

**MANAGED CARE RFP CONSUMER WORK GROUP**  
**Final Summary**

The Department of Health and Human Services (DHHS) Adult Mental Health Services (AMHS) sponsored a consumer workgroup to provide input into the managed care request for proposals (RFP). Specifically in the following topic areas:

- Grievance/appeals process
- Consumer access, consumer choice, eligibility, medical necessity
  - How are these defined and put into practice in a managed care setting?
- Outcomes and performance measures
- Consumer participation and role in the structure of the ongoing work
  - Membership on MCO advisory groups?
  - Membership communication?
  - Membership education?
  - Consumer involvement in QI/QA process?
  - Staff member focused on recovery and consumer services?

DHHS-AMHS contracted with the Advocacy Initiative Network of Maine (AIN) to provide logistical support, provide preparatory information (education & resource), meeting minutes, membership recruitment, meeting co-facilitation with DHHS, and a final summary report. This project was initiated with AIN on May 5, 2006 with a completion date of May 26, 2006. 21 days to develop information guides, recruit participants, inform and educate for meaningful input to RFP language while we simultaneously held the meetings, developed minutes and summaries, has been a daunting undertaking.

In February, DHHS sponsored and AIN promoted in collaboration with GEAR, the parent network, a Managed Care Forum. Solicitation for participation was statewide using many different venues i.e. website, flyers accompanied by letters, going out to all Social Clubs and Peer Centers, agencies, and more than 400 individuals. 120 consumers and parents of children attended this forum. Participants were provided general information about managed care by Chris Koyanagi, Policy Director, Bazelon Center for Mental Health Law. Chris Zukas-Lessard, DHHS Medicaid Special Projects Manager, provided information about the status and focus of Maine's planning efforts. Opportunity to write or call in comments was also given and some of that occurred and was incorporated in the "We the People" report. We believe that that report coupled with input from the stakeholder groups where a few consumers (chosen to represent groups of consumers) have participated gives this process a comprehensive and inclusive array of input from a broad and diverse statewide population of consumers.

We were very encouraged by DHHS' decision to have a consumer managed care RFP workgroup. This work group has been comprised of three consumer representatives that currently sit on the larger managed care stakeholders group along with ten other consumers from all over the state. Department members included Leticia Huttman and Katharine Storer, Office of Consumer Affairs (OCA) representatives and Marya Faust, AMHS. Additional expertise on medical necessity and the grievance/appeals process was given by Dr. James Fine and DHHS Holly Stover and David Hutchinson.

It is important to note that it is the general consensus of this work group and the position of AIN that we neither endorse nor promote the move to a managed care system. However, there is legislation forcing this to happen. The Department has begun the work toward the transition to a managed care system. We do not see the issue of providing consumer input to this process as an option. A request for proposals is being written, it must have as careful, thoughtful, informed, and thorough consumer input, as we can provide into a process that will impact every facet of the lives of recipient's of mental health services.

The group asked for an outline/organizational chart to better understand and focus their input to the correct entity or line of authority.

Marya Faust provided a drawing<sup>1</sup> and shared with us that nothing was set in stone and the purpose of these meetings was to gather input to change/add to this making it whatever we thought it should be.

This has been an incredibly challenging endeavor. I can not help but liken this to being an electrical contractor who has been hired by investors to do the wiring to a multi-million dollar structure without a blueprint of their desired floor plan. Rather some similar floor plans that are something like what they envision but different.

That said, and acting on Marya Faust's direction, we have created a structure<sup>2</sup>, building on the drawing that Marya provided, and have written a very large part of a proposed RFP incorporating national and state expertise, consumer and other stakeholders' input from all the above sources.

We looked at the New Mexico, Arizona, and Colorado RFP's and borrowed from each. Though 98% of what we have used has come from the New Mexico RFP. The New Mexico RFP, in our opinion, contained the most detailed and clearest description of how to create a meaningful partnership with all stakeholders while planning, transitioning, and implementing a recovery oriented mental health plan within a managed care system.

The scope of New Mexico's RFP encompasses many more state agencies and funding streams than Maine is initially undertaking. It makes a great deal of sense to us that that same direction would allow for the most successful and cost-effective achievement of Maine's vision to reduce fragmentation, eliminate duplication of both administrative and mental health services, improve quality and access, while transitioning to a recovery oriented system of care.

As stated in the New Mexico RFP the "braiding" or "blending" the funding, human resources and service capacity available from the various state agencies so as to increase flexibility, maximize available resources and create a seamless single behavioral health service delivery system. This coordinated" funding and resources occurs where multiple agencies and funding streams are used to achieve related customer or system outcomes and there is cross-system collaboration to avoid duplicative services or processes. "Braided" funding is the pooling and coordination of resources from various agencies to provide needed services, while maintaining the integrity of each agency's funding stream are tracked separately, particularly where there is categorical funding.

We are not systems experts or experts in managed care. We are however the experts in our

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<sup>1</sup> Appendix : M. Faust Draft page 1

<sup>2</sup> RFP Draft Page 13

own lives and recovery. We have used or are using the Maine mental health system and our collective experience provides the evidence to our expertise in what “works”.

The following beliefs have influenced how we have determined what constitutes *consumer involvement*:

- We have our own individual cultures<sup>1</sup>, values, beliefs & “norms”
- We can best say what we need in order for our lives to be better & direct the planning for our recovery.
- We are an important part of our community.
- We deserve the opportunity to be supported by our peers, to have a safe & trusting environment in which to share our experiences, and access to current information.
- We can best impact the bias, intolerance & discrimination we experience.
- We can use our collective experience to work effectively with those who serve us & our communities.
- We can collectively create change.
- We can hold the systems with which we are involved accountable.
- Organizations driven by us can best identify our collective needs & we must be supported in our efforts by professionals, providers, communities and systems.
- Organizations driven by us share the responsibility for our involvement with other system partners.
- As we are hired by agencies, we must be supported with appropriate training & supervision and have access to peer support outside of the agencies in which we work.
- We are best able to provide training on our own topics and experiences.
- We have leadership traits & must be supported with the skills and opportunities to effectively use them.
- We have the right and the responsibility to participate in policy decisions affecting our lives.

The Managed Care RFP Work Group believes it would be important for this group to continue to be involved through the RFP writing and review process. We would propose that at least 3 of the members be included in each of those two different processes.

In an effort to be clear about our roles and our needs in this new system we used the New Mexico RFP as a framework on which to build our best effort at incorporating our vision for a truly consumer-driven recovery-oriented mental health system.

Respectively submitted by

The Managed Care RFP Consumer Work Group

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<sup>1</sup> \*"Culture" includes beliefs, norms, values, mindset, and way of looking at the world. The Surgeon General's report says: "Because there are a variety of ways to define a cultural group, (for example, ethnicity, religion, geographic region, age group, sexual orientation, or profession) many people consider themselves as having multiple cultural identities."

# Managed Care RFP Consumer Work Group Input and Draft REQUEST FOR PROPOSALS MAINE

**MAY 31, 2006**

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## **I. INTRODUCTION**

### **A. PURPOSE AND VALUES**

The State of Maine is seeking to establish a statewide system for behavioral health (BH) through the collaboration and association with a single statewide contractor. The existing behavioral health care delivery systems in Maine presents a fragmented and un-coordinated array of services via multiple funding streams and offer varying degrees of accessibility and quality of service delivery. Across Maine's multiple behavioral health care systems as a whole, there has been a decrease in or lack of development of four critical service provision areas: (1) community and home-based services for adults, children and their families; (2) the number of child psychiatrists and other critical behavioral health professionals; (3) overall capacity of behavioral management and rehabilitative services; and (4) overall capacity of case management and intensive outpatient services for adults. The promise of an array of community- and home-based alternatives to institutional care also has not materialized to the full extent that the state would have liked even though attempts have been made in the past.

The Department of Health and Human Services (DHHS) recognizes that the Adult Mental Health System is fragmented and can be difficult to navigate. Major change in the way the state, providers, and consumer organizations do business is required to move to a system that truly promotes recovery, provides good continuity of care, and gives consumers assurance that the mental health system is delivering on its commitments. The overarching goal of this plan for adult mental health services is to deliver in a coordinated way the individualized services that are needed to support recovery of adults with mental illness<sup>1</sup>.

Maine's current behavioral health services and systems have areas of excellence but are not consistently targeted toward supporting the recovery of persons experiencing mental illness or the resiliency of individuals and families who are impacted by mental illness, emotional disturbance, or substance abuse issues. Likewise, while there are high quality mental health and substance abuse service providers in Maine, there is not a consistent effort statewide to encourage and support the use and development of evidence-based and promising practices that offer the highest possibility of the best outcomes for adults, children and families. Maine's Department of Health and Human is seeking a partner to help this group of agencies implement a single behavioral health delivery system throughout Maine; implement the responsibilities bestowed upon the DHHS by LD 468 passed in the 121<sup>st</sup> Legislative Session.; and assure the best possible outcomes for the adults, children and families we serve.

The reasons for Maine's decision to move to managed care are many. Maine's system experienced the following problems that this approach is designed to help solve:

- A 15 year long Consent Decree
- Often insufficient and inappropriate services, especially a lack of attention to evidence based and promising practices and including a workforce not focused on delivery of such practices;
- Lack of common agreement about goals and outcomes with an insufficient focus on recovery and resiliency;
- Not maximizing resources across funding streams;

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<sup>1</sup> DHHS Adult Mental Health Service Plan; Consent Decree 06/30/2005

- Multiple disconnected advisory groups and processes working toward different, sometimes disconnected goals;
- Fragmentation as described in the President’s New Freedom Commission<sup>1</sup> report, that is, multiple service delivery approaches, plans, service definitions, billing processes, and reporting requirements for similar or related services;
- Duplication of effort and infrastructures at state and local levels, resulting in confusion for consumers, families, referral sources and providers;
- Higher administrative costs for providers due to multiple state approaches and multiple contracting entities or intermediaries;
- Insufficient or duplicative oversight of providers and services.

This RFP to select a single managed care organization (MCO) is one of many ways Maine is working to address these problems. This competitive procurement process is being used to select a single offeror (hereinafter the managed care organization or (MCO) that has the experience and expertise to perform the services described in this RFP with the goals of reducing the fragmentation and improving quality and access. The offeror will be required to provide the services identified in the benefit or service package and shall describe how it will ensure a smooth transition of customers from a variety of current networks and funding mechanisms into a single behavioral health system within the first year of the contract. Offerors are encouraged to read and incorporate into their offers the concepts and values evident in the concept paper and other papers, presentations and materials available on the website for this initiative at [www.maine.gov/dhhs/managed\\_care](http://www.maine.gov/dhhs/managed_care).

The purpose of this document is to solicit requests for proposals to implement the plan for the new behavioral health system, including the expectations, values and principles developed by the various stakeholders, advisors, advocates, legislators, providers, and customer and family groups for this new model in Maine. This process is intended to support the recommendations of the President’s New Freedom Commission regarding recovery and resilience. The values and principles identified to be included in the new system are as follows:

Services will be:

- Individual- (customer) centered and family-focused, based on principles of an individual’s capacity for recovery and resiliency;
- Delivered in a culturally competent, responsive and respectful manner via the most appropriate, least restrictive means, including utilization of home- and community-based settings wherever and whenever possible;
- Coordinated, accessible, accountable and of high quality;
- Evaluated with system performance and customer and family outcomes in mind; and
- Physically and programmatically accessible according to the standards of the Americans with Disabilities Act (ADA).

Services will focus on:

- Increasing customer and family abilities to successfully manage life challenges;

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<sup>1</sup> U.S. Department of Health and Human Services. Mental Health: The President’s New Freedom Commission of Mental Health – Achieving the Promise: Transforming Mental Health Care in America, Final Report July 2003 U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

- Facilitating recovery and building resilience;
- Providing integrated and community-based services following the customer-directed model whenever possible;
- Delivering services in a manner that respects regional, community and cultural differences;
- Managing care so as to utilize customer and family abilities and strengths;
- Conducting treatment in consultation with the customer and, where appropriate, his or her family or legal guardian, caregivers and other persons critical to the customer's life and well-being;
- Directing care with the involvement of the customer and family, to the extent possible;
- Providing services that are customer- and family-driven or -operated, as appropriate;
- Ensuring behavioral health wellness promotion, prevention, early intervention, treatment, community support and other activities that further recovery and resiliency;
- Basing services on evidence of effectiveness and the individual customer's and family's preferences;
- Delivering services in a manner that is sensitive to and respects diversity, including race, age, gender, disability, culture, ethnicity, spirituality, sexual identity, literacy level, place of residence and primary language;
- Providing the highest quality of care in a timely manner;
- Providing written, telephonic and electronic information that will be uniformly available to all customers and providers;
- Having mechanisms in place to ensure continuous quality improvement;
- Utilizing appropriate "person first" and "people who" language;
- Ensuring meaningful involvement of customers, family members and customer-run organizations and providers at all levels of the decision making processes concerning operations and oversight of the behavioral health service system;
- Moving toward the goal of using at least five percent (5%) of behavioral health expenditures for customer- and family-operated services;
- The non-interruption of service delivery as individuals move between correctional programs to community programs and from children's programs to adult programs; and
- Transitioning and integrating school-based health services so that health and behavioral health services delivered in the school setting are coordinated and are appropriately connected to services in the community.

In order to effectively and efficiently manage such a values-based delivery system, the selected offeror will need to establish a variety of administrative systems. To the maximum extent possible, the MCO will be expected to work with the DHHS and contracted agencies to integrate administrative systems and to streamline administrative operations among services funded by each agency under contract with DHHS. Accounting must meet the distinct requirements of a variety of funding sources. Not only must the MCO be able to manage all covered behavioral health services (including Medicaid and non-Medicaid services) as listed for mental health and substance abuse services, it must also manage and account for funding and other requirements of state agencies under contract with DHHS. At a minimum, the MCO must be able to identify, track and report allowable and non-allowable expenses and utilization for required state and federal reporting, and must track and report the use of specific federal funding sources such as Medicaid, federal block

**For now we understand SAS are only as they pertain to co-occurring.**

grants and housing funds according to the federal rules and regulations associated with those federal sources. DHHS is, however, open to and encourages recommendations from the MCO about how to change the requirements over which the various agencies have control. To create a more efficient and effective behavioral health delivery system that can fulfill federal requirements and provide a single reporting approach to the funds administered and the services delivered or funded by the state of Maine. The MCO will be expected to meet all administrative requirements related to appropriate state licensure, solvency, reporting, payment to providers and compliance with all applicable federal and state laws and regulations. The MCO can expect to be evaluated on adequacy of information systems, provider networks, and capacity for providing access on a statewide basis; and will be expected to demonstrate mechanisms for maximizing resources and for improving availability and access to culturally relevant services, particularly in rural areas. The MCO will also be expected to produce critical customer/family outcomes and to adhere to delineated system performance requirements. Offerors will be required to demonstrate the capacity to integrate these values and capacities into their proposed plans to deliver the services identified in the behavioral health benefit or service packages.

### **Implementation Schedule**

This new way of developing and managing a single behavioral health delivery system will not occur overnight. It will take time to mature and grow. It is important to distinguish what services and capacities the MCO will be responsible for as of January 1, 2007, and what will need to come later (see Subsection F, Time Frames). It is also important to think about how resources that are not initially purchased together will be coordinated to create a single system of behavioral health services as contemplated by Governor Baldacci and the legislature when it passed and he signed LD 468.

### **A-1 RECOVERY**

The Department is committed to the recovery model as expressed in the Surgeon General's Report on Mental Health<sup>1</sup>; The President's New Freedom Commission – “Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual’s recovery. Resilience means the personal and community qualities that enable us to rebound from adversity, trauma, tragedy, threats, or other stresses – and to go on with life with a sense of mastery, competence, and hope. We now understand from research that resilience is fostered by positive childhood and includes positive individual traits, such as optimism, good problem-solving skills, and treatments. Closely-knit communities and neighborhoods are also resilient, providing supports for their members.” And, and the National Consensus Statement on Mental Health Recovery.<sup>2</sup>

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<sup>1</sup> U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

<sup>2</sup> U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. National Consensus Statement on Mental Health Recovery.

Recovery is cited, within Transforming Mental Health Care in America, Federal Action Agenda: First Steps<sup>1</sup>, as the "single most important goal" for the mental health service delivery system.

To clearly define recovery, the Substance Abuse and Mental Health Services Administration within the U.S. Department of Health and Human Services and the Interagency Committee on Disability Research in partnership with six other Federal agencies convened the National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation on December 16-17, 2004.

Over 110 expert panelists participated, including mental health consumers, family members, providers, advocates, researchers, academicians, managed care representatives, accreditation organization representatives, State and local public officials, and others. A series of technical papers and reports were commissioned that examined topics such as recovery across the lifespan, definitions of recovery, recovery in cultural contexts, the intersection of mental health and addictions recovery, and the application of recovery at individual, family, community, provider, organizational, and systems levels. The following consensus statement was derived from expert panelist deliberations on the findings.

“Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.”

## **The 10 Fundamental Components of Recovery**

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

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

**Empowerment:** Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants,

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<sup>1</sup> U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. Transforming Mental Health Care in America, Federal Action Agenda: First Steps.

desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.

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

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

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

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

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

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

**Hope:** Recovery provides the essential and motivating message of a better future—that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process. Mental health recovery not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn, and fully participate in our society, but also enriches the texture of American community life. America reaps the benefits of the contributions individuals with mental disabilities can make, ultimately becoming a stronger and healthier Nation.

<sup>1</sup> It is recognized that recovery must be highly individualized while sharing many attributes across consumers. Consumer empowerment is an essential ingredient of recovery along with community reintegration and normalization of the life environment. Empowered recovery enables consumers to be not only in charge of their illness but also fully in charge of their lives. Major contributors to the opportunity for individual recovery involve the inclusion of consumer, parent or legal guardian of youth consumers, family and advocates in a broad range of decisions from service planning to resource planning. Other aids to individual recovery involve the availability of consumer-driven and consumer-run programs, services and activities developed in conjunction with consumers and their families.

Mental health services must be integrated with services provided by other human services agencies. Services must be designed to enable children and youth to remain in or return 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. The Department is committed to ensuring an effective system of quality assessment and improvement for the Mental Health Program.

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

\_\_Individuals with mental illnesses can and do recover from their illnesses and lead full and rewarding lives.

\_\_Recovery is a continuing process whereby the individual with a mental illness works to establish and maintain: 1) a reasonable accommodation with the illness, including the development of a satisfying lifestyle that takes the illness into account but is not dominated and limited by it and 2) a satisfying and nurturing niche in society that includes all of the formal and informal social interactions enjoyed by people throughout society.

\_\_Recovery is the overall goal of the mental health care system and the goal for most consumers in the system.

\_\_The overall approach to recovery is for consumers to be empowered to set and achieve their own goals.

\_\_Programs and services are strength based and focus on developing competencies, offering choices, promoting work and learning, providing hope, and celebrating accomplishments and success.

\_\_Services such as clubhouses, drop-in centers, vocational services, self-help groups, peer support, warm lines, housing and education are key elements in the recovery process.

\_\_Consumers and family members have important and valuable contributions to make. Their expertise must be utilized in designing programs, developing service plans, providing services and measuring outcomes.

The recovery model may not be appropriate for all consumers at all times. Implementation of a recovery model does not mean that mental health professionals can simply wait for

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<sup>1</sup> Request for Proposals RFD#HCPFJGof09BH0 Operations of the Colorado Medicaid Community Mental Health Services Program.

people to seek help. Individuals with serious mental illnesses often do not seek help and may need assertive community treatment programs and outreach to help engage them in the services they need. The system must serve consumers 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 consumers. However hospitalization and the restriction of individual civil rights are used as a last resort.

**The Offeror shall demonstrate a commitment to the recovery model throughout its proposal to operate a geographic service area of the Mental Health Program by identifying specific programs, services, policies and procedures that embody the described principles. The Offeror's proposal shall not include a separate section narrating their commitment to the recovery model requirement. Instead, the Offeror shall demonstrate their commitment to the recovery model throughout the responses to the Services, Service Delivery, Consumers, Parents of Children and Youth, Families, and Quality Assessment and Performance Improvement sections of the RFP. The Offeror's proposal shall describe how the Offeror plans to meet the following objectives:**

**\_\_Promote and assist in the recovery of individuals with mental illnesses through innovative services that empower consumers and families to determine and achieve their goals;**

**\_\_Assure access to necessary mental health services for consumers and families, including engaging individuals with serious mental illnesses who may not seek help on their own;**

**\_\_Provide the appropriate mix of mental health services that meets the needs of each individual consumer and family;**

**\_\_Assure that quality services are provided to consumers and families;**

**\_\_Provide all necessary services through a cost-effective system;**

**\_\_Achieve a coordinated system of delivering mental health services to Medicaid consumers; and**

**\_\_Maximize community resources in an effort to maintain the least restrictive level of care for consumers.**

## B. DESIGN FOR BEHAVIORAL HEALTH DELIVERY SYSTEM

### Vision – Quality Behavioral Health Care Promotes Recovery for All

The State of Maine is designing a single behavioral health delivery system in which available funds are managed effectively and efficiently; the support of recovery and development of resiliency is expected; mental health is promoted; the adverse effects of substance abuse and mental illness are prevented or reduced; and behavioral health customers are assisted in participating fully in the life of their communities. The primary purpose of this model is to develop an efficient quality-driven statewide system of behavioral health care that promotes behavioral health and well being of children, adults and families; encourages a seamless system of care that is accessible and continuously available; and emphasizes health promotion, prevention and early intervention, resiliency, recovery and rehabilitation.

### Overview of Plan

The scope of this RFP includes the implementation, operation and administrative oversight for the Maine statewide single behavioral health delivery system. To comply with the legislative charge given to DHHS, the effective date of the contract shall be January 1, 2007 and will end no later than \_\_\_\_\_.

During the first contract year, assuming satisfactory performance, contract terms for the next two years will be negotiated, with dollar amounts negotiated annually. Assuming continued satisfactory performance, a fourth year will be negotiated. Approval of the contract by the Federal Centers for Medicare and Medicaid (CMS) and the Maine Department of Administrative and Finance Services (DAFS) must be obtained before the effective date. Following the approval of the contract, the MCO shall be required to work closely with the DHHS to ensure it is able to provide a smooth transition from the current diversified behavioral health delivery systems originating at the various state agencies to a single service delivery model. This would mean that: (1) services will continue with uninterrupted delivery; (2) contracted and subcontracted providers will continue to be paid for the services they deliver; (3) data will continue to be reported; and (4) current performance standards continue to be met. The MCO shall be required to demonstrate the ability to implement and carry through the transition processes identified in this document, as well as Phases One and Two of DHHS's Behavioral Health System Development Plan. The MCO shall be responsible for the provision of behavioral health services for the current Maine customer populations, as well as newly eligible customers, beginning on January 1, 2007. DHHS will not pay the MCO for any costs incurred prior to January 1, 2007, even though significant transitional activities will be expected in order to assure a smooth transition on January 1, 2007.

### Services

As part of the planning process for this RFP, the agencies and departments within DHHS have worked together during the last year to draft common service definitions and requirements (see Appendix \_\_). These draft definitions are intended to describe both current and desired services for future development. Requirements for all the listed services are now being developed; key examples are also included as drafts in Appendix \_\_. These services reflect DHHS's intent to enhance the range and availability of evidence-based community services for recovery and resilience, as well as the development of shared standards. One key example of change in how services are currently defined and organized

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Would this be the DHHS AMH Service Plan in the Consent Decree?

Do we have this?

across agencies involves community support. These changes as envisioned are described here as an indication of our interest in enhancing the system's recovery orientation. DHHS is in the process of reviewing possible revisions to how individuals with serious mental illness and children with serious emotional and behavioral disturbances experience case management and skill-building services. Specifically, DHHS is discussing the possibility of developing a community support service that would encompass the various activities that case managers and others perform. These activities include: case management, individual skill-building and individual interventions provided in the psychosocial rehabilitation programs.

Best practice and other literature indicate that individuals with serious mental illnesses and their families do better with a case management model that is more service delivery oriented than a "broker" model of case management (although at certain times they may need an individual to act as a broker). Specifically, individuals are able to learn the skills they need to negotiate human services systems and community services rather than having a case manager perform these activities on their behalf. They also have 'one' individual who is responsible for providing brokerage services and skill-building services, rather than having separate case managers for supported housing or supported employment. A good community support staff person would be able to perform most of these functions for an individual. Community support has been very effective in breaking down the individual "silos" of case management that are attached to a specific program model. It also reduces individuals' and families' perception of having multiple staff perform case management duties. Community support activities the DHHS/Collaborative is considering include:

- Identifying barriers that impede the development of skills necessary for independent functioning in the community;
- Participating in the development of the individual's ongoing service plan;
- Individual intervention, which develops interpersonal and community coping skills, including adaptation to home, school and work environments;
- Monitoring and self-management of symptoms, which shall have as its objective the identification and minimization of the negative effects of psychiatric symptoms that interfere with the individual's daily living financial management, personal development, or school or work performance;
- Assisting persons served to increase social support skills that ameliorate life stresses resulting from a person's disability;
- Coordinating to gain access to necessary rehabilitative and medical services, as well as coordination of services in the individual's service plan;
- Monitoring and follow-up to determine if the services accessed have adequately met the individual's needs; and
- Ensuring availability 24 hours a day, seven days a week for individuals who are in crisis, but who may not need mobile crisis or crisis residential services.

Such community support services are envisioned to be delivered in various community settings including school, home or work. Community support may be provided to individuals or groups. For individuals who need more intensive case management and skill-building services, community support may be provided by 'teams' of individuals. Community support teams can play an important function for individuals who use more intensive services, such as Assertive Community Treatment (ACT), Multisystemic Therapy (MST), or Intensive Home Services. Community support services could

be used as a step-down service for ACT, MST and Intensive Home Services. Community support team services would allow a moderate level of support to individuals and families who do not need the frequency and intensity of ACT, MST or Intensive Home Services. Another example of a cross-agency service development priority is in the substance abuse area, and particularly DWI-related services. This is an area where numerous agencies are currently involved in funding-related interventions. The Maine Department of Transportation (DOT), for example, receives DWI funds collected by Maine's courts (\$\_\_\_/conviction), totaling approximately \$\_\_\_\_\_ annually. DOT's Traffic Safety Bureau returns the funds to the community from which they were collected, using these funds as match to receive federal traffic safety funds (TEA-21). Additionally, Traffic Safety Education and Enforcement (TSE&E) collected by courts and the DMV total approximately \$1 million annually. Half these funds are used by the Bureau for Public Information and Education as match to receive federal TEA-21 money. Although these DWI-related funds, by statute, go back to the community, the MCO/SE will be in a crucial position to coordinate with local communities to optimize use of these similar funds to reduce drug- and alcohol-related injuries and deaths. Working with these and other DWI-related funds, the MCO can play an important role in promoting best practices and support appropriate common standards for intervention/prevention/education in this area.

**We are not sure if our system works this same way, but think this is a very good idea.**

**Resources and Locations**

**No information has been made available on this.**

**Collaborative Approach**

**During this initial phase it appears that DHHS and its agencies AMHS, CBHS, OSA and others +/- form a kind of procurement collaborative. For our purposes her we have titled this function the DHHS/Collaborative and distinguish it from the Behavioral Health Work Group (BHWG)**

**Managed Care Stakeholders Group; Managed Care Forum "We the People"; RFP Work Groups. (others?)**

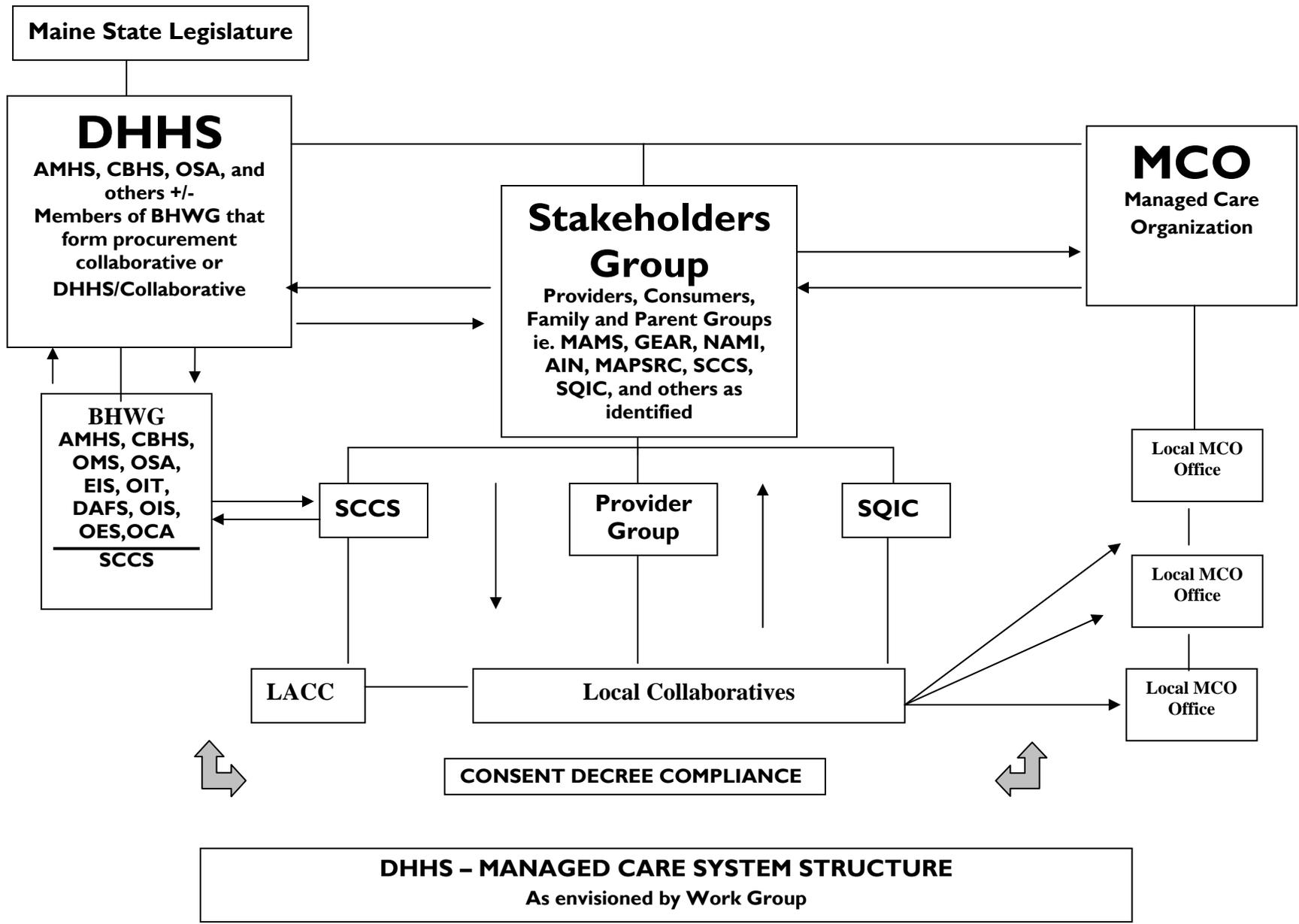
The concepts for the procurement were developed with extensive public input along with input from each of the state agencies included within the Collaborative. The direction is the culmination of a careful review of all aspects of all of the comments and recommendations

made through the public process, as well as of state and federal requirements currently existing. The experience of the various members of the DHHS/Collaborative, and comments from the many hundreds of individuals and groups, including customers, families, providers, advocates and other stakeholders, were reviewed and evaluated and used to propose meaningful change.

