially similar to the Draft Contract included with this RFP as Attachment A. The terms of the Draft Contract may become contractual obligations following award of this RFP.

Prior to the execution of a contract with the Department, successful Offerors shall provide documentation that contract signing authority is vested in the individual signing the contract.

I. DEBARMENT AND SUSPENSION

1. By submitting a proposal in response to this RFP, the Offeror certifies to the best of its knowledge and belief that it, its principals and proposed subcontractors:

    a. Are not presently debarred, suspended, proposed for disbarment, declared ineligible, or voluntarily excluded from covered transactions.

    b. Have not within a three-year period preceding the proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property;

    c. Are not presently under investigation for, indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Paragraph II.I.1.b above; and

    d. Have not within a three-year period preceding this application had one or more public transactions (Federal, State, or local) terminated for cause or default.

2. If the Offeror is unable to certify to any of the statements in this certification, provide an explanation as an attachment to the cost proposal. This explanation is exempt from page limitations on the cost proposal, if any. The inability of the Offeror to provide the certification will not necessarily result in disqualification of the Offeror. The explanation will be considered in connection with the Department's determination whether to award a contract to an Offeror.

J. CERTIFICATION OF INDEPENDENT PRICE DETERMINATION

1. By submission of this proposal, Offeror certifies, and in the case of a joint proposal each party thereto certifies as to its own organization, that in connection with this procurement:

    a. The prices in this proposal have been arrived at independently, without, for the purpose of restricting competition, any consultation, communication, or agreement with any other Offeror or competitor as to any matter relating to such prices with any other Offeror, intention to submit a proposal, or the methods or factors used to calculate the offer;

    b. Unless otherwise required by law, the prices which have been quoted in this proposal have not been knowingly disclosed by the Offeror and will not knowingly be disclosed by the Offeror prior to contract award, directly or indirectly to any other Offeror or to any competitor; and

c. No attempt has been made or will be made by the Offeror to induce any other person or firm to submit or not to submit a proposal for the purpose of restricting competition.

2. Each person signing the "State of Colorado, Department of Health Care Policy and Financing, Request for Proposal Signature Page" of this proposal certifies that:

   a. She/he is the person in the Offeror's organization responsible within that organization for determining prices being offered in the proposal and that she/he has not participated, and will not participate, in any action contrary to subsections 1.(a) through 1.(c) above; or

   b. She/he has been authorized, in writing, to act as agent for the persons responsible for such decision in certifying that such persons have not participated, and will not participate, in any action contrary to subsections 1.(a) through 1.(c) above; as their agent does hereby so certify; and she/he has not participated, and will not participate, in any action contrary to subsections 1.(a) through 1.(c) above.

3. A proposal will not be considered for award where subsections 1.(a), 1.(c), or 2 above has been deleted or modified. Where subsection 1.(b) above has been deleted or modified, the proposal will not be considered for award unless the Offeror furnishes with the proposal a signed statement which sets forth in detail the circumstances of the disclosure and the head of the agency, or her/his designee, determines that such disclosure was not made for the purpose of restricting competition.

III. PROGRAM BACKGROUND, OVERVIEW AND AUTHORITY

A. BACKGROUND/OVERVIEW

The Department is the single state agency that operates the Colorado Medicaid program in accordance with the Colorado Medical Assistance Act (C.R.S. 25.5-4-101, *et seq*.) and Title XIX of the Social Security Act. The Colorado Medicaid program provides a wide range of physical and behavioral health services for Members in the fee-for-service (FFS) setting and for those enrolled in managed care. The Colorado Medicaid program is annually funded from appropriations authorized by the Colorado General Assembly and matched by federal funds. For state fiscal year 2006-2007, Colorado Medicaid served 393,077 eligible individuals.

Five contractors currently operate the Community Mental Health Services Program in five geographic service areas. Each contractor operates the Program in a specific geographic service area and only one contractor operates in any given area. Historical program information is included in Attachment B, Historical Mental Health Program Data, and a list of current contractors and their respective service areas is included in Attachment C, Current Contractors (BHOs) and Service Area Map of this RFP. Each contractor is currently known as a Behavioral Health Organization (BHO) and meets the federal requirements of a Prepaid Inpatient Health Plan (PIHP). Federal managed care regulations are available online at: http://www.access.gpo.gov/nara/cfr/waisidx_02/42cfr438_02.html. Covered populations in the Program include adults and children.

This RFP has been designed to respond to current national and local trends in healthcare reform and to incorporate information and feedback from a wide range of Colorado stakeholders and other sources. These sources include Governor Bill Ritter's Colorado Promise and Building Blocks for Health Care Reform plan, recommendations from the Blue Ribbon Commission on Healthcare Reform, the House Joint Resolution 07-1050 Behavioral Health Task Force, the Mental Health Planning and Advisory Council (MHPAC), the Department's Mental Health Advisory Committee (MHAC), and research and recommendations from independent health care consultants contracted by the Department to assist with program evaluation.

Throughout their proposals, Offerors should consider and address the following recommendations developed by MHPAC as guidelines for a "System of Care" approach to providing behavioral health services.

- Persistent Commitment to Adults, Youth, Children & Families. Colorado and its communities make a commitment to the fundamental rights of every adult, child, youth and family to achieve and maintain permanence and stability of support in a safe environment.

- Safety. Services and supports are developed and implemented to best ensure the safety of the child, youth, adult, family, and community.

- Person-Centered. Services and supports are provided in the best interest of the individual to ensure that the individual's and family's needs are being addressed.

- Family-Community Focused. The child is viewed as a part of the whole family. The adult is viewed as a part of the community. Systems, services and supports are based on the

strengths and needs of the entire family or community. Adults, youth, children and their families shall participate in discussions related to their plans, have opportunities to voice their preferences and ultimately feel that they own and drive the plan.

- Individualized. Plans and supports for adults, youth, children and their families are tailored to the unique culture, beliefs and values, strengths, and needs of each child, adult and family member. Funding sources must be flexible to support individualization.
- Culturally Competent. The system of care is culturally competent, with systems, agencies, programs, and services that are responsive to the cultural, racial, spiritual (religious), gender and ethnic differences at the system and individual level.
- Strengths-Based. Services and supports are based on identified strengths of the adult, child, youth, family, and community.
- Early Access. Services and supports should have a prevention and early intervention focus to facilitate wellness for the individual and family.
- Community-Based. Services and supports are provided in the most appropriate and least restrictive environment and in the home community of the adult, youth, child or family. The system of care is community-oriented with the location of services, management and decision-making responsibility resting at the community level.
- Natural Supports. Adults, children and families are supported by family and community social networks and community resources (e.g., service organizations, faith-based organizations and businesses). Services build on and strengthen these natural supports.
- Collaborative. Collaboration between agencies, schools, community resources, youth and families is the basis for building and financing a local comprehensive and integrated system of care that supports easy access to needed services and supports for children, families and adults.
- Adult, Family, Youth, and Professional Partnership. Adults, families and youth are partners with professionals at all levels of assessment, planning, implementation and governance of the system of care.
- Outcome-Based and Cost Responsible. Services and supports are outcome-based with clear accountability and cost responsibility. The system values and funds outcome and quality management. This accountability includes prudent and effective use of public and private funds. As communities find ways to reduce the use of restrictive care, the funding is retained in the community and reinvested in the prevention and early intervention that has made these improvements possible.
- Transition-Sensitive. Children, families, and adults should be ensured smooth transitions through all major changes in their lives. Major changes may include but are not limited to transitioning from youth to adult behavioral health services, moving from an institutional to a community living situation or the reverse, parental separation, changing behavioral health care providers, loss or gain of a major life role, loss or gain of employment, transitioning from supported to independent living or the reverse, and bereavement.

Though not included in this RFP, Offerors should also become familiar with principles that guide systems of care for people with co-occurring disorders. A list of principles is available on the SAMHSA website at: http://coce.samhsa.gov/cod_resources/PDF/OP3-OverarchingPrinciples-8-13-07.pdf.

Community Behavioral Health Focus

The Department embraces the goals and objectives of *HealthyPeople 2010* (http://www.healthypeople.gov/) and seeks to partner with the Offerors to maximize behavioral health for covered Members. *HealthyPeople 2010* defines mental health as: "a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity." The Department expects that successful Offerors will be able to identify the frequencies and severity of behavioral health needs in their Member populations, and will have a proactive plan for promoting their population's behavioral health. In particular, an Offeror's population plan should distinguish between the different behavioral health needs of the disabled adult, non-disabled adult, waiver populations, dual eligible population and children.

Children, disabled adults and non-disabled adults in the Medicaid program may have needs that differ and the Department expects that the Offeror's plan will include methods of identifying and managing serious mental illness (SMI) issues, as well as strategies to address affective, personality disorders, substance use and dependence issues, anxiety and adjustment disorders. Additional population plans for care of waiver and elderly populations in the Offeror's service area may also be beneficial.

Coordinated, Team-Based, Member-Centered Care

The Department wishes to maximize the wellbeing and health of each Member for the resources applied. Not only must each successful Offeror excel in its individual functions, but each must also excel at coordinating its activities with other stakeholders. The Department expects each successful Offeror to be able to foster coordinated and team-based care by their contracted providers with other behavioral health care providers, physical health care providers, long-term care providers, waiver services providers, pharmacists, county and state agencies, and other provider organizations. The Department expects Members to be involved in the creation of their care plans and for those plans to be clearly communicated to Members. Coordination of care involves mechanisms to ensure supported and guided transitions between care settings and expectations that feedback to the Offeror from referral sources is not only expected but also incorporated into the Member's health care record. While the notion of a "medical home" is a powerful and useful concept, the Department also supports the idea of a "health village", i.e. stakeholders working together to optimize the health status of individuals and the community as a whole. Over time, the Department will foster team-based, coordinated care through health information exchanges, electronic personal health records, aligning incentives, and fostering stakeholder dialogue; however, the responsibility for care coordination must be shared by the Department and its behavioral health partners.

Outcomes Emphasis

Traditionally, health care purchasers focus on defining covered populations, defining benefits, ensuring adequate provider networks, and promoting access to care. Increasingly, the Department is focusing on the outcomes and performance associated with the provision of behavioral health services. The Department will partner with the BHOs on improving the

comprehensive behavioral health status of the populations served and performance-based contracting.

Medical Home Implementation

Colorado is in the process of implementing Senate Bill 07-130 regarding the establishment of Medical Homes for children in Colorado, and is moving towards the long-term goal that all Coloradans in the Medicaid or CHP+ programs have a "focal point of care". These standards are largely already reflected in current program requirements but Offerors should become familiar with the standards and embody them, to the extent possible, in their proposed systems of care. Current Colorado Medical Home standards are included in Attachment D, Medical Home Standards.

Potential Program Changes to the Contracts

The Department desires to add one outpatient benefit and increase contractor responsibilities for care coordination and prevention/early intervention activities under the contracts resulting from this RFP. Funding for these new benefit/services for the initial contract term (July 1, 2009 through June 30, 2010) appears extremely unlikely. The Department plans to request funding for subsequent state fiscal years. The new benefits/services are being included in this RFP as options that the Department may exercise during the initial contract term or during one of the four (4) a renewal years when funding is received. These three (3) options are described in more detail in Section VI.J.1 through VI.J.3 of the RFP.

The first potential new benefit is a limited outpatient benefit for individuals with substance use disorders. Prior to 2006, substance abuse treatment was not covered by Medicaid for adults. In July 2006, a limited outpatient substance abuse benefit was added to Colorado Medicaid's fee-for-service benefits. This benefit is currently administered by the Department in cooperation with the Colorado Department of Human Services, Division of Behavioral Health (DBH). DBH is currently responsible for licensing providers. This option is described in Section VI.J.1 of this RFP. If this option is not funded in the first contract year, the current outpatient substance use disorder benefit will continue in its present form.

The enhanced care coordination option is described in Section VI.J.2 and includes increased responsibility for coordinating Member care and health information with physical health care providers, state and local agency service providers, and community resources, as appropriate.

The prevention and early intervention option for Members who are not already receiving behavioral health services is described in Section VI.J.3.

B. FUTURE ISSUES

The Department will be working with other state agencies and task forces in upcoming years to determine the future direction of the Program. Several issues under discussion in the state Medicaid program could alter the scope of the Program and the contract resulting from this RFP. Revisions to the Program that could require revision to the statement of work may include: 1) financing reform to support integrated behavioral health services; 2) expanding the covered diagnoses and/or scope of services; 3) development of electronic cross-system data sharing and standardized performance measures, benchmarks and goals across state systems; 4) the addition of children who have Children's Health Plan Plus (CHP+) mental health benefits to the Program;

5) changes to the way residential treatment is administered; 6) management of psychotropic medications by the BHOs; 7) rebalancing of current BHO service areas; and 8) changes to the current retroactive eligibility policy.

1. **Integration of services.** The Department seeks to move toward an integrated/coordinated service model that will be supported by funding from several state agencies. This model may result in several changes to the Program, including the addition of services, increased expectations for BHOs to coordinate services such as housing and employment training for Members, diversion of low level offenders to behavioral health services, and the implementation of pilot projects that could result in changes to the number of covered Members in a service area. A related topic under discussion involves the development of a mixed services protocol to streamline coordination and potential integration of physical, long-term and behavioral health care services.
2. **Changes in covered diagnoses.** As the Department moves toward improving the behavioral health of all Medicaid Members, one change under consideration is removing the requirement for a behavioral health "Covered Diagnosis", so that the Program may address behaviors that need treatment, regardless of origin. If this change occurs during the life of the contract, it is likely to occur in phases over an extended timeframe.
3. **Development of electronic cross-system data sharing and standardized performance measures, benchmarks and goals across state systems.** System changes such as these will likely alter the requirements for data collection and the required reporting by the BHO Contractors and their subcontractors to better inform and improve the performance of behavioral health services across the State.
4. **Coverage of children.** As the State moves forward with health care reform, the Department anticipates continued discussion around the possibility of combining behavioral health coverage for Medicaid and CHP+ eligible children. Implementation could take a variety of forms, some of which might significantly increase or decrease the covered Members in each contractor's service area.
5. **Changes to Psychiatric Residential Treatment Facilities (PRTF) and Therapeutic Residential Child Care Facilities (TRCCF) administration.** Mental health services for Medicaid Members in PRTFs and TRCCFs are currently administered through fee-for-service Medicaid. There is ongoing discussion at CMS regarding changes to this system, which could necessitate moving service responsibility to the capitated mental health program.
6. **Coverage of psychotropic medications.** The possibility that psychotropic medications would be managed by BHO Contractors has been discussed in the past and may be reconsidered within the term of the contract.
7. **Rebalancing of BHO service areas.** The current service areas were created in 2004 based on stakeholder input and factors such as population density and provider locations. Changing population trends and support for more effective alignment of the various systems that affect Medicaid Members could result in a service area rebalancing within the term of the contract.
8. **Retroactive Eligibility policy.** The Department's current policy of providing capitation payments for retroactive eligibility of up to 18 months will continue to be evaluated.

Any of these activities could result in a change to the services described in the RFP and/or the statement of work in the contract resulting from this RFP. The Department will include the contractors in the planning, negotiation and implementation process of any changes to the Program which require amendment of the contract. Contractors will be given a reasonable amount of time to prepare for and implement any such changes. It is anticipated that any amendment to the contract would not occur within the first six (6) months of the initial contract period and that adjustments to capitation rates would be considered based on the proposed changes to the statement of work.

OFFEROR'S RESPONSE:

Please provide a statement certifying a willingness to work with the Department on revisions to the contract as necessary to implement any or all of the possible revisions to the Program described above. Please also provide a statement certifying that the Offeror will negotiate in good faith with the Department any contract amendment necessitated by the revision to the Program described above.

C. STATE AND FEDERAL AUTHORITY

C.R.S. 25.5-5-411 directs the Department to administer a statewide, prepaid, capitated system for providing mental health services to Members under the state medical assistance program. C.R.S. 25.5-5-202 establishes the statewide substance abuse treatment outpatient benefit. The Department has the authority to run these Programs under Section 1902(a) of Title XIX of the Social Security Act and a waiver approved by CMS under Section 1915(b) of Title XIX of the Social Security Act.

D. SERVICE AREAS

Each of the five geographic service areas in the Program contains one or more whole counties and is served by one or more Community Mental Health Centers (CMHCs). Managed care organizations will be chosen to serve as the BHO in each of the five geographic service areas of the state. A single Offeror may be chosen as the BHO in more than one geographic service area. The geographic service areas are shown in the table below.

Geographic Service Area	**Included Counties**	**Annualized # of Enrollees*** **(Member Months Divided by 12)**	**Member Months**
Northeast	Larimer, Weld, Morgan, Logan, Sedgwick, Phillips, Yuma, Washington, Kit Carson, Cheyenne, Lincoln, Elbert	50,148	601,772
Metro	Denver	73,597	883,163

Metro West	Boulder, Broomfield, Gilpin, Clear Creek, Jefferson	46,307	555,680
Metro East	Adams, Arapahoe, Douglas	94,695	1,136,337
Western/ Southern	Moffat, Routt, Jackson, Grand, Summit, Eagle, Garfield, Rio Blanco, Mesa, Delta, Gunnison, Pitkin, Lake, Chaffee, Fremont, Park, Teller, El Paso, Montrose, Ouray, Hinsdale, Saguache, Custer, Pueblo, Crowley, Kiowa, Otero, Bent, Prowers, Baca, San Miguel, Dolores, Montezuma, San Juan, La Plata, Archuleta, Mineral, Rio Grande, Conejos, Alamosa, Costilla, Huerfano, Las Animas	147,393	1,768,732

*Estimated from Fiscal Year 2007-08 claims data, used by the Department for the FY2009-10 Budget Request (dated November 3, 2008). These are based on Medicaid Management Information System expenditures divided by rates paid. Historical Program data are included in Attachment B.

IV. GENERAL REQUIREMENTS

The following section outlines the mandatory minimum requirements of this RFP. It is important that each Offeror fully meet the requirements outlined in this section. Offerors unable to demonstrate/attest to these requirements may be disqualified.

A. LICENSING

The Offeror must acquire appropriate Colorado licensure and provide proof of licensure with the proposal. If the Offeror is not licensed as required by the Colorado Commissioner of Insurance at the time of proposal submittal, the Offeror shall attest that the appropriate licensure shall be obtained prior to executing a contract with the Department. The Offeror shall provide verification that the licensure is not suspended, revoked, denied renewal or found to be noncompliant by the Colorado Commissioner of Insurance at the time of contracting.

The Department shall not execute a contract with an Offeror until it has obtained its Certificate of Authority. The successful Offeror will be required to provide a copy of its Certificate of Authority and verification that all licenses, certifications, approvals, insurance or permits necessary to perform the services are not suspended, revoked, denied renewal or found to be noncompliant by the Colorado Commissioner of Insurance prior to the final execution of any contract. Failure to obtain a Certificate of Authority prior to final execution of the contract could result in the cancellation of the award and award of the contract to the next most qualified Offeror.

***OFFEROR'S RESPONSE*:**

The Offeror is required to provide proof of necessary licenses with the proposal, or proof that application for licensure is in progress, as well as verification that existing licensure is not suspended. The Offeror is required to certify that it has in effect all other necessary certifications, approvals, insurance, and permits required to properly perform the services described in this RFP or proposed to be provided in the Offeror's response. Offeror must also certify that it meets federal requirements for a Prepaid Inpatient Hospital Plan (PIHP) as defined in 42 CFR § 438.2. In addition, Offeror is required to certify that each employee

proposed to perform services holds all required licenses or certifications, if any, to perform their responsibilities.

B. BEHAVIORAL HEALTH MANAGED CARE EXPERIENCE

The Offeror must have, through its own organization or its joint venture/partners, experience in the following areas:

1. A minimum of three (3) years experience as a managed care organization delivering a broad range of behavioral health services.

2. A minimum of three (3) years experience with Medicaid serving adult, child, older adult, dual eligible, disabled, and dually-diagnosed Medicaid Members.

3. A minimum of three (3) years experience defining, measuring, monitoring and managing the effects of a broad range of behavioral health services with demonstrated continuous quality improvement in those services.

4. Management of at least one project similar in size and scope to the one described in this RFP.

OFFEROR'S RESPONSE:

The Offeror is required to provide detailed information about its experience to demonstrate each of the qualifications listed above. Indicate whether the experience belongs to the organization or its joint venture/partners. Provide the specific years of the experience for each qualification. Be sure to address all experience for each qualification.

The Offeror is required to provide a detailed description of one project similar in size and scope to the one described in this RFP that the organization has managed, including name, location, key staff, contract dates, and gross contract value, description of services and whether there were any adverse contract actions.

V. EXPERIENCE AND ORGANIZATION

A. ADMINISTRATIVE AND ORGANIZATIONAL STRUCTURE

The Offeror must possesses the corporate resources and commitment necessary to perform as a BHO and successfully implement and operate the Program in the service area identified in the Offeror's proposal. In addition, the Offeror must be able to provide:

1. A sufficient provider network with the skills, experience and specialties necessary to provide the range of services identified in the scope of work.
2. An internal organizational structure of sufficient size and scope to direct and/or perform the scope of work and demonstrate continued improvement of health service delivery.
3. Sufficient qualified staff to review and authorize health care, prior authorizations, concurrent and retrospective reviews, and to coordinate inpatient certification/ recertification of need.

4. An objective system for demonstrating accountability through the use of valid and reliable performance measures, client and administrative outcomes, benchmarks and service goals.

OFFEROR'S RESPONSE:

Offeror's proposal shall include the following:

1. **Offeror's legal name and address, number of years in business under this legal name, total number of employees, including contracted staff, and the organization's location(s), including any offices in Colorado.**
2. **Description of why the organization should be selected for this contract.**
3. **Evidence of the organization's ability to perform the variety of services required for this contract and its ability to use creative and innovative solutions in providing behavioral health services to Medicaid Members.**
4. **Description of the internal organizational structure, including a delineated management structure. The organizational structure shall clearly define lines of responsibility, authority, communication and coordination within and between various components and departments of the organization, and be easily understood and accessible by those interfacing with the organization. Include an organizational chart. Provide the number and type of proposed staff.**
5. **Assurance that the organization has or can provide sufficient qualified staff.**
6. **Describe the system for demonstrating accountability.**
7. **If subcontractors (exclusive of the Offeror's provider network) will be utilized for this contract, identify the portion of the work to be subcontracted, provide a full description of the subcontractor's experience and qualifications to perform that work, and the percentage of the overall work each subcontractor will perform.**
8. **A list of all behavioral health managed care projects performed or completed within the past seven years. Include for each project:**
    a. **The name and location(s) of each project;**
    b. **The population(s) served and number of covered lives;**
    c. **Any corrective action plans required by the project client or an external quality review organization (EQRO) relating to contract non-compliance and/or deficient contract performance;**
    d. **Adverse contract actions and/or project-associated litigation (including terminations and/or cancellations) in which the Offeror was (or is) involved;**
    e. **A Project Contract Manager with contact information;**
    f. **A stakeholder organization reference with contact information. For this purpose, a stakeholder organization is defined as a client-based group that represents individuals with behavioral health issues, that is not funded significantly with money from the mental health managed care organization(s) for the service area or their subcontractors. Organizations funded in part by federal block grant dollars may be used as a reference.**

9. **A description of the Offeror's experience with the electronic data interchange (EDI) of ANSI ASC X12N 837 formatted encounter data, 834 HIPAA-compliant transactions sets for reporting eligibility, and general ability to process paper and electronic claims and report encounters.**

B. KEY PERSONNEL

The Offeror is required to have permanent senior officers for the Program. Senior officers must be employed by the BHO and shall include, at a minimum:

1. BHO Executive Director (ED) or Chief Executive Officer (CEO) or Contract Manager (CM) who has ultimate responsibility for the management of this agreement, for maintaining compliance with Federal and State laws and the requirements in this agreement, and the authority to sign and formally bind the organization to contract agreements. The ED/CEO/CM position shall be the equivalent of a 1.0 full-time employee. This position must be Colorado-based.
2. BHO Chief Financial Officer (CFO) with experience and demonstrated success in managed health care, responsible for effective implementation and oversight of the budget, accounting systems, and all financial operations of the Offeror in compliance with Federal and State laws and the requirements of this agreement. The CFO position shall be the equivalent of at least a .5 full-time employee.
3. BHO Chief Medical Officer (CMO) who must be a Colorado-licensed, Board-certified psychiatrist, and who has responsibility for the effective implementation of all clinical/medical programs and quality management and utilization management programs in compliance with Federal and State laws and the requirements of this agreement. The CMO position shall be the equivalent of at least a .5 full-time employee.
4. BHO Outcomes or Quality Improvement (QI) Director who has responsibility for overseeing Member and administrative outcomes across service lines, coordinating improvement activities across the BHO, benchmarking performance against other BHOs and federal and state requirements, and setting BHO-specific performance goals and objectives. The Outcomes or QI Director position shall be the equivalent of a 1.0 full-time employee. This position must be Colorado-based.
5. BHO Member and Family Affairs Director who has responsibility for oversight of Member grievance and appeals management, information regarding Member rights and responsibilities, maximizing of Member satisfaction with behavioral health care received, and involvement of Members and families in BHO service planning, advisory groups and governance. The Member and Family Affairs Director position shall be the equivalent of a 1.0 full-time employee. This position must be Colorado-based.

The Department reserves the right to approve the assignment to the BHO Program of key personnel responsible for managing the Colorado contract, including any of the following possible positions: Executive Director/Chief Executive Officer/Contract Manager, Chief Financial Officer, Chief Operating Officer/Program Operations Director, Director of Utilization, and Outcomes or Quality Improvement Director. Key personnel that are proposed shall perform the positions for which they are proposed. Any new senior officer shall have at least the same qualifications as the individual proposed for that position.

OFFEROR'S RESPONSE:

Offeror's proposal shall provide names, titles, and resumes for the Offeror's proposed key personnel as well as any other key staff to be employed by the Offeror for the project. Offerors must provide a positive statement verifying that the roles and responsibilities of senior staff that require at least 1.0 FTE are independent of any other behavioral health provider organization in the State of Colorado, with the goal of eliminating any potential conflict of interest between employers.

VI. STATEMENT OF WORK

The statement of work outlined in this RFP describes the components of a quality, cost-effective, behavioral health managed care program predicated on the principles of the recovery and resilience model, Member empowerment and the preservation of individual civil rights.

Offerors chosen to operate the Program in a geographic service area(s) shall perform the services described in this RFP in compliance with the provisions of the draft contract, attached to the RFP as Attachment A, and all pertinent state and federal statutes, regulations and rules. The federal managed care regulations, 42 C.F.R. 438, Parts 1 through 812, are available online at: http://www.access.gpo.gov/nara/cfr/waisidx_02/42cfr438_02.html. The federal confidentiality regulations, 42 CFR Part 2, are attached to the RFP as Attachment E.

The BHO shall be an entity that contracts with the Department to provide, deliver, arrange for, pay for or reimburse the cost of medically necessary covered behavioral health services furnished by the behavioral health providers in the BHO's network. The BHO shall have the ability to assume the risk of providing medically necessary covered behavioral health services to all enrolled Members in the geographic service area under a capitated payment system.

A. POPULATIONS SERVED AND ENROLLMENT

Medicaid Members residing in the Offeror's service area are enrolled into the Offeror's plan and are eligible to receive Medicaid behavioral health benefits unless exempt pursuant to 10 C.C.R. 2505-10, Section 8.212. Currently, the number of exempted individuals is less than 25. Enrollment into the Program occurs automatically each month and is effective on the day in which the individual becomes eligible for Medicaid. Members shall be automatically reenrolled when they lose and regain eligibility. Members are enrolled to the date that Medicaid eligibility began and/or reenrolled retroactively to the date that eligibility was reinstated up to a maximum of eighteen (18) months. Capitation payments are made to BHOs for the established period of retroactive eligibility. Disenrollment from the Program shall not be permitted except as provided in 10 C.C.R. 2505-10, Section 8.212.

The Health Insurance Portability and Accountability Act (HIPAA) 834 Benefit Enrollment and Maintenance transaction generated from the Medicaid Management Information System (MMIS) shall be utilized to verify Medicaid eligibility and enrollment in the Offeror's plan. The transaction guide is available at no cost at www.wpc-edi.com. The Department requirements can be found by selecting Companion Guide 834 – (02/2006) at:
http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1218102958082.

The following individuals are not eligible for enrollment in the Program:

1. Qualified Medicare Beneficiary only (QMB-only).
2. Qualified Working Disabled Individuals (QWDI).
3. Qualified Individuals 1 (QI 1).
4. Special Low Income Medicare Beneficiaries (SLMBs).
5. Undocumented aliens, including non-qualified, undocumented and qualified aliens who have not met the five-year bar are eligible for Federal Medicaid for care and services related to the treatment of an approved emergency medical condition.
6. Program of All-inclusive Care for the Elderly (PACE).
7. Not used.
8. Individuals who are inpatient at the Colorado Mental Health Institute at Pueblo (Institute) who are:
    a. Found by a criminal court to be Not Guilty By Reason of Insanity (NGRI).
    b. Found by a criminal court to be Incompetent to Proceed (ITP).
    c. Ordered by a criminal court to the Institute for evaluation (e.g. competency to proceed, sanity, conditional release revocation, and pre-sentencing).
9. Any other individuals ages twenty-one (21) through sixty-four (64) who are receiving inpatient treatment in the Colorado Mental Health Institute at Pueblo and/or the Colorado Mental Health Institute at Fort Logan.
10. Individuals who are NGRI, in the community on Temporary Physical Removal (TPR) from the Institute and eligible for Medicaid are exempted from the Program while they are on TPR. TPR individuals remain under the control and care of the Institute.
11. Individuals residing in the Regional Centers and associated satellite residences for more than ninety (90) days.
12. Individual exemptions as defined in 10 C.C.R. 2505-10, Section 8.212.

B. RECOVERY AND RESILIENCY MODEL

Recovery Model

The Department is committed to the recovery model as expressed by the National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation in December 2004. It is recognized that recovery must be highly individualized while sharing many attributes across the Member population. Individual empowerment is an essential ingredient of recovery along with community reintegration and normalization of the life environment. Empowered recovery enables Members to be not only in charge of their illness but also in charge of their lives. Techniques promoting health literacy, written Member care plans, self-management skills and early symptom education, and peer and group education are various approaches to promote empowerment.

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

The principles of a recovery model include the following values and assumptions:

- Self-Direction: To the highest degree possible, Members lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life.
- Individualized and Person-Centered: There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal behavioral health.
- Empowerment: Members have the authority to choose from a range of options and to participate in all decisions that will affect their lives, and are educated and supported in so doing.
- Holistic: Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, behavioral health and healthcare treatment and services, complementary and naturalistic services, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for Member access to these supports.
- Non-Linear: Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the Member to move on to fully engage in the work of recovery.
- Strengths-Based: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, Members may engage in new and expanded life roles. The process of recovery moves forward through interaction with others in supportive, trust-based relationships.
- Peer Support: Mutual support, including the sharing of experiential knowledge, skills and social learning, plays an invaluable role in recovery. Members encourage and engage other Members in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.
- Respect: Societal acceptance and appreciation of Members, including protecting their rights and eliminating discrimination and stigma, are crucial in achieving recovery. Self-acceptance and regaining belief in oneself are also vital. Respect ensures the inclusion and full participation of Members in all aspects of their lives.
- Responsibility: Members have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Members must

strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.