The DHHS/Collaborative approach to purchasing behavioral health services is designed to be responsive to the needs of Maine's most vulnerable individuals and families whether they are eligible for MaineCare benefits or services from non-MaineCare resources. The desired outcome is to improve the quality of life for Maine's citizens by improving access to prevention and treatment services, promoting care coordination, minimizing administrative burden, improving customer and family involvement, and delivering quality prevention and treatment services efficiently and effectively for both the state agencies and customers and their families. Additional information regarding each of the departments, agencies, and individuals that make up the DHHS/Collaborative and their current responsibilities can be found in \_\_\_\_\_ . The successful MCO will be the offeror who proposes a plan that most effectively addresses the directions identified in this RFP, and proposes the most efficient and effective use of available resources.



**Do we have  
this  
information?**



## **C. STRUCTURE AND RELATIONSHIPS**

### **Structure**

DHHS is looking for a partner as much as an administrator or management entity. The selected MCO must be flexible, able to work with multiple agencies and competing demands, and committed to change as the system and the DHHS/Collaborative evolve. One key to the identification of local needs and involvement is the ability to receive broad-based input regarding behavioral health access and availability from local areas. This will be accomplished through the development of an approach that includes local planning groups developed and/or assisted by DHHS/Collaborative agencies' staff. The following describes the various administrative and collaborative units involved in the development, management and operational requirements of the new interagency behavioral health service delivery system.

### **The DHHS/ Purchasing Collaborative**

Each state agency on the DHHS/Collaborative has and will retain responsibility for the reporting, accounting and oversight of the funds, staff and services in its budget. However, the collective whole will be concerned with what those funds and resources can produce in terms of services and outcomes. The DHHS/Collaborative will make decisions about how funds, staff and service capacities are utilized in order to achieve commonly desired performance and outcomes. The DHHS/Collaborative will consider customer and family input as part of its oversight function. The DHHS/Collaborative will seek to establish the right balance between local variations that address local needs and common approaches statewide that: (1) assure consistent quality, accountability and access; (2) avoid duplication of effort at local levels; and (3) avoid confusion by creating uniformity in billing, contracting, universal credentialing, infrastructure development and processes.

### **Interagency Staff/ Behavioral Health Work Group (BHWG)**

The DHHS/Collaborative to date has conducted its day-to-day work through an interagency team called the Behavioral Health Work Group (BHWG). Shortly after the Legislature mandated that the Department move to behavioral health managed care for all MaineCare funded mental health and substance abuse services, the Behavioral Health Work Group was formed. The BHWG has guided and will continue to guide the development of the new behavioral health system until a contract with the MCO has been selected and is operational. At that point, the existing members of the work group, with the addition of a number of advisors nominated by and chosen from various advocacy and consumer groups will continue to guide the work on this initiative. (Maine Behavioral Health Managed Care Program Department of Mental Health and Human Services Concept paper 12/13/05 & update 3/2/06 hereinafter called DHHS Concept Paper.) The DHHS/Collaborative will work through the BHWG to establish interagency staff teams to work with and oversee the work of the MCO. The contract will include specific deliverables including service and administrative requirements, as well as specific system performance and customer and family outcomes that must be met and consequences if they are not. These will form the basis of contract oversight of the MCO by the DHHS/Collaborative, through an interagency MCO oversight team. In addition to the MCO oversight team, BHWG will establish interagency teams to address quality issues and other program development issues that may arise as the DHHS/Collaborative works with the MCO. The BHWG will also identify \_\_\_# interagency staff teams to work with locally designated staff of the MCO in the \_\_\_# geographic areas of the state used by multiple state health and human services agencies for planning and service

Is this a separate issue for ME?

provision and a \_\_\_\_# “area” addressing Native American issues. These interagency staff teams will provide consultation and support for translating state policy to local DHHS/collaborative areas and with Native American tribes within their designated area. These interagency staff teams will work with MCO staff and local planning groups within each area to help them identify needs and develop programmatic recommendations, and to resolve problems or issues that may arise regarding services, service delivery, customer and family or provider concerns and issues affecting service quality within that geographic area.

**The Statewide Quality Improvement Council (SQIC)** to meet federal advisory council requirements and to provide consistent, coordinated input to the behavioral health service delivery system in Maine. The membership of the SQIC includes representatives of the following groups: (1) customers and family members; (2) providers of both children and adult mental health and substance abuse services; (3) state agencies responsible for behavioral health, education and vocational services, housing, corrections or criminal justice, MaineCare and social services, health policy planning, developmental disabilities planning, disabilities issues and advocacy; (4) mental health and substance abuse service advocates; and (5) other individuals necessary to assure appropriate geographic and cultural representation. The MCO will be expected to interact with the BHWG as an advisory council.

### **Local Collaboratives**

We are interested in ensuring that broad state level collaborative efforts are reflected in well developed local collaboratives. Such local collaboratives are to be identified based on existing community planning structures or formed to help create and sustain the partnerships among local agencies, community groups, elected officials, families, customers, Consumer Council System, providers and advocates. These systems are intended to help in identifying needs/resources, as well as in ensuring the relevance of services/supports to improve the quality of life of those affected by behavioral health concerns. More information about these local functions, group composition and development processes can be found in draft guidelines in the \_\_\_\_\_. These guidelines are still in development. It should be noted here that these local roles are advisory in nature, serving as a strong voice for a designated sub-state geographic area (judicial districts) and Native Americans, rather than as a formal administrative body. Identification and development of local collaboratives is intended to take place this year prior to the January 1, 2007 initiation of a contract with the MCO/SE. Both state staff and the MCO will need to support this development process (see “Relationship Between the MCO and the Local Collaboratives,” Section I of this RFP). State staff will ensure that local participants receive training and orientation regarding behavioral health issues facing Maine and local areas. These state staff will then be available to assist local groups in their development and coordination efforts. The goal is to maximize the ability of these local groups to work effectively with the new MCO in initial planning/coordination for services in their area. Although funding will not be provided to these groups in Phase One, the advisory role of the local collaboratives is intended to be a strong and active one. The MCO will be expected to share information with them and consult with and strongly consider their input on service delivery issues in their geographic or cultural area to provide valuable information for the MCO as it works to assure the best possible services throughout Maine.

Will the state revitalize the QIC's or is there another plan for organized local area input other than the SCCS.

**Consumer Council System** (See Appendix page 11 Consent Decree; Supplemental Plan for Increased Consumer Involvement in the Planning, Delivery, and Evaluation of Adult Mental Health Services October 27, 2005)

The Consumer Councils will provide a review mechanism for AMHS regarding:

- Major policy and procedure development and implementation;
- Budget and program initiatives;
- Training and educational needs;
- Issues raised directly by consumers, as well as the opportunity for dialogue with DHHS staff and other stakeholders; and
- Review and direction on consumer concerns regarding managed care implementation.

The Consumer Council System will consist of at 8 - 11 area councils and one statewide council (Transitional Planning Consumer Council System minutes 5/10/06).

### **Relationship between Consumer Council System and DHHS/Collaborative**

(Consent Decree; Supplemental Plan 10/27/05) DHHS/AMHS will: --Involve the Councils in the selection process for key AMHS staff, including the Director;

--Present issues in as timely a manner as possible so that feedback can be meaningful;  
---Present data collected for quality assurance and quality improvement to the Councils for their review;

--Work with the Councils to develop a clear "report card" for measuring system improvement;

--Work with the Councils to develop measures for recovery at the individual, program, and community level as well as monitoring the success in implementing change. DHHS had proposed in the plan dated 6/30/05 that consumers be involved in the licensing review process through participation on licensing teams. The opinion of the key stakeholders convened to review this plan was that this is not the avenue through which consumers wish to address system improvement. The councils will provide input to DHHS through a broader system perspective rather than through individual agency licensing participation. AMHS will continue this discussion with the Councils.

--Continue the support of the Statewide QIC including its role in reviewing and making recommendations regarding the Community Mental Health Block Grant.

--Inventory mental health agencies to determine their adherence with the contract requirement to include consumers on the boards of directors, and work with the Councils to assist agencies in meeting this requirement.

It is the recommendation of the Consumer Managed Care RFP Workgroup that at least 3 consumer representatives become part of the BHWG. These representatives will come from the membership of the Consumer Managed Care RFP Workgroup until the Statewide Consumer Council is formed. At which time newly elected consumer representatives will become members of the BHWG.

### **Managed Care Organization (MCO)**

With direction and oversight from the DHHS/Collaborative, the MCO will implement the philosophy, principles, values and service requirements directed by the DHHS/Collaborative. The MCO will be responsible for contracting with providers, paying provider claims, assuring care coordination, conducting utilization review and utilization management activities, assuring quality review and service delivery improvement, universal credentialing of practitioners and provider agencies, privileging practitioners to deliver critical services or service approaches,

evaluating and monitoring of service delivery and conducting any other administrative functions necessary to achieve the goals of the DHHS/Collaborative. The MCO will be the agent of the DHHS/Collaborative and will “coordinate,” “braid” or “blend” the funding, human resources and service capacity available from the various state agencies so as to increase flexibility, maximize available resources and create a seamless single behavioral health service delivery system for Maine. “Coordinated” funding and resources occurs where multiple agencies and funding streams are used to achieve related customer or system outcomes and there is cross-system collaboration to avoid duplicative services or processes. The resources themselves are not mixed, but activities and goals are collaboratively agreed. “Braided” funding is the pooling and coordination of resources from various agencies to provide needed services, while maintaining the integrity of each agency’s funding stream. Funds in a braided approach are used for their original intent and are tracked separately, particularly where there is categorical funding for a particular program such as MaineCare or federal block grants, and usually for the purpose of accounting to federal program administrators. An agreed set of services may be provided by multiple agencies to shared clients through the braiding approach, with tracking of specific eligibility for services. “Blended” resources are created when separate agencies contribute to a common pool or commingle funds into a single source from which agreed service goals are met, offering both significant flexibility for state and local agencies and reduced amounts of work on reporting and accountability. Often blended funds are used to pay for activities that cannot be billed to a specific funding source. Whether resources are “coordinated,” “braided,” or “blended,” the MCO will serve the DHHS/Collaborative’s intention to create services that are easier to administer, constitute a more person-centered approach, and further recovery and resiliency-oriented outcomes.

### **Relationship between Consumer Council System and the MCO**

The Consumer Council System will be part of the local collaboratives. The MCO, along with state staff, will be expected to work with local collaboratives to conduct necessary needs assessments, strategic planning, development of group processes and mechanisms to address program development and service and support delivery in the local community. Local collaboratives will provide the MCO with information about needs, gaps, service quality and local cultural issues affecting the local community. Local collaboratives will be the system’s local community voices to assure interagency coordination at the local level. The MCO will be responsible for assisting the DHHS/Collaborative’s interagency teams and local community groups with the development of local collaboratives to address the specific needs of different geographic areas and culturally diverse populations within Maine, considering specific cultural, rural, frontier, border and other differences

### **Relationship Between the Managed Care Organization (MCO) and the Local Collaboratives**

The local collaboratives and the MCO, along with state employee interagency team members assigned to geographic and Native American areas, will work together to determine local needs, services and supports. The MCO, along with state staff, will be expected to work with local collaboratives to conduct necessary needs assessments, strategic planning, development of group processes and mechanisms to address program development and service and support delivery in the local community. Local collaboratives will provide the MCO with information about needs,

gaps, service quality and local cultural issues affecting the local community. Local collaboratives will be the system's local community voices to assure interagency coordination at the local level. The MCO will be responsible for assisting the DHHS/Collaborative's interagency teams and local community groups with the development of local collaboratives to address the specific needs of different geographic areas and culturally diverse populations within Maine, considering specific cultural, rural, frontier, border and other differences

### **MCO and Provider Relationships and Accountability**

The following contract oversight measures will be included in the DHHS/Collaborative's mechanisms for contract accountability, at a minimum:

- In its contracts with providers, the MCO will be required to include clearly defined, contractually enforceable sanctions so that if the contracted provider(s) does (do) not perform according to agreed-upon standards and expectations, immediate correction or remedy will be possible.
- The MCO will be subject to oversight by state interagency teams or individuals directed by the DHHS/Collaborative to evaluate or review performance and the MCO will make available to such designated teams or individuals such data and staff or individuals as necessary to determine whether the MCO is meeting contract requirements.
- Negative trends or poor performance by the MCO and its providers will receive prompt attention and response by the DHHS/Collaborative to include specific, enforceable timeframes for resolution of identified problems and the possibility of monetary withholds or penalties.
- The MCO will establish mechanisms to track and trend grievances, appeals and utilization data, and to meet all stated reporting requirements.
- The MCO will, through local collaboratives, give customers and their families specific and meaningful roles in assessing quality of services and in reviewing quality and utilization review data, including aggregate data about customer complaints, grievances and appeals.
- The MCO will establish a tracking and data collection system that will capture all payer sources. The identified MCO oversight team will document, track and resolve issues and provide reports that ensure and enforce compliance.
- Identified trends or recurrent customer or provider complaints, grievances or appeals will be subject to sanctions once identified by the MCO oversight team, the BHWG or the DHHS/Collaborative and once the MCO has been given an opportunity to correct the issue giving rise to the complaint, grievance or appeal.
- Implementation of a Behavioral Health Early Warning System (EWS) will serve to monitor real-time system indicators. These indicators will be identified initially by the DHHS/Collaborative through the BHWG, but may be changed from time to time after input from the local collaboratives and after discussion with the MCO.
- All mandated state and federal behavioral health data submission requirements for the MCO will be reviewed regularly.
- Contract requirement for compliance with national standards of quality will be enforced; the specific standards to be used must be proposed by the offeror.
- State-directed contract performance monitoring through the use of an External Quality Review Organization (EQRO) in accordance with Section 1902 (a) (30) [C] of the Social Security Act will be utilized, especially for services with Medicaid dollars.
- There will be enforcement tracking of adherence to the "medically necessary" service definition for MaineCare services or the criteria for clinical, rehabilitative or supportive

services as approved by the DHHS/Collaborative for other funding streams.

- There will be enforcement tracking of adherence to all state or federal requirements associated with each fund source managed by the MCO.

The provider capacity and infrastructure in Maine is fragile. Some providers still receive all or a significant portion of their funds in monthly allocations or based on programmatic budgets rather than reimbursable service units. The DHHS/Collaborative wishes to move to encounter based service delivery and/or reporting to capture consistent service utilization data for the system as a whole. The MCO will be expected to make changes carefully and with attention to the transition needs of providers as well as the needs of customers and families to assure that the provider capacity in Maine is maintained and can adjust appropriately with programmatic, data and system changes introduced by the MCO and/or required by the DHHS/Collaborative. The MCO will be expected to provide training and technical assistance to providers in billing, evidence-based practices, utilization review criteria and any other matters necessary to assist providers to make a successful transition. The new single behavioral health delivery system with its attention to recovery and resiliency and to evidence-based practices will require that many providers make changes in the services they provide and in the way they report, bill and account for services provided. However, these changes should be incorporated with enough information and technical assistance to assure that provider capacity is not lost as the system grows and evolves. The MCO is expected to work with Maine's providers to adjust their services or to develop new services to meet the behavioral health needs of Maine's citizens as identified by the DHHS/Collaborative, local collaboratives or the MCO. The MCO must be able to demonstrate that it has offered adequate technical and financial support or other necessary opportunities for the development of currently existing community resources. The MCO may provide services directly, but only after determining (1) that no current Maine provider is able and/or willing to provide the necessary services and even with appropriate technical assistance and (2) only after consultation with the BHWG and presentation of evidence of technical assistance/development efforts. These requirements will assure that the MCO will maintain provider capacity.

#### **D. GEOGRAPHIC AREAS FOR SERVICE DELIVERY PLANNING**

As the MCO begins to look at geographic areas in which to contract with providers or provider groups to deliver services for children, adolescents and adults, attention should be given to the geographic areas identified by several of the DHHS/Collaborative agencies for reconfiguring their own service delivery and staff assignments. Prior to the DHHS BDS merger there were three common geographic areas (see Appendix\_\_\_) encompass multiple judicial districts and will be used across multiple state agencies for behavioral health planning and delivery purposes. The MCO will be asked to provide a service delivery plan for each geographic area and for the state as a whole, taking into consideration the input of local collaboratives within each service area. Initial service delivery plans should be provided in the offeror's proposal. Interim service delivery plans for Phase One will be expected before the beginning of the contract term, January 1, 2007. During Phase One (January 1, 2007 through\_\_\_\_\_), more comprehensive service delivery plans will be developed with the input of local collaboratives and the DHHS/Collaborative's interagency teams. As the delivery system matures, the MCO will be required to revise these service delivery plans annually to take into consideration the needs and priorities identified by the local collaboratives and to account for any changes in state or federal requirements and any changes in provider capacity and subcontracting arrangements. Guidelines for the development of service delivery plans will be developed by the BHWG in consultation with the MCO and local collaboratives. These guidelines will include attention to services and

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What are the geographic areas now 3, 6, or more

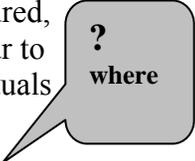
Starting in mid- fiscal year when would Phase One end?

plans that will increase over time the state's commitment to recovery and resiliency as outcomes and to the use of evidence-based and promising practices as treatment modalities. It should be noted that evidence-based practices might in fact be new and emerging practices for which evidence is being developed, especially for customer- and family-operated services or for services that utilize peer supports, self-direction and empowering principles for customers and families. Individuals representing customer- and family-operated services or services that utilize billable peer supports, self-direction and empowering principles for customers and families are expected to be included in the planning process.

**E. POPULATIONS AND FUNDING**

**Phase One**

The MCO will be expected to serve at least the same number of individuals currently served, proportionate to the amount of dollars available and to changes in Medicaid enrollment. Actual amounts available will depend on state and federal appropriations for FY 07. The ratio of adults to children; persons with mental illness, substance abuse and co-occurring disorders; insured, uninsured and poverty status; and the ethnicity breakdown of those served must be similar to those served in FY 06. Offerors who are able to show plans for serving additional individuals will receive additional consideration in the proposal review process. Data books may be found \_\_\_\_\_



**BREAKDOWN OF POPULATION AND FUNDING:**

Please note that the State of Maine also anticipates continuing to provide services for the uninsured through General Fund dollars \_\_\_\_\_



Primary Care Provider (PCP) and physical health specialists are expected to provide health services, within the scope of their licenses, including behavioral health services to treat behavioral health conditions. The MCO will be financially responsible for these services. When medically indicated, their PCP and physical health specialist will refer members, without any need for MCO prior approval, to behavioral health providers, whose services the MCO will cover.

**Phase Two**

During Phase Two, additional dollars and responsibilities for additional services and populations will be required of the MCO. The MCO will meet with the DHHS/Collaborative to ensure appropriate knowledge of the services slated for Phase Two is understood. It is expected that the MCO will serve at least the same number of individuals that the State of Maine currently serves. These additional funds and programs will be dependent on FY 08 and FY 09 appropriations. Dollar amounts and program responsibilities will be negotiated with the MCO before January 1, 2007, and may include the following:

**BREAKDOWN OF POPULATION AND FUNDING:**



**TOTALS ??????**

## **Requirements Regarding Expenditures for Behavioral Health Services for Customers and Families – Limitations on Administrative and Other Costs**

One of the reasons for collaborative purchasing is to reduce the duplicative administrative infrastructures managing different parts of the behavioral health services and funds available within Maine. Reducing the administrative burden on providers is also a goal. These two efforts together will help to stretch limited dollars and make the use of those dollars more efficient. To assure this efficiency and make sure the greatest amount of dollars possible are used for customer and family services, the DHHS/ Collaborative will require that a specified percentage of each fund source be spent on direct services and will limit the amount that may be spent on administrative and other non-service costs. Over the life of the contract with the MCO, the DHHS/Collaborative intends to see an increasing percentage of funds managed by the SE to be spent on services and a decreasing percentage spent on these non-service costs.

### **Administrative Functions**

The following functions are considered administrative expenditures:

- Salaries and benefits for Behavioral Health staff of the MCO;
- Information systems, to include data collection and submission;
- Financial reporting;
- Direct provider contracting and oversight processes;
- Provider credentialing and privileging;
- Customer services;
- Marketing;
- Claims processing;
- Recruiting and staff training;
- Training and education for customers and providers;
- Network development;
- Quality assurance/quality management/quality improvements;
- Customer satisfaction;
- Care coordination distinct from case management;
- Utilization review/utilization management;
- Credentialing;
- Customer advisory board;
- Grievances and appeals;
- Supplies, non-clinical;
- Purchased services, non-clinical;
- Audit;
- Legal and risk management;
- Depreciation and amortization;
- Capital outlay;
- Facility expenses;
- Staff travel;
- Licenses, taxes and insurance;
- Profit;
- Tracking of the service delivery as individuals move between correctional services to community services and from children's services to adult services; and
- Tracking of compliance to ADA standards.

In addition to its own administrative and other non-service costs, the SE will need to work with providers to identify ways to assist providers in lowering their administrative costs. During Phase Three of the contract, the DHHS/Collaborative will require that the MCO work jointly with providers to hold down the total amount of administrative and non-service costs at both the MCO and the provider levels so that the greatest amount of available funds possible will go to direct services for customers and families. At the same time, the DHHS/Collaborative knows that non-service related expenditures are critical for assuring quality and accountability and for supporting the involvement of customers and families and for assuring community voices are heard. These costs fund training; data collection and reporting; customer, family and community education; quality improvement activities; and grievance and appeals processes. They also sometimes help support advisory groups, community input groups, and workforce development activities. Currently, different fund sources have either fund source limitations or a tradition that specified amounts are expected to be spent on funding for service providers rather than funding for a managing intermediary. Each fund source has a limitation or a history of different amounts of service dollars utilized and different proportions required to be used for “enhanced services” or to be withheld as “incentive funds” that can be earned based upon specified performance in key areas. For example, the current Regional Care Coordinators (RCCs) are allowed 12 percent for non-service related expenditures and may earn an additional three percent (called an “incentive withhold”) based on innovative proposals or performance that exceeds requirements. Current services provided and amounts expended through this incentive withhold process are listed in charts above, as well as in Appendix G, and must be continued at least through the first six months of the MCO’s contract with the DHHS/Collaborative. After that time, these services may or may not be continued so long as the MCO is meeting the requirement about minimum proportions spent on service-related expenditures and is reinvesting in new and innovative services to meet the behavioral health needs of Maine’s citizens.

How will incentives work in ME ?

Maine’s MaineCare program currently requires \_\_\_\_\_ may be spent on non-service costs. DHHS also encourages the MCO to expend a significant portion of either the 15 percent or the service-related 85 percent on “service enhancements.”

After the first six months of Phase One, an increasing percentage of funds will be required to be spent on services such as these that go beyond those required by the funding source. The money for these new, innovative or alternative services will be referred to as “community reinvestment” funds. Use of these funds and changes from existing enhanced services will be determined in consultation with the DHHS/Collaborative.

### **Community Reinvestment**

“Community reinvestment” funds may come out of the service-related costs or the administrative or non-service related costs so long as the required proportion of the funds that must be spent on direct service-related costs is maintained. Services currently considered MaineCare enhanced services as of December 31, 2006 must be continued for at least six months and may be counted toward the MCO’s community reinvestment obligation. If the MCO proposes to change the enhanced services or withhold projects, MCO must first consult with the DHHS/Collaborative through the BHWG. (See Appendix \_\_\_ for a list of MaineCare MCO enhanced services as of \_\_\_\_\_.)

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Reinvestment dollars from block grant and related general fund monies were used in the past to upgrade clinical practices, such as:

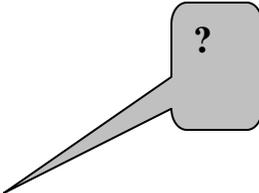
- Implementing use of Addiction Severity Index (ASI) and the Symptom Distress Scale;
- Implementing Maine’s Pharmacotherapy Initiative and integrated services for persons with co-occurring disorders;
- Implementing peer support services;
- Initiating intensive outpatient services; and
- Upgrading data systems and data collection activities.

ME’s equivalent?

Some fund sources the MCO will manage currently have no non-service related costs taken out of them before they go to a service provider. Other fund sources will have a very small amount or nothing allowed for administration (for example, emergency shelter grant funds or particular federal or foundation grants that limit administrative costs). These dollars will be relatively smaller amounts; however, the MCO will be required in these circumstances to manage these fund sources within those limitations, in some cases simply as a pass-through. In Phase One, the MCO must utilize at least 85 percent of the total available MaineCare managed care dollars (state general fund and federal match) for service-related costs, that is, for contracts with service providers or for behavioral health services rendered by the MCO itself. The amount of available administrative dollars for the fee-for-service portion of MaineCare will be determined, but those dollars are only available for utilization review activities. However, the DHHS/Collaborative is seeking input from offerors about mechanisms to fund the fee-for-service and retroactive cases within MaineCare.

The MCO must utilize at least 88 percent of each federal block grant (substance abuse and mental health) and the related state general fund that counts as maintenance of effort for these funds for service-related costs. The MCO must utilize at least 96 percent of any other state general funds for non-MaineCare children, youth and adults (including adults coming out of prison into the Community Corrections program) for service-related costs. For other specialized fund sources, the proportion that must be expended for service-related costs in Phase One will be identified in the contract between the MCO and the DHHS/Collaborative.

The DHHS/Collaborative will require that the MCO hold three percent of its total amount of funding available through this contract as a community reinvestment account (held in a separate account in the joint name of the MCO and the DHHS/Collaborative or its designated fiscal agent). These funds will be spent on existing enhanced services and incentive withhold services and programs as well as any new and innovative services to address the needs of priority populations or communities within Maine. Before expending these additional funds, the MCO will consult with and obtain approval from the DHHS/Collaborative to determine how these funds will be used. This community reinvestment account can be used for service-related expenditures or for limited administrative activities that will enhance Maine’s service delivery system, but not for general operations of the MCO or for profit. Expenditures from this account will count as service related or administrative, depending on the type of expenditure. Examples of acceptable uses of these funds might be new services or programs designed to prevent out-of-home placement of children or diversion of adults from jails or prisons; or enhanced capacity of school-based health clinics to conduct Early and Periodic Screening, Diagnosis, and Treatment assessments (EPSDT). Other acceptable uses might be for training of providers, workforce development, capacity building to deliver new evidence-based practices or logistical support for low-income customers or family members to participate in their own care, on local collaboratives, or in evaluation activities, etc.



## **BREAKDOWN:**

<b>Sources of fund</b>	<b>Minimum % Direct Services Phase I</b>	<b>Community Reinvestment</b>	<b>Performance Withhold</b>
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Finally, in Phase One, the MCO will be expected to meet or exceed the amount of service-related and non-service related dollars (whether in the basic funding or from the community reinvestment account) currently spent on customer and family-operated services, support groups, training, quality evaluation and improvement activities, etc. The goal for each phase will be to increase the proportion of available dollars spent on customer or family-operated activities and services moving toward the goal of five percent of the total available dollars. In Phase Two, the expectation will be that the amount of dollars spent on service-related expenditures will increase by at least one percent in each fund source (for example, to 86 percent for Medicaid and block grant and to 97 percent of other general fund dollars). It is expected that the community reinvestment amount will grow by approximately one percent to four percent of the total available dollars. Offerors are encouraged to propose use of more funds for direct service-related costs and for community reinvestment in Phases Two and Three.

Also in Phase Two, the MCO will be expected to begin working with providers and practitioners as well as with state staff to inventory the amounts and proportions of dollars spent on administrative activities rather than direct behavioral health services for customers and their families at all levels. In this two-year phase, the MCO, in conjunction with providers, practitioners, customers, families, the QIC and state staff, will determine appropriate levels of non-service related costs expended by providers and propose to the DHHS/Collaborative a plan to begin reducing that burden and increase the percentage of service-related costs that can be expended by providers. In Phase Three, the MCO will further increase direct service-related expenditures either at the MCO level, the provider/practitioner level or both.

### **Payments to MCO**

Payments to the MCO may come in a variety of ways. For example, the MCO may receive prospective capitated payments of MaineCare managed care funds. For MaineCare fee-for-service, the DHHS/Collaborative will work with the MCO to determine how best to pay for services. The DHHS/Collaborative will also ask for assistance from the MCO in helping determine how to best make payment for services that are delivered when a MaineCare eligibility determination is still pending, or where services have already been rendered and MaineCare eligibility is established retroactively.

The MCO may receive reimbursement for specific services from other fund sources upon receipt of evidence of service delivery (encounter data). It may receive a monthly or quarterly allocation of set dollars available for specific purposes or programs. Finally, it may receive a specific set of dollars based on a budget for certain activities against which it may draw funds as the budgeted amount is needed or expended. Specific billing mechanisms will be determined prior to January 1, 2007. One-half of one percent of certain fund sources will be withheld pending proof of performance by the MCO.

In any case, the MCO will have to provide data or other information required by the DHHS/Collaborative to justify the expenditure of funds provided to the MCO.

## F. TIME FRAMES

January 1, 2007 is just the *beginning* of a much longer process. System change of this magnitude is not something accomplished with the “flip of a switch” or on one particular day. Rather, on January 1, 2007, a new system *begins*. It will take a number of years beyond that time for the partnerships, relationships and expectations of this new behavioral health delivery system to fully evolve. The DHHS/Collaborative reserves the right to expand or reduce the current mandatory benefit or service package at any time during the contract period following negotiations with the successful offeror.