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

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

Resiliency Model

Despite some similarities in goals and philosophy, the child and adult behavioral health systems have developed different conceptual frameworks and language, along with independent service systems. This reflects real and important differences between the needs and developmental trajectories of children and adults, and services designed to support them. The recovery model assumes a degree of self-determination and personal responsibility that does not apply globally to children and youth.

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

Towards this goal, the Offeror shall ensure that staff working with children, youth and their families utilize a “recovery and resilience model” in developing appropriate behavioral health services. Services must be integrated with services provided by other human services agencies and must be designed to support children and youth in remaining in or returning to an appropriate home or non-restrictive community environment where each individual can develop a healthy sense of identity and well-being, and can succeed in school, the family and the community. Furthermore, the Offeror shall proactively identify at-risk children and youth with traits or risk factors warranting early intervention.

The Offeror shall demonstrate a commitment to the recovery and resiliency model throughout its proposal by identifying specific programs, services, policies and procedures that embody the described principles. The Offeror shall demonstrate a commitment to proactive care rather than relying solely upon reactive models of care. The Offeror's proposal shall not include a separate section narrating their commitment to this requirement, but shall demonstrate its commitment to the recovery and resiliency model throughout the responses to the Services, Service Delivery, Member and Family Affairs and Outcomes, Quality Assessment and Performance Improvement sections of the RFP. The Offeror's proposal shall describe how the Offeror plans to meet the following objectives:

1. Promote and assist in the recovery of individuals with mental illnesses and/or co-occurring substance use disorders through innovative services that empower Members and families to determine and achieve their goals;
2. Assure access to medically necessary covered behavioral health services for Members and families, including engaging individuals with serious mental illness and/or co-occurring substance use disorder who may not seek help on their own;
3. Provide the appropriate mix of behavioral health services that meets the needs of each individual Member and family;
4. Assure that high quality services are provided to Members and families;
5. Provide all necessary services through a cost-effective system;
6. Achieve a coordinated system of delivering medically necessary covered behavioral health services to Medicaid Members;
7. Maximize community resources in an effort to maintain the least restrictive level of care;
8. Identify and monitor episodic behavioral health needs and support intervention in a coordinated and minimally disruptive manner. Offeror's response should include screening strategies for common episodic behavioral health conditions such as affective disorders, eating disorders, adjustment disorders and coping disorders;
9. Identify and monitor persistent behavioral health needs and support intervention in a coordinated and minimally disruptive manner. Offeror's response should include screening strategies for proactively identifying and locating persons with persistent behavioral health conditions; and
10. Promote the well-being of the population served through preventive and population-based behavioral health interventions.

C. SERVICES

The Offeror shall provide or arrange for the provision of all medically necessary covered behavioral health services, including services identified under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) regulations 42 C.F.R. Sections 441.50 to 441.62 and HB 99-1116, The Child Mental Health Treatment Act. The Offeror shall provide medically necessary covered services as outlined in Attachment F, Covered Procedures, to Members with mental health covered diagnoses listed in Attachment G1.

In providing or arranging for the provision of all medically necessary covered behavioral health services, the Offeror shall meet all of the requirements of federal managed care regulations, and federal confidentiality regulations, 42 CFR Part 2. In addition, the Offeror shall ensure that the array of services is linguistically and culturally accessible to all Members, including racially and ethnically diverse communities, the community with disabilities, and Members who are deaf and hard of hearing.

1. State Plan Services - MANDATORY

a. Inpatient Hospital – Adult 21-64. A program of psychiatric care in which the Member remains twenty-four (24) hours a day in a facility licensed as a hospital by the state. This service is limited to forty-five (45) days per state fiscal year.

b. Inpatient Hospital - Under 21. A program of care for Members age twenty (20) and under in which the Member remains twenty-four (24) hours a day in a psychiatric hospital, or other facility licensed as a hospital by the State. This service is limited to forty-five (45) days per State fiscal year, except as otherwise required by EPSDT as described in 10 C.C.R. 2505-10, Section 8.282. Members who are inpatient on their twenty-first birthday are entitled to receive inpatient benefits until discharged from the facility or until their twenty-second birthday, whichever is earlier, as outlined in 42 C.F.R. 441.151.

c. Inpatient Hospital - 65 and Over. A program of care for Members age 65 and over in which the Member remains twenty-four (24) hours a day in an institution for mental diseases, or other facility licensed as a hospital by the State. This service is limited to forty-five (45) days per State fiscal year.

d. Outpatient. A program of care in which the Member receives services in a hospital or other health care facility, but does not remain in the facility twenty-four (24) hours a day, including:

   i. Psychiatrists. Services provided within the scope of practice of medicine as defined by state law.

   ii. Psychosocial Rehabilitation. Rehabilitative services include any remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his/her practice under state law, for maximum reduction of mental disability and restoration of a recipient to his/her best possible functional level.

      a. Group. Therapeutic contact with more than one Member, of up to and including two hours.

      b. Individual. Therapeutic contact with one Member of more than thirty (30) minutes, but no more than two hours. This service, in conjunction with Individual Brief services, is limited to thirty-five (35) visits per state fiscal year, except as otherwise required by EPSDT as described in 10 C.C.R. 2505-10, Section 8.282.

      c. Individual Brief. Therapeutic contact with one Member of up to and including thirty (30) minutes. This service, in conjunction with Individual services, is limited to thirty-five (35) visits per state fiscal year, except as otherwise required by EPSDT as described in 10 C.C.R. 2505-10, Section 8.282.

iii. School-Based Services. State Plan outpatient mental health services provided to pre-school and school-aged children and adolescents on site in their schools, with the cooperation of the schools.

iv. Clinic Services, Case Management. Medically necessary case management services provided in a licensed community mental health center or clinic by a licensed/qualified non-physician practitioner or physician.

v. Medication Management. Monitoring of medications prescribed and consultation provided to Members by a physician or other medical practitioner authorized to prescribe medications as defined by State law, including associated laboratory services as indicated.

e. Emergency Services. Services provided during a mental health emergency which involve unscheduled, immediate, or special interventions in response to a crisis situation with a Member, including associated laboratory services as indicated.

2. 1915(b)(3) Waiver (Alternative) Services - MANDATORY

a. Vocational Services. Services designed to assist adult and adolescent Members who are ineligible for state vocational rehabilitation services and require long-term services and supports in developing skills consistent with employment and/or in obtaining employment.

b. Home-Based Services for Children and Adolescents. Therapeutic services to address the mental health needs of youth Members with serious emotional disturbances, provided in their homes and involving family members.

c. Intensive Case Management. Community-based services averaging more than one hour per week, provided to children with serious emotional disturbances and adults with serious mental illness who are at risk of a more intensive twenty-four (24) hour placement and who need extra support to live in the community.

d. Prevention/Early Intervention Activities. Screening and outreach to identify at-risk populations, proactive efforts to educate and empower Members to choose and maintain healthy life behaviors and lifestyles that promote mental and behavioral health. Services can be population-based, including proven media, written, peer, and group interventions, and are not restricted to face-to-face interventions.

e. Clubhouse and Drop-in Centers. In clubhouses, Members utilize their skills for clerical work, data input, meal preparation, providing resource information or reaching out to fellow Members. Staff and Members work side-by-side, in a unique partnership. In drop-in centers, Members with mental illnesses plan and conduct programs and activities in a club-like setting.

f. Residential. Any type of twenty-four (24) hour care, excluding room and board, provided in a non-hospital, non-nursing home setting, where the Offeror provides supervision in a therapeutic environment. Residential services are appropriate for children, youth, adults

and older adults who need twenty-four (24) hour supervised care in a therapeutic environment.

g. Assertive Community Treatment (ACT). A service delivery model providing comprehensive, individualized, locally-based treatment to adult Member with serious mental illness. ACT services are provided by a multidisciplinary treatment team and are available twenty-four (24) hours a day, seven (7) days a week, 365 days a year.

h. Recovery Services. Recovery-oriented services promote self-management of psychiatric symptoms, relapse prevention, treatment choices, mutual support, enrichment, social supports, and rights protection. Services may be provided at schools, churches or other community locations. Services include, but are not limited to, peer counseling and support services, peer-run employment services, peer mentoring for children and adolescents, recovery groups, warm lines and advocacy services. The Department expects Offerors to utilize the competency-based guidelines included in Attachment H for training peer support specialists.

i. Respite Services. Temporary or short-term care of a child, adolescent or adult provided by adults other than the birth parents, foster parents, adoptive parents, family members or caregivers with whom the Member normally resides, that is designed to give the usual caregivers some time away from the Member to allow them to emotionally recharge and become better prepared to handle the normal day-to-day challenges.

Successful Offerors shall regularly evaluate the effectiveness of the 1915(b)(3) Waiver (Alternative) services over the life of the contract. Any changes to the alternative services shall be proposed to and approved by the Department prior to implementation of the changes.

OFFEROR'S RESPONSE:

Offeror must include all mandatory State Plan and 1915(b)(3) Waiver (Alternative) Services in its proposal and demonstrate the ability to provide these services to Medicaid Members eligible for the Program. The Offeror's proposal shall describe its process for providing or arranging for the provision of each service, and how State Plan services will be used in conjunction with 1915(b)(3) Waiver (Alternative) services to maximize available resources and outcomes for its Members. Any additional services that the Offeror plans to provide to its Members may be included in this section of the proposal. The Offeror's proposed package of 1915(b)(3) Waiver (Alternative) Services shall be summarized using the table in Attachment I. This summary shall include the type of services, the capacity/number of Members to be served, the number and location of service sites, and any special population(s) to which these services would be offered. The Offeror's description of required services shall demonstrate a commitment to the principles of a recovery and resiliency model.

3. Evidence-based and Promising Practices

Evidence-based practices usually refer to programs or practices that are proven to be successful through research methodology and have produced consistently positive patterns of results. The implementation of proven, well-researched programs is rapidly becoming standard practice today and is required by most funding sources. Promising practices are those that may have demonstrated efficacy through qualitative evaluation protocols but have not yet been supported by quantitative, peer-reviewed scientific publication. The Department encourages Offerors to use as many evidence-based and promising practices as possible in its service delivery.

Offerors' implementation of these practices should demonstrate fidelity to the tested model used for each evidence-based practice, when available, in order to assure the effectiveness of the service provided. Such fidelity should be required except when adjustment is specifically described and justified for good cause, such as administering the practice in rural areas or to account for cultural differences. An authoritative source for five of the adult evidence-based practices, including fidelity checklists, is available on the SAMHSA website at http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/about.asp.

During the life of the contract, the Offeror shall provide at least four (4) evidence-based or promising practices from the list of Adult Services below and measure performance against at least two (2) important aspects of each of the selected practices annually. Offerors proposing the most comprehensive, progressive package of evidence-based or promising practices will be scored the highest for this section.

Please note that some services included in the following lists of evidence-based or promising practices for adults and for children/youth are already included as mandatory State Plan or 1915(b)(3) Waiver (Alternative) services. This requirement is designed to focus on outcomes of specific evidence-based or promising practices and does not suggest that practices not selected for measurement are not required in terms of contractual obligations, if medically necessary.

Services for Adults

a. Assertive community treatment - A multi-disciplinary team provides intensive services to individuals with the most severe mental illnesses. Team services include treatment, help in managing symptoms of the illness, immediate crisis response, case management, peer support, medication management, supportive therapy and practical on-site support in coping with day-to-day demands.

b. Member-run/Peer Services - A promising practice whereby individuals with serious mental illness provide supports and services for other adults with serious mental illness.

c. Crisis services - Mobile crisis teams, intensive in-home services, short-term or emergency hospitalization and residential placement have all proven effective in addressing crises. Services include evaluation and assessment, crisis intervention and stabilization, and follow-up planning. Programs intervene immediately and often are available twenty-four (24) hours a day, seven (7) days a week.

d. Illness management - Services to assist individuals to recognize any deterioration in their condition, to anticipate problems and how to respond so as to manage their illness, develop coping and problem-solving skills, and live successfully in the community despite signs and symptoms of serious mental illness.

e. Integrated treatment for individuals with co-occurring mental illness and substance use disorders - Integrated treatment merges the treatment of serious mental illness with the treatment of a co-occurring substance use disorder. Integrated treatment can be provided by mental health programs, substance abuse programs or new programs established specifically to furnish such care. Integrated treatment may include a residential component and/or intensive outpatient services.

f. Psychiatric rehabilitation - Psychiatric rehabilitation programs combine several services for which the evidence base is strong. Services include: supported employment, supported housing, disability management, medication education and management, family psychoeducation and case management as well as other services focused on successful community living.

g. Psychoeducation for families - Provision of emotional support, information and education on the illness of the family member (in general) and specific information on managing crises and day-to-day problems for the individual Member (with the Member's consent), provision of resources during periods of crisis, and teaching of problem-solving skills to families of adults with serious mental illness.

h. Psychotherapy – Psychotherapy is a process of interaction between a trained professional and an individual or group seeking help to address psychological symptoms by modifying responses, behaviors, thoughts or other processes. Several psychotherapeutic approaches have been found effective, including: (i) Cognitive Behavioral Therapy for anxiety disorders, including panic disorder and obsessive-compulsive disorder; (ii) Interpersonal and brief dynamic therapy for depression; and (iii) Dialectical Behavioral Therapy for individuals with borderline personality disorder.

i. Supported employment - Individuals are placed in employment and provided back-up psychiatric rehabilitation services that focus on skills needed to maintain employment, such as social skills (i.e. how to get along with supervisors and coworkers, timeliness and appropriate grooming and dressing) and stress management along with behavioral health treatment (including medications and medication management). Generally, supported employment also includes an on-site job coach.

j. Supported housing - Individuals live in their own home (room, apartment, or other location) and receive supportive clinical and psychiatric rehabilitation in order to maintain their stability in the community. Services are available at mental health facilities or can be brought to the individual in their home setting when needed. Disputes with landlords and other tenants are addressed through interventions and social skills training.

k. Adult behavioral health promotion – Interventions designed to promote behavioral health of adults; for example, screening for post-partum and other forms of depression, and proactive strategies to identify and manage mood disorders, substance use disorders, psychotic disorders, and personality disorders.

OFFEROR'S RESPONSE:

Offeror shall select at least four (4) of the Adult evidence-based and promising practices listed above, a minimum of one (1) of which is designed for co-occurring mental illness/substance use disorder populations. Offeror shall describe its proposed implementation plan and two (2) associated measurements/metrics that will be performed for each selected practice annually, along with associated benchmarks. In addition, Offeror shall describe its rationale for selecting each practice and what each practice is intended to demonstrate.

Services for Children and Adolescents

During the life of the contract, the Offeror shall provide at least four (4) evidence-based or promising practices from the list of Child and Adolescent Services below and measure performance against at least two (2) important aspects of each of the selected practices annually. Offerors proposing the most comprehensive, progressive package of evidence-based or promising practices will be scored the highest for this section.

a. Brief hospitalization for suicidal children and adolescents - Can be an effective placement for treatment.

b. Crisis services - Mobile crisis teams, intensive in-home services, short-term or emergency hospitalization and residential placement have all proven effective in addressing crises. Services include evaluation and assessment, crisis intervention and stabilization, and follow-up planning. Programs intervene immediately and often are available 24 hours a day, 7 days a week.

c. Family-based Cognitive Behavioral Therapy - Families play a critical role in social and emotional development of children and short-term outpatient family-focused treatments are effective for conduct problems, ADHD, emotional disturbance (specifically, anxiety, depression and grief) and other problems. Services have cognitive-behavioral structural or strategic foundations and often are combined with individual therapies and medication management.

d. Home-based services - Crisis-oriented services designed to preserve the family's integrity and prevent unnecessary out-of-home placements by creating support systems that strengthen the family's coping skills after crisis treatment is completed. Includes counseling, skills training and coordination of services. Termed "family preservation services" in the child welfare system.

e. Intensive case management - Clinically-oriented, intensive case management reduces the need for out-of-home care. Case managers are available to children and their families to assist with coordination of services and daily living problems.

f. Multimodal treatment for attention deficit/hyperactivity disorder - A combination of parent and child education about diagnosis and treatment, specific behavior management techniques, medication management and appropriate school programming and supports.

g. Multi-systemic therapy – An intensive community-based program for youth involved with the juvenile justice system that provides a range of services to develop independent

skills among youths and assistance to their families. Interventions are brief, three to four (3-4) months, and intensive, often daily. Multi-systemic therapy employs behavioral training for parents, cognitive-behavioral therapies and functional family therapy to address the child's problems across environments.

h. Psychoeducation for families - Provision of emotional support, information and education on the child's disorder (in general) and specific information on managing crises and day-to-day problems for the individual child, provision of resources during periods of crisis, and teaching of problem-solving skills to families of children with serious mental or emotional disorders.

i. Psychotherapy for children - Psychotherapy is often employed in the treatment of children with mental and emotional disorders and many practices that are well supported in the adult treatment literature have been utilized successfully with children, although they are less well studied. Psychotherapies are especially important alternatives for children who are unable to tolerate, or whose parents prefer them not to take, medications. They are also important for conditions for which there are no medications with well-documented efficacy.

j. School-based services - School-based mental health services (including pre-school services) have been found to be effective not only in improving students' mental health outcomes, but also in strengthening academic performance and reducing behaviors such as aggression and bullying. Evidence-based school-based services include: (1) targeted classroom-based contingency management for ADHD that successfully reduces aggression; (2) cognitive group interventions to modify adolescents' depressed thinking styles; (3) teaching social problem solving skills, (4) cognitive group interventions, and 5) early childhood interventions such as “Incredible Years”, “ECE Cares”, and the “Teaching Pyramid”.

k. Child behavioral health promotion strategies – Interventions designed to prevent development of mental/behavioral conditions and promote behavioral health; for example, promotion of strategies to assist with coping, stress management, peer pressure and identifying early warning symptoms of conditions for early intervention.

A repository containing information on evidence-based practices in mental health and substance use disorder treatment is available online at http://www.nrepp.samhsa.gov/. Information focused on children’s mental health is available at http://systemsofcare.samhsa.gov/resourceguide/ebp.html. A database of evidence-based practices for substance use disorder treatment may be found at http://www.adai.washington.edu/ebp/.

OFFEROR’S RESPONSE:

Offeror shall select at least four (4) of the Child and Adolescent evidence-based and promising practices listed above and describe its proposed implementation plan and two (2) associated measurements/metrics that will be performed for each selected practice annually, along with associated benchmarks. In addition, Offeror shall describe its rationale for selecting each practice and what each practice is intended to demonstrate.

D. SERVICE DELIVERY

The Offeror shall ensure that services are provided through a well-organized service delivery system. The service delivery system shall include mechanisms for ensuring access to high quality, general and specialized care, from a comprehensive provider network. The Offeror's provider network shall include CMHCs and other providers. The provider network shall not be limited to CMHC providers, but shall also include essential community providers, other private/non-profit providers, as well as providers with experience in serving individuals with complex needs, e.g. individuals with dual diagnoses and those with chronic physical conditions in addition to mental health needs. The Offeror's provider network shall also include providers capable of billing both Medicare and Medicaid. The Offeror shall have a system for credentialing providers. The Offeror's overall service delivery system shall include specific mechanisms for individual Member intake and assessment, service planning and the coordination and continuity of care. Within its service delivery system, the Offeror shall promote the provision of behavioral health services by primary care physicians and behavioral health systems of care.

OFFEROR'S RESPONSE:

Historically, the Program has been challenged in providing services for clients with multiple and complex needs, particularly in non-traditional treatment settings. The Offeror's proposal shall include plans for how behavioral health services will be delivered to clients living in long-term care and assisted living facilities, to clients with mental illness and a co-occurring developmental disability, to frail elderly or disabled clients who are unable to travel to treatment sites, to clients with co-occurring disorders and involvement in the criminal justice system, and to clients who have multiple, chronic physical conditions that impact their behavioral health treatment. The Offeror's description of its service delivery system shall demonstrate a commitment to the principles of a recovery and resiliency model.

1. Access to Care

The Offeror shall assure access to care for all Members in need of covered behavioral health services through the provision of the following:

a. Varied geographic location of providers.

b. Minimum hours of provider operation to include service coverage from 8:00 a.m. to 5:00 p.m. Monday through Friday and emergency coverage twenty-four (24) hours a day, seven (7) days a week. Extended hours of operation and service coverage must be provided at least two days per week at clinic treatment sites, which may include additional morning, evening or weekend hours, to accommodate Members who are unable to attend appointments during standard business hours. Offeror shall encourage individual network providers to offer flexibility of appointment times to Members whenever possible.

c. Providers located throughout the Offeror's service area within thirty (30) miles or thirty (30) minutes travel time to the extent such services are available.

d. Community-based access. To increase accessibility and improve outcomes, behavioral health services shall be provided in multiple community-based venues, based on a determination that the services are medically necessary, appropriate to the client's needs, and that providing treatment at an alternative site does not put the provider's safety at undue risk. Alternative treatment sites may include but are not necessarily limited to schools, juvenile detention centers, federally qualified health centers, homeless shelters, acute care facilities, assisted living facilities, and clients' homes.

e. Evening and/or weekend support services for Members and families that include access to clinical staff, not just an answering service or referral service staff.

f. Member toll-free telephone number for Offerors with operations outside the calling area of the geographic service area.

g. Identification of Members who unexpectedly miss appointments or discontinue treatment. Appropriate and timely steps shall be taken to contact Members to determine if there is a problem that can be resolved and to promote continuation of services. The Offeror must recognize that different strategies and levels of effort are appropriate for different populations (e.g. age groups, diagnosis, severity of illness, culture, language, etc.) and conduct outreach efforts that are appropriate for different populations, using numerous attempts and multiple methods that could include mail, telephone, e-mail, text messaging, home visits, or other efforts that are reasonably calculated to ensure verifiable contact.

h. Criteria for discharge from treatment/services. Offeror should establish clear and specific criteria for discharging Members from treatment and criteria should be included in Member materials and information. Individualized criteria for discharge agreed upon by Member and Provider should be noted in the Member's health care record and modified, by agreement, as necessary.

i. Standards for timeliness of service, including:

    i. Emergency services shall be available by phone, including by TTY accessibility, within fifteen (15) minutes of the initial contact, in person within one (1) hour of contact in urban and suburban areas, in person within two (2) hours of contact in rural and frontier areas.

    ii. Urgent care shall be available within twenty-four (24) hours from the initial identification of need. For the purpose of this RFP, an urgent condition is a behavioral health condition manifesting by acute symptoms that has the potential to become an emergency health condition in the absence of treatment, or any other condition that would place the health or safety of the Member or another individual in serious jeopardy in the absence of medical or behavioral treatment.

    iii. Routine services shall be available upon initial request within seven (7) business days. Routine services include but are not necessarily limited to an initial

individual intake and assessment appointment. Placing Members on waiting lists for initial routine service requests is not acceptable.

iv. Outpatient follow-up appointments within seven (7) business days after discharge from an inpatient psychiatric hospitalization or residential facility.

v. Medication management appointment timeliness may vary according to the Member's circumstances, needs and/or agreed upon treatment/care plan.

OFFEROR'S RESPONSE:

Offeror's proposal shall describe how the contractor will offer both required and extended hours of operation and service coverage, access to alternative treatment sites, detail policies and procedures relating to Members who miss appointments and/or discontinue treatment, outline criteria for discharge from treatment, and address timeliness standards as described above.

2. Provider Network

The Offeror shall establish and maintain a comprehensive provider network capable of serving the behavioral health needs of all Members in the Program. The provider network shall take into account the anticipated Medicaid enrollment, the expected utilization of services and the characteristics and health care needs of specific Medicaid populations represented in the geographic service area. The Offeror's network plan shall at a minimum address the following:

a. The numbers, types and specialties of providers, particularly psychiatrists and child psychiatrists, required to furnish covered services and care coordination;

b. The number of network providers accepting/not accepting new Medicaid Members by provider type and smaller geographic breakdown within service area;

c. The geographic location of providers in relationship to where Medicaid Members live;

d. The potential physical barriers to accessing providers' locations; and

e. The cultural and language expertise of providers;

The Offeror shall offer to contract with essential community providers located in the Offeror's geographic service area, as defined in C.R.S. 25.5-5-404.2. The Offeror's network shall include both essential community providers and other private/non-profit providers, thus allowing Members choice and facilitating continuity of care. If the Offeror is unable to provide covered services to a particular Member within its network, the Offeror shall provide the covered services out of network at a cost to the Member no greater than that of in-network services. Co-location of staff in high volume physical health locations and methodology to support smaller, dispersed physical health providers with the behavioral health needs of their covered population is expected.

The Offeror shall have a system for monitoring patient load on its provider network so that it can effectively plan for future needs and recruit providers as necessary to assure adequate access to all covered services.

OFFEROR'S RESPONSE:

The Offeror's proposal shall include a description of the unique qualities of the service area and how it will address the challenges and opportunities presented. The Offeror must demonstrate a provider network capable of accommodating the specialized needs of Members and Member choice of providers. Offeror must address all requirements listed above. The Offeror must also describe how it will know when/if its provider network becomes inadequate and its corresponding action plan.

State statute requires that Offerors shall offer to contract with all essential community providers, including Community Mental Health Centers (CMHCs) and Federally Qualified Health Centers (FQHCs), in their geographic service area. The Offeror's proposal shall include a list of Letters of Intent or Statements of Intent obtained from essential community providers in its geographic service area, or an explanation of why the Offeror has been unable to get such letters or statements of intent. Offerors with existing contracts with essential community providers are not required to obtain new letters of intent, but existing letters should be noted in the above mentioned list. Letters of intent must be available upon request by the Department, but are not to be included in the Offeror's proposal.

3. Intake and Assessment

The Offeror shall ensure that each Member seeking to access services receives an individual intake and assessment within contractual timeframes for the level of care needed. Group orientations at service locations may be offered for adult Members, if desired and appropriate for Member characteristics, provided that no personal health information is shared. These orientations may not take the place of an individual Member intake and assessment with a qualified clinician. The intake and assessment process shall address the developmental, cultural and linguistic needs of Members. The Offeror shall screen Members for mental illness and substance use disorders and assist Members in accessing needed care. Intake and assessment appointments shall be scheduled for all Medicaid Members on an equal basis, regardless of whether or not a Member is accessing services in his/her assigned BHO. The Offeror shall cooperate with other BHOs in sharing information, arranging payment for services, or transferring benefits without undue intervention by the Member and/or family members.

OFFEROR'S RESPONSE:

The Offeror's proposal shall include a description of its proposed intake and assessment process, including options for Members who cannot physically access a treatment site for this process. Offeror shall describe its process for coordination of information, payment for services, and benefits transition with other BHOs.

4. Service Planning

The Offeror shall have an effective service planning system, which utilizes the information gathered in the Member's intake and assessment to build a comprehensive plan of service. The service plan may also be known as a treatment plan or a client care plan, and shall include measurable goals, strategies to achieve the stated goals and a mechanism for monitoring and revising the service plan as appropriate. Each Member seeking services shall have an individualized service plan, developed by the Member and/or the designated Member representative and the Member's provider or treatment team. The service plan shall be signed by the Member and reviewing professional. If a Member chooses not to sign his/her service plan, documentation shall be provided in the Member's medical record stating the Member's reason for not signing the plan. Service planning shall take place annually or if there is a change in the Member's level of functioning and care needs.

The Offeror shall coordinate with County departments of social services in regards to children and youth in out-of-home placements, including foster care and subsidized adoptions. While not every child entering the foster care system may require a behavioral health assessment, all Medicaid eligible children/youth should receive an initial behavioral health assessment, upon request, within contractual timeframes. The Offeror shall coordinate behavioral health and substance use disorder referrals and services with County case workers and shall provide training to County staff on accessing behavioral health care for Members at least on an annual basis.

5. Coordination of Care

The contractor shall have written policies and procedures to ensure timely coordination of the provision of covered services to its Members to promote and ensure service accessibility, attention to individual needs, continuity of care, maintenance of health and independent living. The policies and procedures shall also address the coordination and provision of covered services in conjunction with other medical and behavioral health plans that may be providing services to the Member and ensure that, in the process of coordinating care, each Member's privacy is protected consistent with the confidentiality requirements in 45 C.F.R. Parts 160 and 164.

Contractor shall provide care coordination, which shall address the Member's need for integration of behavioral health and other services. This includes identifying, providing, arranging for and/or coordinating with other agencies and providers to ensure that the Member receives the health care and supportive services that shall allow the Member to remain in her/his community. Recognizing the importance to Members of needed medical care, the contractor shall make every reasonable effort to assist individuals to obtain necessary medical treatment. The contractor shall coordinate with the Member's medical health Providers to facilitate the delivery of health services, as appropriate. If a Member is unable to arrange for supportive services necessary to obtain medical care due to her/his mental illness, these supportive services shall be arranged for by the contractor or another person who has an existing relationship with the Member (whenever possible).

OFFEROR'S RESPONSE:

The Offeror's proposal shall include detailed description of its plan for coordinating not only covered services but other health care and supportive services required by its

Members. The proposal should include a plan for assisting Members to access needed medical care and documentation of these efforts.

6. Special Behavioral Health Populations

The Offeror is responsible for ensuring the provision of covered, medically necessary care for all Members, including providing coordination and continuity of care for Members who are involved in multiple systems and those who have multiple needs.

Offeror shall provide for care coordination and continuity of care for the listed populations as follows:

a. Members residing in a long-term care/nursing facility – The Offeror shall provide outreach to nursing facilities and assisted living facilities in its service area to determine the best approach to serving their Medicaid residents. The Offeror shall provide medically necessary covered behavioral health services on-site in nursing facilities and assisted living facilities for residents who cannot reasonably travel to a service delivery site for their services. Residents able to travel to service delivery sites may be required to receive their behavioral health services at a delivery site.

b. Dually or multiply eligible Members - Medicaid is the payer of last resort for dual or multiply eligible Members. The Offeror shall ensure that behavioral health services are provided to dual or multiply eligible Members and assist Members in finding qualified Medicare providers who are willing to provide covered services. If qualified Medicare providers cannot be identified or accessed, the Offeror shall provide medically necessary covered behavioral health services under the BHO contract.

c. Dually or multiply diagnosed Members - The Offeror shall be responsible for providing medically necessary behavioral health services to Members with a covered behavioral health diagnosis and co-occurring diagnoses of developmental disabilities, traumatic brain injury, and/or substance use disorders. The Offeror shall be responsible for all medically necessary covered services to treat the covered psychiatric diagnosis and shall have a mechanism for working with developmental disability services or other appropriate agencies/health care providers to secure agreement regarding the medical necessity of psychiatric services to treat the covered psychiatric diagnosis and resulting behaviors. If the Offeror determines that the Member does not have a covered behavioral health diagnosis, Offeror shall inform the Member about how services not covered under the contract may be obtained, pursuant to federal Medicaid managed care rules.

d. Members with special health care needs - Federal regulation 42 C.F.R. 438.208(a)(2)(i) and (ii) allow states to exempt PIHPs from meeting special requirements for coordination and continuity of care for persons with special health care needs. The Offeror shall, however, share with a health plan/provider serving the Member with special health care needs the results of its identification and assessment of the Member's needs to prevent duplication of those activities.