During all phases of the project, the DHHS/Collaborative will require the successful offeror to fully comply with all statements, promises and plans submitted within its proposal that are accepted by the DHHS/Collaborative and any subsequent agreements reached with the DHHS/Collaborative through the BHWG. In addition, the offeror and its subcontractors shall comply with any state or federal regulations or statutes, including but not limited to those pertaining to the Balanced Budget Act affecting Medicaid or Medicaid managed care on the regulations’ or statutes’ effective dates and those required under provisions for the receipt of federal block grant or other federal funding. The MCO will also be expected to support the ability of Maine to demonstrate fulfillment of all relevant federal requirements (e.g., maintenance of effort; set-asides; Treatment Episode Data Set (TEDS) reporting; performance measurement; and required block grant applications report information). A description of the phases is provided below.

### **Phase One (State FY 2007 - January 1, 2007 through June 30, 2007)**

The goal of this phase is to assure a successful transition from the current multiple systems to one behavioral health delivery system. Specifically, the DHHS/Collaborative will select the MCO they feel is most likely to be able to assure that: (1) services continue to be delivered; (2) providers continue to be paid in a timely fashion; (3) state- and federally-required data is collected and reported; and (4) performance and outcomes are no less than they have been to this point. The MCO must be able to demonstrate its ability to meet the behavioral health service needs and provider network capacity beginning January 1, 2007, and to maintain continuity of care and system stability. The MCO will maintain a contract or method of paying all providers interested in contracting for services, and that meet mandatory requirements and who received state controlled funds as of December 31, 2006. Contingent on satisfactory performance, the MCO shall continue to reimburse eligible providers for a minimum of six months while a network is being established.

It is anticipated that a new network may require up to twelve months to develop. The process of developing a network should represent a fair selection among willing and appropriately qualified and credentialed providers who provide services and show outcomes in concert with the stated goals and vision of the DHHS/Collaborative. Nothing in these expectations will guarantee any particular provider any particular amount of funding during FY 2007. The MCO will make these provider-contracting decisions with input from the DHHS/Collaborative based upon service needs, available resources, and provider performance (see Procurement Library for range of rates for current services).

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Need

In some cases, the DHHS/Collaborative will require the use of certain providers for particular services or populations. Furthermore, in order to meet the needs of Native Americans, during all phases of the contracting periods the MCO will be expected to maintain contracts with Indian Health Service and with all tribal providers, including all providers,” that meet minimal universal credentialing requirements for service delivery within Maine. During Phases Two and Three, state-operated services may be considered essential providers. During any phase, the DHHS/Collaborative may require specific providers to be funded for specific purposes. During Phase One, unless approved otherwise by the DHHS/Collaborative, the MCO will be expected to maintain all current service capacity funded as required or enhanced services provided by current system’s providers and state agencies through community providers. The exception will be changes in services the MCO shows can be provided more cost-effectively or that will increase access to community-based services in less restrictive environments than are currently available. During the first six months, the transition will focus on ensuring access to care, payment for providers, data systems and collections and maintaining performance levels from FY 06. Several

ME’s  
Regional  
Team  
Leaders?  
ICM’s ?

tasks will require the development of policies, procedures, and implementation plans in order to ensure a smooth transition. For example:

- Moving from multiple reimbursing agencies to one;
- Managing accountability for evidence-based practice and efficient utilization;
- Moving to new technical systems required for interacting with utilization and claims paying entities;
- Developing coordination between physical health and behavioral health providers to meet the needs of individuals served;
- Ensuring appropriate coordination of pharmacy services; and
- Recognizing prior authorizations for services for the first 90 days of the transition.

While expectations are high, they are also realistic. The DHHS/Collaborative anticipates that the single MCO will be able to provide the current level or amount of services for at least the current number of service recipients and probably more, with decreased administrative costs. The expectation is that, over time, the MCO will be able to utilize the funds available to provide new, different or additional services. However, the DHHS/Collaborative agencies are aware that there are not enough funds to address all the behavioral health service needs of all Maine’s citizens.

Additionally, funds available for each year are subject to state and federal appropriation processes. The DHHS/Collaborative will work with the MCO to identify priority populations and services that are required or expected of the MCO and its provider network within the available dollars in each succeeding year of the contract. At a minimum, expectations for Phase One (contract Year One or FY 2007) will include:

1. Provision of services described in the benefit packages identified for each eligibility group and funding source, such as:

- Developing and providing a continuum of school-based behavioral health services and programs;
- Developing and providing programs interfacing with other systems such as Aging and Long-Term Services, Developmental Disabilities, Child Welfare, Juvenile Justice, adult corrections at local and state levels and primary health care;
- Coordinating with housing, employment and community educational programs necessary for quality community life;
- Developing and promoting a range of culturally appropriate services, especially for

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Native Americans and persons with mobility or sensory disabilities;

- Maintaining and developing specialty programs serving persons within corrections, probation and parole and community corrections and adult and juvenile justice and juvenile detention system involvement, including Driving While Intoxicated (DWI) programs, individuals in drug and mental health courts, homeless individuals, adult probationers and parolees and juvenile offenders;

- Ensuring that those involved in the life of a child or adolescent and family in the CBHS Protective Services or Juvenile Justice Services systems receive the behavioral health services they need in a timely manner and that services are coordinated and integrated;

- Enhancing the MaineCare managed care benefit package through the continued provision of enhanced services for behavioral health provided under the current (as of December 31, 2006) DHHS program for at least six months unless changes are agreed to by the DHHS/Collaborative;

- Providing access to appropriate and timely services for individuals with special health care needs; and

- Maintaining or developing specialty programs such as those for individuals who are homeless and have a mental illness, pregnant women, victims of sexual abuse, injection drug users and for individuals who have physical, cognitive, sensory, and/or mental/emotional disabilities;

1. Development of contracts with providers to assure that services are delivered according to local area and cultural needs, as identified by local collaboratives. Certain providers will be considered “essential”; the MCO will need to maintain a contract or method of payment with such providers for appropriate clients. Provider capacity for serving particular linguistic, refugees or cultural groups including but not limited to the and the deaf, blind, hard of hearing or visually impaired must also be maintained; in Phase Two, state-operated services may be considered essential providers;

2. Management of a system of care that coordinates and meets the behavioral health needs of the customers, including coordination between funding sources and coordination with physical health providers;

3. Promotion of a public health model that supports preventive care, early intervention and attainment of public health benchmarks;

4. Development of statewide behavioral health provider access based upon geo-access standards,

5. Operation of quality assurance and utilization management programs that ensure access to quality health care;

6. Operation of a management information system (MIS) and decision support system designed to meet the multiple funding, tracking and reporting requirements of the DHHS/Collaborative’s customers;

7. Development and provision of customer, family and provider education and training;

8. Establishment and implementation of a reinvestment account of at least three percent of behavioral health expenditures for increasing statewide access to behavioral health services (see Section I);

9. Establishment of a collaborative atmosphere among state departments and agencies, and community providers; and



ME's  
equivalent

10. A grievances and appeals process that meets state expectations and that meets federal requirements for MaineCare enrollees. Performance measures for the MCO during Phase One will be focused on assuring a smooth transition, continuing current service delivery and service capacity, meeting state and federal data collection and reporting requirements, and maintaining the outcomes and performance currently experienced in the multiple service delivery systems operated by various DHHS/Collaborative agencies. See Section III for further detail on performance measures.

**Phase Two (State FY 2008 and State FY 2008 – July 1, 2007 through June 30, 2008)**

During Phase Two, the MCO will work with the DHHS/Collaborative to identify more effective ways of combining multiple funding sources and funding mechanisms to increase service capacity, supporting local collaboratives and facilitating the customer outcomes and system performance the DHHS/ Collaborative desires. Performance objectives and deliverables will be developed and specified for this phase during Phase One so that clear progress toward the behavioral health system the DHHS/Collaborative envisions is accomplished. Local collaboratives will be formed and effectively operating, so will provide increasing input and information about service needs and quality issues within their geographic area. Additional resources will be sought collectively by the DHHS/Collaborative agencies and the MCO to address unmet needs and identified priorities for service expansions. Phase Two will also see the inclusion of additional funding streams and other resources not included in the initial phase.

**Phase Three (State FY 2009 and Beyond - Beginning by July 1, 2008)**

Phase Three is anticipated to begin no later than July 1, 2009. By this time, the system should be maturing, performance and outcomes should be clear and adjustments to the system can be undertaken based on those results. Any final funding streams planned to be included in the responsibilities of the MCO will be in place and all coordination with other related resources (local and statewide) will have been accomplished. The initial behavioral health service plan will be revised according to the needs identified by local collaboratives, the MCO and the DHHS/Collaborative.

New funding streams will continue to be sought to meet these needs.

**G. DELEGATION**

The MCO shall not assign, transfer, or delegate to the subcontractual level key management functions including, but not limited to, care coordination and universal credentialing without the explicit written approval of the DHHS/Collaborative. Any proposal to subcontract required functions initially must be made explicit within the offeror's proposal. The agreement by the DHHS/Collaborative to permit subcontractor functions will not relieve the MCO of any responsibility, obligation or liability for that function.

i. Only delegate those activities, functions and/or responsibilities agreed to in writing by the DHHS/Collaborative;

ii. Have a written document (Agreement), signed by both parties, that describes the responsibilities of the MCO and the delegate; the delegated activities; the frequency of reporting (if applicable) to the MCO; the process by which the MCO evaluates the delegate; and the remedies, including revocation of the delegation, available to the MCO if the delegate does not fulfill its obligation;

- iii. Have written policies and procedures to ensure that the delegated agency meets all standards of performance mandated by the DHHS/Collaborative;
- iv. Have written policies and procedures for the oversight of the delegated agency's performance of the delegated functions;
- v. Have written policies and procedures to ensure consistent statewide application of all utilization management criteria if any parts of utilization management are delegated;
- vi. Include in its agreement with the delegate whether the MCO or the delegate shall oversee the performance of the subdelegate to ensure that there is a mutually agreed document in place for any subdelegated functions;
- vii. Be ultimately accountable for all delegated activities and may not under any circumstances abrogate any responsibility for decisions made by a delegate regarding delegated functions;
- viii. Provide a list of all delegates to the DHHS/Collaborative;
- ix. Ensure that it notifies the DHHS/Collaborative of any proposed new agreement for delegation at least thirty (30) calendar days prior to the proposed beginning date of the Agreement or any material changes to existing Agreements;
- x. Ensure the delegate takes corrective action if the MCO identifies deficiencies; and
- xi. Revoke delegation or impose other sanctions if the delegate's performance is inadequate, in accordance with MCO'S policy and procedures.

## **H. SCOPE OF PROCUREMENT**

The scope of the procurement includes the implementation and operation of the new integrated behavioral health delivery system. The Collaborative will award the contract to a single offeror. The effective date of the proposed contract is January 1, 2007. Approval of the contract by the Federal Centers for Medicare and Medicaid (CMS) and Maine Department of Administrative and Finance Services (DAFSA) must be obtained before the effective date. The initial term of the contract is expected to be four years, with renegotiation of the contractual terms for the purpose of continuing the services described in this RFP and adding additional services and funding for three (3) additional years. The first renegotiation will be at the end of Phase One (year one) assuming satisfactory performance and will be for two years (Phase Two) with annual negotiation of funding. The second renegotiation will be for a final or fourth year (Phase Three), again assuming satisfactory performance. In no case shall the contracts, including the renewals thereof, exceed a total of four (4) years in duration.

**I. OFFEROR QUALIFICATIONS AND CONFLICT OF INTEREST**

**J. PROCUREMENT MANAGER**

**K. PROCUREMENT LIBRARY**

**L. DEFINITION OF TERMINOLOGY**

**ManCareRFP  
Consumer Work  
Group would like  
copies of these  
when completed.**

**II. CONDITIONS GOVERNING THE PROCUREMENT**

**MANDATORY TECHNICAL SPECIFICATIONS – STATEWIDE  
ENTITY (SE) REQUIREMENTS AND MANDATORY REQUESTS  
FOR INFORMATION**

This section defines the expectations and requirements of the successful offeror in several work areas that have been identified by the DHHS/Collaborative as being critical to a successful implementation of the new behavioral health service delivery approach and that will constitute the scope of work for the MCO. Each area includes Mandatory Requests for Information, the responses to which will be evaluated as the main part of the offeror’s proposal. The successful offeror must demonstrate a commitment to principles of recovery and resiliency and the values and philosophy of the DHHS/Collaborative expressed throughout this RFP. These values and principles and the offeror’s commitment to them, must be exhibited in its responses to each part of this section.

The ideas in this RFP have been assimilated from a variety of public meetings and from input of DHHS/Collaborative agencies to identify the elements necessary for successful implementation of the new approach to delivery and funding of behavioral health services in Maine. The requirements in this section are not necessarily all-inclusive, but the offeror’s responses will be considered part of the scope of work to which the successful offeror will be obligated upon the negotiation of a final contract. The DHHS/Collaborative may change some aspects of the requirements and require additional responses from the successful offeror during the contract negotiation process. Answers to each Mandatory Request for Information should be thorough and reflect a total understanding of the concepts outlined in this RFP and related documents in the appendices and the Procurement Library. The offeror must assure that all the expectations and requirements in this section and throughout this RFP are addressed in its responses to the Mandatory Requests for Information. The offeror should repeat the Mandatory Requests for Information in the order they are listed in this section and provide its response after each one. The offeror should clearly distinguish its response through changes in font, formatting or other

obvious method so that the reviewers can easily determine that all Mandatory Requests for Information have been responded to and can easily find and follow the offeror's response.

## **A. PROGRAM ADMINISTRATION AND SUPPORT**

### **Organizational Capacity**

#### ***Expectations***

Not only must the MCO be able to manage all listed behavioral health (mental health and substance abuse) services for those eligible for those services (see Appendix \_\_\_), it must also manage and account for funding and other requirements of state agencies within the DHHS/Collaborative. At a minimum, the MCO must be able to identify, track and report allowable and non-allowable expenses and utilization for required state and federal reporting and implement quality improvement, quality management and care coordination mechanisms that assure the delivery of cost-effective quality services for those customers receiving behavioral health services through the DHHS/Collaborative. Offerors must demonstrate evidence of experience with and knowledge of Maine's unique needs, and a dedicated in-state presence. It must also demonstrate the existence of a fully staffed, professionally qualified organization capable of managing a complex program including risk-based funding, programmatic funding and population-based funding, serving a variety of diverse populations. The organization, and its subcontractors, must be able to meet all administrative requirements related to appropriate state licensure, solvency, reporting, payment to providers and compliance with all applicable state and federal laws and regulations. The offeror must agree to change key Maine personnel if the DHHS/Collaborative determines such a change to be in the best interests of the state. The successful offeror must develop and maintain as many of the prescribed functions in Maine as possible and all employees must be within the United States.

#### ***Mandatory Requests for Information***

A1. Provide the name and address of the offering company/organization, including any "doing business as" either in Maine or in other locations.

A2. Provide a summary of the offeror's eligibility qualifications according to the criteria outlined in this RFP.

A3. Provide a table of the organization or organizational chart including an explanation of the functions of the significant operating units within Maine and in other locations.

A4. Provide the names and titles of the offeror's corporate CEO, CFO, CIO and Medical or Clinical Director and provide the names, titles, job descriptions, qualifications/credentiaing, resumes and FTE requirements of key personnel for the contract, including, but not limited to, the Maine CEO; CFO; CIO; Medical Director; Clinical Director; Maine staff that will lead the MCO's customer and family relations and provider relations activities; Maine staff assigned to liaison with the disability community, and Maine staff that will work with Collaborative staff and with local

collaboratives in each of the \_\_\_# geographic areas of Maine and in the \_\_\_# "area" with Native communities. If any such positions are not currently filled or individuals are not committed to these positions, the offeror must provide the job qualifications of each position.

A5. Indicate the offeror's willingness to participate in a common New Mexico NAL.

A6. Explain how the offeror will fill a critical vacancy if a position (as defined by the DHHS/Collaborative) set out in the staffing pattern becomes vacant; describe how the offeror will assure that if a critical position remains vacant for over 15 business days, the offeror will cover the position with overtime or a temporary or contract employee until the vacancy is filled;

Does ME have an equivalent ?

acknowledge that the DHHS/Collaborative or its members will reduce payments to the MCO by the amount associated with a vacant position if it is not filled and the DHHS/Collaborative has to provide staffing to fulfill critical tasks assigned to that position.

A7. Describe the timeline and process for how the offeror will replace critical leadership staff if the DHHS/Collaborative believes it is in the best interests of the state to do so.

A8. Provide copies of all Articles of Incorporation, bylaws, partnership agreements, or similar documents of the offeror including any legal entity having an ownership interest of five percent or more.

A9. Provide a list of all persons having an ownership interest of five percent or more, including their name, address and percentage of ownership.

A10. Provide a list of all management boards and committees, including membership; the title and position and place of employment of the member if employed by the offeror or any subsidiary or parent company; and place of employment of any member not employed by the offeror, subsidiary or parent company.

A11. Provide documentation describing the offeror's relationship to parent, affiliated or related business entities including, but not limited to, subsidiaries, joint ventures, or sister corporations.

A12. Provide a copy of the offeror's Insurance Division license that allows assumption of risk for prepaid capitated contracts under state law, or provide a detailed plan for how such a license will be in effect before January 1, 2007.

A13. Provide copies to the DHHS/Collaborative or its designee of all reports (in last 12 months) provided to the Insurance Division concurrently with the filing for the license or most recent reports required of currently licensed entities.

A14. Describe how the offeror has met or has the capability to meet all inspection and audit requirements delineated under state licensure law and all applicable requirements and standards delineated under state or federal law, regulations, or policy for each state agency within the DHHS/Collaborative and each funding source to be utilized by the MCO to provide the services and benefits described in this RFP.

A15. Demonstrate how the offeror has and will maintain an organizational structure within Maine designed to fulfill the requirements of the RFP.

A16. Describe what functions the offeror proposes to conduct in Maine and what functions will be performed outside the state, including the number and qualifications of staff associated with each function.

A17. Indicate what decisions will be made by the offeror's organizational structure and staff within Maine and what decisions will be made by an entity or offeror's staff outside Maine.

A18. Describe the offeror's experience, knowledge and history with Maine and its unique needs.

A19. Describe the offeror's experience in other jurisdictions similar to Maine demographically or similar in terms of the scope of work with multiple funding streams.

A20. Provide the number of MaineCare, MaineCare and other government-funded customers the offeror currently serves in Maine and in other jurisdictions, by each major fund source.

A21. Include the name, primary contact person and number of customers for each jurisdiction for which the offeror provides or has provided administration or management of behavioral health services and benefits in the last five years).

A22. Provide contact names and information and references for all government contracts held in the last five years.

A23. List any pending lawsuit or bankruptcy petitions, any lawsuit or bankruptcy that has been concluded within the last five years, or any current investigation of the offeror, its parent or subsidiaries that may be relevant to the operation of this program. Include a brief description of each item listed.

A24. Describe how the offeror will maintain such insurance as is currently required by applicable state and federal laws and regulations, including liability insurance for loss, damage, or injury (including death) of third parties arising from acts and omissions on the part of the offeror, its agents, and employees, workers compensation, unemployment insurance and stop loss insurance.

A25. Provide a copy of the offeror's liability insurance policy, workers compensation policy, unemployment insurance policy and any other relevant insurance policies.

A26. Certify and provide evidence that the offeror will provide a drug-free workplace as required by the Drug-Free Workplace Act of 1988 as defined at 28 CFR Part 67 Sections 67.615 and 67.620, for all its offices and locations that will be part of this contract.

## **Organizational Philosophy and Commitment to Values and Principles**

### ***Expectations***

The DHHS/Collaborative represents a unique process that has engaged by law multiple state agencies that are committed to preventing or lessening the adverse impacts of mental illness and substance abuse and improving the lives of Maine's citizens who face mental illness or substance abuse, and related issues such as domestic violence, sexual assault, incarceration, homelessness, unemployment, etc. As a result, it is critical that the successful offeror have a set of corporate values and be committed to goals similar to the goals of the DHHS/Collaborative. The successful offeror must be flexible and work with the DHHS/Collaborative to implement an approach never before tried statewide across so many agencies and funding streams. The successful offeror must be willing to propose solutions and make adjustments as the DHHS/Collaborative process unfolds and react positively to concerns identified by others. The DHHS/Collaborative is not looking for just a money manager, but rather for an entity that will help it fulfill the promise of the legislation that created it and the hopes and dreams of its stakeholders about a better system of care and better lives for people served. Therefore, the offeror must demonstrate a commitment to problem-solving and to performance and outcomes that will support recovery, develop resiliency, promote independence and improved quality of life, as well as a process consistent with the DHHS/Collaborative values about the importance of stakeholder voices, community-based care, customer/family driven services, and collaboration with local systems and with related systems critical to the outcomes the DHHS/Collaborative seeks.

### ***Mandatory Requests for Information***

A27. Describe the offeror's service delivery philosophy, values and corporate culture and how the offeror will work within the contract to promote the vision, values and principles described in this RFP, especially a commitment to recovery, resiliency, community-based services, customer/family involvement and cultural competence, and especially to promote independence and improved quality of life.

A28. Describe the ways in which customers and families are or will be included in the operations of the offeror in general or specifically in other jurisdictions, and how the offeror intends to include customers and families in the performance of the contract in Maine.

A29. Demonstrate evidence of the disability experience and knowledge and dedication to provision of services for individuals with disabilities in addition to mental illness and substance abuse.

A30. Describe the offeror's commitment to and steps it takes and will take to assure compliance with the American's With Disabilities Act (ADA) within its own operations and by its subcontractors and providers.

A31. Describe how the offeror proposes to work with the DHHS/Collaborative, Statewide Consumer Council System (SCCS) Statewide Quality Improvement Council (SQIC), BHWG and interagency state teams and local collaboratives to fulfill the aims of the contract.

A32. Describe how the offeror will utilize the SCCS, SQIC as an input and advisory mechanism to assure the programs and processes the MCO implements will work appropriately in and for Maine.

A33. Describe how the offeror will identify issues, offer solutions, listen to concerns identified by the DHHS/Collaborative and its stakeholders, and make adjustments to its business approach as warranted to meet the DHHS/Collaborative's goals as this process unfolds throughout the three phases of the contract.

A34. Describe how the offeror will work with the judicial system regarding court-ordered behavioral health treatment service.

A35. Describe how the offeror will work with facilities responsible for incarceration of individuals charged or convicted of crimes or status offenses and who are in need of behavioral health treatment within those facilities and upon release.

## **Administrative Burdens**

### ***Expectations***

The DHHS/Collaborative's goals include reducing the administrative burden on providers and reducing the confusion for customers and their families. The expectation is that the successful offeror will make things as consistent and friendly for providers as possible. The DHHS/Collaborative will require the MCO and its subcontractors to utilize consistent written and electronic forms for universal credentialing, daily operations, clinical assessments, utilization review, service authorization and billing purposes. The DHHS/Collaborative expects the MCO to utilize national standards as a basis for the single universal credentialing form and for other forms and processes. The MCO must submit as part of its proposal all forms and procedures affecting providers it proposes to utilize in the implementation of its proposal, and must be willing to adjust those forms based on input from providers, customers and families and local collaboratives, and based on requirements of the DHHS/Collaborative and its respective fund sources. Forms and procedures will be agreed to, adjusted or developed by an interagency workgroup working with the successful offeror, along with providers and other stakeholders. It will take considerable effort on the part of the MCO and the DHHS/Collaborative agencies' staff to help providers make the transition to these often new and consistent forms and procedures. While the forms will need to be consistent, it is possible the MCO, with the DHHS/Collaborative's approval, will allow the inclusion of a very limited number of specific questions on each form that apply only to a single subcontractor or to meet the needs of a specific state agency. Forms may be consolidated, modified, added or deleted just prior to and during the contract period. Those changes will be done in consultation with providers, customers and families, local collaboratives, participating state agencies and other appropriate parties, and only upon the final approval of the DHHS/Collaborative through its BHWG. The

DHHS/Collaborative encourages the limitation of prior authorization by the MCO to those services that are high-cost, highly restrictive or for which alternatives are being developed and encouraged, in order to reduce administrative burden on providers.

### ***Mandatory Requests for Information***

A36. Provide copies of all forms and related procedures intended for use by providers, customers or family members, including forms for universal credentialing, daily operations, clinical assessments, utilization review, service authorization and billing forms proposed to be used for the contract; if the forms are electronic, so indicate and provide a hard copy of the computer screen as the user would see it.

A37. Describe how the offeror will work with the DHHS/Collaborative and system stakeholders to adopt, select, modify, develop or plan to utilize common consistent forms and procedures.

A38. Describe how the offeror will work with providers to make the transition to the use of common consistent forms and procedures.

A39. Describe how the offeror will inform customers, families, referring agencies and other stakeholders about the transition to the use of common forms and procedures and the effect of this transition on these stakeholders.

A40. Describe how the offeror will implement a single universal credentialing and re-credentialing process for organizational providers and individual practitioners, including any proposal regarding privileging of practitioners to conduct specialized assessments or to provide specific services requiring special training or experience (e.g., forensic evaluations, sexual abuse/trauma, mobile crisis services, etc.).

A41. As this collaborative effort is aimed at the reduction of high-end services and the establishment of less restrictive, community-based services, describe specific strategies and steps you would take to make this transition, i.e., rates, utilization, capacity building, etc.

A42. Describe any use of technology the offeror will utilize to reduce the administrative burden on providers, and make access to information easier for providers, customers, families, referring entities and the public, including how the offeror will make this technology available for those who need it and provide training in its use.

A43. Describe what other actions the offeror's organization will take to reduce administrative burdens on providers and help assure that the most possible dollars go to direct services and that providers are able to spend the least amount of time possible getting paid while still assuring quality of services and compliance with rules and regulations.

A44. Describe how the offeror will work with the state agencies in the DHHS/Collaborative and with providers to help reduce any duplication in audit and quality oversight processes while assuring quality of services and compliance with rules and regulations.

## **Finances and Cost Proposal**

### ***Expectations***

The DHHS/Collaborative expects the offeror to be able to segregate all financial information related to the DHHS/Collaborative partners from other lines of business. The offeror must be able to report financial information in a manner consistent with the needs of each funding agency within the DHHS/Collaborative, with the rules and regulations of each funding source, and in a manner that utilizes generally accepted governmental accounting principles and standards. The DHHS/Collaborative expects and will work with the MCO to develop common and consistent reporting mechanisms where the DHHS/Collaborative agencies have the flexibility to do so.

Throughout the process, the DHHS/Collaborative will require the MCO to examine rates and funding mechanisms to help assure that the system has incentives to move toward those services that promote recovery and resiliency and move away from those services that do not produce adequate outcomes for customers and their families. These decisions will have to take into account available resources and funding stream constraints. The DHHS/Collaborative will work with the MCO, local collaboratives, behavioral health service providers, the SCCS, SQIC and other stakeholders to make the most of these available resources and will use and expect the MCO to use financial incentives to keep the system moving toward the required customer and family outcome and system performance goals. Because there are multiple funding streams and multiple service delivery populations (some of which are entitled to certain services and some of which are not), there will need to be multiple funding mechanisms for the MCO. Some of the funding contracted to the MCO will be financially risk-based, most likely a capitation amount or per-member (customer), per-month payment for each eligible and enrolled individual. In other cases, the funds provided will be based on a budget or rate for specific deliverables or activities. In still other cases, there may be a global or program budget to serve particular populations for particular services or programs, with specification of amounts of services to be provided, dollars to be spent or numbers of persons to be served. In some cases, funds may be paid on a fee-for-service basis. The DHHS/Collaborative may recoup from the MCO erroneous payments such as those based upon duplication or inappropriate payments. Some of the populations covered by these fund sources are entitled to certain services once they are made eligible (e.g., MaineCare). This will result in different services being available for different groups of people, some as an insurance payment and some on a program funding or population funding basis. All financing must be in compliance with Balanced Budget Act (BBA) requirements regarding the use of Medicaid funds. However the individual funding streams are provided to the MCO, the DHHS/Collaborative will work with the MCO initially and over time to make the dollars as flexible and as interchangeable as possible within the restrictions of the state or federal funds involved. An example is the "Wraparound Service Agreement" funds administered by CBHS. Those funds are used extremely flexibly for services and products for children and families, including undocumented children, as part of their treatment plan, to maintain them at home and in their communities and therefore reduce out-of-home placement. It is expected that those funds, as well as others that can be identified, will be used in that manner with any enhancements that are practical. The DHHS/Collaborative and the MCO will work together to identify state and federal constraints that preclude more efficient use of funds or better services or access. These constraints will be the basis of joint advocacy as this initiative unfolds. They will also be the basis of a requirement for community reinvestment of some of the funds managed by the MCO/ to encourage and provide incentives for cutting edge and alternative service delivery. These community reinvestment dollars will come from limitations on non-direct care costs and limitations on percentage of revenue over expenditures that can be retained by the managed care organization.

*MaineCare Managed Care* - The offeror must provide a MaineCare managed care cost proposal for each specified rate cell for each MaineCare managed care population group. The offeror's proposal is to be based upon the anticipated enrollment specified in the Procurement Library. Summaries of current expenditures for current services and populations are available in the Procurement Library. For the non-fee-for-service MaineCare population, the rate information is to be provided on a Per-Member-Per-Month (PMPM) basis for each rate cell and include a total

PMPM. The cost proposals on a PMPM basis are to be categorized into behavioral health service expenses and administrative expenses, keeping in mind the allowable administrative costs and the required proportion that must be used for direct service-related costs (Section I). The PMPM categorical expenses are to be totaled by rate cell. The offeror is expected to provide separate proposals for each of the first two years of the contract. Any deviation from the specified requirements may result in an invalid cost proposal and in an invalid RFP response. For non-fee-for-service MaineCare populations, the offeror is expected to describe the methodology used to determine each cell's rate and are expected to fully justify the expenses for each rate cell. Justification is to include, but is not limited to: expense trending, utilization trending, enrollment projections, profit percentages, administrative expenses and capitation expenses. By accepting the negotiated capitation rates for the identified MaineCare eligibles, the offeror agrees that the capitation rates are sufficient to assure the financial stability of the MCO with respect to the delivery of services included in the contract to the recipients covered in the contract. The offeror, by responding or submitting a response to this RFP, acknowledges that the payment for non-fee-for-service MaineCare eligibles is a risk payment and the offeror should not agree or accept capitation rates if the offeror cannot perform the duties and requirements set forth in the contract for the capitation rates agreed upon between the DHHS/Collaborative and the offeror during the capitation rate negotiation.