The Offeror shall provide for care coordination, which shall address the Member's need for integration of behavioral health and other services.

e. Members involved with the correctional system - The Offeror shall collaborate with agencies responsible for the administration of jails, prisons and juvenile detention facilities to coordinate the discharge and transition of incarcerated adult and child/youth Members for the continuation of prescribed medication and other health care services prior to reentry to the community.

f. Female Medicaid Members for a period of one (1) year post-partum.

g. Child/Youth Members in out-of-home placements, foster care, and subsidized adoptions - Studies show that the incidence of emotional, behavioral and developmental problems for children/youth in this population is several times higher than the general population and that adopted children and children in kinship placements are disproportionately represented in the child psychiatric population. Issues may include, but are not limited to, attachment/reactive disorder, ADHD, affective disorders, oppositional defiant disorder, post-traumatic stress disorder, and issues resulting from one's own or parental substance use disorder and sexual abuse. In addition, children may be dealing with social stigma, grief, loss, guilt, rejection, and identity issues relating to adoption. Therefore, the Offeror's provider network shall include clinical staff who have expertise in identifying and addressing clinical issues that are unique to children who are adopted and their families. Staff should be familiar with the unique needs of adoptive families, be able to provide psycho-educational as well as practical therapeutic interventions, and know of and refer families to community resources that may be helpful.

OFFEROR'S RESPONSE:

The Offeror shall describe its plan for coordination of behavioral health care with any other medical or behavioral health plans providing services to Members, including its method for identifying Members who may require assistance accessing physical health care services.

The Offeror shall describe its plan to ensure required care coordination and continuity of care for the populations listed below. The Offeror's plan shall include how it will identify Members who require care coordination services, resources required to provide this support, and how care coordination for Members will be evaluated.

a. Members residing in a long-term care/nursing facility.
b. Dually or multiply eligible Members.
c. Dually or multiply diagnosed Members.
d. Members with special health care needs.
e. Members involved with the correctional system
f. Female Medicaid Members for a period of one (1) year post-partum.
g. Child/youth Members in out-of-home placements, foster care, and subsidized adoptions.

7. Member Service Transitions

The Offeror shall develop, implement, and monitor written policies and procedures regarding service transitions for all Members. In addition, the Offeror shall demonstrate its awareness of the unique set of challenges faced by youth and families when the youth transitions from the child to the adult behavioral health system. These may include application for adult Medicaid benefits, service and provider changes, lack of service coordination even within a provider organization, and failure of providers to recognize the additional time, training and support necessary for youth with behavioral health disorders to achieve customary developmental milestones. With the exception of sexual development, youth with serious behavioral health challenges are delayed in every area of psychosocial development. There may also be significant resistance to accepting the label of mental illness or a substance use disorder among youth as they approach adulthood, and accompanying resistance to engaging in treatment.

OFFEROR'S RESPONSE:

The Offeror shall submit a plan in its proposal showing how it shall ensure effective and timely transitions for all Members. The Offeror's plan shall include how it will identify Members who need assistance with transitions, resources required to provide this assistance, and how transitions for Members will be evaluated. At a minimum, the Offeror's plan should address the specialized needs of adult and youth Members as noted below:

a. Adults

i. Behavioral health Member transitions to/from another BHO;

ii. Behavioral health Members whose treating qualified service provider becomes unable to continue service delivery for any reason;

iii. Behavioral health Member transitions to/from an assisted care facility or long-term care placement for Members who continue to require behavioral health services;

iv. Behavioral health Member transitions from the correctional or community corrections system back to the community;

v. Behavioral health Member discharges from an inpatient, sub-acute, psychiatric residential treatment facility, or mental health institute; and

vi. Behavioral health Members whose needs result in temporary or longer-term treatment/care in another BHO's service area.

b. Youth

i. Assistance with application for adult Medicaid benefits, including submitting applications in advance so that reapplication may be made, if necessary, without losing benefits and assisting families, as needed, to transfer diagnoses

used in the child behavioral health system to the appropriate adult diagnoses;

ii. **Provide person-centered, strengths-based programming for youth from ages fourteen to twenty-five (14-25), focusing on education, employment, social and problem-solving skills, symptom management, reaction to stigma, sexual and gender identity, living situation/ housing, personal health care, transportation resources, substance use disorder prevention or relapse prevention, and cultural and spiritual resources;**

iii. **Assist youth and family to create a Safety Net of community supports, including a reliable family-like or healthy peer connection;**

iv. **Assess internal business practices, communication channels, and administrative support necessary to ensure a smooth transition for youth Members to the adult behavioral health system; and**

v. **Provide training and a curriculum to educate staff about the unique needs of this population.**

8. Cultural Competency

The U.S. Department of Health and Human Services, Office of Minority Health, provides the following definition of cultural competence: "Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities." Cultural affiliations may include, but are not limited to race, preferred language, gender, disability, age, religion, deaf and hard of hearing, sexual orientation, homelessness, and geographic location. The Offeror shall facilitate culturally and linguistically appropriate care in compliance with 42 CFR §438.206(c)(2). In addition, the Offeror will implement the following requirements:

a. The Offeror shall develop, implement, and promote a written strategic Cultural Competency Plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services. Policies shall support the provision of health care services that respect individual health care attitudes, beliefs, customs and practices of Members related to cultural affiliation. The Offeror shall have sufficient staff with cultural competency to implement and oversee compliance with the Offeror's Cultural Competency Plan and policies. While not required, Offerors may wish to utilize the Colorado Division of Behavioral Health Cultural Competency Plan as a resource. The plan is available online at http://www.cdhs.state.co.us/dmh/PDFs/dmh_cultural-competency-plan.pdf.

b. The Offeror shall make a reasonable effort to identify Members whose cultural norms and practices may affect their access to health care. Such efforts may include inquiries conducted by the Offeror of the language proficiency of Members during the Member's orientation visit or while being served by participating providers, or improving access to health care through community outreach and Offeror publications.

c. The Offeror shall develop and/or provide cultural competency training programs, as needed, to network providers and Offeror staff regarding (a) health care attitudes, values, customs and beliefs that affect access to and benefit from health care services, and (b) the medical risks associated with the Member population's racial, ethnic and socioeconomic conditions.

d. The Offeror shall conduct initial and ongoing organizational self-assessments of cultural competency activities and shall integrate cultural and linguistic competence-related measures into internal audits, performance improvement programs, Member satisfaction assessments, provider audits, and staff performance evaluations.

e. The Offeror shall make a reasonable effort to develop and implement a strategy to recruit and retain qualified, diverse and culturally competent clinical Providers including, but not limited to, providers who represent racial and ethnic communities, the deaf and hard of hearing community, disability community, and other culturally diverse communities being served. The Offeror shall include a mechanism for including in its provider network providers who are from diverse communities with cultural and linguistic competence to provide services to the target community. Mechanisms may include the use of telemedicine to address geographic barriers to accessing clinical providers from diverse backgrounds.

f. The Offeror shall provide access to interpretative services by a qualified interpreter for deaf or hard of hearing Members in such a way that it shall promote accessibility and availability of covered services.

g. Translation for Oral and Written Communications

    i. The Offeror shall offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to any Member with limited English proficiency at all points of contact, in a timely manner, during all hours of operation.

    ii. The Offeror shall assure the competence of language assistance provided to limited English proficient Members by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the Member).

    iii. The Offeror shall provide to Members in their preferred language verbal offers informing them of their right to receive language assistance services. Written notices of this right shall be provided to Members in their preferred language, upon request.

    iv. The Offeror shall make available Member-related materials that are easily understood, written at no higher than 6th grade English reading level and

comparable numeracy level, and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

v. The Offeror shall develop policies and procedures (as needed) on how the Offeror shall respond to requests from participating providers for interpreter services by a qualified interpreter. This shall occur particularly in service areas where language may pose a barrier so that participating providers can: (i) conduct the appropriate assessment and treatment of non-English speaking Members (including Members with a communication disability) and (ii) promote accessibility and availability of covered services, at no cost to Members.

OFFEROR'S RESPONSE:

The Offeror shall describe its strategy for providing culturally competent behavioral health care services to its Members, including:

a. An overview of the Offeror's Cultural Competency Plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services, and a positive statement that the Offeror shall have sufficient staff with cultural competency to implement and oversee compliance with the Plan .

b. How the Offeror will identify Members whose cultural norms and practices may affect their access to health care and its plan to outreach these Members.

c. Offeror's plan for recruiting and retaining qualified, diverse and culturally competent clinical staff within its provider network and a positive statement that the Offeror will offer single case agreements to culturally competent staff outside of its network, if required to meet a Member's needs.

d. How it will respond to requests from its provider networks for services by a qualified interpreter.

e. How it will monitor whether or not language services are being provided to all Members, upon request, and how it will address gaps or inadequacies found.

9. Informal Caregivers

The Offeror shall appropriately communicate with, understand and manage the roles and expectations of Members' informal caregivers. Informal caregivers are typically a Member's family and/or friends and may help coordinate health care services for the Member during recovery periods, including the scheduling of appointments, requesting of medical records (if caregiver is the designated Member representative), and arranging transportation.

The Offeror shall ensure that informal caregivers are integral members of the care team in that the informal caregiver continues the Member's treatment and recovery at home. The Offeror shall ensure that caregivers' needs and concerns are satisfied so caregivers are well-equipped to provide care for the Member.

The Offeror shall use communication with the caregivers that is of high quality, timely, accurate, and provided in a manner that can be easily understood by the caregiver. The relationship between The Offeror and informal caregivers should be characterized by shared goals, shared knowledge, and mutual respect.

10. EPSDT

Other than information pertaining to substance use disorder treatment, the Offeror shall share protected health information with the Department's EPSDT Outreach and Case Management agencies without requiring any special releases or other permission from the Member, unless the Offeror has previously obtained written and explicit instructions from the Member not to share information with the Department's EPSDT agencies. Release of any information pertaining to a Member's substance use disorder treatment requires either a valid Release of Information signed by the Member, the Member's designated representative, or a Qualified Service Organization Agreement (a sample QSOA is included in Attachment J).

11. Other Service Delivery Issues

a. Scheduling and Transportation Assistance - The Offeror shall assist Members with scheduling and rescheduling appointments, and with scheduling transportation to those appointments, upon request by the Member, the Physician or the Department. Payment for non-emergency transportation is otherwise covered under Medicaid.

b. Wrap-Around Benefits - The Offeror shall assist Members to identify and to obtain Medicaid Wrap-Around Benefits. These benefits are Medicaid services that are not covered by the Program, but are covered for Medicaid Members enrolled in the Program either by referral or direct access to fee-for-service Medicaid Providers. Assistance may include completing paperwork, including Prior Authorization Requests and Letters of Medical Necessity, and coordinating appointments and other interactions with Wrap-Around program staff or Single Entry Point (SEP) staff.

c. Overlapping Programs - The Offeror shall accept primary responsibility for delivering medically necessary covered behavioral health services to all Members, even if a separately funded program or entity offers Members the same or similar services. The Offeror may refer Members to receive services under these other programs or from these other entities only if the Offeror: (1) determines that the Member is not inconvenienced by having to seek care elsewhere, (2) coordinates the referral, and (3) records specifically which services were obtained and from where.

d. Homelessness - The Offeror shall coordinate health care services for homeless Medicaid Members with the services provided to these individuals by other agencies and organizations (e.g. public health providers, transportation, shelters, home and community-based care, developmental disabilities, local school districts, child welfare, IDEA programs, Title V, families, caregivers and advocates). The Offeror shall be knowledgeable about the continuum of housing options in its service area, and about housing advocacy, networking and resource development. The Offeror shall provide training to educate staff on the unique needs of this population.

E. MEMBER AND FAMILY AFFAIRS

The Department is committed to the principles of the recovery and resiliency model, specifically Member empowerment, community integration and normalization of the life environment. The Offeror shall have an Office of Member and Family Affairs, headed by a Director who is an Offeror employee, to work with Members and families. Responsibilities shall include encouraging Member recovery and involving the Member, parent or legal guardian of a youth Member, family members and advocates in service planning, resource planning, Member-driven and Member-run services and activities, and when possible, employing Members. The Offeror's Office of Member and Family Affairs shall include, at a minimum, the responsibilities of handling grievances and appeals, providing federally required Member information and communicating and upholding Member rights. The Offeror shall also establish and maintain a Member/Family Advisory Board composed of Offeror, Member and family representatives, to collaborate with and provide ongoing input to the Offeror about programs and services, Member rights, and other key components of the Program. The following guidelines, approved by the National Association of State Mental Health Program Directors Board in 1989, should be considered when determining the level and degree of Member participation in Offeror program management.

> "The National Association of State Mental Health Program Directors recognizes that former… mental health consumers have a unique contribution to make to the improvement of the quality of mental health services in many arenas of the service delivery system. The significance of their unique contributions stems from expertise they have gained as recipients of mental health services, in addition to whatever formal education and credentials they may have.
>
> Their contributions should be valued and sought in areas of (program development, policy development, policy formation, program evaluation, quality assurance, system designs, education of mental service providers, and the provision of direct services as employees of the provider system. Therefore, ex-consumers should be included in meaningful numbers in all these activities. In order to maximize their potential contributions, their involvement should be supported in ways that promote dignity, respect, acceptance, integration and choice. Support provided should include whatever financial, educational or social assistance is required to enable their participation. Additionally, client-operated self-help and mutual support services should be available in each locality as alternatives and adjuncts to existing mental health service delivery systems."

1. Grievances and Appeals

The Offeror shall comply with 10 CCR 2505-10, Section 8.209, of the Medicaid state rules for Managed Care Grievance and Appeals Processes. (See also Attachment K.)

2. Member Rights

The Offeror shall comply with federal regulations at 42 C.F.R. 438.100 pertaining to Member rights, and ensure that its staff and providers take those rights into account when furnishing services to Members. The Offeror shall post and distribute Member rights to stakeholders.

3. Member Information

The Offeror shall meet the federal requirements regarding Member information as outlined in 42 C.F.R. 438.10. Member information should include how to locate information and updates to the Colorado Prescription Drug List (PDL) program.

4. Ombudsman for Medicaid Managed Care

The Offeror shall utilize and refer Members to the Ombudsman for Medicaid Managed Care to assist with problem-solving, grievance resolution, in-plan and administrative law judge hearing level appeals, and referrals to community resources, as appropriate. The Offeror shall share protected health information, with the exception of psychotherapy notes, with the Ombudsman upon request, without requiring a signed release of information or other permission from the Member, unless the Offeror has previously obtained written and explicit instructions from the Member not to share information with the Ombudsman.

OFFEROR'S RESPONSE:

The Offeror's response to the Member and Family Affairs section shall demonstrate a commitment to the principles of a recovery and resiliency model. The Offeror's proposal shall detail how the Office of Member and Family Affairs shall meet the needs of the Member and family, including:

1. **Procedures for handling Member grievances and appeals;**
2. **Providing required Member information;**
3. **Disseminating information about and promoting Member rights;**
4. **Advocating for Members and families;**
5. **Outreach to Members and families to identify their concerns;**
6. **Assisting Members and families to access behavioral health services;**
7. **Providing Members and families a voice within the policy and decision-making groups of the Offeror's organization through meaningful representation on groups and the formation of advisory councils. Offeror's proposal shall include the groups available to Member/family participation, the percentage of each group and/or advisory council membership to be comprised of Members/family, and how participants are to be selected from the Member/family population;**
8. **Assuring that Members throughout the service area can participate in groups and advisory committees, despite potential challenges involving distance, limited income, and/or transportation availability;**
9. **What kind of accommodations the Offeror anticipates needing to provide to assist Members/families with meaningful participation;**

10. **Educating Members and families about mental illnesses and the mental health system, as well as substance use disorders and the substance use disorder treatment system;**
11. **Providing organizational, technical and other assistance to Member and family organizations;**
12. **Utilization of peer advocates, including self-advocates and family members of special behavioral health populations identified in section VI.D.6, to support and/or assist other Members;**
13. **Supporting advocacy forums and trainings; and**
14. **How Member/family participation will be assured in Offeror's subcontracted provider organizations.**

F. OUTCOMES, QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

For all covered services, the Offeror shall maintain an outcomes, quality assessment and performance improvement program that complies with 42 C.F.R. Section 438.200. The scope of the Offeror's outcomes, quality assessment and performance improvement program shall include all requirements in this section but is not limited to these requirements. Outcomes and performance improvement efforts are designed to ensure that the frequency and intensity of behavioral health disorders are proactively identified, prioritized, intervened upon, and tracked for peer and historical improvement.