*MaineCare Fee-for-Service* - The offeror must provide the following information in the cost proposal for MaineCare fee-for-service:

- A proposed rate structure including the methodology and justification for the proposed rate structure, i.e., administrative fee, fee-for-service schedule or other; and
- The cost proposal should contain a narrative that includes a discussion of the key assumptions and data related to the cost proposal, including, at a minimum, a description of medical expenses, utilization trend, unit cost trend, profit margins, administrative expenses and projected enrollment. The DHHS/Collaborative reserves the right to make changes in the reimbursement amounts and methodology in future years. The DHHS/Collaborative will continue to evaluate the cost/benefit of modifying the reimbursement system to improve services to members. The DHHS/Collaborative will continue to evaluate the feasibility of a more detailed diagnosis or behavioral health-based rate system and reserves the right to adopt changes, pursuant to the contract provisions, as warranted. The DHHS/Collaborative will fund the MCO to provide the following UR services for fee-for-service behavioral health services:
  - Prior authorization and retrospective post-payment reviews of psychiatric hospital inpatient children, adolescents and adults and of partial psychiatric hospitalization; and
  - Prior authorization of outpatient neuropsychiatric and psychological services and of rehabilitation hospital inpatient. The DHHS/Collaborative is interested in the offeror's suggestions about mechanisms to fund the MCO to manage the MaineCare fee-for-service behavioral health benefits.

***Mandatory Requests for Information***

A45. Describe how the offeror will comply with net worth requirements and maintain a fidelity bond that meets the amount specified for the time specified under the Maine Insurance Code.

A46. Describe how the offeror will maintain adequate protections against financial loss due to outlier (catastrophic) cases and customer utilization that is greater than expected for all applicable periods of the contact, including how the offeror will comply with all state and federal laws and regulations regarding solvency, risk and audit and accounting standards.

- A47. Provide copies of the offeror's most recent audited financial statements for each line of business operated, showing a separation between commercial and public accounts and between various contracts and various public fund sources for which the offeror is responsible.
- A48. Describe how the offeror will identify other insurance held by the offeror's customers and other insurance that may be required to pay for services provided to customers (third party liability), coordinate benefits with third parties, furnish the DHHS/Collaborative with documentation or other information necessary for DHHS/Collaborative agencies to pursue their rights under state or federal law and provide information and documentation to DHHS/Collaborative agencies in the event costs are recovered from a third party for any service provided by the MCO or its subcontractors.
- A49. Describe processes and procedures for tracking funding and expenditures from each fund source in the contract, and for tracking all financial information for the contract separately from other lines of business, including providing an independently audited financial statement annually for each separate fund source and providing the DHHS/Collaborative with the original copy of the audit report in accordance with the State Auditor's schedule.
- A50. Describe the offeror's capacity for providing to the DHHS/Collaborative program and fiscal reports on a monthly, annual or ad hoc basis as required or requested; these reports should be available for all funding sources, i.e., CBHS, Medicaid and all others.
- A51. Describe the offeror's capacity and experience in maintaining accounting systems that are in accordance with generally accepted governmental accounting principles and standards.
- A52. Describe any findings in any of the offeror's prior three years of audits (including subsidiaries or other organizational entities sharing the same financial management and accounting staff) where the finding is associated with the management or expenditure of public or governmental funding sources; explain any past corrective action taken or currently being taken to address these findings.
- A53. Describe methods to identify and prevent fraud and abuse in any funding source and to recoup monies found to be inappropriately billed by or paid to any provider or subcontractor.
- A54. Describe the process the offeror proposes to determine how to expend community reinvestment monies to support the vision and goals of the DHHS/Collaborative for the new behavioral health delivery system, including the appropriate involvement of the DHHS/Collaborative, SCCS, SQIC, local collaboratives, customers and families and providers in making that determination, and how these funds will be accounted for once expended.
- A55. Identify the financial institution(s) and the joint account format in which the offeror proposes to set aside the community reinvestment and the performance withhold funds required in the contract (see Section I of this RFP).
- A56. Provide the offeror's cost proposal for MaineCare non-fee-for-service populations as described earlier in this subsection.
- A57. Describe the mechanism the offeror recommends the DHHS/Collaborative utilize to pay for fee-for-service MaineCare services and for retroactive cases.
- A58. Describe the proportion of funding made available to the offeror that will be spent on direct services by subcontract providers and by offeror-owned and operated services or employed practitioners during Phase One of the contract, utilizing the list of allowed administrative activities and the minimum required expenditures on direct services described elsewhere in this RFP.

A59. Describe how the offeror will cooperate with the DHHS/Collaborative or its designee in the provision of all financial records necessary for the DHHS/Collaborative to assess the offeror's compliance with these financial requirements.

A60. Describe how the offeror will comply with or be able to meet the federal substance abuse and mental health block grant requirements set forth in Appendix \_\_\_.

## **Management Information Systems (MIS) for Data Collection, Reporting and Utilization for Decision-Making**

### ***Expectations***

Data for decision making that is accurate, timely and consistent, gleaned from a variety of sources and used to drive system planning, budgeting, quality management and performance evaluation are critical to the DHHS/Collaborative's success. Decisions made at all levels must be based on consistent analyses and interpretations of these accurate and timely data. The offeror must demonstrate an ability to accurately and timely collect, report and utilize data. Included in the information analyzed must be literature, reports and first-hand accounts that describe evidence based and promising practices from other jurisdictions as well as information generated from within Maine's behavioral health system. The offeror must maintain a management information system (MIS) and address operational issues about the data to be supplied, who will supply the data, how the data will be exchanged, and how the data will be kept secure. The offeror's MIS must support daily operations and monitor the integrity of the service system and the performance of service providers; have the capability of adapting to any future changes necessary as a result of modifications to the service delivery system and its requirements; and ensure data submission timeliness, accuracy, and completeness.

Each of the agencies included within the DHHS/Collaborative have distinct data collection mechanisms, unique data systems and specific reporting requirements. Some of these requirements are state controlled; some are requirements of federal or other fund sources. The MCO must be able to gather data from multiple sources and prepare reports as required by each agency and for the DHHS/Collaborative as a whole. The MCO must also be able to export required data to the various state agencies in an agreed upon format. It is also expected that the MCO's MIS will feed required data to the MaineCare Medical Information System (MMIS) for MaineCare claims processing purposes. The MIS must also provide for the multiple funding streams' multiple service delivery populations and multiple funding mechanisms with which the MCO will be working. A sample of data elements currently collected by each participating agency is attached as Appendix \_\_\_. In Phase One, specific data elements, as well as any data elements required by Maine's \_\_\_\_\_ Implementation and Comparison guides for electronic claims, must be collected by the MCO and reported to the identified agency in a manner that will satisfy the fund source requiring the collection and/or reporting of that data element. The MCO will be expected to work with the funding DHHS/Collaborative agencies to make data collection and reporting more common among the multiple funding streams and to help design a single data system for collecting and reporting behavioral health service utilization, provider, customer, performance and outcome data. Currently, each state agency provides services that are defined differently with different methods of billing and accounting for these services. The implementation of the Health Insurance Portability and Accountability Act (HIPAA) requires a common approach to the coding, and therefore the definitions, of services that are essentially the same activity. Several state agencies that pay for services subject to



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HIPAA requirements are working together to make sure their data systems and service definitions are consistent. HIPAA requires the use of certain standardized codes and service definition sources, including Common Procedural Terminology (CPT) codes and Health Care Common Procedure Coding System (HCPCS) codes. While these codes and service definitions may not be familiar to many behavioral health providers, HIPAA requirements and the implementation of the DHHS/Collaborative are coinciding to make these changes necessary. The state agencies involved in the DHHS/Collaborative are creating a common service taxonomy, common service definitions and common service billing codes for all behavioral health services to be funded by state-controlled dollars. The MCO and its subcontractors will be required to utilize only HIPAA-compliant data and billing systems and to comply with all aspects of federal CMS and HIPAA security, confidentiality and transactions requirements. Standards are specified in the MaineCare Systems Manual and at 42 CFR 431.306(b). Specific data capability requirements that must be addressed in the offeror's response to the questions in this subsection are as follows:

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ME's equivalent

- The offeror is required to maintain complete provider information for all providers contracted with the offeror and its subcontractors and any other non-contracted providers who have provided services to date.
- The offeror must transmit a provider network file to DHHS at least on a monthly basis no later than the 28th day of each month and prior to the submission of encounter files, to include all contracted and non-contracted providers who have provided service to date, and providers who have been terminated from contract. The file is a general replacement file each month with no deletions from the file until three years past the date of the provider's termination or denied status. Once a provider is shown on the file, the provider should continue to be reported regardless of whether any encounters are reported.
- The offeror must provide complete and accurate designation of each provider according to the data elements and definitions included in the MCO/ASO Systems Manual, including assignment of unique provider numbers to each type of certification the provider organization has, according to DHHS's classification of provider type.
- The offeror must be able to accept, maintain and transmit all required customer information.
- The offeror must be able to monitor retroactive eligibility of its consumers, ensuring that providers' claims for services are recognized as valid for the retroactive period as long as the claims are submitted within 120 days of the date the customer's eligibility is determined.
- The offeror must be able to generate member information to providers and subcontractors within 24 hours of receipt of the MaineCare enrollment roster from DHHS.
- The offeror must maintain and transmit to subcontractors data using a unique ten-digit number assigned by one or more members of the DHHS/Collaborative to be used for client identification and adjudication of claims, and the offeror's capability to match the ten-digit number with the customer's Social Security number, or any number used within the offeror's system to track the customer.
- The offeror must maintain a special medical status identifier on its system's database consistent with DHHS's MaineCare system for this field. This requirement also applies to any subcontractor who maintains a copy of the customer rosters for the purpose of distributing eligibility or roster information to providers or verifying customer eligibility.
- The offeror must track changes in the customer's category MaineCare and other fund source of eligibility to ensure appropriate services are covered and appropriate application of copays.
- The offeror must maintain accurate customer eligibility and demographic data.

- The offeror must provide automated access to providers regarding customer eligibility for services by fund source; and provide an automated voice response system for providers to verify eligibility, especially for MaineCare.
- The offeror must have standard protocols for the transfer of claims information between the offeror and its subcontractors/providers, audit trail activities, and the communication of data transfer totals and dates;
- The offeror must meet both state and federal standards for processing claims.
- The offeror must generate remittance advices to providers.
- The offeror must participate on a committee with the DHHS/Collaborative to discuss and coordinate systems-related issues and identify any coding issues that could disrupt the DHHS/Collaborative's and its agencies' ability to report services consistently and accurately.
- The offeror must edit claims to ensure providers licensed to render the services being billed are submitting services, that services are appropriate in scope and amount, that customers are eligible to receive the service and that services are billed in a manner consistent with national coding criteria (e.g., services provided in a residential setting are coded with an inpatient type of bill, discharge type of bill includes discharge date, etc.).
- The offeror must submit to each funding DHHS/Collaborative agency at least 50 percent of its encounters within 30 days of the date of service, at least 75 percent of its encounters within 60 days and at least 90 percent of its encounters within 90 days, according to the specifications included in the MaineCare Systems Manual, regardless of whether the encounter is from a subcontractor or sub-capitated arrangement. All encounters must be submitted within 120 days of the date of service, regardless of whether the encounter is from a subcontractor or sub-capitated arrangement.
- The offeror must submit encounter files with no more than 3 percent of encounters denied in any given submission. The offeror must submit corrections to 90 percent of any encounters that are denied within 10 working days of the notice of denial; with 100 percent of corrections made within 30 days.
- The offeror must submit adjustments/voids to encounters previously accepted by HSD within 30 days of the adjustment or void of the claim by the offeror or its subcontractors.
- The offeror must have a written contractual requirement of subcontractors or providers that they pay their own claims to submit encounters to the offeror on a timely basis, which ensures that the offeror can meet its timeline requirements for encounter submission.
- The offeror must edit encounters prior to submission to prevent or decrease submission of duplicate encounters, encounters from providers not on the offeror's provider network file and other types of encounter errors.
- The offeror must have a formal monitoring and reporting system to reconcile submissions and resubmissions of encounter data between the offeror and the DHHS/Collaborative agencies to assure timeliness of submissions, resubmissions and corrections and completeness of data. The offeror will be required to report the status of its encounter data submissions overall on a form developed by the DHHS/Collaborative (the form to be acceptable for the MaineCare fund source and DHHS).
- The offeror must have a formal monitoring and reporting system to reconcile submissions and resubmissions of encounter data between the offeror and the subcontractors or providers who pay their own claims to assure timeliness and completeness of their submission of encounter data to the offeror.

- The offeror must comply with the most current federal standards for encryption of any data transmitted via the Internet (this also applies to subcontractors). A summary of current CMS and HIPAA guidelines is included in the MaineCare Systems Manual.

The DHHS/Collaborative is also in the process of expanding the state's AVATAR Electronic Patient Chart system to include HIPAA-compliant electronic records for individuals who currently receive behavioral health services through DOH. The AVATAR system is particularly helpful in tracking treatment for adults with co-occurring disorders who are cared for in different parts of the health system, and for tracking and transitioning adolescents from the child to the adult service system. The MCO will be able to assist the DHHS/Collaborative in further expansion and use of the Electronic Patient Chart system. As indicated earlier, some providers are not used to electronic billing and many are not used to electronic charting. The MCO will be expected to develop a plan to assist in moving providers toward the ability to use these electronic processes. The MCO will need to provide technical assistance and training as needed to all participating providers to ensure collection and reporting of required information.

***Mandatory Requests for Information***

A61. Describe the hardware, software, and information resources that will be used by the offeror to accept, transmit, maintain and process customer, provider, prior authorization, and claims information. In the description of resources, include a description of key Information Systems (IS) staff and their responsibilities and how they interface with other divisions within your organization and with subcontractors.

A62. Describe the offeror's capacity to manage customer-specific information, including information about the eligibility of and services received by individuals applying for or receiving services from any program funded through the DHHS/Collaborative, addressing all the expectations described in this section.

A63. Describe how the offeror will ensure its ability to disseminate enrollment and/or assignee information to providers within 24 hours of the offeror receiving the information, addressing all the expectations described in this section.

A64. Describe real-time mechanisms the offeror will use to maintain information for the provision of services and care coordination across the state, including persons served and services provided to the general population or population groups in prevention and early intervention programs.

A65. Describe the offeror's capability to maintain and transmit data to subcontractors using a unique ten-digit number assigned by one or more members of the DHHS/ DHHS/Collaborative to be used for client identification and adjudication of claims, and the offeror's capability to match the ten-digit number with the customer's Social Security number.

A66. Describe the hardware, software, and information resources of any subcontractors who will be responsible for any of the functions carried out by the offeror's internal information systems team (e.g., if the subcontractor is responsible for receipt and dissemination of an enrollment roster, if the subcontractor processes claims and submits encounters to the offeror); are the hardware, software, and system resources of the offeror and its subcontractors currently in place or are they in process of development?

A67. Describe any contingency plans for system failure in any critical business areas.

A68. Describe the offeror's service encounter data collection and reporting capacity, addressing all the expectations described in this section, specifically the offeror's MIS capacity to capture service-related information on each customer by service provider; include the offeror's MIS capacity to:

- Accept HIPAA-compliant electronic service information;
- Use standardized codes;
- Collect and report encounter data;
- Maintain provider-specific fee schedules;
- Support automated payment adjudication;
- Produce HIPAA-compliant Explanation of Benefits (EOB);
- Make timely payment of claims;
- Interface with financial systems; and
- Produce timely and required monthly, annual and ad hoc reports.

A69. Describe who will maintain the offeror's MIS and address operational issues about the data to be supplied and reported, including who will supply the data, how the data will be exchanged, how the data will be kept secure and how timely changes to the MIS will occur.

A70. Describe the offeror's capacity to do the following:

- Maintain and retain secure electronic and hard copy records including clinical, data and financial;
- Develop and establish mechanisms for monitoring and reporting sentinel/critical events, e.g., incarcerations, deaths, suicides, suicide attempts and involuntary hospitalizations, detentions for protective custody and detention for alleged criminal activity;
- Develop and implement systems for payment of last resort and third party liability (TPL);
- Manage and account for unique funding streams and other requirements of state agencies within the DHHS/Collaborative;
- Develop any necessary support for sliding-fee scale procedures; and
- Identify, track and report allowable and non-allowable expenses within each geographic area, entities and providers ("allowable" expenses are expenses that are reimbursable).

A71. Describe how the offeror will submit invoices and required program reports to the DHHS/Collaborative, by fund source as necessary, in a format consistent with the specifications of each DHHS/Collaborative member agency and to submit electronically, real time demographic service provisions, billing and outcome information reports to each DHHS/Collaborative member agency providing funding and no less than monthly aggregate reports to the DHHS/Collaborative as a whole (it should be noted that each agency currently requires unique information which may require reporting data using different demographic criteria such as age categories., geographic areas, etc.); such invoices and reports will be required on a monthly or annual basis and will include but not be limited to:

- Documenting and reporting to the DHHS/Collaborative the process for verifying that TANF-funded participants are receiving TANF assistance or are TANF eligible;
- Financial reports detailing the expenditures incurred under the TANF Substance Abuse Treatment Program, as needed to meet federal reporting requirements;
- Documenting and reporting to the DHHS/Collaborative the process it will use to verify eligibility of MaineCare customers and medical necessity for state MaineCare plan services for such customers;
- Identification of how it will comply with all federal block grant requirements, including the Community Mental Health Services (CMHS) and Substance Abuse Prevention and Treatment (SAPT) block grants and other federal requirements (see Appendix \_\_);

- Collecting and tracking of service data for ALTSD individual clients for services and service data tracked for other services including monthly and quarterly to meet quarterly state reporting requirements and annual federal reporting requirements, as follows:
  - Activities of Daily Living (ADL) and Independent Activities of Daily Living (IADL) assessment: seven ADLs and 10 IADLs;
  - Nutrition assessment: 10 questions that provide a nutritional risk score;
  - Service data: month of service, units of service provided for ALTSD peer counseling services;
- Collecting monthly treatment attendance data for individuals covered through Maine's Department of Corrections, including but not limited to budget expenditures as well as inmate/offender demographics, criminal history, classification/risk and behavior;
- Providing School-Based Health Centers (SBHCs) with the ability to log, track and generate statistical reports from health promotion and/or prevention activities including visit counts, user counts, ICD-9 and CPT reports in addition to client and encounter information, by center and statewide;
- Providing information on data collection concerning the collaboration between SQIC's and mental health services paid for through special education funds;
- Collecting and generating accurate statewide statistics tracking identification and service delivery and quality for individuals with other disabilities and mental illness or substance abuse, including but not limited to persons with developmental disabilities and mental illness (DDMI), Autism spectrum, traumatic brain injury and co-occurring mental illness and substance abuse;
- Ensuring that Preventive Health Services (PHHS) Block Grant Funds are utilized in compliance with the following requirements:
  - Activities shall be designed to increase awareness of sexual assault issues with the desired impact of decreasing the incidence of sexual assault and increasing the number of victims seeking treatment.
  - The activities shall target public/private elementary, middle, and high school and college students/faculty; and law enforcement/judicial system personnel; and
  - The offeror shall ensure that sexual assault prevention and intervention services are provided in compliance with PHHS Block Grant requirements;
- Utilize data from the Youth Risk and Resiliency Survey and the Safe Schools Report regarding type and classification of drug use, pattern of usage and criminal offense-related data, specifically:
  - *Drug use and other drugs* pertains to marijuana, cocaine, methamphetamines, hallucinogens, inhalants and heroin;
  - *Youth Risk and Resiliency Survey* collects data on substance use including all forms of tobacco, alcohol and other drugs; and
  - *Safe Schools Report* collects data on drug and alcohol violations categorized as criminal offenses and the number of drug and alcohol violations reported to law enforcement officials.

A72. Describe and provide examples of how the offeror will provide information that identifies trends, defines future program direction, controls health care expenditures, and detects fraud and

abuse and maintains system integrity, including supporting daily operations and monitoring the performance of service providers.

A73. Describe how the offeror will respond to changing needs, including adapting to any future changes necessary as a result of modifications to the service delivery system and its requirements and taking advantage of technological advancements.

A74. Describe the offeror's data collection system's capacity to respond to requests by the DHHS/Collaborative for changes in the type of data collected and reported and the manner in which encounter and other customer or provider-specific data is collected and reported.

A75. Describe specifically how the offeror proposes to move from the current service definitions and codes to the newly developed common service definitions and codes, a draft of which is in Appendix \_\_\_\_, including what efforts the offeror will make during the transition period prior to January 1, 2007 to ready providers to report and bill for the new service definitions and codes.

A76. Describe how the offeror will estimate the number of encounter records to be received from providers and subcontractors and how the offeror will monitor and transmit electronic encounter data to DHHS according to encounter data submission standards, in order to monitor the completeness of the data being received and to detect providers or subcontractors who are transmitting partial or no records.

A77. Describe how the offeror will ensure data submission timeliness, accuracy and completeness by subcontracted providers, including provider compliance with sentinel event and disease-reporting requirements, behavioral health related HEDIS® information and encounter data submission.

A78. Describe the offeror's strategies, resources and capabilities to collect, report annually and use MHSIP data, including drawing a statistically valid sample for both MaineCare and non-MaineCare customers, and train MCO and provider staff in the collection and reporting of MHSIP data and conducting the survey; to track satisfaction data for behavioral health services; report MHSIP data annually including drawing a statistically valid sample from which to collect MHSIP data from both MaineCare and non-MaineCare customers; and train its staff in the collection and reporting of MHSIP data and in conducting the survey.

A79. Demonstrate capabilities (data management systems, hardware and software capabilities, qualified and trained personnel, data reporting capabilities) to collect, maintain, and manage the information to meet the needs of each DHHS/Collaborative agency's funding streams, including, but not limited to, MaineCare, federal mental health and substance abuse block grants and other federal and state funds.

A80. Describe how the offeror will provide technical assistance for providers to assure that accurate and valid data is collected and reported.

A81. Describe how the offeror will comply with all HIPAA requirements.

A82. Describe how the offeror will comply with the confidentiality requirements for substance abuse treatment and customer data, pursuant to 42.CFR Part 2; (note: these requirements are more stringent than HIPAA privacy requirements).

A83. Describe with examples how utilization management (UM) data and reports will be used internally to track and trend evidence of under- and over-utilization and how monthly UM reports will be provided to the DHHS/Collaborative, and to the SCCS. SQIC and local collaboratives as required by the DHHS/Collaborative, in a format to be determined by the DHHS/Collaborative after consultation with the MCO; reports will include a written narrative

analysis at least quarterly identifying potential indications of trends within the data, interpretations of system issues potentially responsible for the trend.

A84. Describe the offeror's capacity to collect, manage and report data necessary to support the measurement aspects of quality assurance and quality improvement activities, specifically to track and determine whether the DHHS/ Collaborative's performance and outcome requirements are being met (see Quality Management subsection) and to track, analyze and report to the DHHS/Collaborative monthly, identified indicators that will enable the state to determine potential problem areas within quality of care, access or service delivery. A85. Describe the offeror's ability to design sound quality studies, to apply statistical analysis to data and to derive meaning from statistical analysis.

A86. Describe how the offeror will utilize data for research and evaluation purposes to improve the behavioral health delivery system in Maine.

A87. Describe how the offeror proposes to work with the DHHS/Collaborative to move toward more common data collection and reporting mechanisms while still being able to report as required by the various fund sources involved.

A88. Describe the roles of customers, families, providers, local collaboratives the SCCS, the SQIC and other stakeholders in the offeror's collection, reporting and analysis of data for quality assurance and improvement purposes.

A89. Describe how the offeror will use Internet systems to transmit data electronically and to maintain a web site for dispersing information to providers and members, and be able to receive comments electronically and respond when appropriate

A90. Describe the offeror's system backup and recovery plan.

A91. Describe how the offeror will meet each of the conditions required for provider enrollment and the acceptance, maintenance and transmission of required provider data.

A92. Describe the procedures for coordination between your provider relations division and external subcontractors and internal MIS staff that will ensure the accurate assignment of provider type and specialty, along with other data required to be reported for providers, as well as the prompt entry of provider information into the offeror's system.

A93. Describe how the offeror will meet each of the conditions required for customer enrollment and eligibility notification and the acceptance, maintenance and transmission of required customer data.

A94. Describe the protocols and procedures the offeror will and its subcontractors follow to ensure appropriate release of customer information, in accordance with federal HIPAA standards.

A95. Describe the offeror's proposed automated access system for providers to obtain customer enrollment information; address the cross-reference capability of the system to the customer's unique ten-digit ID number and their most current category of eligibility.

A96. Describe your proposed dissemination of ID cards to members; include a sample of a current or proposed ID card showing information as it is disseminated to the customer.

A97. Describe the procedures the offeror and your subcontractors will follow to ensure compliance with federal and state standards and what sanctions or remedial actions will be invoked if failure to meet these standards occurs.

A98. Describe the edits that are performed and procedures for correcting encounter data when post-review denies a claim that has already been accepted by DHHS as a valid paid encounter.

A99. Describe how the offeror will train providers in the use of an electronic HIPAA compliant billing system.

A100. Describe how the offeror will meet each of the conditions required for encounter and provider network reporting and the acceptance, maintenance and transmission of required encounter and provider network data.

A101. Describe how the offeror will assure that all encounters are submitted to HSD within the specified timelines, regardless of the particular subcontracting arrangement.

A102. Describe the activities the offeror will undertake to ensure complete reporting of payment information by providers on the encounters submitted.

A113. Describe how the offeror will comply with or be able to meet the federal substance abuse and mental health block grant requirements set forth in Appendix \_\_ of this RFP.

## **Network Capacity**

### ***Expectations***

The MCO must be able to demonstrate its ability to meet the behavioral health service needs and provider network capacity beginning January 1, 2007, and to maintain continuity of care and system stability. The MCO must maintain a contract or method of paying all providers interested in contracting for services that meet mandatory requirements and who received state controlled funds as of December 31, 2006. Contingent on satisfactory performance, the MCO shall continue to reimburse eligible providers for a minimum of six months while a network is being established. It is anticipated that a new network may require up to twelve months to develop.

The process of developing a network should represent a fair selection among willing and appropriately qualified and credentialed providers, rather than simply an arbitrary process of maintaining currently existing business relationships. Nothing in these expectations will guarantee any particular provider a particular amount of funding during FY 2007. These provider contracting decisions will be made by the MCO with input from the DHHS/Collaborative based upon service needs, available resources and provider performance. In some cases, the DHHS/Collaborative will require the use of certain providers for particular services or populations.

### ***Mandatory Requests for Information***

A104. Describe in detail the offeror's provider network development plan to assure that services are available throughout Maine and that sufficient providers are available to meet the service needs of entitled and priority populations.

A105. Describe how the offeror will assure a sufficient network that includes access to the full continuum of skilled behavioral health providers to deliver the full range of behavioral health services funded by the DHHS/Collaborative, from the most to the least restrictive settings, and that encourages and supports illness self-management and recovery for adults and self-direction and the development of resiliency for children and their families.

A106. Describe how the offeror will assure a provider network for services for individuals who have mental health and substance abuse treatment needs, such as a serious and persistent mental illness; serious emotional, behavioral and/or neurobiological disorders; short-term mental conditions; substance abuse disorder(s); and/or behavioral conditions related to traumatic brain injury or other disability; or chronic illness such as mental retardation and/or developmental disability with a mental illness or substance abuse, specifically a network that is able to:

- Provide services and interventions that are based on the individual's strengths and promote the customer's optimal functioning, with the goal of assisting the

customer in participating fully in the life of his/her community;

- Provide services in a fully integrated and coordinated manner for individuals who have dual or multiple diagnoses of mental illness, substance abuse, mental retardation, developmental disabilities and/or physical illnesses and/or disability;
- Provide individualized services and interventions according to the customer's assessed behavioral health need(s), at the most clinically appropriate, least restrictive level of care;
- Provide timely access to medically necessary behavioral health care;
- Provide access to services and treatments that assist in the rehabilitation and attainment of the highest possible quality of life for persons with serious mental illness, chronic addictive disorder or severe emotional disturbance; and
- Increase the capacity for delivery of community-based services and supports (for children) in the statewide behavioral health network.

A107. Describe how the offeror will work with the provider network to implement policies and procedures for coordination of physical and behavioral health services and monitoring its implementation.

A108. Describe how the offeror's network will ensure the continuity and coordination of a customer's medical and behavioral health care among practitioners treating the same customer, including the monitoring of medications.

A109. Describe how the offeror will develop and implement behavioral health clinical practice guidelines for major behavioral health diagnoses for infants, children, youth, adult and elderly populations; describe how the offeror will assure that these guidelines will be consistent across the state, including the use of utilization management criteria and processes to access those services, and how the offeror will assure the guidelines are based on the Maine definition of medical necessity, and other criteria approved by the DHHS/Collaborative for clinical, rehabilitative or supportive services, professionally accepted standards of practice and national guidelines, and with input from practitioners and customers.

A110. Describe how the offeror will ensure a smooth transition for customers and their families in situations when a network provider leaves the network.

A111. Describe how the offeror's network will ensure that the provider network is sufficient to assure that medically necessary services are provided for entitled populations and that priority populations are served based on DHHS/Collaborative-established criteria for which individuals should be served first.

A112. Describe the proposed transition before January 1, 2007, including how the offeror will work with current and new providers to assure a full range of services is available throughout Maine and how the offeror and its network will assure a smooth transition for customers and their families if a change of providers is necessary for their treatment or services.

A113. Describe how the offeror will work collaboratively with providers, including peer providers, to improve the quality of service delivery throughout Maine.

A114. Describe how the offeror will work with the SCCS, SQIC and local collaboratives to identify and address the service needs in local areas and to oversee the quality of services provided in these local areas.

Will pharmaceuticals be phased in next contract?

## **Reimbursements to Providers**

### ***Expectations***

The offeror must make timely and accurate payments to its contracted and non-contracted providers and maintain compliance with all state and federal laws and regulations regarding timely payments. Any professional services provided by a behavioral health provider within the MCO network to MaineCare eligible consumers, whether in an emergency room or in an inpatient or outpatient hospital setting, will be covered by the MCO. Any behavioral health services provided by a physical health provider in an emergency room or in an inpatient setting will be covered by the MCO. The MCO will cover outpatient hospital services that require the use of a psychiatrist or psychological revenue code for billing the services. Pharmacy claims prescribed by a physical health provider will be covered by the MCO. Behavioral health services provided by providers will be covered by the MCO even when the primary diagnosis is a behavioral health diagnosis. Facility costs, including emergency room costs, will be covered by the MCO unless there is a specific psychiatric revenue code on the facility claim form. The DHHS/Collaborative expects the offeror to establish specific provider reimbursement systems that provide automatic adjudication, electronic payment capabilities and electronic claims submission capability, and to have the ability to make special payments to unique providers such as FQHCs and IHS. [See Procurement Library for a list of current range of rates provided for current services by various state agencies and a list of current providers receiving funding from the various fund sources and agencies (data books).] The MCO must assist providers unable to bill electronically to gain the tools and training necessary to do so, and must accept paper claims until providers are able to bill electronically.

### ***Mandatory Requests for Information***

A115. Describe anticipated provider reimbursement arrangements, specifying the providers, provider types, or provider networks and the services that may be reimbursed through fee-for-service, program budgets, risk or subcapitation approaches, case rates or other forms of funding; include any steps taken to assure no adverse or unintended consequences will occur because of a specified funding mechanism or that any such consequences have been mitigated to the extent possible. Include specific fiscal strategies and steps to facilitate the transition to greater use of less restrictive community-based services (i.e., rates, utilization, capacity building).

A116. Describe any anticipated provider incentives (including any risk withhold arrangements, if any); provide copies of any proposed contract or subcontract language pertaining to provider incentives, the purpose of the incentive, how the incentive will be calculated and specific steps that will be taken to ensure that customers are not disadvantaged as a result of proposed incentives.

A117. Describe the process or procedure to be used for coordination of benefits between other third party payers and the DHHS/Collaborative agencies' funds.

A118. Describe how timely payments will be made to contracted and out-of-network providers, consistent with state and federal laws and the contract, including methods for assuring adequate cash flow during a specified interim time period for providers transitioning from program-based budgets and reimbursement to fee-for-service or other reimbursement mechanisms; specifically, describe how the offeror will pay at least 90 percent of clean claims within 30 days; 99 percent

of clean claims within 90 days; and how it will pay contracted providers under block grant or other funding types in a timely manner, no less than monthly.

A119. Describe how the offeror will assure payment, at a minimum, within the range of existing rates contained within this RFP (see Procurement Library for range of rates), subject to agency appropriations in any given year; for MaineCare services, describe how the offeror proposes to negotiate rates and if unable to reach agreement with providers, pay at least the fee-for-service schedule rates (MaineCare fee-for-service rates for FY 2006 are available in the Procurement Library).

A120. Describe the offeror's plan to move toward common rates for the same services regardless of fund source, taking into account appropriations, market, federal regulations, and other legal or regulatory constraints.

A121. Describe the offeror's utilization review and prior authorization mechanisms and how denied claims will be minimized.

A122. Describe accounting mechanisms that will be used to identify and track multiple funding streams.

A123. Describe how the offeror will establish specific provider reimbursement systems, claims submission capability and have the ability to make special payments to unique providers such as FQHCs and IHS and tribal/pueblo providers;

A124. Describe how the offeror will reimburse court-ordered services for juveniles and adults and parole board-ordered services for adults, while working with courts and parole boards to assure that ordered services are medically necessary or otherwise appropriate based on DHHS/Collaborative guidelines.

A125. Describe any unique financing or reimbursement mechanisms the offeror expects to utilize to make payments to IHS and tribal and urban Indian providers that furnish services to Native Americans.

## **Contracting with Providers**

### ***Expectations***

The MCO must be able to demonstrate its ability to meet the behavioral health service needs and provider network capacity beginning January 1, 2007, and to maintain continuity of care and system stability. The MCO will maintain a contract or method of paying all providers interested in contracting for services that meet mandatory requirements and who received state controlled funds as of December 31, 2006. Contingent on satisfactory performance, the MCO shall continue to reimburse eligible providers for a minimum of six months while a network is being established. It is anticipated that a new network may require up to twelve months to develop. The process of developing a network should represent a fair selection among willing and appropriately qualified and credentialed providers, rather than simply an arbitrary process of maintaining currently existing business relationships. Nothing in these expectations will guarantee any particular provider a particular amount of funding during FY 2007. These provider contracting decisions will be made by the MCO with input from the DHHS/Collaborative based upon service needs, available resources and provider performance. In some cases, the DHHS/Collaborative will require the use of certain providers for particular services or populations. The successful offeror will demonstrate an approach to working with providers that is collaborative, and that includes incentives and rewards, that is, formal and informal incentives for providers to learn, grow and change, and to "do the right thing" consistent with the DHHS/Collaborative's vision for system performance and customer and family outcomes. These

could include resources, recognition, attention, mentoring and sanctions to encourage the system and its components to perform in the desired way. The MCO may choose to provide some services itself, if existing providers are unable or unwilling to provide needed services. However, the MCO shall make an attempt to assist Maine providers to be able to provide such services and shall require approval from the DHHS/Collaborative before delivering services directly rather than through contracted providers.

***Mandatory Requests for Information***

A126. Describe network development practices and plans to develop the provider network within Maine.

A127. Describe how the offeror will assure network capacity to provide all required behavioral health services covered by the DHHS/Collaborative RFP and defined in the common service definitions found in Appendix \_\_\_.

A128. Describe how the offeror will maintain contracts for at least six months with those providers with contractual relationships to one or more of the DHHS/Collaborative agencies or their agents effective December 31, 2006. Note: the MCO is not obligated to make active use of those contracts if other qualified providers can perform those services within a reasonable distance and timeframe and the provider capacity within Maine is generally not diminished.

A129. Describe how the offeror will establish and maintain ongoing contracts with “essential” providers identified by DHHS/Collaborative partners.

A130. Describe how the offeror will assure a smooth transition from any current provider to any new provider as the MCO’s provider network is developed, including allowing customers to continue with existing current providers to maintain continuity of care.

A131. Describe continuity of care practices and care coordination procedures in cases where customers receive services from multiple agencies or systems.

A132. Describe how the MCO proposes to interface with local collaboratives to identify service gaps and needs and assure intersystem coordination at the local level, and how SCCS, SQIC and local collaboratives will be able to impact the MCO’s decision making about contracts to meet these needs.

A133. Provide assurances and evidence that the offeror will be able to provide the DHHS/Collaborative copies of any and all subcontracts within sixty days of the subcontract execution and will provide the DHHS/Collaborative copies of any provider or practitioner review and/or audit schedule so that the DHHS/Collaborative may participate if it so desires.

A134. Describe how the offeror will manage all subcontracts through program reviews/audits, and reporting, and ensure that all subcontractors are held to the same stipulations as the DHHS/Collaborative in regards to services provided, budget requirements, reporting requirements and any other requirements;

A135. Describe how the offeror will develop and communicate policy and procedures regarding subcontractor performance and functions.

A136. Describe how the offeror will develop and implement uniform standards for provider credentialing, including how the offeror will assure that behavioral health staff of its provider network meet state and federal requirements, including, but not limited to, education, licensure, cultural competence, behavioral health experience and staff-to-client ratio.

A137. Describe any special privileging the MCO proposes to do for specialty providers or services.

A138. Describe how the offeror will utilize peer services, peer practitioners and customer- or family-operated providers, including how the offeror proposes to increase the proportion of

expenditures for such providers and what special supports or assistance the offeror believes will be necessary to reach the goal of spending five percent of the system's expenditures on customer- and family-operated services.

## **Provider Training and Technical Assistance**

### ***Expectations***

Although several different types of billing practices and service identifiers have been used by the members of the DHHS/Collaborative, the intent is to minimize the administrative burden on providers. Some providers will not be used to billing for each service or providing encounter-based service utilization data. Some providers are accustomed to budgeted program budgets. Any switch to service billing will require assistance from the MCO and from the DHHS/Collaborative. Service authorization processes and criteria are also likely to change for many providers. The DHHS/Collaborative does not want to see provider capacity lost due to this transition, at least not without other capacity for alternative services or alternative providers developed in the process. The DHHS/Collaborative will be expected to assist providers in the transition and throughout the contract to assure adequate access to services throughout the term of the contract. Within the early planning phase of the new behavioral health delivery system, consistent service definitions and coding for services have been established (see Appendix \_\_\_). The DHHS/Collaborative will work with the MCO to train providers on how to use the new service definitions and requirements and how to bill for each service they are contracted to provide. In addition, provider training regarding the processes and procedures required by the MCO for billing and service authorization will be necessary. In addition to changes in billing practices, service authorizations and service definitions, the MCO is expected to work with providers to develop new capacity, especially around evidence-based and promising practices as they emerge in the field. The MCO must assist providers in making service delivery transitions to these new practices as appropriate for the customers being served.

### ***Mandatory Requests for Information***

A139. Provide or describe training materials that will be used to assist providers in working with new billing mechanisms and requirements, service authorization processes and criteria, and administrative policies and procedures of the MCO, including any changes to such.

A140. Describe the tracking and reporting system designed to identify training needs.

A141. Describe the mechanisms the offeror will utilize to identify, track and respond to provider questions and concerns about billing, service delivery and provider relations issues.

A142. Describe the evaluation of training and education methods, including the effectiveness, based upon the monitoring and analysis of the tracking and reporting outcomes.

A143. Describe the relationship the MCO will develop with customers, families, providers or provider groups, academic institutions, and other resources to help in developing provider capacity and expertise.

A144. Describe the methods the MCO will use in working with local collaboratives and with the SCCS, SQIC to identify and report provider concerns and provider training needs and opportunities.

A145. Describe how the MCO will incorporate new and emerging practices into the training opportunities made available for providers.

A146. Describe the competencies the MCO will require of or strive to develop in its provider network.

## **Relation to Local Collaboratives and the SQIC**

### ***Expectations***

Maine has many different geographic areas with their own needs, perspectives and local culture and flavor. Local collaboratives will be the voice of these various local communities to advise the DHHS/Collaborative and MCO, to identify and help address service needs and gaps, assure interagency coordination at the local level and to help evaluate local service delivery effectiveness. (See Draft Guidelines for local collaboratives in the Procurement Library.) The DHHS/Collaborative expects to identify and work with at least \_\_\_\_ local collaboratives, based summarily on the \_\_\_\_\_ districts in Maine. The Collaborative has also committed to working with additional local collaboratives representing tribal groups that wish to develop such a local collaborative. These local

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collaboratives will consist of a range of local players representing multiple systems or communities (including but not limited to representatives of providers, criminal justice, faith-based organizations, local elected officials, schools, health facilities, jobs and housing offices, local offices of state agencies, tribal groups, state-supported local planning groups such as DWI councils and maternal and child health councils, and customers and their families). They will play critical roles in bringing a local perspective to the MCO's and the DHHS/Collaborative's statewide efforts and in shaping the delivery system and the expected outcomes in local communities throughout Maine. The MCO will be expected to help nurture these local collaboratives, utilize local collaboratives for information, provide information that will be the basis of their planning and listen to local input regarding service delivery in local areas. The MCO will have an active role interacting with the local collaboratives and will be expected to hear, take seriously and act on the suggestions and input from these local collaboratives. At the state level, the SCCS and the SQIC are statutorily-created advisory bodies representing all geographic areas of the state as well as the perspective of providers, customers, families, advocates and state agencies. The SQIC is the advisory body to the DHHS/Collaborative, and the MCO will be expected to utilize the SQIC as an advisory body to the operations of the MCO.

### ***Mandatory Requests for Information***

A147. Describe how the offeror will develop positive working relationships with local collaboratives identified by the DHHS/Collaborative to meet the expectations outlined above.

A148. Describe how the offeror will assist local collaboratives to fulfill their responsibilities.

A149. Describe how the offeror's staff living in and working in the \_\_\_\_# regional areas in Appendix \_\_ (\_\_\_\_# geographic regions and one addressing Native American issues) will interact with local collaboratives at the judicial district or tribal levels.

A150. Describe how and how often the offeror's statewide or national staff will interact with local collaboratives.

A151. Describe what the offeror proposes to provide (e.g., training, technical assistance, capacity building, planning or logistical resources, etc.) for local collaboratives within designated judicial districts or within Native American tribes.

A152. Describe how the offeror will provide local collaboratives with regular aggregate and trended service utilization information for their geographic area or population.

A153. Describe how the offeror will provide local collaboratives with regular aggregate and trended information about customer and family complaints and grievances from that geographic area or for that population, compared to the state as a whole.

A154. Describe the offeror's proposed process for meeting regularly with the local collaboratives (generally monthly) to discuss service needs, priorities and quality.

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A155. Describe how the offeror will make available to local collaboratives a public opportunity to indicate service needs that are not being met or are inadequately met before entering into contracts with providers to serve that geographic area.

A156. Describe how the offeror will utilize the input of local collaboratives to develop contracts, hold providers accountable, or provide additional training or technical assistance within each geographic area.

A157. Describe how the offeror will offer assistance to or guidance for local collaboratives about the types of system interfaces that will work in their communities for referrals to and from and collaboration among behavioral health providers, adult corrections, juvenile justice, protective services, schools regarding individual education plans, child welfare agencies, primary care physicians, etc.

A158. Describe how the offeror will build consultation with local collaboratives into quality management and improvement planning and implementation, focusing particularly on locally-identified desired outcomes for that geographic area or population, and on customer- and family-driven service quality evaluation processes.

A159. Describe how the offeror will utilize data and information developed by local collaboratives regarding perceptions of service quality and service outcomes.

A160. Describe how the offeror will offer training for local collaborative members regarding

A161. Describe how the offeror intends to utilize local collaboratives to develop service area plans for each of the \_\_\_\_\_# geographic regions of the state and the \_\_\_# Native American region (see Appendix \_\_\_).

A162. Describe how the offeror will utilize the SCCS and the SQIC for advice and input during the planning, implementation and evaluation of services under the contract.

A163. Describe how the offeror will make available to the SCCS and SQIC information, training, technical assistance and data about MCO operations or proposed operations.

A164. Describe how the offeror will utilize data and information from the SCCS and SQIC in its operations under the contract, including making available sufficient public opportunity for input before operations commence or change at the beginning and throughout the contract.

A165. Describe how the offeror will utilize the SCCS and SQIC and its members throughout the transition period before the contract begins to prepare for a smooth transition of providers and customers and their families.

## **Disaster Planning**

### ***Expectations***

The MCO must submit a comprehensive disaster behavioral health response plan to the DHHS/Collaborative by \_\_\_\_\_. The MCO, through specific subcontract language, shall ensure that its network providers participate in disaster response planning efforts at their local area level. The MCO, through specific subcontract language, must ensure that provider plans are consistent with the protocol for overall statewide disaster behavioral health response included in the Maine Department of Health Emergency Operations Plan, which serves as an annex to the Maine Emergency Agency Administration (see Procurement Library). The MCO must also be responsive to any declared state of emergency and assure that local providers assist local communities to meet its residents' behavioral health needs in the emergency.

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equivalent

***Mandatory Requests for Information***

A166. Describe the offeror's experience with behavioral health aspects of disaster management, critical incident management and creation and implementation of multi-systemic or multi-agency emergency response protocols, including the offeror's plans or approach to disaster management.

A167. Describe how the offeror will ensure that the needs of entitled and priority populations are addressed in the local area emergency plan.

A168. Describe how the offeror will ensure and assist each provider to develop and maintain an emergency response protocol that evidences collaboration with emergency management, law enforcement and other first responder personnel; the providers' protocol shall utilize disaster mental health/psychosocial programming, and be consistent with the protocol for overall statewide disaster mental health response included in the Maine Department of Health Emergency Operations Plan, which serves as an annex to the Maine Emergency Response Administration and other DHHS/Collaborative agencies' emergency response plans.

				White = Phase I
Core Performance Measures				L.Gray = Phase II
Utilization/Encounter Based Measures				Gray = Phase III
				Future Contract
AREA	DATA REQUIREMENT/ DATA SOURCE	FREQUENCY	FORMULA	BENCHMARK/STANDARD
<b>Geographic Distribution of BH Providers by Provider Type</b>	Geo-Access Reports	Monthly	Actual physical distance from customer to an <i>appropriate</i> (operationally defined as: licensed, credentialed, in active practice, willing & able to accept new customers) BH provider.	90 percent of current members in urban locations will have access to an <i>appropriate</i> BH provider within a driving distance of 30 miles; 90 percent in rural locations: 60 miles; 90 percent in frontier locations: 90 miles.
<b>Customers Served Annually (see “Populations and Funding charts, p. ___)</b>	Enrollment/Service Encounter Data	Monthly	Number of active registered/enrolled customers who have been provided at least one encounter per month of treatment/services during the fiscal year (duplicated).	<p>The number of individuals served will not be less than the number of individuals served in FY 06.</p> <p>By category:</p> <ul style="list-style-type: none"> <li>• SA Community-Based Customers (co-occurring)</li> <li>• MH Customers</li> <li>• Children/Youth Customers/ Families</li> <li>• Native Americans Customers</li> <li>• SMI Adults Customers</li> <li>• Seniors Customers</li> <li>• SED Children/Youth Customers</li> <li>• Juvenile Justice Involved Children/Youth Customers</li> <li>• Children/Youth in Custody of CYFD Customers/Families</li> <li>• Adults Leaving Prison and Probationers and Parolees in the Community Under the Supervision of Maine Criminal Division</li> <li>• Adults With Co-occurring Mental Health and Substance Use Disorders (DOH)</li> </ul>
			Proportion of members receiving mental health services per 1000 population.	
			Proportion of discharges from inpatient psychiatric services per 1000 population.	
			Proportion of discharges from residential treatment services per 1000 population.	
			Proportion of members receiving outpatient services per 1000.	
			Proportion of members experiencing a serious mental illness (SMI) for the above categories.	
			Proportion of members receiving MH services only who are diagnosed with a co-occurring SA/MH disorder.	
			Proportion of members receiving both substance abuse and mental health services.	
			Proportion of members receiving SA services only who are diagnosed with a Co-occurring SA/MH disorder.	
			Proportion of members receiving MH services per 1000.	
			Units of MH services provided by service category. Units of MH services provided by recipient by service category.	

<b>Utilization/Encounter Based Measures</b>				
<b>AREA</b>	<b>DATA REQUIREMENT/ DATA SOURCE</b>	<b>FREQUENCY</b>	<b>FORMULA</b>	<b>BENCHMARK/STANDARD</b>
<b>RTC Readmissions</b>	Claims and Encounter data	Quarterly	<p>[1] <u>Numerator</u>: Total number of admissions to an RTC within 30 days of an RTC discharge during contract period.</p> <p>[1] <u>Denominator</u>: Total RTC discharges during contract period.</p> <p>[2] <u>Numerator</u>: Total number of admissions to an inpatient psychiatric facility within 30 days of an RTC discharge during contract period.</p> <p>[2] <u>Denominator</u>: Total RTC discharges during contract period.</p>	No more than 18 percent of children/ adolescents readmitted within 30 days post discharge from an RTC setting to [1] the same or to [2] a higher level of care.
<b>Community-Based MaineCare Behavioral Health Services</b>	Financial Reports; Claims and Encounter Data	Quarterly and Annually	Estimated expenditures (based upon date of service) for the previous year will be based upon an annualized estimate of services provided through March 31 and paid through July 1. Adjustments will be made by October 31 to reflect actual services provided during the previous year.	MaineCare expenditures will increase from the previous calendar year by five percent for community-based services as negotiated with and approved by the Collaborative.
<b>Increased Wraparound Services</b>	Financial Reports; Claims and Encounter Data	Quarterly and Annual reports	Estimated expenditures (based upon date of service) for the previous year will be based upon an annualized estimate of services provided through March 31 and paid through July 1. Adjustments will be made by October 31 to reflect actual services provided during the previous year.	The MCO shall increase expenditures from the previous calendar year by five percent for community-based services as negotiated with and approved by the DHHS/Collaborative.

<b>Utilization/Encounter Based Measures</b>				
<b>AREA</b>	<b>DATA REQUIREMENT/ DATA SOURCE</b>	<b>FREQUENCY</b>	<b>FORMULA</b>	<b>BENCHMARK/STANDARD</b>
<b>Community-Based Behavioral Health Services</b>	Financial Reports; Claims and Encounter Data	Quarterly and Annual reports	<p><u>Numerator</u>: Expenditures for non-24-hour setting services</p> <p><u>Denominator</u>: Total service expenditures.</p> <p>Estimated expenditures (based upon date of service) for the previous year will be based upon an annualized estimate of services provided through March 31 and paid through July 1.</p> <p>Adjustments will be made by October 31 to reflect actual services provided during the previous year.</p>	<p>The statewide entity shall increase non-MaineCare and MaineCare expenditures from the previous calendar year by five percent for community-based services as negotiated with and approved by the Collaborative.</p> <p>75 percent of all expenditures shall be for services that occur outside of a 24-hour setting (RTC, TFC, 23-hour observation, hospital, detox facility, sub-acute, group home, shelter care, etc.) for each age group</p>
<b>BH Penetration Rate</b>	Claims and Encounter Data	Monthly	<p><u>Average customer months</u>: total number of months for all customers (by age and ethnicity) in a given category during the year/12;</p> <p><u>BH Penetration Rate</u>: calculated value for average customer months /number of customers (by age and ethnicity) in the specific category who received the BH service.</p>	<p>Rates will not be less by age and ethnicity group than those achieved in FY 07; for non-enrollees, the absolute number shall not be less than FY 07.</p> <p>NOTE: FY 07 performance shall not be less than FY 06 numbers.</p>
<b>Emergency Room Services Utilization Rates</b>	Claims and Encounter data	Monthly	<p><u>Numerator</u>: The number of BH (either mental health or substance abuse) crisis or emergency room presentations for treatment by customers.</p> <p><u>Denominator</u>: Number of customer months divided by 1000 and multiplied by 12.</p>	<p>The number of BH crisis or emergency room presentations shall not exceed 8.5 visits per 1000 customer months (annualized).</p>
<b>Mental Health Engagement Rate</b>	Claims and Encounter Data	Monthly	<p><u>Numerator</u>: Customers with two or more MH services within 30 days after initiation.</p> <p><u>Denominator</u>: Customers with index MH service.</p>	<p>60 percent of customers with index MH service will receive two or more mental health services within 30 days after initiation of services.</p>

<b>Utilization/Encounter Based Measures</b>				
<b>AREA</b>	<b>DATA REQUIREMENT/ DATA SOURCE</b>	<b>FREQUENCY</b>	<b>FORMULA</b>	<b>BENCHMARK/STANDARD</b>
<b>Substance Abuse Engagement Rate</b>	Claims and Encounter Data	Monthly	<u>Numerator:</u> Customers with two or more substance abuse services within 30 days after initiation. <u>Denominator:</u> Customers with index substance abuse.	60 percent of customers with index SA service will receive two or more SA services within 30 days after initiation of services.
<b>Effectiveness of Community-Based Substance Abuse Services for Adults</b>	Client Outcome Reports Addiction Severity Index-Lite (ASI)	Quarterly and Annually	*Change over time in composite scores in all/some of the seven life domains. <u>Numerator:</u> Number of clients at discharge with an improvement in all/some of the seven life domains. <u>Denominator:</u> Number of clients at intake with an initial composite score in all/some of the seven domains.	Improvement in three or more of the life domains of all BH clients with substance abuse disorders. (At minimum, it is recommended that Domain #3 (Alcohol/Drug Use) and Domain #7 (Psychiatric) be examined.) The threshold will be determined from FY 05 and FY 06 baselines.
<b>Access</b>				
<b>AREA</b>	<b>DATA REQUIREMENT/ DATA SOURCE</b>	<b>FREQUENCY</b>	<b>FORMULA</b>	<b>BENCHMARK/STANDARD</b>
<b>Customer Support Services</b>	Electronic Call Tracking Data	Monthly and Annual	Call received/call answered within 30 seconds; abandoned calls tracked separately.	90 percent of the member services calls will be answered within 30 seconds or less based on the reported average, with no more than 10 percent abandonment rate.
<b>Customer Access</b>	Enrollment data	Monthly	Percentage of non-hospitalized members who are assigned a community support worker within three working days of application for service.	85% Phase I 95% Phase II
<b>Clinical Assessments</b>	Enrollment data	Monthly	Percentage of members who apply for community support services while an inpatient in a psychiatric facility who are assigned a community support worker within two working days.	85% Phase I 95% Phase II
<b>Customer Satisfaction</b>	SAMHSA/DHHS Adult Satisfaction Survey	Annual	Percentage of members reporting positively about access to service, by service area.	85% Phase I 95% Phase II

<b>Access</b>				
<b>AREA</b>	<b>DATA REQUIREMENT/ DATA SOURCE</b>	<b>FREQUENCY</b>	<b>FORMULA</b>	<b>BENCHMARK/STANDARD</b>
<b>Clinical Assessments</b>	Regular Assessment Reports	Monthly	<u>Numerator:</u> Number of adults presenting with a psychiatric issue who are screened for substance abuse. <u>Denominator:</u> Total number of individuals presenting with a psychiatric issue. <u>Numerator:</u> Number of adults presenting with a substance abuse issue who are screened for psychiatric issues. <u>Denominator:</u> Total number of individuals presenting with a substance abuse problem.	85 percent of adults presenting with a psychiatric issue are screened for substance abuse. 85 percent of adults presenting with a substance abuse issue are screened for psychiatric issues
<b>Denials/1000 Service Requests</b>	EWS and SE Reports	Monthly	<u>Numerator:</u> number of service denials. <u>Denominator:</u> number of service requests.	Denials of services per 1000 requests will not increase above previous year's average.
<b>Continuity of Care</b>				
<b>AREA</b>	<b>DATA REQUIREMENT/ DATA SOURCE</b>	<b>FREQUENCY</b>	<b>FORMULA</b>	<b>BENCHMARK/STANDARD</b>
Discharge w/ Treatment Plan	Enrollment/Service Encounter Data		Percentage of acute psychiatric discharges attending an outpatient Mental Health visit within: 3 days 7 days 30 days Over 30 days <u>Numerator:</u> number of discharges from inpatient psychiatric facility, w/data for subsequent treatment provision within 3/7/30 calendar days of discharge. <u>Denominator:</u> Total number of discharges from inpatient psychiatric facility.	Breakdown by categories: State Psychiatric Institutes; Community Hospitals and private psychiatric hospitals (Spring Harbor, Acadia) 75 percent of individuals discharged from psychiatric inpatient facilities receive follow-up services within 3 days of discharge. 90 percent or more of individuals discharged from psychiatric inpatient facilities receive follow-up services within seven days of discharge. 30-day follow-up care is received by 60 percent or more of individuals discharged from psychiatric inpatient facilities.

<b>Continuity of Care</b>				
<b>AREA</b>	<b>DATA REQUIREMENT/ DATA SOURCE</b>	<b>FREQUENCY</b>	<b>FORMULA</b>	<b>BENCHMARK/STANDARD</b>
Discharge w/ Treatment Plan	Enrollment/Service Encounter Data		Percentage of acute psychiatric inpatient discharges who receive outpatient medication services within:  14 days of discharge  30 days of discharge  Over 30 days of discharge	Breakdown by categories: State Psychiatric Institutes; Community Hospitals and private psychiatric hospitals (Spring Harbor, Acadia), geographic and provider
	Enrollment/Service Encounter Data		Average length of stay in psychiatric inpatient treatment in days.	Breakdown by categories: State Psychiatric Institutes; Community Hospitals and private psychiatric hospitals (Spring Harbor, Acadia)
	UR/Service Review		Average length of stay in psychiatric inpatient treatment post discharge ready in days	Breakdown by categories: State Psychiatric Institutes; Community Hospitals and private psychiatric hospitals (Spring Harbor, Acadia)
	Enrollment/Service Encounter Data		Average length of stay in PNMI residential treatment in days.	Breakdown by PNMI category
	UR/Service Review		Average length of stay in PNMI post discharge ready in days	
	Enrollment/Service Encounter Data By geographic location and facility		Number of members residing in PNMI Residential Setting with more than 8 beds	
Wait List-PNMI	Enrollment data		Number waiting for PNMI Services	By geographic location
<b>Bed Capacity</b>	Provider data By geographic location and facility		Bed Capacity	By geographic location
<b>Bed Occupancy</b>	Encounter data By geographic location and facility		Bed Occupancy: Bed Days	By geographic location
<b>Re-admissions</b>	Enrollment/Service Encounter Data		Percentage of acute psychiatric care discharges re-admitted within:  7 days 30 days 60 days	Breakdown by categories: State Psychiatric Institutes; Community Hospitals and private psychiatric hospitals (Spring Harbor, Acadia)  <b><i>Expectation: reduction with improved continuity of care</i></b>

			90 days 180 days	
<b>Continuity of Care</b>				
<b>AREA</b>	<b>DATA REQUIREMENT/ DATA SOURCE</b>	<b>FREQUENCY</b>	<b>FORMULA</b>	<b>BENCHMARK/STANDARD</b>
Discharge Planning	Service Review		Percentage acute psychiatric inpatient discharges where community provider participated in discharge planning	
<b>Inpatient Treatment Planning</b>	Service Review		Percentage of inpatient discharges where community provider participated in hospital treatment planning since admission.	Breakdown by categories: State Psychiatric Institutes; Community Hospitals and private psychiatric hospitals (Spring Harbor, Acadia), geographic and provider
<b>Customer Satisfaction</b>	Annual SAMHSA/DHHS Adult Satisfaction Survey(s) that are culturally sensitive and linguistically appropriate, approved by BHWG – CCS		Percentage of members reporting satisfaction with participation in their treatment planning  Surveys shall have sufficient distribution rates to ensure response rates that will achieve statistical significance, based on number and demographics of customers accessing BH services in six-month period.  Children and youth surveys should be developmentally appropriate and created distinct from adult or family surveys. Sample size shall have at least a 95 percent level of confidence for the responses to each item, alpha of +/- 5 percent.	85 percent of respondents will indicate at least moderate satisfaction with services provided, increasing to 90 percent in Phase Three.
<b>Crisis Plan</b>	Service Review		Percentage of members who have had two or more psychiatric admissions within the last year who have crisis plans.	Baseline Phase I Percentages Phase II and III
<b>Advance Directive</b>	Service Review		Percentage of members receiving	Baseline Phase I

			acute psychiatric services who have an advance directive.	Percentages Phase II and III
<b>Continuity of Care</b>				
<b>AREA</b>	<b>DATA REQUIREMENT/ DATA SOURCE</b>	<b>FREQUENCY</b>	<b>FORMULA</b>	<b>BENCHMARK/STANDARD</b>
<b>Emergency Room</b>	Enrollment/Service Encounter Data		Length of stay in Emergency Department for psychiatric crisis services for four or more hours	Baseline Phase I Percentages Phase II and III
<b>Consumer-Driven</b>	Service Review		Percentage of members receiving inpatient psychiatric services whose record shows evidence of participation in treatment planning	Baseline Phase I Percentages Phase II and III
	Service Review		Number of involuntary admissions that are in accordance with the law and meet medical necessity criteria.	Baseline Phase I Percentages Phase II and III
<b>Direct Service Provision</b>	Reviews of Treatment Plans and Treatment Attendance Documentation/ Progress notes	Quarterly	<u>Numerator</u> : Number of cases reviewed in which progress notes or attendance documentation shows that treatment needs were addressed for 96 percent of indicated treatment needs. <u>Denominator</u> : Total number of cases in which treatment documentation is reviewed.	96 percent of assessed treatment needs are met in 90 percent of cases
	ISP		During any phase, the Collaborative may require specific providers to be funded for specific purposes.	Reduction of unmet needs Treatment would be individualized & self-directed Wide availability of EBP & Best Practice