1. Practice Guidelines

The Offeror shall meet the requirements of the draft contract, federal managed care regulations, and the 42 CFR Part 2 confidentiality regulations when adopting practice guidelines.

2. Performance Improvement Projects

The Offeror shall have in progress a minimum of one (1) performance improvement project (PIP) and one (1) focused study with intervention or two PIPs annually. At least one (1) PIP or the focused study must be outcome-focused. PIPs will be validated by the Department's external quality review organization (EQRO). The primary objective of the PIP validation is to determine compliance with requirements set forth in 42 CFR 438.240(b)(1), including:

a. Measurement of performance using objective valid and reliable quality indicators;
b. Implementation of system interventions to achieve improvement in quality;
c. Empirical evaluation of the effectiveness of the interventions;
d. Planning and initiation of activities for increasing or sustaining improvement.

The Offeror shall summarize the status and results of each performance improvement project in the annual quality report and when requested by the Department. The status and results of each

performance improvement project shall be submitted on the agreed upon schedule in sufficient detail to allow the Department and/or its designee to validate the projects.

3. Performance Incentives

In support of the Department's increased focus on contractor accountability, performance and outcomes, a significant number of new performance measures have been added to the RFP, some of which will be associated with a program to incentivize contractors to meet or exceed the high standards set by the Department. Following final execution of the contract, the Offeror will work with the Department to develop a performance incentive program and implementation timeline based on specific performance measures included in this RFP. The Department may set aside up to 2.5% of total capitation rates beginning in contract year 2 to support this program as outlined in the following table:

Contract Year 1	Measurement finalization and base-lining Conduct and report measurements
Contract Years 2-5	Full implementation of incentive program

4. Performance Measurement

The Department is interested in measuring changes in overall behavioral health outcomes for all of its Members. During the life of the contract, the Offeror shall participate in the annual measurement and reporting of the performance measures required by the Department, with the expectation that this information will be placed in the public domain. The Offeror shall calculate additional performance measures when they are developed and required by CMS or the Department. The current required performance measures are attached in Attachment L. The Offeror shall work with the Department to develop agreed-upon measurement criteria, reporting frequency and other components of this requirement.

5. Colorado Client Assessment Record (CCAR)

The CCAR is a functional assessment tool that was developed in Colorado. The tool is used throughout the Colorado public mental health system to individually assess and record mental health clients' level of functioning and collectively calculate performance measures within the public mental health system.

The Offeror's provider network shall complete the CCAR tool for mental health clients in the Program and comply with established guidelines and instructions as described in the CCAR Completion Instructions attached hereto as Attachment M. Specifically, a CCAR must be completed on Members:

- Upon admission to BHO services,
- Every twelve (12) months following admission to BHO services, and

- When there is a change in the Member's' functioning or level of care.

CCARs are not required for Members who participate only in prevention/early intervention activities and who have not otherwise accessed any Program mental health treatment services. Once a Member begins receiving mental health treatment services in the Program, a CCAR is required.

The Offeror shall submit an electronic text file of all completed CCAR tools to the Department and/or designee via a Novell Portal and secure FTP server. As Colorado moves towards greater integration of its public healthcare systems, the Department and the Colorado Department of Human Services, Division of Behavioral Health will work together to enhance the CCAR with the goal of access to better data and shared outcomes.

6. Member Satisfaction

Maximizing Member well-being and independence are the primary objectives of the Department within the given cost structure. The Offeror shall monitor Member perceptions of well-being and functional status, as well as accessibility and adequacy of services provided by the Offeror. Offerors will support DBH's efforts to collect Member satisfaction data via the statewide Mental Health Statistics Improvement Program (MHSIP) and the Youth Services Surveys for Families (YSS-F). Additional information on the MHSIP and YSS-F is available at www.mhsip.org. Offerors may also be asked to conduct a replacement survey as directed by the Department in collaboration with the DBH. The Department is considering the use of the ECHO 3.0 Adult and the ECHO 3.0 Child/Parent survey tool as part of this data collection effort.

7. Quality of Care Issues

The Offeror shall have a system for identifying and addressing all alleged quality of care concerns, including those involving physician providers, and shall take action as necessary to address all confirmed quality of care concerns. The Offeror may use the process of its professional review committee, as set forth in C.R.S. 12-36.5-104, when a quality of care concern is brought to its attention. The Offeror is not required to disclose any information that is confidential by law.

8. Quality Improvement Committee

The Offeror shall have a mechanism in place for its Quality Improvement Director to participate in the Department's Behavioral Health Quality Improvement Committee (BQuIC), to provide input and feedback regarding quality improvement priorities, performance improvement topics, measurements and specifics of reporting formats and time frames, and other collaborative projects.

9. Health Information Systems

The Offeror shall maintain a health information system that collects, analyzes, integrates and reports data. The system shall provide information on areas including, but not limited to, utilization, grievances and appeals, and third party liability. The Offeror shall make all collected data available to the Department and/or designee and upon request to CMS.

10. External Quality Review (EQR)

The Offeror shall participate in annual, external independent reviews to validate performance improvement projects and performance measures and to review compliance with Department standards and contract requirements. External quality review activities shall be conducted in accordance with federal EQR regulations 42 C.F.R. Part 438 and the CMS mandatory activity protocols.

11. Annual Quality Report

The Offeror shall maintain a process for evaluating the impact and effectiveness of the outcomes, quality assessment and improvement program on at least an annual basis. The Offeror shall submit an annual report to the Department and/or designee, detailing the findings of the Program effectiveness.

12. Quality Improvement Plan

The Offeror shall develop and implement a quality improvement plan. The plan shall delineate future quality assessment and performance improvement activities based on the results of those activities in the annual report. The plan shall integrate findings and opportunities for improvement identified in studies, performance outcome measurements, enrollee satisfaction surveys and other monitoring and quality activities. The plan is subject to the Department and/or designee's approval.

OFFEROR'S RESPONSE:

The Offeror's proposal shall describe the Offeror's outcomes, quality assessment and performance improvement program, as well as the mechanisms for meaningful Member and family community involvement in the quality assessment and performance improvement program. The Offeror should include a description of its efforts to promote health information exchange (between Offeror and Department, Offeror and providers, providers to providers, and providers to acute care facilities and social services) within the limitations of 42 CFR Part 2. The Offeror must attest that it will collaborate and negotiate with the Department in good faith regarding the final structure and implementation of agreed upon performance measures and incentives.

G. COMPLIANCE AND MONITORING

The Offeror shall have a system for ensuring compliance with Program rules, requirements, and confidentiality regulations. The system shall include mechanisms for conducting utilization management, program integrity and compliance reporting activities as well as the submission of encounter data and maintenance of records. All aspects of the system shall be focused on providing high quality, medically necessary services in accordance with contract requirements.

1. Utilization Management

The Offeror shall establish and maintain a utilization management program to monitor access to and appropriate utilization of covered services. The program shall be under the direction of an appropriately qualified clinician. Utilization determinations shall be based on written criteria and guidelines developed or adopted with involvement from practicing providers or nationally recognized standards. The utilization management process shall in no way impede timely access to services. Minimum utilization management policies and procedures are included in Attachment N of this RFP.

2. Program Integrity

The Offeror shall have a mandatory compliance plan and administrative and management arrangements or procedures designed to prevent and detect fraud, abuse and misuse of Medicaid funds and resources. The Offeror shall report possible instances of Medicaid fraud to the Department within contractual timeframes. The Offeror shall describe how frequently, and by what method, it shall assure that Providers' CPT billing accurately reflects the level of services provided to clients so that there is no intentional or unintentional upcoding or miscoding of services.

3. Encounter Data

The Offeror shall submit encounter data to the Department and/or its designee on all State Plan and 1915(b)(3) Waiver (Alternative) services. The Offeror shall submit data certifications for all data utilized for the purposes of rate setting (42 C.F.R. 438.604 and 438.606). Data certification shall include certification that data submitted is accurate, complete and truthful, and that all "paid" encounters are for covered services provided to or for enrolled Members.

Currently, contractors are required to submit encounter data in two formats: ANSI ASC X12N 837 and flat file format. Ideally, the encounter data submitted in 837 file format mirrors the data submitted in flat file format in type and number of encounters. At some point in the future, the Department may choose to eliminate the requirement for flat file data submission, but for the purpose of this RFP, data submittal in both file formats is required.

The Offeror shall either demonstrate or contract for knowledge and experience with the Electronic Data Interchange (EDI) of ANSI ASC X12N 837 formatted encounter data for these submittals. Detailed format information for the ANSI 837 transaction is available at www.wpc-

edi.com. HIPAA companion guides to prepare systems to work with the Colorado Medicaid program and details of acceptable Colorado Program values can be found at:

http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1218102958082. Data submission must comply with the federal confidentiality requirements of 42 CFR Part 2, and may require the development of Qualified Service Organization Agreements (QSOA).

The Offeror shall submit encounter claims data to the Department or its designee in 837 format for submittal to the Medicaid Management Information System (MMIS) on a monthly basis, no later than thirty (30) calendar days following the data collection month. In addition, the Offeror shall submit encounter data to the Department on a quarterly basis in a flat data file format. These files are due no later than sixty (60) calendar days following the data collection quarter.

The Department reserves the right to change format requirements at any time, following consultation with the Offeror and retains the right to make the final decision regarding format submission requirements.

4. Compliance Reporting

The Offeror shall have a mechanism to systematically track, monitor and report all information requested in the draft contract as summarized in the Compliance Reporting requirements included in draft contract Exhibit R.

5. Maintenance of Records

The Offeror, subcontractors and contracted providers shall maintain a complete file of all records, documents, communications and other materials which pertain to the operation of the Program or the delivery of services under this contract sufficient to disclose the nature and extent of services/goods provided to each Member. All such records, documents, communications and other materials shall be maintained for six (6) years as required in the draft contract.

OFFEROR'S RESPONSE:

The Offeror's proposal shall describe its proposed compliance plan, including what efforts routinely will be made to detect fraud, how it will be investigated, what resources will be utilized to investigate possible fraud and abuse, and the qualifications of staff assigned to these functions. If this responsibility will be delegated, please describe to whom it will be delegated and provide the same information for that individual or entity. In addition, the Offeror's proposal shall describe how the Offeror proposes to conduct compliance and monitoring activities, in compliance with 42 CFR Part 2, and meet data submission, compliance reporting and maintenance of records requirements. The Offeror's proposal shall also describe its process for addressing deficits and systemic issues identified through compliance monitoring, trends identified in reporting and trends/concerns identified by grievances received from Members.

H. REIMBURSEMENT AND RATES

Rate Setting Methodology

Behavioral health capitation rates are set in conformance with federal regulations found at 42 CFR 438.6(c)(1)(i). The Department contracts with an independent actuary to prepare and certify actuarially sound rate ranges and Department contracts for rates within the rate ranges. The actuary uses primarily historical expenditure and practice patterns as the basis for certification. The certification document and rate book is attached as Attachment O. The Department envisions substantial evolution in its rate setting methodology based upon program improvements and enhancements and rate reforms consistent with State Auditor recommendations and in collaboration with DBH. Significant changes are not anticipated until at least the first renewal year of the new contract.

Actuarially sound rates are calculated by category of eligibility and geographic/BHO region. For fiscal year 2008, rates were developed primarily using a blend of the encounter-based and historical-based rates, with the encounter data weighted thirty percent (30%) and historical data weighted seventy percent (70%) to develop the per capita rates. For fiscal year 2009, rates were developed using an adjusted blend of encounter- and historical-based rates, with encounter data weighted thirty-five percent (35%) and historical data weighted sixty-five percent (65%). The encounter-based component of the rate uses Medicaid fee-for-service pricing for determining the unit cost assigned to each encounter. This includes the cost-based fee-for-service reimbursement methodology for the community mental health centers, which make up over half of encounters submitted in the previous few years. We expect that future rate development will give greater weight to the encounter data component.

Other factors that may be used to calculate rates include, but are not limited to, audited financial report data, administrative expenses, inflationary factors, and any other managed care specific adjustments required by the State. Managed care specific adjustments may include but are not limited to adjustments for incurred but not reported (IBNR) encounters, data smoothing, risk adjustment, and policy changes.

Annualized trend adjustments are applied to historical data to project capitation rates into the following fiscal year. Trend is calculated using historical fee increase data, audited unit cost increase data, and any changes in utilization that may occur over time. The trend is then applied to the encounter rates and historical rates to derive the base rate for the future time period.

Performance incentive payments will be partially or wholly funded by reductions in capitation rates. However, rates will remain within actuarially sound rate ranges calculated by the Department's actuaries.

Offerors will also need to procure the services of an actuary to certify that the rate ranges proposed in the RFP comply with all federal and state laws and regulations, including the federal regulation that requires rates to be actuarially sound. Offerors also certify that the rates are sufficient and adequate to provide for the financial soundness of the contractor.

I. CONTRACTOR TRANSITION PROCESS

1. Transition at the termination or expiration of a contract resulting from this RFP

In the event that an Offeror is terminated or its contract expires, the Offeror shall provide services through the end of the contract term and pay for all covered services for all Members for the period for which monthly prepayment has been received prior to the date of contract termination. The Offeror shall provide the Department and/or its designee with all materials and information related to the Program, Members and the services provided to those Members, to ensure a smooth transition to a follow-on contractor and uninterrupted services. The Offeror shall notify all Members who have received services within the past year of the upcoming transition. The notification shall be approved by the Department and shall be developed in conjunction with a follow-on contractor, if applicable.

The Offeror shall submit for approval a detailed plan for the transition of its Members to a follow-on contractor which includes the schedule for key activities and milestones.

The Offeror shall:

a. Make provisions for continuing all management and administrative services and the provision of direct services to Members until the transition of all Members is completed and all other requirements of the current contract are satisfied.

b. Designate a person with appropriate training to act as the transition coordinator. The transition coordinator shall interact closely with the Department and the staff from the follow-on contractor to ensure a safe and orderly transition.

c. Provide all reports set forth in this Agreement and necessary for the transition process. This includes providing to the Department, until the Department is satisfied that the Offeror has completed all outstanding obligations, the following additional reports. These reports shall be due on the fifth (5th) day of each succeeding month for the prior month.

    i. Monthly claims aging report by provider/creditor including IBNR amounts;

    ii. A monthly summary of cash disbursement; and

    iii. List of all outstanding obligations necessary to complete the contract.

d. Notify subcontractors of contract termination or expiration as directed by the Department.

e. Notify all Members that the Offeror will no longer serve as the Member's managed care organization. The Offeror shall be financially responsible for all costs associated with this notification. The notification is subject to Department approval.

f. Notify each Participating Provider in writing that the Offeror's contract with the Department has ended. The written notice shall include the contract end date and shall explain to the Participating Provider how the provider can continue participating in the Medicaid program. The Offeror shall be financially responsible for all costs associated with this notification. The notification is subject to Department approval.

g. Complete payment of all outstanding obligations for covered services rendered to Members. The Offeror shall cover continuation of services to Members for the duration

of the period for which payment has been made, as well as for inpatient admissions up until discharge.

h. Cooperate with a follow-on managed care organization during transition period including, at minimum, sharing and transferring Member information and records. The Department will notify the Offeror with specific instructions and required actions at the time of transfer.

i. Return any funds advanced to the Offeror for coverage of Members for periods after the contract end date to the Department within thirty (30) calendar days of the expiration or termination of the contract.

j. Supply all information necessary for reimbursement of outstanding claims.

k. Provide the Department, in a format prescribed and approved by the Department:

   i. A list of each Participating Provider, including Providers who are not contracted with the Department;

   ii. A list of Members who are receiving case management services;

   iii. A list of all services requiring Offeror prior authorization; and

   iv. A list of all Members receiving prior authorized services, the approved duration of which extends beyond the contract termination date.