<b>Linkage with Primary Care</b>				
<b>AREA</b>	<b>DATA REQUIREMENT/ DATA SOURCE</b>	<b>FREQUENCY</b>	<b>FORMULA</b>	<b>BENCHMARK/STANDARD</b>
<b>Physical Health</b>	Service Review/Health service encounter data		Percentage of members whose record shows evidence of linkage with a primary care provider.	
<b>Physical Health</b>	Enrollment/Health Service Encounter data		Prevalence of health risks in members Prevalence of chronic illness in members Per member primary health care costs Percentage of members who had at least one visit/checkup with a primary care physician in the past 12 months	
<b>Dental Health</b>	To be determined		Percentage of members who had at least one dental visit in the past 12 months	
<b>Eye</b>	Health Service Encounter data		Percentage of members who had at least one eye appointment in the last two years.	
<b>Physical Health</b>	Service Review/Health service encounter data.		Percentage of members whose record shows evidence of regular preventative health screens.	
<b>Evidence-based Treatment</b>				
<b>AREA</b>	<b>DATA REQUIREMENT/ DATA SOURCE</b>	<b>FREQUENCY</b>	<b>FORMULA</b>	<b>BENCHMARK/STANDARD</b>
	Enrollment/Service Encounter Data		Number of evidence based treatments by region, by provider, by statewide distribution	
			Number of members receiving recognized evidence based treatment	Increase of one adult and one child evidence-based practice due to increase in federal funding
			Number of evidence based treatments meeting fidelity standards	90% Phase I

			by region, by provider, by statewide distribution	100% Phase II
<b>Recovery/ Community Integration/Outcomes</b>				
<b>AREA</b>	<b>DATA REQUIREMENT/ DATA SOURCE</b>	<b>FREQUENCY</b>	<b>FORMULA</b>	<b>BENCHMARK/STANDARD</b>
<b>Consumer Recovery Review</b>	<b>**All Data Sources</b> EIS, ISP, Service Review, Satisfaction Survey, Grievance Analysis, UR/Service Review, Enrollment data, Provider data, Annual Consumer Survey, SAMHSA National Outcome Measure LOCUS Consumer Council Survey (new) Consumer Council Review of all other data sources (new)		<b>**Universal Recovery Outcomes</b> Decrease in ER visits Decrease in wait time in ER Decrease in hospitalizations Decrease in # of grievances filed Increase in overall customer satisfaction Increase in #'s reporting: Living where I choose Safe, affordable housing Engaged in meaningful activity (work, education, hobby, etc.) Choosing the services I need including consumer developed and directed recovery tools and programs. Consumer involvement in medication decisions. Physical Health needs met Transportation is available for appointments, shopping, consumer involvement activities & social activities	outcomes that will support recovery, develop resiliency, promote independence and improved quality of life, as well as a process consistent with the Collaborative values about the importance of stakeholder voices, community-based care, customer/family driven services
	Service Review – ISPs Functional Assessment – Level of Care Utilization System (LOCUS)  Annual SAMHSA/DHHS Adult Satisfaction Survey		Percent of members reporting gains in recovery goals. Percentage of members with documented improved level of functioning over 12 month period Percentage of members who maintain stable level of functioning over 12 month period. Percentage of members with documented reduced level of functioning over 12 month period Percentage of members reporting positively about outcomes/well-being	Review and phase-in consumer self-report measures of functioning-wellbeing and personal recover during start-up period
	SAMHSA National Outcome Measure SAMHSA National Outcome Measure		Percentage of members in competitive part time, full time employment Percentage of members with contact with the criminal justice system, and arrests and incarcerations per member.	
	SAMHSA National Outcome Measure		Percentage of members reporting satisfaction with friendships and community	

			involvement	
<b>Recovery/ Community Integration/Outcomes</b>				
AREA	DATA REQUIREMENT/ DATA SOURCE	FREQUENCY	FORMULA	BENCHMARK/STANDARD
	SAMHSA National Outcome Measure		Percentage of members residing in stable/non-temporary (To be defined) living situations.	
<b>Recovery And Resiliency Oriented Service Approaches</b>	Claims and Encounter Data; Provider Contracts/Service Profiles; Financial Reports	Monthly	<u>Numerator:</u> Expenditures for Wraparound and PSR services <u>Denominator:</u> Total service Expenditures	Total expenditures for the provision of wraparound services and psychosocial rehabilitation services will increase by five percent in Phase Two and by another 10 percent in Phase Three
<b>Consumer-Run Programs</b>	Annual increase each year by 1 to 1.5 percent Annual Budget Review Consumer Satisfaction Survey Consumer Recovery Review ISP	Annually	<b>Customer/family run programs</b> increase in funding for these programs toward the goal of at least five (5%) of the total behavioral health budget planned for in and begun in phase one, increased in phased two and accomplished in phase three.	Strengthening of existing club and peer center infrastructure. Increase in available education & training to consumer initiatives in fiscal & business management, recovery programs Increase # of clubs & peer centers in areas where they do not exist % reporting being made aware of & engaged in peer support, WRAP, Leadership Academy, Warm Lines and other resources: social clubs, peer centers, statewide consumer network for connection to state, local and national recovery resources, events & activities.
	ISP, Satisfaction Survey, Grievance Analysis, UR/Service Review, Annual Consumer Survey, Consumer Council Survey (new) Consumer Council Recovery Review		MCO will described how they will support and implement Consumer Designed and Developed, Recovery based In-home supports to meet the individual needs: Crisis; short-term; long-term; (all existing In-home supports will be reviewed and revised to meet the above standards.	<b>Empowerment:</b> Least restrictive setting Help fill in the gap of numerous unmet needs Support medication therapy
<b>Housing</b>	Provider Intake and Discharge Forms	Quarterly	<u>Numerator:</u> Number of SA, MH and Co-occurring Adults served living in safe, affordable, decent housing of their choice <u>Denominator:</u> Total number of SA, MH and Co-occurring Adults served	Number of SA, MH and Co-occurring Adults served who are living in safe, affordable, decent housing of their choice shall increase by five percent annually

<b>Recovery/ Community Integration/Outcomes</b>				
<b>AREA</b>	<b>DATA REQUIREMENT/ DATA SOURCE</b>	<b>FREQUENCY</b>	<b>FORMULA</b>	<b>BENCHMARK/STANDARD</b>
<b>Employment</b>	Provider Intake and Discharge Forms (DOL, DVR and/or OWTD data), Collect Workforce Data and Unemployment Insurance Data	Quarterly	<u>Numerator:</u> Number of SMI adults working for pay in competitive employment at least 15 hours per week <u>Denominator:</u> Total number of SMI adults served	Proportion of SMI adults working shall increase annually by at least 10 percent until 70 percent is reached
<b>Financial Assistance for Adults with MH/SA Needs on Parole/ Probation</b>	Request Forms & Expenditure Invoice Verification	Monthly	<u>Numerator:</u> Number of adults referred for financial assistance. <u>Denominator:</u> Number of working days to meet request for financial assistance.	Financial assistance will be provided to adults referred from Maine within three working days of an approved request at a rate of 80 percent and within five working days at a rate of 96 percent.
<b>Workforce Issues</b>	To be determined	To be determined	To be determined	To be determined
<b>Rights, Dignity, and Respect</b>				
<b>AREA</b>	<b>DATA REQUIREMENT/ DATA SOURCE</b>	<b>FREQUENCY</b>	<b>FORMULA</b>	<b>BENCHMARK/STANDARD</b>
	Annual Satisfaction Survey		Percentage of members who report they were treated with dignity and respect	Breakdown by geographic area and service type
	Annual Satisfaction Survey		Percentage of members reporting satisfaction with services being culturally appropriate.	
	Annual Satisfaction Survey		Percentage of members reporting satisfaction with quality and availability of materials in alternative languages and formats.	
	Annual Satisfaction Survey		Percentage of members who report they were informed about their rights as a recipient of mental health services in a	

			way that they could understand.	
<b>Accountability</b>				
<b>AREA</b>	<b>DATA REQUIREMENT/ DATA SOURCE</b>	<b>FREQUENCY</b>	<b>FORMULA</b>	<b>BENCHMARK/STANDARD</b>
	Grievance Analysis MCO Contract Accountability Reports	Quarterly Reporting – review available to Consumer Councils	<b>Accountability</b> contract accountability, enforceable sanctions immediate correction or remedy	
	Grievance Analysis MCO Contract Accountability Reports	Quarterly Reporting – review available to Consumer Councils	Negative trends or poor performance by the MCO and its providers will receive prompt attention and response, enforceable timeframes	
<b>Provider Payment Timeliness</b>	Claims Aging Reports; Clean Claims Data; Provider Payment Reports	Monthly	Numerator: All clean BH claims paid within 30 (90) days of receipt. Denominator: Total number of clean BH claims received by the SE	The MCO will pay 90 percent of all clean claims received within 30 days and 99 percent of all clean BH claims within 90 days.
	Provider Survey Annual Review UR/Service Review		Reducing the administrative burden on providers is also a goal.	Higher % of funding spent on direct service Increased compensation to Direct Care Providers Higher retention Clearer communication Reduced burn-out Provider user friendly
<b>Non-Clean or Pended Claims</b>	Submitted Claims Data	Quarterly	<u>Numerator:</u> Number of non-clean or pended claims each quarter <u>Denominator:</u> Total number of claims submitted each quarter	No more than 10 percent of claims shall be pended or considered non-clean each quarter (this requires the SE to work with providers to assure they know how to submit clean claims)
<b>Provider Satisfaction</b>	Provider Satisfaction Surveys, approved by BHWG with input from providers	Annually	Surveys shall have sufficient distribution rates to ensure response rates, which will achieve statistical significance, based on number of providers contracted with MCO in 6 month period. Sample size shall have at least a 95 percent level of confidence for the responses to each item, alpha of +/- 5 percent	85 percent of respondents shall show a moderate degree of satisfaction with provider network management and provider interactions with by SE, increasing to 90 percent by Phase Three

<b>Customer/Family-run Programs (Participation)</b>				
<b>Customer/family-run programs</b>	MCO reports as specified by the Collaborative	Quarterly	FY 06 MaineCare MCO BH expenditures multiplied by .005 Estimated FY 07 MCO Behavioral Health expenditures effective July 1, 2007 may be adjusted based upon final expenditures	More than one-half of one percent of the MaineCare expenditures for behavioral health services in FY 07 will be used for customer/family-run programs
<b>Customer/Family-run programs</b>	MCO reports as specified by Collaborative	Quarterly	<u>Numerator:</u> FY 08 expenditures for family/customer run programs <u>Denominator:</u> FY 07 expenditures for customer/family run programs.	Increase in funding for customer/family run programs toward the goal of at least five percent of the total behavioral health service expenditures. Baseline and annual increase TBD based upon FY 07 and FY 08 data.
<b>Customer/Family-run programs</b>	MCO reports as specified by Collaborative	Quarterly	<u>Numerator:</u> FY 09 expenditures for family/customer run programs <u>Denominator:</u> FY 08 expenditures for customer/family run programs.	Increase in funding for customer/family run programs toward the goal of at least five percent of the total behavioral health service expenditures. Baseline and annual increase TBD based upon FY 08 and FY 09 data.
<b>Customer/Family Advisory Meetings</b>	Minutes of Meetings	Monthly	The MCO will be required to submit the minutes of each customer advisory board meeting monthly.	At least monthly customer advisory meetings held or attended (including but not limited to the SQIC).

<b>Children and Youth/Prevention</b>				
<b>AREA</b>	<b>DATA REQUIREMENT/ DATA SOURCE</b>	<b>FREQUENCY</b>	<b>FORMULA</b>	<b>BENCHMARK/STANDARD</b>
<b>School Success</b>	PED Reports (Pre-K to 20 yrs) re School Attendance, Grades, Drop –Out Status, and Graduation)	Annually except attendance and grades (4x/year)	<u>Numerator</u> : Number of children/youth served who improve school attendance, grades, drop-out status or graduation <u>Denominator</u> : Total number of children/youth served	Proportion of children/youth with diagnosed mental illness and/or substance abuse served who improve school performance shall increase annually by at least five percent
<b>Incarceration Rates</b>	Juvenile Detention, Jail Records and NMCD Records	Monthly	<u>Numerators</u> : Number of customers served with one justice system encounter and with multiple justice system encounters, by age and ethnicity <u>Denominator</u> : Total number of customers served, by age and ethnicity	Proportion of served individuals with justice system encounters (jail, juvenile detention centers, prison) shall decrease annually by at least 5 percent; recidivism rates for customers with justice system contacts shall decrease by at least 5 percent annually
<b>Number of DWI Fatalities</b>	DOH Epidemiological Records	Quarterly	Number of DWI fatalities in 10 NM counties with most DWI fatalities historically; Number of DWI fatalities in all NM counties	10 NM counties show a reduction in DWI fatalities in Phase Two and rates are within national standards in all ME counties by Phase Three
<b>Youth Suicides</b>	DOH Epidemiological Records; Death Certificates; Treatment Plan Progress Notes	Quarterly	<u>Numerator</u> : Number of children/adolescents served (or number of plans reviewed) who complete and who attempt suicide/significant harm to self <u>Denominator</u> : Total number of children/adolescents served or charts reviewed	Total number of suicides and suicide attempts among youth served shall be reduced by 5 percent annually
<b>Percent of 30 Day Alcohol Use by 12-17 Year Old Youth</b>	Pre- and Post-tests using standardized instruments	Tools will be administered at the beginning and at the end of service. Providers submit quarterly reports that track progress by objective.	Pre- and post-test data analysis of youth who receive evidence-based prevention services compared against a comparison group of like youth.	Two percent annual reduction of 30 day alcohol use from pre- to post-test by youth receiving evidence based prevention services. This exceeds statistical significance.
<b>Percent of 30 Day Tobacco Use</b>	Pre- and Post-tests using standardized	Same as above	Pre- and post-test data analysis of youth who receive evidence-based	Two percent annual reduction of 30 day tobacco use from pre- to post-test by youth receiving

by 12-17 Year Old Youth	instruments		prevention services compared against a comparison group of like youth.	evidence based prevention services. This exceeds statistical significance.
<b>Children and Youth</b>				
<b>AREA</b>	<b>DATA REQUIREMENT/ DATA SOURCE</b>	<b>FREQUENCY</b>	<b>FORMULA</b>	<b>BENCHMARK/STANDARD</b>
<b>Percent of 30 Day Marijuana Use by 12-17 Year Old Youth</b>	Pre- and Post-tests using standardized instruments	Tools will be administered at the beginning and at the end of service. Providers submit quarterly reports that track progress by objective.	Pre- and post-test data analysis of youth who receive evidence-based prevention services compared against a comparison group of like youth.	Two percent annual reduction of 30 day Marijuana use from pre- to post-test by youth receiving evidence based prevention services. This exceeds statistical significance
<b>Percent of 30 Day illicit drugs Use by 12-17 Year Old Youth</b>	Pre- and Post-tests using standardized instruments	Same as above	Pre- and post-test data analysis of youth who receive evidence-based prevention services compared against a comparison group of like youth.	Two percent annual reduction of 30 day illicit drug use from pre- to post-test by youth receiving evidence based prevention services. This exceeds statistical significance.
<b>Statewide sales of Tobacco products to minors (18 years and under) shall not exceed twenty percent.</b>	Tobacco sales compliance checks	Once per year early spring.	Number of non-consummated sales of tobacco products to minors per random assignment of all tobacco retailers.	Maintenance of 63 percent rate of tobacco sales to minors, not to exceed 20% non-compliance.
<b>An increase Of perception of Harm from using alcohol, tobacco and other drugs (ATOD)</b>	Pre- and Post-tests using standardized instruments	Tools will be administered at the beginning and at the end of service. Providers submit quarterly reports that track progress by objective.	Pre- and post-test data analysis of youth who receive evidence-based prevention services compared against a comparison group of like youth.	Statistically significant increase of the perception of harm of ATOD by youth who participate in evidence-based prevention programs.

<b>Administrative MCO Measures</b>				
<b>AREA</b>	<b>DATA REQUIREMENT/ DATA SOURCE</b>	<b>FREQUENCY</b>	<b>FORMULA</b>	<b>BENCHMARK/STANDARD</b>
	To be developed by MCO.		Consumer complaints & rates of grievances.	
	To be developed by MCO.		Telephone Access to MCO: Timeliness & responsiveness.	
	To be developed by MCO.		Rate of Service Denials by Service Type.	
	To be developed by MCO.		Telephone Access to managed care organization – Calls answered in greater than 30 seconds.	
	To be developed by MCO.		Timely claims payment – Percentage of clean claims paid within 30 days.	
	To be developed by MCO.		Telephone Call abandonment rate.	
	To be developed by MCO.		Percentage of service providers reporting satisfaction with MCO Services/Operations.	
	To be developed by MCO.		Percentage of members reporting satisfaction with MCO services.	
	To be developed by MCO.		24 hour turn around on all required reports.	

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## **B. BENEFITS AND SERVICES**

### **Phase One (January 1, 2007-June 30, 2007)**

#### ***Expectations (See Section I for description of Phases)***

Although initial work and design of the transition from a multi-agency system to a DHHS/Collaborative approach has occurred, a central focus and expectation for the first contract year is the offeror's ability to identify and implement processes and procedures to transition to the new paradigm for behavioral health service delivery. Critical to this activity is the assurance that there will be:

- Continued delivery of services without disruption;
- Timely payment of providers;
- Collection and accurate reporting of data for multiple systems/fund sources; and
- Maintenance of at least current performance and outcomes.

In addition to those fundamental requirements, the selected offeror must be able to assist the DHHS/Collaborative in the refinement of expectations, including the identification of methods to maximize funding; shifts in service approaches to maximize community-based and evidence based and promising practices that support recovery and resiliency; the implementation of the Statewide Behavioral Health Plan; and the further development of goals and performance and outcome measures for Phases Two and Three of the contract period. The DHHS/Collaborative is seeking resources to conduct a process, cost and outcome evaluation of the DHHS/Collaborative process. The MCO will be expected to cooperate and participate in that evaluation process.

#### ***Mandatory Requests for Information***

B1. Describe how the offeror proposes to assure continuity of services to at least the same numbers and types of individuals and families as were being served prior to the implementation of the DHHS/Collaborative approach.

B2. Describe how the offeror will ensure that all services included within the "covered services" of each DHHS/Collaborative agency on December 31, 2006 are continued on January 1, 2007 for at least six months, and how existing customers and their families as well as providers and potential customers and families will be notified about how to continue receiving services without disruption after January 1, 2007.

B3. Describe contingency plans the offeror will use to assure that any confusion about services, authorizations or providers will be cleared up with clear instructions about how to receive or deliver services to prevent disruption of care after January 1, 2007.

B4. Describe how the offeror will begin to develop new approaches to increase community and home-based services that promote recovery and resiliency, including increasing billable wraparound and psychosocial rehabilitation service approaches to begin in Phase One or Phase Two.

B5. Describe how the offeror will support and encourage billable self-help, self-directed and peer support services, including increasing customer and family-operated service models and any provider incentives to utilize appropriate peer support and customer/family-operated services.

B6. Describe how the offeror will make use of evidence-based practices and how the offeror will work with providers and customer/family groups to expand and evaluate or research promising practices that will support customer and family recovery and resiliency.

B7. Describe what techniques the offeror will use to monitor customer and family involvement and integration into the new behavioral health services delivery system.

Would this be the DHHS AMH Service Plan in the Consent Decree?

B8. Describe how the offeror will interact with state-operated facilities, especially DOH and CBHS operated treatment facilities, in Phase One; specifically, how the offeror will conduct pre-admission reviews to suggest or arrange for alternative treatment settings and how will the offeror assure that community provider representatives (case managers or hospital/facility liaisons) participate in hospital/facility treatment teams to arrange discharge plans from the beginning of admission.

B9. Describe how the offeror proposes to work with the DHHS/Collaborative toward movement of state-operated resources and programs into the single behavioral health delivery system and towards more community-based service delivery models during Phase Two, while maintaining state facility employees as state employees.

B10. Describe the offeror's detailed transition work plan to move from the current systems to the new single behavioral health delivery system, specifically addressing continuity of services, education for providers and customers/families, changes to data collection and billing practices, changes to utilization review processes, changes to quality oversight processes (including provider credentialing and subcontracting), and the use of SCCS, SQIC and local collaboratives in the transition process; include specifically activities the offeror believes it will be necessary for the DHHS/Collaborative and its member agencies to do to assist in this transition.

B11. Provide preliminary service plans for each of the \_\_\_\_# regions of the state that are being utilized by the health and human services secretaries for planning and staff deployment (see Appendix \_\_), and how the offeror plans to update these service plans during Phase One for Phase Two.

### **Persons Served and Services Offered**

***Expectations*** (see Principle –Medical Necessity Appendix page 1 and Medical Necessity Definition page 3)

Other than universal prevention services, a needs-based approach to the planning and purchasing of services will be utilized, with a recognition that behavioral health services will continue to be available to people in Maine based on a combination of financial eligibility, clinical criteria, federal and state mandates, and individual/family need. The new behavioral health system will utilize current resources more efficiently so that services and persons served will not be reduced due to the development of the MCO (except to the extent affirmative choices are made to change some current facility-based or less effective services into other, more community-based or more recovery/resiliency-oriented services). Those eligible to receive services are individuals who:

- Are federal- or state-mandated to receive services with targeted funds;
- Meet categorical criteria associated with individual fund sources; and
- Are in need of services as determined by medical necessity definition or other criteria used to make judgments about the utilization of services. Even with these priorities, there are not enough resources to provide all needed services for everyone in those groups. Not all services will be available to everyone. Some services will only be available for certain types of individuals based upon the requirements of the various agencies. Although MaineCare requires “medical necessity,” other agencies may not. Services will only be available for any given individual if that individual is eligible for the service due to financial or clinical criteria and an assessment indicates a need for the specific service at that time based on “medical necessity” and/or program criteria. After meeting federal and state fund source requirements, other criteria will be used to prioritize who will have access to services.

These criteria will be set by the DHHS/Collaborative with significant input from the MCO, the SCCS, SQIC, and local collaboratives.

Given the low employment rate among persons with serious mental illness and the effectiveness of supported employment, the MCO will be expected to work with DOL, and DVR, and local workforce boards and providers to increase employment opportunities for adults with serious mental illness, adults with substance abuse disorders and transitional age youth. Given that of the five million households in the country with “worst case” housing needs, 1.4 million of them have a person with a disability; and given the high number of homeless individuals and families who have behavioral health needs, the MCO will be expected to work with MHA, local housing authorities, homeless shelters and providers to increase access to decent, safe, affordable housing for persons with behavioral health needs.

Stats for ME?

### ***Mandatory Requests for Information***

B12. Describe how the offeror proposes to utilize established eligibility criteria for each funding source to purchase or provide “covered” services for at least the following populations (specify how services will be made available for those populations entitled to services by federal or state statutes):

- Individuals who are enrolled in MaineCare, including individuals covered by MaineCare waivers who also have behavioral health diagnoses (e.g., developmentally disabled, disabled and elderly, HIV/AIDS, medically fragile children);
- Individuals with special health care needs as defined by MaineCare;
- Children and their families referred by or involved in the state’s protective services, juvenile justice services, tribal social services (NOTE: “referred by” means children, youth and families who have been formally referred by the county Protective Services or the Juvenile Probation/Parole office, Juvenile Correctional Facilities or the Tribal Social Services. “Involved with” means individuals and families who have an open case with PS, JJS or Tribal Social Services);
- Families in Need of Services (FINS) as defined by the MSA Article 3, Family in Need of Services Act, Section 32-A3A-2;
- Children under the age of 18 and their families at high risk for entry into CBHS’s Protective Services or Juvenile Justice Services;
- Children placed out-of-home such as those in foster care/adoption;
- Individuals in transition (all age transitions, with some increased awareness of the unique needs of the 14-25- and 0-3-year-old populations);
- Adults with serious mental illness or severe or long-term substance abuse who are not eligible for MaineCare;
- Adults and children participating in the TANF program;
- People under the supervision of the MDOC (probation or parole) who meet criteria established by MDOC, specifically individuals in community corrections programs;
- Individuals who are incarcerated in or should be diverted from jail or juvenile detention facilities;
- People who meet age criteria for services from ALTSD;
- Individuals with behavioral health diagnoses who have brain injury;
- Homeless individuals;
- Women who are pregnant and/or parenting, especially those with substance abuse disorders;

- Individuals whose current insurance combined with income is insufficient to meet their identified clinical/service needs; and
- Individuals who are uninsured or not Medicaid eligible with incomes up to 150 percent of the federal poverty guidelines, and who meet clinical criteria;

B13. Since not everyone within these priority populations can be served with the available funding, describe how the offeror will work to assure that individuals with the following diagnostic categories are prioritized:

- Adults with severe and persistent mental illness;
- Children with severe behavioral, emotional, and/or neurobiological problems/disorders;
- Individuals with a neurobiological disorder;
- Individuals with special health care needs (ISHCN);
- Individuals with co-occurring disorders (substance abuse and mental illness);
- Individuals who are dually or multiply diagnosed (mental illness with any other diagnosed disability); and
- Individuals with long-term or severe substance use disorders.

B14. Describe how the offeror will, within those diagnostic categories identified above, assure that providers utilize at least the following risk factors to determine who will receive services first among those not entitled to services by the fund source or by state or federal law:

- Use of multiple behavioral health services;
- Intensive use of behavioral health services;
- At risk of developing severe emotional, behavioral, and/or neurobiological problems/disorders;
- Intention/plan to hurt self or other(s) as evidenced by written, verbal or behavioral indicators;
- Suicide attempt during the past year (adult, child or parent);
- Substance abusing behaviors that may ultimately result in harm to self or others, especially drinking and driving, use of alcohol or drugs and engaging in unprotected sexual activity, intravenous drug users, etc.;
- Infants, toddlers and preschoolers exhibiting difficulty in relationships, attachments, self-regulation or behavior problems;
- Multiple delinquent acts or law enforcement contacts by child;
- Multiple school problems, including suspension or expulsion from school during last year, especially youth in exhibiting behavior problems and referred by school personnel, parents, child care centers, juvenile probation officers, etc.;
- Runaway/throwaway children/adolescents;
- Homelessness or near homelessness;
- Children whose parent(s) had/have mental illness;
- Children whose parents are incarcerated, involved with the criminal justice system, or on parole or probation;
- Physical, sexual, emotional abuse or neglect past or current;
- Multi-generational history of familial maltreatment, neglect or abuse;
- Teen pregnancy during past year or a teen parent;
- Child/youth experiencing cultural, sexual and/or gender identity issues;
- Witness to or participation in violence, at school, or in the community;
- New or shifting family situations/environments that cause psychological distress,

stressful family situations, individual/family challenges;

- Death of a family member or close friend during the past year;
- Parents and families of 0-6 year old youth, referred by human services or related agency;
- Children who have experienced trauma through natural disaster, war/conflict etc.;
- Individuals in danger of being institutionalized (including nursing homes), especially those likely to be placed in facilities out-of-state.

B15. Describe the processes and procedures the offeror will use to verify eligibility for services based upon eligibility and clinical criteria, including risk factors, appropriate to each funding source, including the offeror's processes and procedures for tracking services across funding sources.

B16. Describe how the offeror proposes to assure a behavioral health screening is conducted within 24 hours of admission on every child/adolescent entering the Protective Services and Juvenile Justice Services in CBHS, and make appropriate referrals for further assessment and treatment.

B17. Describe how the offeror will assure follow-up for necessary behavioral health services identified through EPSDT screens of children and adolescents.

B18. Describe methods to assure a delivery system that appears "seamless" to the individual in need of services, regardless of fund sources utilized to pay for their care (including commercial insurance, co-pays and other cost-sharing mechanisms where appropriate, based on ability to pay).

B19. Describe how the offeror will assure that services are provided in accordance with professional standards of care, ensuring that all service components are provided by adequately trained, licensed and qualified staff as appropriate to services provided and as stipulated by the Maine Licensing Boards; NOTE: If the MCO fails to provide services in accordance with professional standards of care, the MCO will not be paid for such services, or if such services have already been paid for by the DHHS/Collaborative, the MCO will be required to refund the payment for such services.

B20. Describe how the offeror will present recommendations regarding the efficient and effective delivery of behavioral health services across funding sources, including any current recommendations the offeror has that it proposes to implement during Phase One of the contract period.

B21. Describe how the offeror will assist the DHHS/Collaborative to increase funding sources, federal matching funds and/or other mechanisms of improving the range of services and service delivery.

B22. Describe the offeror's commitment to and proposed actions to assist the DHHS/Collaborative to develop a workforce capable of delivering the best services possible, especially those that are evidence-based or promising practices.

B23. Describe how the offeror will facilitate the creation of and utilize any state certified customer/family workforce capable of supporting proactive participation in: advisory groups, quality improvement activities, complaints and grievance processes, and customer/family/peer provided MaineCare and non-MaineCare reimbursable services.

B24. Describe how the offeror will work with DHHS/Collaborative agencies, SCCS, BHPC and local collaborative to utilize all available workforce incentives and initiatives and to ensure public and private employers are available to support transitions to employment for youth

transitioning to adulthood or for adults with serious mental illness or severe substance use disorders.

B25. Describe how the offeror will work with DHHD/Collaborative agencies, SCCS, SQIC, and local collaboratives to assure that persons with mental health and substance abuse disorders have access to safe, affordable, decent housing of their choice, and to increase the availability of such housing, including methods of paying for rent and/or mortgage payments.

B26. Describe how the offeror will seek or assist providers in seeking additional shelter plus care or other housing assistance funding for the populations served pursuant to the contract.

## **Utilization Review and Utilization Management**

### ***Expectations***

Utilization review (UR) and utilization management (UM) are processes for assuring that the right services are provided at the right time in the right amount to assure the best possible outcomes and the best possible use of limited financial and staff resources. These UR/UM processes also provide data that should be used for monitoring system performance and for making adjustments in services and systems to assure that customer/family outcomes are what they are expected to be. While UR/UM activities do sometimes result in a denial of certain higher levels of care, denial of services or saving money is not the goal of UR/UM activities. Rather, the goal is to make sure the appropriate level of care to adequately meet the individual's needs is provided to effect the best possible outcome and to make sure higher levels of care are used when necessary and for only the length of time necessary to assure good outcomes for individuals served.

The DHHS/Collaborative expects appropriate UR/UM activities to be performed so that excellent services are provided with neither over nor under utilization. The MCO will be expected to apply criteria developed by the DHHS/Collaborative or proposed by the MCO and adopted by the DHHS/Collaborative to determine who gets what services and how much and in what order; what processes will be used to make these decisions; and to make sure that providers are paid for services for those individuals that are directed by the DHHS/Collaborative. UR/UM activities help to identify groups or types of individuals who are not receiving the appropriate services, and, as a result, are not having their needs adequately met. UM data can also be used to help determine what kinds of service utilization trends are occurring that should be encouraged or redirected in order to create the best outcomes for customers and their families. Good UR/UM and good service delivery requires the development and utilization of a consistent assessment that moves with the individual and family served across service settings and a single administrative file to document service delivery and UR/UM activities for each service recipient. The MCO will be expected to perform UR/UM activities for services funded by MaineCare managed care and MaineCare fee-for-service (see Appendix \_\_\_), and for other services for which a UR function is appropriate.

### ***Mandatory Requests for Information***

B27. Describe how the offeror will assure the MaineCare medical necessity definition will be applied for MaineCare services for MaineCare enrolled customers/families.

B28. Describe how the offeror will assure that the same criteria are utilized for MaineCare fee-for-service and managed care and, to the extent appropriate, for similar services funded through other fund sources (see Appendix \_\_\_ for required UR functions for MaineCare fee-for-service).

B29. Describe how the offeror, with the DHHS/Collaborative, the SCCS, the SQIC, and local collaboratives, and with the approval of, the DHHS/Collaborative will develop appropriate criteria for clinical, rehabilitative, or supportive services covered by other funding streams. If the offeror has existing criteria it suggests for Phase One, please describe and provide those criteria, forms and procedures it recommends.

B30. Describe the offeror's capacity to comply with national standards for UM.

B31. Describe how the offeror will move the service delivery, especially high-volume providers, system toward the ability to follow proposed timeliness standards for response to routine, urgent and emergent situations (see Performance and Outcome Measures, Tables).

B32. Describe how the offeror will move the service delivery system toward the delivery of behavioral health treatment services based on a comprehensive clinical assessment, which adheres to DSM IV diagnoses and whenever possible, with the DC 0-3 for children ages 0-3 years of age.

B33. Describe how the offeror will work with providers to create and maintain a single administrative centralized file with comprehensive behavioral health treatment and outcome information, including school success, housing, employment, justice system involvement, etc. (see Proposed Performance and Outcome Measures Tables for Phase Two and Three.), for all persons receiving services pursuant to the contract.

B34. Describe the offeror's suggestions for implementation of a single, developmentally appropriate screening/assessment process and/or tools and customer/family driven plan of care (or individual services or treatment plan) to assure consistent care across providers and involved systems and appropriate and timely discharge planning; if the offeror has proposed forms and assessment and/or treatment plan instruments it proposes, please provide them along with associated instructions or procedures for their use.

B35. Describe thoroughly or provide the uniform definitions, clinical criteria, processes and procedures and forms the offeror proposes to use throughout the service delivery system for determination of what individuals and families are priorities to receive services and for authorization or review of specific services for an individual or family, whether before or after the fact.

B36. Identify the offeror's capacity to assure children/adolescent providers utilize two PED assessment tools (Youth Risk and Resiliency Survey and the Safe Schools Report) for appropriate children/youth in appropriate situations.

B37. Describe the offeror's proposed retrospective, prospective and concurrent review mechanisms, identifying for which populations and services it proposes to use these mechanisms, and for which services the offeror proposes to require authorization prior to service delivery and for which services the offeror proposes to have "open access" with only concurrent, retrospective or no clinical reviews.

B38. Describe how the offeror will assure timely UR decisions and include an explanation of how timely UR/UM decisions will be made when insufficient or improper documentation is submitted by a provider.

B39. Describe how the offeror will coordinate UR authorizations with and provide appropriate data for any state-owned, vendor-operated claims payment system (e.g., for fee-for-service MaineCare).

B40. Describe how the offeror will track the effectiveness of prior authorization processes and make adjustments to criteria, mechanisms, forms or services for which prior authorization is required.

- B41. Describe how the offeror will assure timely review of any clinical denial of services and how alternative levels of care will be suggested and providers and customers/families assisted in accessing those alternative levels of care; include a description of how providers and customers/families may appeal denials of authorization for services.
- B42. Describe how the offeror will assist the DHHS/Collaborative agencies to train for and implement the common assessment and service plan documents and the required service authorization processes and forms.
- B43. Provide a description of the offeror's UR/UM structure, including the role of relevant individuals such as behavioral health medical directors, providers, customers and families, local collaboratives, SCCS, SQIC, etc.
- B44. Describe how the offeror will ensure that appropriate active practitioners and customers and their families will participate in development, adoption, adjustment, and application of clinical practice criteria.
- B45. Provide documentation of the methods by which the offeror will evaluate at least annually the consistency of UR/UM reviewers, including any delegated UR/UM reviewers, in applying criteria in decision-making.
- B46. Describe how the offeror and its subcontractors will use appropriately licensed health and behavioral health professionals (whose education, training and experience are commensurate with the URs that they conduct and decisions that they make) to supervise all UR decisions.
- B47. Describe how UR/UM aggregate data will be shared with local collaboratives and used to make decisions about service utilization changes.
- B48. Describe methods for identifying utilization patterns and changing those patterns when the patterns suggest inappropriate use of most restrictive or intense, highest cost services such as out-of-home or facility-based services for adults and children.
- B49. Describe how, utilizing the service patterns analysis and input from the SCCS, SQIC and local collaboratives, the offeror will make recommendations to the DHHS/Collaborative for service changes that will increase services and outcomes for Maine's citizens.
- B50. Explain how the offeror will work with the DHHS/Collaborative and physical health managed care organizations to assure UR criteria are the same or at least not inconsistent for similar services.

## **Care Coordination**

### ***Expectations***

By facilitating timely access to and utilization of appropriate services, care coordination can help to avoid duplication of services and reduce the costs of unnecessary services, and reduce the incidence and costs of inappropriate emergency room and inpatient care. Care coordination is an administrative function that must be performed across all populations who need this assistance with their services, especially customers/families with high or special behavioral health care needs. Care coordination is the single point of contact within the MCO for individuals who need help accessing care or coordinating care across multiple providers. It is customer-centered and customer-directed, family-focused when appropriate, culturally competent, strength-based and recovery/resiliency oriented. Care coordination ensures that *medical and behavioral* health needs are identified and services are provided and coordinated with the customer, and family if appropriate. Care coordination of children's services will actively involve children and their families throughout the decision-making process from initial planning through implementation and evaluation. Care coordination of adult services will actively involve the adult receiving

services and will be directed by that adult with assistance in decision-making as needed. Care coordination decisions should be based on clinical criteria for determining medically necessary covered services in order to increase outcomes for customers, not other financial or administrative criteria. Care coordination is an office-based administrative function of the MCO rather than a service and is not separately reimbursed by behavioral health fund sources. It is not the same as case management which is a therapeutic service provided largely face-to-face and mostly by subcontracted providers for only those customers/families in need of such services and indifferent levels of intensity depending on the customer/family's need. Care coordination will be operated by the MCO as a dedicated independent function that is linked to other MCO systems such as quality improvement/management, customer services, and complaints and grievances. The care coordinator coordinates services within the behavioral health delivery system, as well as with other service providing systems. It may be provided through telephone contact or face-to-face as necessary. Whenever services are not working for the customer/family, the MCO is responsible for assuring services are changed to improve effectiveness and satisfaction. The MCO care coordinators responsible for making these changes. The care coordinator may interface and collaborate with a customer's case manager for those who receive case management services. The MCO, in conjunction with the DHHS/Collaborative, will develop criteria for identifying persons with high needs, high risk and high utilization or multi-system or multi-provider services to initiate treatment planning and service coordination with the customer and others, including IFSP and ISP teams, who are working with the customer. Criteria will include: such issues as acuity of need, need for multiple services and/or systems, past high usage of behavioral health services, children transitioning from the children's system to the adult system; and high risk of needing intensive behavioral health services. The criteria for determining those who need service coordination activities will be approved by the DHHS/Collaborative, published and widely distributed, and utilized as standard criteria throughout the service delivery system. The MCO will work with the identified customer and/or family to identify a provider that will serve as the customer's clinical home. The MCO, in conjunction with the DHHS/Collaborative, will develop a process for implementation of a single, developmentally appropriate screening/assessment process and customer/family-driven plan of care (or individual services or treatment plan with appropriate discharge planning components) to assure consistent care across providers and involved systems. The MCO care coordination function will be responsible for sharing the service plan with primary care providers to ensure optimum care and communication between primary care and behavioral health care as well as among involved behavioral health providers and across other service providing systems involved in the customer's life. The plan of care may be developed by the care coordinator or by the case manager for those who receive case management services. In all cases, the plan of care will be developed with the customer/family.

The care coordinator is ultimately responsible to assure that the plan of care meets the individuals' /family's needs and is consistent across service providers, whether developed by the care coordinator or the case manager.

***Mandatory Requests for Information***

B51. Describe how the offeror proposes to identify proactively individuals for whose care they are responsible who need care coordination assistance, including but not limited to, MaineCare-eligible individuals with special health care needs, as required by federal regulation, and persons with multiple or complex needs.

- B52. Identify the offeror's designated person(s) and the organizational structure (including location, ensuring coverage throughout the state, and to whom care coordinators will report) the offeror proposes to use to assure care coordination activities and to serve as the single point of contact for the customer/family in need of such services.
- B53. Describe the qualifications of staff who will function as care coordinators; include a position description for this position.
- B54. Describe how the offeror will ensure access for each customer/family to a qualified provider who will be the customer's/family's clinical home and who will be responsible for developing and implementing a comprehensive treatment plan for each customer/family (e.g., MCO care coordinator, clinical home practitioner or case manager).
- B55. Describe how the offeror will identify and track the clinical home for each customer/family and how a single administrative file will be maintained for that customer/family.
- B56. Describe how the offeror will communicate to customers/families the existence of the care coordination function and how they can request such assistance with care.
- B57. Describe how the offeror will communicate to the customer/family the care coordinator's name and how to contact him/her or the single point of contact for any customer/family for whom care coordination is determined to be unnecessary.
- B58. Describe how the customer's/family's clinical home care coordinator or provider will ensure the provision of necessary behavioral health services and actively assist customers and providers in obtaining such services.
- B59. Describe the relationship between the care coordinator and the individual/family's clinical home provider, and the case manager for customers/families assigned MCO care coordinators and for community-based case managers.
- B60. For those children/adolescents with IEPs, describe the relationship among the care coordinator, the child's/adolescent's clinical home provider, the child's/adolescent's school-based treatment providers, and any case manager for the child/adolescent or family, assuring no duplication of effort and no unnecessary overlap in assessments, services or requirements.
- B61. Describe how the child's/adolescent's IEP and his/her treatment or service plan and providers will be coordinated or become the same to avoid duplication or inconsistent service provision.
- B62. Describe how the offeror will monitor progress of customers/families to ensure that services are received, assistance is provided in resolving identified problems, duplication of services is avoided, and linking of customers to on-site face-to-face case management is available when needed.
- B63. Describe how providers will consistently receive communication regarding service recipient status and follow-up care by a specialist provider.
- B64. Describe how the offeror will identify and use community resources to improve delivery of care coordination.
- B65. Describe how the offeror will address perceived conflicts between advocacy and utilization functions associated with care coordinators.
- B66. Describe how the offeror proposes to participate with the DHHS/Collaborative during the time between the award of the contract and its implementation January 1, 2007 to develop policies and procedures to guide joint treatment planning with the MCO and providers for children and adolescents and for adults.
- B67. Describe the offeror's experience with the use of predictive modeling or other care

coordination approaches and/or external referrals to identify and manage the care of high-risk individuals.

## **Case Management**

### ***Expectations***

Case management is a set of therapeutic services delivered primarily face-to-face in community settings (generally not office settings) and intended to ensure that individuals receive the services they need in a timely, appropriate, effective, efficient and coordinated fashion. Case management is not for everyone. It is designed for individuals and families who cannot otherwise access services, obtain the benefits of services, and/or reach their treatment and service goals without assistance. Case management is customer-centered, family/customer-focused when appropriate, culturally competent and strength-based. Providers are encouraged to offer this service in the communities they serve. It is the DHHS/Collaborative's expectation that the MCO contract with one or more providers in each community for those customers who need this service. If no qualified providers are available, the MCO may provide this service directly until provider capacity is developed. Additionally, the DHHS/Collaborative is working on a new concept that may become a specific service definition called "community support services," which will encompass some elements of case management and psychosocial rehabilitation programs (e.g., skill-building). The standards and provider qualifications for this new service are being developed by an interagency team of DHHS/ Collaborative agency staff.

The case manager is an individual or team who has direct contact with the customer/family and other service providers in the community and in any treatment setting in which the customer/family is found, including homes, schools, correctional facilities, workplaces, etc. Case managers are responsible for the plan of care and for information sharing when customers/families receive behavioral health care from multiple providers. Case managers assess a customer's/family's needs and strengths; monitor the plan of care, coordinate, advocate for and link customers to all needed services related to the targeted case management program, based on a plan of care determined by an interdisciplinary team; problem-solve when services are not going well or needs are not being met; assist customers/families to make good choices about services; in some cases directly provide counseling, modeling, housing supports, job coaching, crisis intervention services, in-home services or other services necessary to promote the customer's/family's recovery or resiliency; and monitor outcomes.

### ***Mandatory Requests for Information***

B68. Describe how the offeror will structure case management services, including what organization(s) will provide what types of case management services for which specific populations.

B69. Demonstrate how the offeror will cover the entire state and ensure that face-to-face case management services are delivered for those who need this level of service.

B70. Describe how customers will access the MCO care coordination function and case management services, how these functions will be different, and what criteria will be used to determine which customers will receive which level of case management services.

B71. Describe how the offeror will monitor the progress of customers/families receiving case management services to ensure that services are received and the plan of care's effectiveness is evaluated.

B72. Describe how the offeror will utilize case management services to promote coordination of physical and behavioral health care, and coordination of behavioral health treatment with social services including employment, housing and educational services.

B73. Describe how the offeror will measure and evaluate outcomes for those customers/families receiving case management services.

B74. Describe how the offeror will assure that a discharge plan from case management services is prepared and how graduation from one level of case management service to another or to regular behavioral health services will occur.

B75. Describe how case managers will be supervised and how case consultation for direct service providers will occur with the availability of a case manager supervisor during all hours during which the service is provided or is required to be available, especially in 24/7 case management service models.

B76. Demonstrate the offeror's knowledge of and experience with evidence-based practices in case management models for different populations, describing clear expected outcomes for each population and model (specifically address adults with serious and persistent mental illness, children with serious emotional disturbances, persons with forensic involvement, persons who are deaf or hard of hearing or who have special disabilities requiring special workforce competence).

B77. Describe the role the offeror's subcontracts for or provision of case management services will play in ensuring public and private employers are available to support transitions to employment and in supporting youth and adults in case management services who want to and are capable of working.

B78. Describe the case manager's or case management team's role in preventing and intervening in crisis or emergency situations, specifically in the process of deciding whether a customer will be hospitalized, civilly committed or otherwise detained against his/her will.

B79. Describe how the offeror will assist the DHHS/Collaborative to train case managers in illness management and recovery (IMR) models and service approaches, including skill-building, relapse prevention, medication self-management and peer support.

## **Coordination with Primary Care**

### ***Expectations***

Physical and behavioral health services must be well coordinated. Both physical and behavioral health care providers need access to relevant medical records of mutually served individuals to ensure maximum benefits of services for that person. Confidentiality and HIPAA laws apply during this coordination process, so procedures for sharing information will need to be developed by the MCO in conjunction with the DHHS/Collaborative. The MCO will implement policies and procedures designed to maximize the coordination of physical and behavioral health services and address the medical and behavioral health needs of individuals served. Similar mechanisms for coordination with behavioral health providers will be required of physical health providers in the MaineCare program. The Medical Director of the (mental health) MCO will be required to meet regularly with Medical Directors of the MCOs that provide physical health care for the MaineCare program, the Medical Directors of relevant programs of the DHHS/Collaborative agencies (especially DHHS, DOH, CBHS, MCD), and the Medical or Clinical Director of any vendor that implements utilization review processes for the MaineCare fee-for-service program to assure coordination between physical and behavioral health care occurs for individual service

recipients and between systems of care. Key medical directors or clinical leaders of critical health and behavioral health providers will also be asked to work with the MCO, the Collaborative, and MCO Medical Directors to maximize mechanisms for coordination of care. The Medical Directors group may engage others and will work closely with the primary care network, including but not limited to federally qualified health centers (FQHCs) and rural health clinics to maximize coordination between physical and behavioral health care. Placement of behavioral health practitioners in these primary care clinics may be one approach utilized to increase care coordination between systems of care. Processes, forms, approaches and requirements that are implemented as a result of these meetings and other efforts of the DHHS/Collaborative, must be adopted and adhered to by the MCO.

***Mandatory Requests for Information***

B80. Describe how behavioral health providers will be strongly encouraged or required to obtain consultations and assistance with psychopharmacotherapy and diagnostic evaluations from a psychiatrist or other behavioral health specialist with prescribing authority when clinically appropriate.

B81. Describe how behavioral health providers will be encouraged to be available for consultations with primary care practitioners in clinic, hospital or emergency room settings.

B82. Describe the offeror's experience and knowledge of care coordination mechanisms between health and behavioral health care providers, between mental health and substance abuse providers, and among behavioral health providers serving common customers/families; describe in detail the offeror's proposed protocols for sharing information between such providers.

B83. Describe the offeror's experience with and plans to implement integrated services for persons with co-occurring disorders of mental illness and substance abuse and describe in detail the integrated services the offeror plans to make available in Maine.

B84. Describe the processes and procedures necessary to coordinate physical and behavioral health care for high-risk categories of behavioral health clients identified.

B85. Describe how the offeror will assure that providers forward a written report of the outcome of any referral containing sufficient information to coordinate the individual's care to the primary care provider by the behavioral health provider and vice versa, within seven calendar days after screening and evaluation.

B86. Describe how the offeror will assure that providers forward a written report of the outcome of any referral containing sufficient information to coordinate the individual's care and/or to determine acceptance into care to other behavioral health providers within seven calendar days after screening and evaluation.

B87. Describe how the offeror will educate and assist behavioral health providers to make appropriate referrals for physical health consultation and treatment, and how the offeror will work with primary care providers to make appropriate referrals for behavioral health services.

B88. Describe how the offeror will assure that behavioral health providers will keep the customer's primary care physician (PCP) or other health care practitioner informed of the following:

- Drug therapy;
- Laboratory and radiology results;
- Sentinel events such as hospitalization, emergencies, and incarceration;
- Discharge from a psychiatric hospital or from behavioral health services;
- Transitions in level of care; and

- Progress in meeting individual service or life goals that affect physical health care.
- B89. Describe how the offeror will assure that critical services are continued until any disputes about who pays for such services (e.g., medications, laboratory services, etc.) are resolved.

## **Commitment to Cultural Competency**

### ***Expectations***

***Cultural Competency descriptive of Maine plus.*** The MCO will offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each customer with limited English proficiency at all points of contact, in a timely manner during all hours of operation. The MCO will meet the needs of persons with disability, including assistive services for persons who are deaf, blind, hard of hearing or visually impaired, at no cost to each customer at all points of contact, in a timely manner during all hours of operation. The MCO will ensure that the provider will maintain accessibility and availability for language assistance services, including bilingual staff and interpreter services, at no cost to each customer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

### ***Mandatory Requests for Information***

B90. Describe how the offeror will meet the expectations outlined above, specific to Maine's cultural needs.

B91. Describe the offeror's strategies to recruit, retain, and promote at all levels of the organization a culturally diverse staff, including leadership positions representative of the demographic characteristics of the service area.

B92. Describe how the offeror will identify cultural clinical consultants to support staff of the MCO and of providers to give appropriate direction for cultural issues that arise in the therapeutic setting and in interactions about service authorization or use.

B93. Describe how the offeror will ensure that MCO and provider staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically (including deaf and hard of hearing) appropriate service delivery and dispute resolution.

B94. Describe how the offeror will assure that customers and their families receive information, assistance and services in their preferred language, including verbal offers and written notices informing them of their right to receive language assistance services.

B95. Describe how the offeror will assure the competence of language assistance provided to customers with limited English proficiency and their families by interpreters and bilingual staff; how will the offeror assure that family and friends will not be used to provide interpretation services (except upon explicit request of the customer).

B96. Describe how the offeror will make available easily understood customer-related materials and post signage in the languages of the commonly encountered group and/or groups represented in the service area; provide examples of such materials and signs.

B97. Describe how the offeror will develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability and oversight mechanisms to provide culturally and linguistically appropriate services, with incentives and penalties attached.

B98. Describe how the offeror will conduct initial and ongoing organizational provider assessments and or assist providers in conducting self-assessments of culturally and linguistically competent-related activities.

B99. Describe how the offeror will encourage or require providers to integrate cultural and linguistically competent-related measures into their internal audits, performance

improvement programs, customer satisfaction assessments, and outcomes-based evaluations.

B100. Describe the offeror’s capacity and process for ensuring that data on the individual customer/family’s race, ethnicity, tribe and spoken and written language are collected in health records, integrated into the organization’s management information systems and periodically updated.

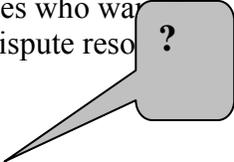
B101. Describe how the offeror will maintain a current demographic, cultural and epidemiological profile of the communities and geographic areas served, as well as a needs assessment, to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area; and how the offeror will utilize local collaboratives and customers and families of various cultural, ethnic and disability groups to assist with this process.

B102. Describe how the offeror will ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing and resolving cross-cultural conflicts or complaints by customers or their families.

B103. Describe how the offeror will regularly make available to the public (especially local collaboratives, SCCS, and the SQIC) information about its progress and successful innovations in implementing culturally and linguistically competent standards, and provide public notice in local communities about the availability of this information.

B104. Describe how the offeror will support the use of traditional healers, promotoras, cultural practitioners and traditional healing approaches for customers and their families who want

B105. Describe the offeror’s language capabilities for service provision and dispute resolution.



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## **Native American Issues**

### ***Expectations***

The offeror must be flexible to meet the needs of the diverse cultural and regional populations of the state, including Native Americans. ....

### ***Mandatory Requests for Information***

Native American issues.....

## **Services for Individuals with Special Health Care Needs (ISHCN)**

### ***Expectations***

ISHCN is defined as, “individuals who have or are at an increased risk for a chronic mental, developmental, behavioral, neurobiological or emotional condition, and who also require health and related services of a type or amount beyond that required by persons generally.” The guiding principle for this definition is that the person must be at individual risk and have a functional need. The primary purpose of the definition is to identify ISHCN so that the MCO can facilitate access to appropriate services. The definition also allows for a flexible targeting of individuals based on clinical justification and discharging them to routine care when special services are no longer needed.

Within the broader category of ISHCN, there is a significant subpopulation of customers who have neuropsychological disorders. Neuropsychological disorders (NPDs) consist of several complex disorders, which often involve significant physical, behavioral, social and educational issues and problems. Care for persons with certain of these disorders and who also have behavioral health disorders will need to be addressed by the SE. These disorders include, but are not limited to: Autism Spectrum Disorders (ASD) which include Autistic Disorder with mental illness and/or substance abuse; Pervasive Developmental Disabilities (PDD) Not Otherwise

Specified with mental illness and/or substance abuse; Asperger's Disorder with mental illness and/or substance abuse; Developmental Disabilities with mental illness and/or substance abuse (DDMI) and Brain Injury (BI) with mental illness and/or substance abuse.

The DHHS/Collaborative will work with the MCO and stakeholders to include neuropsychological and behavioral health assessments, as indicated, to diagnose or rule out NPDs for those who may need such assessments. Uniform diagnostic and assessment criteria will be developed to assist in this process. EDSPT screens for all children and youth eligible for MaineCare need to be completed, and appropriate referrals need to be made when ASD, DD or BI are suspected. Community outreach and screening of high-risk populations under age 21 should be conducted to insure early identification and treatment for persons with NPDs. The MCO shall identify from among its recipients, individuals with special behavioral health care needs, using the proposed definition and criteria for identification. The DHHS/Collaborative will work with the MCO in developing new ways of identifying ISHCN.

***Mandatory Requests for Information***

B115. Describe how ISCHN individuals will be identified, especially within the following groups:

- Individuals who are eligible for SSI as disabled under Title XVI;
- Individuals participating in MaineCare Home and Community Based waiver programs (DD, D&E, HIV/AIDS, and Medically Fragile Children);
- Children receiving foster care or adoption assistance support through Title IV-E;
- Other children in foster care or out-of-home placement;
- Children who are described in the Individuals with Disabilities Education Act;
- Individuals who have physical, cognitive, sensory, mental/emotional disabilities;
- Individuals who have developmental disabilities and co-occurring mental illness and/or substance abuse; and
- Other individuals who, by merit of a behavioral health clinical assessment, should be identified as an ISCHN.

B116. Describe potential enhanced services available to ISCHN within the offeror's program, including specialized assessment, diagnoses, treatment, and case management or care coordination.

B117. Describe coordination of care among agencies, including schools, and between behavioral health and physical health providers for ISCHNs.

B118. Identify processes and procedures used to appropriately assess, treat and coordinate the care of NPDs;

B119. Explain the offeror's experience with successful implementation of EPSDT screening, and how the offeror will assure EPSDT screening occurs and service needs identified are met for ISCHNs.

B120. Describe how the offeror will assure that sufficient access to providers who have expertise in addressing conditions specific to ISHCNs where workforce expertise is an issue, and how the offeror will provide training, technical assistance, or consultation for providers confronted with ISHCNs but without the necessary expertise to adequately address their needs.

B121. Describe how the offeror will plan to work with existing centers of excellence such as the Center for Development Disabilities (CDD) at the University of New Mexico (UNM) and other in-state resources.



ME's equivalent?

B122. Describe the national or out-of-state resources will the offeror bring to bear to assess, treat, provide consultation for providers, conduct training about current information and research, provide technical assistance or otherwise address the needs of ISHCNs and their treatment providers.

B123. Describe the methods the offeror will utilize to develop and distribute a customer services handbook describing providers and programs available to ISCHNs.

B124. Describe the special mechanisms, personnel, policies or procedures will the offeror use to assure adequate care coordination for customers with multiple and complex special physical, mental, neurobiological, emotional and/or behavioral health care needs.

### **Services for Children and Adolescents in Protective Services and Receiving or Released from Juvenile Justice Services and Under the Supervision or Custody of CYFD**

#### ***Expectations***

Most children/adolescents in state protective services and most adolescents paroled from CBHS correctional facilities have behavioral health needs. Those at high risk of having an unsuccessful parole or who are difficult to place in foster care or adoptive homes due to substance abuse or mental illness are a high priority for the DHHS/Collaborative. CBHS will identify the individuals to be served and will provide supervision while they are on parole status or in the custody of the state. The MCO will be required to assure that these individuals are served and that reports about their contacts with treatment providers and progress will be reported as required by the individual's Juvenile Justice System (JJS) or Protective Services worker. The MCO will be expected to use or contract with providers who use a strength-based multi-disciplinary family-inclusive approach to identify and develop strategies to address the safety, well-being and permanency of the child and family in all planning, evaluation and service delivery for children/adolescents. The MCO will be expected to coordinate with JJS or Protective Services workers as well as foster or adoptive parents or biological parents to assure that treatment needs are being met, children/adolescents are safe, and that any conditions of parole or release are being fulfilled, with the goal of achieving good customer/family outcomes as well as preventing repeat of abuse or neglect that resulted in state custody, or preventing the return to juvenile justice facilities due to violation of parole or re-offense.

CBHS has used the Children's Functional Assessment Rating Scale (CFARS) and the North Carolina Family Assessment Scale (NCFAS) to measure functioning level with children and families. It is our expectation that the MCO will continue to use the CFARS and NCFAS to measure child and family functioning, at least for the first year of the SQIC contract. The MCO and the Collaborative, in consultation with SQIC, will negotiate within the first year of the contract about continued use of these instruments or substitution of other, more useful instruments developed to use throughout the new behavioral health system. For the first year, the general performance measures expected include the following:

- Improving the functioning level of the client (child/youth) – measured by improved CFARS scores (a CFARS will be administered within 30 days of intake, every 90 days thereafter and at discharge from services for children ages five through 18).
- Improving the functioning level of the family (as appropriate) – measured by improved NCFAS scores.

### ***Mandatory Requests for Information***

B125. Describe in detail the process, procedures and methods to assure the coordination of services, including discharge planning, and the development of “wraparound” approaches to meet the needs of those children who are under the supervision of or at risk of coming under the supervision of CBHS.

B126. Describe the development of an array of services that enables children to be served within the least restrictive setting and in close proximity to their families.

B127. Describe how the MCO will proactively involve Protective Services and Juvenile Justice System workers in assessing the need for services and in decisions being made about services.

B128. Describe the specific strategies the MCO will use to improve the assessment of behavioral health needs for children and youth in the protective and juvenile justice systems and improve provision of appropriate behavioral health services to address identified needs.

B129. Describe how the offeror will assure a behavioral health screen is conducted within 24 hours for every child/adolescent entering the child protective services system and make appropriate referrals for further assessment and treatment.

B130. Describe how the offeror will work with the DHHS/Collaborative to develop criteria to determine which children/adolescents who enter the juvenile justice system will receive a behavioral health screen.

B131. Describe how the offeror will work with in-facility behavioral health providers to prepare for discharge or release of adolescents and assure that service linkages are established before the adolescent is released from state juvenile justice facilities.

B132. Describe how the offeror will work with foster families and biological families to assure that children/adolescents are receiving the behavioral health treatment and services they need; that overall functioning of the child is improved in the areas of safety, permanency/stability and well-being; and that families are prepared to support children/adolescents moving back home or moving into adoption.

B133. Describe how the offeror will utilize the CFARS and NCFAS to measure functioning of the child and family and what process the offeror proposes to work with CBHS in the establishment of a single assessment and outcome measurement instrument for children, adolescents and families.

B134. Describe the offeror’s proposed staffing pattern to establish a specific liaison for children, youth and families issues to work on the myriad of behavioral health systemic and individual issues that arise with children/adolescents in the Child Protective and Juvenile Justice Systems on a daily basis, including but not limited to: identifying and resolving service gaps; improving communication; integrating treatment plans; assessing the needs for services in consultation with the DHHS/Collaborative; making decisions about services; improve the assessment of behavioral health needs for children in both systems; improving the provision of appropriate behavioral health services to address identified needs; and functioning as a partner to state staff in resolving systemic and difficult individual-specific issues.