2. Implementation of contract resulting from this RFP

a. Transition Period

Transition period shall be from the final execution of the contract until July 1, 2009. During the transition period, a successful Offeror which is not an incumbent contractor (new contractor) shall prepare to perform the services required under the terms of the contract and shall collaborate with the Department to effectuate a seamless transition with the incumbent contractor in order to prevent interruption of services and promote continuity of care to Members. Upon final execution of the contract, the Department and any new contractor shall immediately collaborate to:

   i. Define project management and reporting standards;

   ii. Establish communication protocols between the new contractor, the Department, and the incumbent managed care contractor and providers for the service area;

   iii. Establish an implementation plan that includes the schedule for key activities and milestones; and

   iv. Define expectations for content and format of contract deliverables.

b. Transition Plan

Following execution of the contract, the new contractor shall develop a comprehensive written implementation plan to monitor progress throughout the transition periods. The new contractor shall submit the implementation plan to the Department for review and approval no later than thirty (30) calendar days prior to the date the first Member is assigned to the new contractor's Plan.

No later than thirty (30) calendar days prior to the date the first Member is assigned to the new contractor's Plan, the new contractor shall designate its key personnel and shall submit to the Department updated organizational charts and the resumes of each key personnel position for Department approval. The new contractor shall have sufficient personnel working and operating during the transition period to successfully prepare to be fully compliant with the terms of the contract on July 1, 2009.

The new contractor shall include in the Implementation Plan a detailed description of its implementation methods, staff assigned to be accountable for completing tasks and timetables, including, at a minimum, the following components:

i. Human resource and staffing plan;

ii. Facilities acquisition and installation plans;

iii. Customer service plan;

iv. Telephone systems plan;

v. Data systems plan, including hardware and equipment acquisition and installation, operating system and software installation, and file installation;

vi. Website development plan;

vii. System readiness testing and acceptance testing plan and a data conversion plan to include, at a minimum, intake, closure, eligibility, demographics, encounters, and other file data;

viii. Network development plan, including analysis and plans to effect a smooth transition;

ix. Clinical services transition, or service continuation;

x. Pending grievance, appeal, and customer service case transition;

xi. Quality management/utilization management plan;

xii. Security, business continuity, disaster recovery, and contingency plan;

xiii. Communication plan that includes a plan to communicate with Members, family members, and other stakeholders regarding the transition;

xiv. Communication and transition plan with any existing managed care contractors and providers;

xv. Plan to meet other administrative start-up requirements;

xvi. Transfer of electronic data and records;

xvii. Transfer of hard copy records;

xviii. Budget plan for transition expenses, including contractor travel, personnel;

xix. Member Handbook and Provider Manual completion;

xx. Claims and eligibility interface development;

xxi. Compliance plan;

xxii. Financial reporting plan;

xxiii. Pricing of encounters;

xxiv. Orientation and training plan; and

xxv. Post-implementation deliverables.

The new contractor shall provide the Department with verbal and written Implementation Plan updates and shall cooperate and communicate with the Department to resolve transition and implementation issues to the Department's satisfaction.

3. Operational and Financial Readiness Review

Prior to and subsequent to the first Member enrollment, the new contractor shall cooperate with the Department to assess the new contractor's readiness and ability to provide covered services to new and transferring Members and to resolve any identified operational deficiencies.

Upon Department request and approval, the new contractor shall develop and implement a corrective action plan in response to deficiencies identified during the readiness review. The new Contractor shall receive new and transferring Members only if the readiness review factors and corrective action plan requirements are met to Department's satisfaction.

At a minimum, the new contractor shall cooperate with Department to review the following areas:

a. Network sufficiency and management including reviews of subcontracts;

b. Adequacy of staffing;

c. Customer service;

d. Quality management/utilization management;

e. Financial management;

f. Information processing and system testing;

g. Transition of Members;

h. Routine communications with transferring Members;

i. Continuity of care for transferring Members; and

j. Continuity of pending grievance, appeal, and customer service cases.

J. ADDITIONAL BENEFIT/SERVICE OPTIONS

The Department is seeking funding for each of the options described in this section. These options represent additional services and benefits that either have not previously been included in the Program or were included to a lesser extent. If funding is appropriated, budgeted and otherwise made available, it is expected that the Department will exercise the options at the earliest opportunity in accordance with the option clause in the contract. The Department reserves the right to unilaterally exercise any or all options, or may determine not to exercise any option, during the initial contract term or during one of the four (4) renewal years, in the sole discretion of the Department. If funding is available prior to the final execution of the contract, the Department reserves the right to exercise any or all options by the inclusion of the optional work in the original contract. If funding is made available during the initial contract term or during a subsequent state fiscal year, the Department reserves the right to exercise any or all options when funding is available. Services described in each option below shall be performed in accordance with the statement of work and under the same terms and conditions as the base work described in this RFP. Should anticipated funding not be received, Offerors agree to negotiate in good faith with the Department on necessary contract modifications.

1. Substance Use Disorder Outpatient Benefit – Option #1

The Department currently provides a limited fee-for-service outpatient substance use disorder benefit for Medicaid Members, administered in cooperation with the DBH. A limited inpatient rehabilitation benefit for adolescent Medicaid Members with substance use disorders is also provided under Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT).

Research has shown that providing integrated substance use disorder treatment and mental health treatment to individuals with co-occurring disorders is significantly more effective than providing each in isolation.

This option adds the current Medicaid fee-for-service outpatient substance use disorder benefit to the BHO services. Outpatient substance use disorder services shall be managed by the Offeror for Medicaid Members with a covered substance use disorder (listed in Attachment G2) whether or not the individual has a co-occurring mental illness diagnosis. Services shall be included in the category of mandatory State Plan services.

The Department expects that individuals seeking substance use disorder treatment only would continue to utilize the same provider network as under the current fee-for-service benefit.

Individuals without a co-occurring mental health diagnosis shall not be required to access the mental health system provider network to obtain substance use disorder services. However, mental health screening shall be provided to all Members accessing substance use disorder services. Special Connections, a program for pregnant women on Medicaid who have substance use disorders, will not be included in the Program.

Each Member seeking services shall have an individualized service plan, developed by the Member and/or the designated Member representative and the Member's provider or treatment team. Substance use disorder treatment plans and reviews shall comply with DBH Substance Use Disorder Treatment Rules.

At a minimum, the Offeror shall extend contract offers to the current Medicaid provider network for these services. Offerors are encouraged to offer contracts to other eligible providers or provider networks that may fit with their service delivery model.

Approved services shall be provided by a practitioner or facility with a substance use disorder provider specialty type. Qualified providers are:

a. Facilities licensed by the DBH

b. Licensed physicians

c. Licensed non-physicians to include Psychologists, Nurse Practitioner, Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist, and Licensed Professional Counselor (LPC).

The above licensed physician and non-physician practitioners shall also be certified or licensed addiction counselors with the following credentials:

a. Certified or Licensed Addiction Counselors (CAC II, CAC III or LAC) by the Department of Regulatory Agencies (DORA),

b. Certified by the National Association of Alcohol and Drug Abuse Counselors (NAADAC) as an NCAC II or MAC, or

c. Licensed physicians who are also certified in Addiction Medicine by the American Society of Addiction Medicine (ASAM).

Services available under this benefit are limited to:

a. Substance Use Disorder Assessment. An evaluation designed to determine the most appropriate level of care, based on criteria established by the American Society of Addiction Medicine (ASAM), the extent of drug/alcohol use, abuse or dependence and related problems, and the comprehensive treatment needs of a Member with a drug/alcohol diagnosis.

b. Individual and Family Therapy. Therapeutic substance use disorder counseling and treatment services with one Member per session. Family therapy must be directly related to the Member's treatment for substance use, abuse and/or dependence.

c. Group Therapy. Therapeutic substance use disorder counseling and treatment services with more than one Member of up to and including three hours per session.

d. Alcohol/Drug Screening. The collection of urine to test for the presence of alcohol and/or drugs. Substance use disorder counseling services are provided along with screening to discuss results with Member.

e. Targeted Case Management. Medically necessary coordination and planning services provided with or on behalf of a Member with a substance use disorder diagnosis. Services may include service planning, advocacy and linkage to other medical services related to substance use diagnosis, monitoring and care coordination.

f. Social/Ambulatory Detoxification. Services are provided on a residential basis, excluding room and board, by a facility that has DBH licensure. Includes supervision, observation and support for individuals whose intoxication/ withdrawal signs and symptoms are severe enough to require a twenty-four (24) hour supervised program but do not require hospitalization.

g. Inpatient Rehabilitation Services for Youth. Therapeutic inpatient rehabilitation program, including ongoing multi-level assessment, individual and family therapy, psycho-educational and experiential therapeutic group, aftercare planning, and case management. While not a covered service for all Members with substance use diagnoses and no co-occurring mental health diagnosis, this service will now be provided to youth, if medically necessary, under EPSDT.

Principles of effective treatment of substance use disorder are available on the National Institute on Drug Abuse, National Institutes of Health, US Department of Health and Human Services website at: http://www.drugabuse.gov/PODAT/PODAT1.html.

The following evidence-based or promising practices relating to substance use disorders will be added to the baseline services list of adult evidence-based and promising practices described in Section VI.C.3 of this RFP.

a. Motivational Interviewing for Substance Use Disorder or Co-occurring Populations – Motivational interviewing refers to a counseling approach in part developed by clinical psychologists Professor William R. Miller, PhD, and Professor Stephen Rollnick, PhD. It recognizes and accepts that clients who need to make changes in their lives approach counseling at different levels of readiness to change their behavior. Motivational interviewing is non-judgmental, non-confrontational and non-adversarial. The approach attempts to increase clients' awareness of the potential problems caused, consequences experienced, and risks faced as a result of their behavior.

b. Seeking Safety – Seeking Safety is a present-focused therapy to help people attain safety from trauma/PTSD and substance abuse. It may be conducted in group and individual format; for women, men, and mixed-gender; and in a variety of settings.

c. Matrix Intensive Outpatient Program for the Treatment of Stimulant Abuse – The Matrix model intensive outpatient treatment was developed with an awareness of the diversity of factors that contribute to drug and alcohol problems. To produce the best opportunity for success, the needs of the individual client are considered in the design of each treatment plan.

Drug and Alcohol Coordinated Data System (DACODS) is a data collection instrument that collects clients' specific data at admission and discharge from substance use disorder detoxification and substance use disorder treatment. It is used throughout the Colorado public substance use disorder treatment system to record client characteristics and accomplishment of goals in treatment, and to collectively calculate performance measures within the public substance use disorder treatment system.

The Offeror shall utilize DACODS for all substance use disorder clients in the Program and comply with established guidelines and instructions. DACODS data shall be gathered at admission and discharge for each client receiving substance use disorder treatment or detoxification in the Program, using the procedures described in the DACODS Manual.

DACODS information shall be entered directly into DBH's Treatment Management System (TMS) web portal.

Substance Use Disorder Benefit Effectiveness

C.R.S. 25.5-5-313 states that on or before January 1, 2011, the Colorado state auditor shall submit a report to the legislative audit committee analyzing the costs and savings to the medical assistance program of providing outpatient substance abuse treatment. The Offeror shall implement a process for evaluating the effectiveness of the outpatient substance use disorder services provided under this benefit and its impact on the Member, including measures for service quality, effectiveness and member satisfaction. The Offeror will also be required to ensure timely submittal of encounter data for use in monitoring and cost analysis.

OFFEROR'S RESPONSE:

The Offeror shall describe how it will assist the Department with the successful integration of the outpatient substance use disorder benefit into the Program, including how services will be incorporated smoothly so that no service break occurs for Members who currently access substance use disorder services only. Responses should include the process by which Members who have a substance use diagnosis only may access these services without being required to participate in the mental health services provider network or treatment locations, but will still be screened for any potential co-occurring mental illness. Responses should also include the Offeror's plan for identifying Members with co-occurring mental illness and substance use disorders and how they will be served. Offeror shall attest to its willingness to offer contracts to eligible service providers who are not already in the BHO or Medicaid provider networks.

2. Enhanced Care Coordination Services – Option #2

The Department seeks to align the Program more closely with current trends in behavioral health services, including increased responsibility of its contractors for care coordination services. Care coordination includes the coordination of all care, including non-medical care, affecting an individual's health and well-being (e.g. providing connection to community housing, child care, long-term care, and employment resources). Offerors may wish to refer to the February 2008 SAMHSA report on "Reimbursement of Mental Health Services in Primary Care Settings"

available online at *http://download.ncadi.samhsa.gov/ken/pdf/SMA08-4324/SMA08-4324.pdf* for additional information.

Enhanced care coordination may be accomplished in a variety methods and settings, but in all cases requires consistent communication of health care information to all involved parties, using the required, valid Releases of Information.

The Offeror shall provide the level of service described below, which exceeds that required under the baseline services described in this RFP. The Offeror shall comply with federal regulations in 42 CFR Part 2 pertaining to the confidentiality of any substance use disorder treatment information, which are stricter than either mental health confidentiality requirements or HIPAA requirements. Regulations in 42 CFR Part 2 protect all information about any person who has applied for or been given diagnosis or treatment for alcohol or drug abuse at a federally assisted program. See 42 CFR §2.11 (definition of a "patient"). Former clients and deceased clients are protected under both Part 2 and the HIPAA Privacy Rule. See 42 CFR §§2.11 and 2.15 and 45 CFR §§164.501 and 164.502(f).

The Offeror shall promote and assure service accessibility, attention to individual needs, continuity of care, and maintenance of health at the highest level possible. Appropriate information exchange between providers is expected to reduce duplication and improve outcomes.

a. The Offeror shall coordinate with any other medical and behavioral health plans that are providing services to the Member.

b. The Offeror shall coordinate the healthcare delivery system for Medicare-eligible Members so that such Members can simultaneously receive care from network providers who are Medicare-approved. In the event that the network has few or no Medicare-approved providers, the Offeror shall coordinate out-of-network care with Medicare-approved providers.

c. The Offeror shall be knowledgeable of all Department HCBS Waiver programs, EPSDT benefits and services, and Medicaid wrap-around benefits and services and coordinate with these programs and services as needed.

d. The Offeror shall require its providers to identify whether a behavioral health Member has a primary care physician/practitioner and encourage and assist the individual to engage in primary care. The Offeror shall require its subcontractors and qualified service providers to share information with the behavioral health Member's primary care physician/practitioner and promptly communicate relevant information in accordance with governing regulations concerning confidentiality and sharing of mental health and substance use disorder treatment information.

e. The Offeror shall assist behavioral health Members with establishing a relationship with and making use of their primary care physician/practitioner for preventive, routine, and urgent care. In addition, the Offeror shall have a process to ensure that behavioral health Members who have urgent or emergent medical needs have access to urgent care and

emergency medical services. The Offeror shall not exclusively rely upon hospital emergency rooms to fulfill this requirement.

f. The Offeror shall collaborate with Colorado Medicaid Health Plans to address integration of mental health, substance use disorder, and primary care service delivery at the system level. The Offeror shall designate a "Health Plan Liaison" or similar position to work with the health plans and any other involved entities on complex cases and overall coordination issues.

OFFEROR'S RESPONSE:

Offeror shall describe how it will address the optional care coordination requirements described above and explain how they will coordinate with the care coordination proposed with the baseline RFP services.

3. Prevention/Early Intervention Services – Option #3

Prevention/early intervention services are included in the current contract as Section 1915(b)(3) waiver services. Based on an analysis of encounter data submitted for this category of service, the Department has determined that the primary allocation of costs and focus of these services is on existing clients, i.e. Members who have already accessed behavioral health services. Examples of these types of services include education focused on relapse prevention and symptom management, nutritional and exercise classes to promote healthy lifestyles, and supportive housing services.

The Department seeks to expand the type, volume and focus of these services under a new administrative requirement. Offerors shall provide screening, outreach and other activities designed to identify and serve at-risk populations within the service area who are not already accessing covered services. Services may be population-based, may include proven media, written, peer, and group interventions, and are not restricted to face-to-face interventions.

The contractor shall utilize a budgeted amount equal to three-quarters percent (.75%) of capitation payments to engage in activities to reduce the risk of development or emergence of behavioral health disorders, to improve overall behavioral health in targeted populations and communities, and to facilitate referrals for covered behavioral health services for persons with identified needs. However, the Offeror is permitted to expend greater than this allotted amount to address prevention/early intervention and associated behavioral health problems. In addition to the above outcomes, the Department anticipates that these services will result in increased penetration rates and provide support for required contractor performance measures.

Prevention/early intervention activities shall be accessible to culturally and linguistically diverse individuals, including the deaf and hard of hearing community. Proposed services must distinguish between child/youth and adult populations. A covered diagnosis will not be required to receive services in this category. The Offeror shall submit a quarterly report detailing the type, location, amount and costs of prevention/early intervention services.

Prevention/early intervention services should be proposed for this option only to the extent that the Offeror can demonstrate that the services will be limited to Medicaid eligibles. For example,

public information campaigns and broad-based community outreach are likely to reach audiences beyond the universe of Medicaid eligibles. The Department assumes that it would be difficult for the Offeror to demonstrate which portion of these services would be attributable to Medicaid eligibles. Member mailings, IVR, and primary care office visit screenings are examples of acceptable programs.

OFFEROR'S RESPONSE:

The Offeror's proposal shall include its plan for providing prevention/early intervention activities to Members in its service as described above, including type, location, volume and target populations to be outreached. The proposal shall also include the mechanisms by which the Offeror intends to measure the effectiveness of prevention/early intervention services overall and with its targeted populations.

VII. OFFEROR'S RESPONSE FORMAT

A. GENERAL INSTRUCTIONS

The Department will select a contractor for each of the five geographic service areas. Offerors may propose to provide services in one or more geographic service areas. A separate, complete, and unlinked proposal must be submitted for each geographic service area. If any element of a proposal for one geographic area is linked to a proposal for another geographic area, the Offeror's proposal may be cause for the proposal to be rejected.

Each Offeror shall submit one (1) hard copy original, clearly marked, twelve (12) exact hard copies and one (1) electronic copy on a CD of the Technical Proposal for each geographic service area for which it is submitting a proposal. In addition, each Offeror shall submit one (1) hard copy original, clearly marked, twelve (12) exact copies and one (1) electronic copy on a CD of a Cost Proposal for each geographic service area proposed. Electronic copies of both the Technical and the Cost proposals on CD must be created with MS Word or Excel, but may be submitted in Adobe Acrobat format.

The Offeror shall submit each hard copy of the proposal in a three-ring binder, which allows the Department to easily incorporate updated pages into the original proposal. The Technical and Cost proposals may be submitted in the same package, but must be in separate binders.

The Technical Proposal binder shall include the Transmittal Letter, "State of Colorado Department of Health Care Policy and Financing Request for Proposal Signature Page" (the "RFP Signature Page", (see Attachment R), W-9, Executive Summary, and the Technical Proposal. The official name of the Offeror's organization, the RFP number, RFP title, and "Original" or "Copy" must appear on the outside of the front cover of each binder.

Proposals must be submitted in a sealed package, with the following information clearly labeled on the outside of the package:

> OFFEROR'S NAME
>
> RFP #HCPFKQ0906BHOR, Operation of the Colorado Medicaid Community Mental Health Services Program
>
> PROPOSALS DUE: Wednesday, February 18, 2009 at 3:00 PM (MT)

No reference shall be made to any pricing information or elements of cost within the Transmittal Letter, Executive Summary or the Technical Proposal. If any element of pricing or cost is referred to in the Transmittal Letter, Executive Summary or Technical Proposal, the Offeror's proposal may be rejected.

Offerors shall provide all information requested in the proposal. Proposals shall:

1. Use standard 8 ½ by 11- inch paper;
2. Use 12-point font;

3. Number all pages of the Technical Proposal consecutively from start to finish (not required for appended materials, the Transmittal Letter, Executive Summary or RFP Signature Page). The Cost Proposal shall be numbered consecutively for all pages from start to finish (not required for appended materials).
4. Include a Table of Contents in the proposal for each binder. The Table of Contents shall list each major section of the proposal, which corresponds to the sections of the RFP.
5. Include tabs that are keyed to the Table of Contents to separate each major section of the proposal.

Offerors may propose to provide services in more than one geographic service area, but must submit separate, complete, and financially unlinked proposals for each geographic service area.

The Offeror shall adhere to the Department's required proposal format and required content. Failure to adhere to these requirements may be cause for a proposal to be rejected.

B. TRANSMITTAL LETTER - PAGE LIMIT: FOUR (4) PAGES

The Transmittal Letter shall be brief and signed by an individual authorized to commit the Offeror to the services and compliance with requirements and fees stated in the Offeror's proposal, for the initial contract period and renewal years. The Transmittal Letter shall not exceed four (4) pages.

The Offeror shall submit a Transmittal Letter for each proposal that it submits on its official business letterhead. The Transmittal Letter shall address the following required provisions:

1. Positively states the Offeror's willingness to comply with all requirements described in the RFP, general concept requirements and other terms and conditions specified in this RFP.
2. Positively states that by submitting a proposal, the Offeror affirms its willingness to enter into a contract substantially similar to the terms to the Draft Contract, published with this RFP as Attachment A.
3. A statement that the submitted proposal shall remain a firm offer for one hundred eighty (180) calendar days after the proposal due date or until the contract is fully executed, whichever comes first.
4. Description of the Offeror's form of business organization (i.e. partnership, non-profit corporation, Colorado Corporation, Non-Colorado Corporation, etc.) and its home state. Non-Colorado corporations must register with the Colorado Secretary of State as a foreign corporation to conduct business in Colorado. Any foreign corporation, limited liability company, or limited liability partnership must affirm that it currently has a Certificate of Good Standing or Certificate of Existence to do business in Colorado. .
5. Disclosure of all current or pending contracts with the State of Colorado and all bids or proposals submitted to the State of Colorado but not yet awarded.
6. Acknowledges receipt of all modifications to this RFP.

7. Identifies all actual, apparent or potential conflicts of interest related to the services described in this RFP and any resultant contract. The conflicts of interest may be personal or organizational. If an actual, apparent or potential conflict of interest exists, include a plan to mitigate the conflict of interest. If a conflict of interest cannot be mitigated or resolved, the proposal may be rejected.

The Offeror shall include in the Technical Proposal binder after the Transmittal Letter the RFP Signature Page, signed in ink by the Offeror, or an officer of the Offeror who is legally authorized to bind the Offeror to the proposal. The Offeror shall include a completed W-9 form after the RFP Signature Page. (NOTE: The RFP Signature Page and W-9 form will not be counted as part of the four (4) page limit for the Transmittal Letter. The Transmittal Letter, RFP Signature Page and W-9 form will not be counted as part of the two hundred and fifty (250) page limit for the Technical Proposal.)

C. EXECUTIVE SUMMARY - PAGE LIMIT: SIX (6) PAGES

The Offeror shall include an Executive Summary as part of the Technical Proposal. The Executive Summary must be factual, brief and cover the core aspects of the proposed program. The Executive Summary shall not exceed six (6) pages. (NOTE: The Executive Summary will not be counted as part of the two hundred and fifty (250) page limit for the Technical Proposal.)

D. TECHNICAL PROPOSAL - PAGE LIMIT: TWO HUNDRED AND FIFTY (250) PAGES (INCLUDING ALL APPENDICES, EXHIBITS OR ATTACHMENTS)

The Technical Proposal for each geographic area shall present a full and complete description of the qualifications of the Offeror to carry out the requirements set forth in Section III through VI, as well as the approach and methods the Offeror proposes to use in completing the work for each geographic area. The Offeror's response must describe how it proposes to meet the requirements in the RFP. Each proposal shall describe a comprehensive quality package of services and programs the Offeror agrees to provide and demonstrate the Offeror's ability as a managed care company.

The Offeror's Technical Proposal must contain all of the information requested in Sections IV through VI under "Offeror's Response" (in bold font). To aid evaluators in reviewing proposals, Offeror shall first repeat the language from the RFP that describes which section of the RFP, including the RFP section number the Offeror is responding to (e.g. "Section VI.E, Member and Family Affairs"), followed by the Offeror's response to that requirement.

The Offeror shall not assume that there will be an opportunity for revisions of proposals. The most favorable proposal shall be submitted as the Offeror's initial proposal.

The Offeror is cautioned to ensure that its proposal adequately describes its proposed program and demonstrates an understanding of the requirements. The proposal should be succinct, self-explanatory and well organized so that reviewers can understand the process that will be used to complete the requirements of this RFP. The Department does not encourage excessive responses and may disqualify proposals that exceed the page limit. Tabular or graphical presentations may

be incorporated in the text of the proposal response or separate attachments. However, evaluators cannot be expected to comprehend all material in attachments whose content and relevance to the proposal description are not clearly integrated into the proposal.

The Technical Proposal shall not exceed two hundred fifty (250) pages, including all appendices, exhibits or attachments. Standard commercial brochures or Member handbooks that are attached as appendices, exhibits or attachments **will be counted** against page limitations.

No reference shall be made to any pricing information or elements of cost within the Transmittal Letter, Executive Summary or the Technical Proposal. If any element of pricing or cost is referred to in the Transmittal Letter, Executive Summary or Technical Proposal, the Offeror's proposal may be rejected.

E. COST PROPOSAL - PAGE LIMIT: NONE

Compensation: The Offeror shall submit a price proposal that includes a statement that certifies the Offeror's willingness and ability to perform the work described within the RFP and the Offeror's proposal for the rates identified in Attachment O-1 for the proposed geographic service area. Offerors should be aware that the Governor has proposed reducing Program capitation rates by three percent (3%), to the median of the actuarially sound rate range, as part of statewide budget cuts. Although final approval of this reduction has not occurred yet and the final rates may vary from these rates, Offerors shall base their proposals on the revised rates. The new rates are provided in Attachment O-1. The new rates are at the median of the actuarially sound rate range. If any Offeror fails to demonstrate this willingness, the Offeror's proposal shall be disqualified.

Budget: The price proposal shall include two program budgets for the initial contract period, July 1, 2009 through June 30, 2010. One program budget shall include only the base RFP requirements (excluding Options); the second program budget shall include the base RFP requirements and all three Additional Benefit/Service Options. The program budgets shall include expected revenues and expenditures in sufficient detail to determine the cost of providing the services described in the Offeror's proposal. The budgets shall be submitted in the template formats provided in Attachment P of this RFP and shall include both a summary and a descriptive narrative.

The Cost Proposal must contain a statement that the Offeror has the financial strength to maintain this contract. Include as an attachment to the Cost Proposal true copies of the Offeror's most recent audited annual financial statements. These statements must include a balance sheet and revenue statements for a reasonable number of previous years. The Offeror must submit one of the following (in order of preference):

1. An audited financial statement; or

2. A financial statement reviewed by a certified public accountant; or

3. A third-party prepared financial statement if an audited or reviewed statement is not available; or

4. Another financial statement prepared in the routine course of the Offeror's business.

This information will be used to assist the Department in making its determination of successful Offeror responsibility in accordance with C.R.S. 24-103-401.

The statements must have been prepared by a Certified Public Accountant and meet the Generally Accepted Accounting Principle standards.

VIII. PROPOSAL EVALUATION

A. EVALUATION PROCESS

The evaluation of proposals will result in a recommendation for award of a contract under this RFP for each of the five geographic service areas. The award will be made to the Offerors whose proposals, conforming to the RFP, will be most advantageous to the State of Colorado, price and other factors considered.

The Department will conduct a comprehensive, thorough, complete and impartial evaluation of each proposal received. First, all proposals will be reviewed by the HCPF Contracts and Purchasing Section for acceptance. The HCPF Contracts and Purchasing Section will be responsible for ensuring that: 1) The Offeror's proposal complied with the due date and time; 2) The Offeror's "State of Colorado, Department of Health Care Policy and Financing, Request for Proposal Signature Page" meets requirements; 3) The Offeror included the appropriate number of proposal copies; and 4) The Offeror was registered with the State of Colorado's BIDS web site prior to the due date and time.

Proposals will then be evaluated by the Evaluation Committee for whether the mandatory minimum requirements have been met. The Technical and Cost Proposals that meet the mandatory minimum requirements will be evaluated by the Evaluation Committee using the evaluation criteria listed below. Criteria will be weighted as stated in the table below to reflect relative importance. The number of points given for each criterion will be based on the evaluator's assessment of the response, how the responses meet the requirements of the RFP, and whether required statements and submissions were provided. The optional services will be evaluated as part of the total proposal.

The Evaluation Committee may, if it deems necessary, request clarifications, conduct discussions or oral presentations, or request best and final offers; however, it may proceed to an award recommendation without any of these activities. Offerors selected to participate in these activities would be those which, based on the scores, are reasonably susceptible of being selected for award. The Evaluation Committee may adjust its scoring based on the results of such activities, if any. However, proposals may be reviewed and determinations made without such activities and Offerors should be aware that the opportunity for further explanation might not exist. Therefore, it is important that proposals are complete.

The Committee will then make an award recommendation subject to the final approval of HCPF's Procurement Director. Upon review and final approval of the Evaluation Committee's

recommendation for award, the HCPF Procurement Director will issue a "Notice of Intent to Make an Award" letter that will be sent to all Offerors, announcing the Department's intent to make an award to the selected Offeror. At approximately the same time, a notification of the award is published on the Colorado BIDS web site.

Failure of a proposal to comply with the requirements of this RFP may result in the proposal being disqualified as a non-responsive proposal.

B. PROPOSAL EVALUATION CRITERIA

The evaluation committee will use the following criteria in evaluating the proposals and recommending an award:

General Requirements - MANDATORY	Met/Not Met
Licensing and PIHP Requirements	
Managed Care Experience	
Medicaid Experience	
Continuous Quality Improvement Experience	
Management of a Project of Similar Size and Scope	
Technical Proposal Criteria	Weighting
Experience	40
Administrative and Organizational Structure	15
Quality of Proposed Key Staff	15
Services	50
Evidence-based & Promising Practices - Adult	15
Evidence-based & Promising Practices – Child/Youth	15
Service Delivery	50
Access to Care	50
Provider Network	50
Member Service Transitions	15

Cultural Competency	25
Special Behavioral Health Populations	10
Member and Family Affairs	25
Outcomes, Quality Assurance and Performance Improvement	50
Compliance and Monitoring	30
Substance Use Disorder Services (Optional Work)	20
Enhanced Care Coordination Services (Optional Work)	20
Prevention/Early Intervention Services (Optional Work)	20
Price Proposal	
Price	Met/Not Met
Proposed Program budget	50