B135. Describe how the offeror will work with DHHS/Collaborative agencies to develop services and supports to meet the specialized behavioral health needs of children who are transitioning from the state’s foster system through emancipation.

B136. Describe how the offeror will work with DHHS/Collaborative agencies to develop services and supports to meet the specialized behavioral health needs of children who have been adopted from the state’s foster care system.

B137. Describe how the offeror will cooperate with and assure the cooperation of providers in participating in family team decision-making and multidisciplinary meetings as needed for children/adolescents and their foster or adoptive parents or facility-based caregivers.

B138. Describe how the offeror will cooperate in the implementation of reasonable efforts for children and families, including the authorization of integrated in-home and school-based services and supports to help avoid out-of-home placements and/or achieve permanency for children/adolescents.

B139. Describe how the offeror will train staff, providers and the community in the philosophy and use of wraparound approaches and methods, including how the offeror will establish flexible funding for those services and products that are traditionally non-clinical but which are part of the child/adolescent's treatment plan and serve to maintain the child functioning in a home setting and in the community.

B140. Describe how the offeror will assure that providers, in conjunction with DHHS/Collaborative agency staff, will actively participate in discharge planning in a proactive and timely manner at the beginning of an inpatient, residential or treatment foster care placement for state custody children/adolescents and ensure its implementation.

B141. Describe how the offeror will assure that providers and its own care coordinators will be compliant with timelines for the provision of reports to the court or appearances before the court.

B142. Describe how the offeror will ensure that EPSDT screening for behavioral health is being completed for all children/adolescents who are MaineCare recipients, and that the screening is being tracked and appropriate referrals for further assessment, treatment and follow-up are implemented, especially for state custody children/adolescents.

B143. Describe how the offeror will assure the provision of medically necessary behavioral health services, including screening, assessment and treatment, if indicated, for the first 60 days of detention for MaineCare eligible children/adolescents placed in county juvenile detention centers.

B144. Describe how the offeror will provide for the timely conduct of the behavioral health portion of the evaluations and reports for MaineCare eligible children/adolescents court ordered to the Youth Diagnostic and Development Center (YDDC) for 15-day diagnostic evaluations, in accordance with court expectations.

B145. Describe how the offeror will credential appropriately licensed professional staff in the Protective Services and Juvenile Justice Systems to function as providers of assessments and evaluations for PS/JJS clients, so that the psychological, psychosocial and biopsychosocial evaluations performed by PS/JJS staff to determine levels of care for PS/JJS clients in the new behavioral health system will be accepted by the MCO.

B146. How will the offeror participate with the DHHS/Collaborative agencies during the time between the award of the contract and its implementation to develop policies and procedures to guide joint treatment planning between the MCO and providers for children/adolescents, especially those in state custody.

B147. How will the MCO work with the state's Protective Services to meet the Adoption and Safe Families Act (ASFA), Child and Family Service Review (CFSR) that pertains to "wellbeing," that is, those factors that have to do with the provision of appropriate and timely behavioral health services to the Protective Services client population.

## **Services For Adults with Behavioral Health Needs Who Are Released From Prison and Who Are Under The Supervision or Custody of MDOC**

### ***Expectations***

Adults under the supervision of MDOC often have behavioral health needs. Those at high risk of having an unsuccessful parole due to substance abuse or mental illness are a high priority for the Collaborative. MDOC will identify the individuals to be served and will provide supervision for their parole situation. The MCO will be required to assure that these individuals are served and that reports about their contacts with treatment providers and their progress will be reported as required to the individuals' parole officers.

### ***Mandatory Requests for Information***

B148. Describe the offeror's process to assess and provide appropriate behavioral health assessment, treatment planning and services statewide for parolees leaving Maine prisons, remaining under the supervision of Maine Department of Correction (DOC) through parole status, and identified by MDOC as a priority for behavioral health services.

B149. Describe how the offeror will assure an array of service providers throughout the state able and willing to serve the individuals referred from MDOC.

B150. Describe the offeror's proposed staffing pattern to establish a specific liaison for adult correctional issues to work on the myriad of behavioral health systemic and individual issues that arise with adults in or released from adult correctional facilities.

B151. Describe how the offeror and its provider network will work closely with parole officers so that behavioral health needs and requirements of parole are well coordinated and not in conflict.

B152. Provide the offeror's 24-hour emergency contact telephone number for such individuals and MDOC, and how will the offeror assure that each provider responsible for services for MDOC referred individuals provides the MCO and MDOC such an emergency contact number.

B153. Describe how the offeror will maintain a database on offender demographics and program activity, assuring timely access to such information by the Collaborative.

B154. Describe how the offeror will assure that providers work closely with correctional facilities staff to ensure a smooth transition from December 31, 2006 to January 1, 2007 for current service recipients using appropriate past treatment/programming history.

B155. Describe how the offeror will work with adult correctional facilities to assure appropriate re-entry of adults ready for release from prison and currently receiving treatment within the prison, including how public benefits, financial assistance, housing and employment issues will be addressed jointly with MDOC.

B156. Describe any special treatment approaches the offeror will make available for sexual offenders or other offenders required by law or a court to register or be tracked in a special manner.

B157. Describe how the offeror will assure that providers or the MCO will comply with court or MDOC requirements for timely written reports or oral presentations/testimony about MDOC referred customers.

B158. Describe how the offeror will work with families of adult parolees (parents, spouses, children, siblings, etc.) to include them appropriately in the customer's care.

B159. Describe how the offeror will provide addiction treatment in accordance with the American Society of Addictive Medicine (ASAM) placement criteria, appropriate to the

severity of substance abuse or addiction of the individual and by appropriately licensed professionals.

## **Pharmacy Services**

**Not included at this time**

## **Transportation Services**

### ***Expectations***

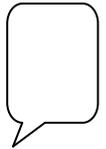
MaineCare will continue to be the primary source of payment for transportation services during Phase One, and perhaps during Phases Two and Three as well. To the extent non-emergency transportation continues to be a MaineCare benefit, the responsibility for transportation services will likely be with the MaineCare MCOs or utilized collaboratively in an integrated transportation pilot with other state agencies. For those individuals who are MaineCare recipients or who are MaineCare-eligible, incentives and disincentives will be utilized to encourage the use of least expensive forms of transportation consistent with customer and family needs. The MCO will be required to work closely and proactively with MaineCare and with transportation and local behavioral health providers to maximize the availability of transportation services for MaineCare and non-MaineCare eligible behavioral customers. For those individuals who are not MaineCare eligible, the MCO will be expected to assist in accessing transportation resources. The DHHS/Collaborative will work to try to prevent reduction of access to existing transportation benefits or services, and to increase coordination of public transportation services through other sources. The offeror will coordinate and manage the delivery of the transportation benefit to members receiving behavioral health services with the MaineCare MCO transportation contractor. The offeror will coordinate with the MCO as necessary to perform this function. Such coordination will include receiving information from and providing information to the MCO regarding members, providers and services; meeting with the MCO to resolve provider and member issues to improve services, communication and coordination; contacting the MCO as necessary to assure quality transportation services are available for MCO consumers.

### ***Mandatory Requests for Information***

B182. Describe how the offeror will connect customers with transportation resources to assure access to offered behavioral health services, especially in rural and frontier areas.

B183. Describe how the offeror will provide mobile service capacity or alternative service delivery methods for those areas where and those customers for whom transportation is most problematic.

B184. Describe how the offeror will assure that publicly funded transportation offered or utilized by the offeror or its providers meets accessibility standards of the Americans with Disabilities Act (ADA).



## **School-Based Services**

### ***Expectations***

School-based behavioral health centers and school-based services are critical components of the Maine behavioral health delivery system. The MCO will be required to ensure that behavioral health providers work in an integrated fashion with public schools throughout Maine for both services and collaboration and that local collaboratives include school officials and require school involvement. The MCO will work with the DHHS/Collaborative to increase access to behavioral health services for children in schools and their families. There are currently about 35 school-based health centers in Maine offering a variety of health and behavioral health services. The state's MaineCare program has been working with schools to expand school-based services and to reinstitute administrative claiming for services in schools. The DHHS/Collaborative is interested in at least doubling the number of school-based health centers, and including behavioral health services in as many of those centers as possible. The DHHS/Collaborative believes this is a critical aspect of Maine's efforts to decrease youth suicide and address a number of issues affecting the behavioral health of children/adolescents ranging from untreated mental illness to substance abuse.

ME's #s ?

### ***Mandatory Requests for Information***

B185. Describe how the offeror will sustain and increase school-based behavioral health screening and services for youth in school and as part of a needs assessment.

B186. Describe how the offeror will assure coordination and integration of behavioral health care with health care services delivered in school-based settings, including BIA and tribal schools, broadly and through IFSPs and IEPs specifically.

B187. Describe policies, procedures and methods designed to improve implementation, delivery and funding for school-based behavioral health services and track that data.

B188. Describe how the offeror proposes to work effectively with and reimburse school-based health centers for behavioral health services delivered in these settings.

B189. Describe how the offeror will provide for the integration of services into the school culture.

B190. Describe how the offeror will work with local community health care systems to coordinate the behavioral health services provided in and out of schools.

B191. Describe how the offeror will improve the sustainability of school behavioral health services through diversification of funding [including increased financial and in-kind support from the served school district(s) and foundation and government grants] and the development of community partnerships.

B192. Describe how the offeror will assist schools to increase their capacity to access MaineCare reimbursements and other funding sources within the control of the MCO and the DHHS/Collaborative for behavioral health services.

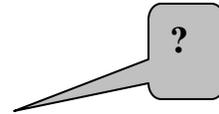
B193. Describe how the offeror will assist schools-based health centers and school-based services to develop third party billing and reimbursement mechanisms to fund behavioral health services in the schools.

B194. Describe how the offeror will build a full continuum of school behavioral health services including working with schools, DHHS/Collaborative agencies, universities and community colleges to provide training; increase prevention programs; increase awareness of students and teachers; and provide screening, direct services, case management services, and enhanced school behavioral health interventions including strong linkages with physical and behavioral health systems in the community.

## **Telemedicine**

### ***Expectations***

Telehealth (or telemedicine) Describe how Maine will use telemedicine



### ***Mandatory Requests for Information***

B195. Describe the offeror's experience with the use of telehealth in the delivery of behavioral health services in rural and frontier areas.

B196. Describe the offeror's experience with determining funding sources for telehealth infrastructure and services, especially behavioral health services.

B197. Describe strategies the offeror will use to increase access to telehealth technology, especially for rural communities in Maine..

B198. Describe the partnerships the offeror will pursue to encourage the use and development of telehealth as a means of extending access for behavioral health services.

B199. Describe how the offeror will utilize existing resources to increase the viability of telehealth approaches within the behavioral health delivery system.

B200. Describe the offeror's approach to training behavioral health practitioners and customers/families on the use of telehealth approaches to service delivery.

B201. Describe the offeror's data system's capacity to use telehealth technology where available. Note: all computerized or web-based telemedicine must be Bobby accessible.

B202. Describe how the offeror plans to coordinate with MDOC and its current telemedicine network.

## **Quality Assurance/Performance Measures and Outcomes**

### ***Expectations***

The State of Maine and the MCO will be committed to the delivery of quality health care in all of its activities and to maximizing the benefits of services and minimizing the risk to members.

The state sets high quality standards for the delivery of health care, and will hold the MCO accountable for achieving these standards. The MCO will be expected to demonstrate a quality improvement culture, that is, an organizational and system-wide culture that fosters and supports constant learning, change, identification of any

quality problems quickly and dealing with them in a prompt and effective manner, challenging of sacred principles and trying out new ideas throughout the public behavioral health care system.

The MCO must know and be able to articulate how it is performing and the outcomes it is achieving compared to goals it has set for itself, taking into account customer, family, funder and public expectations.

The MCO will be expected to use quality measures such as the HEDIS data set, the Mental Health Statistical Improvement Project (MHSIP), The Early Warning System Reports, the customer and provider surveys, and the External Quality Review Organization's annual results as means to evaluate quality assurance and to provide opportunities for quality improvement. The MCO must be able to demonstrate active processes for assessing quality performance, identification of opportunities for improvement and initiation of targeted quality interventions, as well as regular monitoring of the intervention's effectiveness. Compliance with the Medicaid Behavioral Health Standards is required.

The MCO will be responsible for the implementation of system performance measures and customer/family outcome measures that satisfy different audiences or different purposes. The MCO will be expected to implement a quality improvement process that assures data is used to monitor both system performance and customer/family outcomes.

Customers, family members and local collaboratives must have a meaningful role in the monitoring of service quality and in deciding what to do to improve the quality of services in their geographic locations or for their populations. Local collaboratives will play a critical role in providing information about the quality of services and in guiding changes that need to be made. The MCO will have primary responsibility for assuring that provider services are of high quality, do no harm and move the system toward the DHHS/Collaborative's vision and goals.

During Phase One, performance and tracking measures will emphasize:

- Continued delivery of services without disruption;
- Timely payment of providers;
- Collection and accurate reporting of data for multiple systems/fund sources; and
- Maintenance of at least current performance and outcomes.

Failure to meet performance and outcomes measures at or exceeding the indicated benchmark or standard will result in financial penalties. There will also be contractual requirements about performance measures associated with specific fund sources that may not result in financial penalties but will be a contractual requirement, the failure of which may be considered a breach of contract. During Phase One, the MCO will work with the Collaborative, local collaboratives, the SCCS, and the SQIC to identify and refine additional expected performance and outcome measures for Phase Two. Likewise, during Phase Two, additional performance and outcome measures for Phase Three will be developed. The performance and outcome measures for Phase One, the measures that will be tracked in Phase One in preparation for Phase Two and potential measures for Phase Two and Phase Three along with Prevention measures are included in the tables.

The DHHS/Collaborative is interested in conducting an evaluation of Maine's unique approach to purchasing behavioral health services across multiple fund sources and multiple agencies of state government. The MCO must be a participant in this evaluation. The more transparent and open the quality improvement process is and the more available data are from the MCO, the easier it will be to determine how well the DHHS/Collaborative approach and the MCO are working and how best to make adjustments to assure the success of this process. The evaluation the DHHS/Collaborative wishes to undertake will look at the DHHS/Collaborative process, the performance of the system in terms of meeting goals and solving problems initially identified (see Section I) and the cost effectiveness of this approach. The DHHS/Collaborative is seeking funding to conduct this evaluation and anticipates some funding from foundations or federal grants. However, the willingness of the MCO to participate in the funding of such an evaluation will greatly assist this evaluation process and will allow Maine and the rest of the country to learn from this experience.

#### ***Mandatory Requests for Information***

B203. Provide a detailed quality improvement/quality management (QI/QM) plan showing the processes and steps the offeror will take to track and improve the quality of the system's performance and the quality of services by contracted providers; include short- and long term goals through specific QI activities to meet each set of goals; include

- B204. Demonstrate that the QM/QI program structure and operation has effective policies and procedures for assuring the service needs of high-need customers and their families are met.
- B205. Describe the mechanism by which the QI Program will monitor member health care services provided by contracted or delegated individual practitioners and organizational providers, including, but not limited to, descriptions of audit procedures and timelines and descriptions of procedures for dealing promptly and effectively with quality issues with contractors.
- B206. Describe how your QI/QM program will address all demographic groups receiving services pursuant to the contract, including infants, children, adolescents, adults, seniors and special needs populations; including, but not limited to, specific racial, cultural, ethnic or disability groups; developmentally disabled members including autistic spectrum disorders and brain injured individuals; and any other chronic behavioral health disorder.
- B207. Describe how the offeror's QI/QM plan will include and how the offeror will work to meet the performance and outcome measures for Phase One (see Tables) and track the measures identified.
- B208. Describe how the offeror's QI/QM plan will change each year and how the offeror will work with the DHHS/Collaborative, local collaboratives and the SQIC to reach agreement on performance measures and outcomes and standards/benchmarks for Phases Two and Three, using the Tables upon which to build this agreement.
- B209. Describe how the offeror will incorporate HEDIS® results into its QI/QM plan.
- B210. Describe how the offeror will share with and utilize data and information from the local collaboratives to improve the quality of services.
- B211. Describe the role of customers, families and providers in the development and implementation of the QI/QM plan.
- B212. Describe how the offeror will utilize the results of provider surveys in the QM/QI Plan, incorporate targeted interventions addressing the results into the QM/QI plan, and evaluate quarterly the efficacy of the interventions, making appropriate modifications to the interventions as indicated to achieve the best outcomes.
- B213. Describe the offeror's use of research and evaluation techniques, including any relationships with Maine or other academic institutions, to improve the quality of services and customer and family outcomes.
- B214. Describe the status of the offeror's behavioral health organization accreditation.
- B228. Describe the offeror's credentialing and re-credentialing process and its role in the QI/QM plan.
- B215. Describe in detail the offeror's oversight of all delegated functions, and include policies and procedures to ensure that the delegated entity meets all standards of performance mandated by the state and federal requirements for the program; provide the standards against which your delegates will be evaluated.
- B216. Describe in detail the processes the offeror will initiate to implement, measure and reassess disease management programs for the ongoing needs of behavioral health populations, including how eligibility for such programs will be established (including specific diagnoses or conditions that will warrant disease management approaches) and how recovery/resiliency will be achieved through these programs.
- B217. Describe the mechanisms for quarterly evaluations and written documentation of progress made during EQR-related corrective action plans.

B218. Provide a detailed description of how the offeror will assess member satisfaction, including methods of collecting and evaluating information (including the efforts of local collaboratives) and including the use of MHSIP for adults with serious mental illness and children/adolescents with severe emotional disorders; describe how the offeror will utilize the MHSIP results in the offeror's internal QI/QM program by using areas of decreased compliance as areas for targeted improvement.

B219. Describe how the offeror will identify opportunities for member satisfaction improvement, implements and measure effectiveness of interventions, and inform practitioners and providers of targeted interventions.

B220. Describe how the offeror will monitor complaints, grievances and appeals for evidence of trends; describe the process the offeror will use to report evidence of trends to the Collaborative, the SCCS, the SQIC and local collaboratives.

B221. Describe the offeror's policies and procedures to address prevention, detection, preliminary investigation and reporting of potential and actual MaineCare fraud and abuse, including, but not limited to, protecting the use of limited Medicaid funds; utilizing specific controls such as: claims edits, post processing review of claims, provider profiling and credentialing; utilization and quality management provisions in subcontracts with providers; detection and prevention training provided for employees and providers; systems that can monitor service utilization and encounters for fraud and abuse; and cooperation with DHHS/Collaborative agencies' fraud and abuse or quality units, the Attorney General's MaineCare Fraud Control Unit and other investigatory agencies.

B222. Describe the offeror's policies and procedures regarding provider profiling or other reporting of provider performance and ability to produce good outcomes for customers and their families.

B223. Describe how the offeror will cooperate with any external quality review organization (EQRO) on all state-directed quality review activities; (the EQRO may use encounter data as a mechanism for monitoring quality of care and provider compliance with billing standards; serious levels of inaccuracy and/or incompleteness of data submission may result in sanctions impacting the MCO and/or providers).

B224. Describe how the offeror will process complaints and grievances and utilize information about such to improve the quality of services provided.

B225. Describe how the offeror will cooperate with the DHHS/Collaborative to address concerns raised by legislative or other official bodies interested in the quality of services or the performance or outcomes of the behavioral health delivery system; please provide a sample report.

B226. Indicate the offeror's willingness to provide funding prior to the effective date of the contract to an entity or consultant identified by the DHHS/Collaborative to design and lead an independent evaluation of Maine's experience; the DHHS/Collaborative believes that approximately \$\_\_\_\_\_ will be needed for this evaluation design and start-up. Indicate amount the offeror would be willing to contribute to this process.



B227. Indicate the offeror's willingness to allow the DHHS/Collaborative to have access to all MCO data and information that might be necessary to an open and transparent evaluation process; if any data or information collected or maintained by the MCO will not be available to the DHHS/Collaborative, please describe this data and information and explain why they will not be available.

## **C. CUSTOMER RIGHTS AND PROTECTION**

### **Customer Services and Bill of Rights**

#### ***Expectations***

“Customers” are those individuals who are enrolled in the new behavioral health system, whether as a person who is entitled to certain services or as a person who has been accepted into services after requesting or being referred for services. How the new system provides information and resolution of customer concerns will be a key quality indicator for the MCO. Federal and state requirements guide some of the expectations for customer services. The DHHS/Collaborative is committed to customer and family involvement in the new system at all levels. Customer and family roles and mechanisms for customers and advocates to have meaningful avenues of participation in the system design and operations must be varied. A Customer Bill of Rights ensures that customers understand their rights and responsibilities. The DHHS/Collaborative believes that a knowledgeable customer is more likely to make informed health care choices. The MCO can administer its behavioral health programs more effectively when its customers are informed and involved. The DHHS/Collaborative is seeking a consolidation of all policies concerning a customer’s rights and responsibilities found in existing policy into a Customer Bill of Rights. The MCO will be expected to comply with that Bill of Rights and maintain a grievance system that is highly sensitive and rapidly responsive to customers and their families as an avenue for addressing unresolved problems and issues. The Customer Bill of Rights should be available in culturally and linguistically appropriate formats (at least English & Spanish, and preferably Braille and on video in American Sign Language) and at no higher than a 6<sup>th</sup> grade reading level.

#### ***Mandatory Requests for Information***

C1. Describe the offeror’s customer telephone “hot-line” capabilities including information on the hours of operation, functions provided, and staffing levels.

C2. Describe methods of informing customers of their rights, including the ability to triage grievances, complaints, services, information needs, and how those requirements are connected to appropriate entity.

C3. Describe how the offeror will accept and resolve customer complaints, grievances and appeals.

C4. Describe how the offeror will work with providers, customers and their families to establish a common complaint form, resolution process and customer complaint tracking system, and how the offeror will report the findings to the DHHS/Collaborative, SCCS, SQIC, and local collaboratives.

C5. If the offeror has a proposed Bill of Rights, please provide it.

C6. Describe how the offeror will comply with the policies and procedures about resolution of constituent or customer complaints or with a Customer Bill of Rights utilized by any of the DHHS/Collaborative agencies, including how such complaint processes or Customer Bill of Rights will be contained and distributed in a Customer/Family Handbook.

C7. Describe how the offeror will assure each customer receives written information found in the Customer Bill of Rights

C8. Describe how the offeror will develop and disseminate materials in no more than 6<sup>th</sup> grade reading level and available for those who are deaf, blind, hard of hearing or visually impaired, or non-English speaking.

C9. Describe how customers and their families will be included in the development of materials or the Customer/Family Handbook.

**Grievances and Hearings Within the Statewide Entity** (see Grievance and Appeals Appendix page 7)

***Expectations***

The MCO will establish policies and procedures for complaints, grievances and appeals, (e.g., such as those in the SAMSHA Bill of Rights), so that customer and family concerns are addressed promptly and uniformly without regard to payer source or funding stream. Federal Medicaid and Balanced Budget Act requirements must be followed for Medicaid eligible customers, including the right to a fair hearing for any services denied.

Policies and procedures for the resolution of grievances are necessary to help fulfill the responsibility of safeguarding the customer's and/or family's rights and to provide a mechanism for monitoring the quality of care. Customers will have the right to file a grievance if they are dissatisfied with the services rendered by the MCO or any aspect of its operations.

Customers/families may appeal a utilization review (UR) decision that results in a denial of funding for a service. Dissatisfaction for purposes of filing a grievance or complaint may be expressed either verbally or in writing. An appeal of a UR decision must follow regulatory requirements for MaineCare services. Customers and families must be adequately informed of their right to file a grievance or complaint and the process for filing that complaint as well as the process for filing an appeal from a service denial.

***Mandatory Requests for Information***

C10. Describe how the offeror will evaluate, resolve and report customer/family grievances or complaints, including the process and timelines for decision-making at the provider and MCO levels.

C11. Describe how the offeror will assure that customers are made aware of how to report a grievance or complaint, beginning with the lowest level (i.e., the practitioner or provider) and going up to the MCO or the DHHS/Collaborative, if they are not satisfied.

C12. How will the offeror provide assistance to customers/families who need help filing a grievance, complaint or appeal of a service denial.

C13. Describe in detail how the offeror will investigate any grievance or complaint, including timelines and process for resolution.

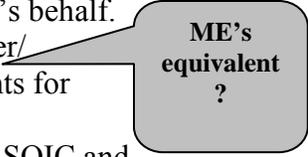
C14. Describe how a customer or family member may appeal a service denial, including the assisting the customer/family in that appeal or filing the appeal on the customer/family's behalf.

C15. Describe how the offeror will assure that requirements of BBA regarding customer/family grievances, complaints and appeals are met as well as those existing requirements for each DHHS/Collaborative partner.

C16. Describe how the offeror will work with the DHHS/Collaborative, the SCCS, the SQIC and local collaboratives to develop a single common complaints, grievance and appeal process, regardless of agency or fund source.

C17. Describe how the offeror will establish a process to ensure that individuals receiving mental health and substance abuse treatment while in the justice or correctional system will be afforded a mechanism to access the complaint, grievance and appeals processes without threat of retaliation or negative impact on their adjudicated status.

C18. Describe how the offeror will work with the DHHS/Collaborative to develop and implement an early warning system (EWS) for tracking trends or patterns in complaints,



ME's  
equivalent  
?

grievances, appeals, service denials, access issues, and/or other pertinent monitoring mechanisms.

C19. Describe how the offeror will take steps to correct identified trends or recurrent customer or provider complaints, grievances, and/or appeals that have been brought to the MCO's attention and that will be subject to sanctions if not corrected within a stated period of time.

## **Marketing and Educational Materials for Customers/Families**

### ***Expectations***

All marketing materials must be accurate, culturally competent and written in a manner that is understandable by the customers/families to be served. The DHHS/Collaborative will approve all marketing and educational materials.

The MCO may direct a person requesting a customer handbook or a provider directory to an Internet site but this does not eliminate the need for hard copy handbooks and directories for those requesting them. Marketing shall not be done for purposes of increasing the number of MaineCare enrollees. However, marketing should be done to assist MaineCare enrollees to maintain their MaineCare certification and to increase the appropriate use of MaineCare services. Marketing should also be done to advertise the availability of other services for priority populations to meet performance and outcome measures.

### ***Mandatory Requests for Information***

C20. Describe how the offeror intends to develop and distribute accurate marketing materials regarding programs and services available through the MCO.

C21. Describe how the offeror will develop a customer services handbook, submit it for approval to the DHHS/Collaborative and distribute it to any person requesting a copy.

C22. Describe the process the offeror will use to disseminate a provider directory to any person requesting a copy.

C23. Describe the process and timelines for provision of a one-page, two-sided summary or brochure summarizing the MCO's benefits, which may be distributed by the Collaborative at its discretion

C24. Describe the offeror's proposed policies and procedures governing the development and distribution of marketing and educational materials for customers and their families.

C25. Describe how the offeror will assure dissemination of materials in no more than 6th grade reading level and available for those who are deaf, blind, hard of hearing or visually impaired, or non-English speaking.

C26. Describe how the offeror will develop targeted marketing materials for transition age youth and young adults (ages 14 to 24) and their families to facilitate movement to the adult system and how youth and young adults and their families will be involved in the development of these materials.

C27. Describe how the offeror will insure that customers and families, particularly those in rural and frontier areas, have available to them, basic informational materials about mental health and substance abuse issues affecting all age groups and populations.

C28. Provide a list of groups and entities to whom the offeror intends to market its services, in what forms and formats.

## **Education of Customers, Families and Providers**

### ***Expectations***

The MCO will be responsible for providing education, training and technical assistance to customers, providers and key stakeholders. The MCO and providers will assist individuals and families with identifying the spectrum of available services, payer source(s) and eligibility requirements including ways those customers and their families may access information and services. The MCO and providers will be expected to disseminate clear policies regarding the individual's right for self-determination and choice of services and service settings, unless a court of law determines that the individual must be served in a particular treatment facility or receive particular identified treatment services.

### ***Mandatory Requests for Information***

C29. Describe the offeror's statewide customer and family education strategy, including goals, target audiences, approaches or media, and timelines.

C30. Describe the methods, timelines and techniques to be applied to inform individuals (including customers/families, potential customers and referral sources) of services, policies and access to providers and services.

C31. Describe how the offeror will provide educational information and materials in Spanish and Native languages, for persons who are deaf, blind, hard of hearing or visually impaired, and for those who cannot read.

C32. Describe the enhanced health and behavioral health education services that will be provided and how the offeror will ensure that customers, families and providers, particularly those living in rural and frontier areas, are aware of and able to receive those educational services.

C33. Describe how and when the offeror will schedule region-specific education and assistance to customers, families and providers regarding the state's new publicly funded behavioral health system.

C34. Describe how the offeror will make available educational materials and information for local collaboratives.

C35. Describe the offeror's plans for developing an educational training curriculum for customers, families, providers and state staff in collaboration with individuals and families and approved by the state at least 60 days prior to implementation of the new behavioral health care system.

C36. Describe how the offeror will provide ongoing training and education regarding services available, how to access services, and how to use billing codes, processes and procedures.

C37. Describe how the offeror will disseminate the principles and core values of the new behavioral health system, and particularly explain the concepts of recovery, resiliency and empowerment.

C38. Describe the offeror's capacity to implement a toll-free, 24-hour bilingual telephone call center staffed by customer friendly individuals to assist customers and providers with identifying and locating appropriate services and/or answering questions.

C39. Describe the offeror's capacity to develop and maintain a provider database indexed by location, expertise, type of service, language, gender and whether customer/family operated.

C40. Describe the offeror's commitment to on-going training and information dissemination for providers about new service approaches and evidence-based and promising practices, using customers and families where appropriate to deliver some of the training and information.

## **Customer, Family and Provider Advisory Activities**

### ***Expectations***

The input of customers and their families, as well as providers, local collaboratives and other stakeholders, is crucial to the MCO and the DHHS/Collaborative in determining how well the behavioral health system is serving and meeting the needs of customers/families. The successful offeror must demonstrate that stakeholder engagement, which is customers, families, advocates, providers and local collaborative members are engaged and involved in all aspects of the public behavioral health care system, from governance and policy development through planning and program development, to quality management and system evaluation. People with mental health and substance abuse issues are recognized by the DHHS/Collaborative as equal partners in all aspects of Maine's behavioral health service system. Each individual, including children, youth, adults, the elderly and people with developmental disabilities and other diagnosed disabilities and, where appropriate, their families, shall have opportunities to have an equal voice in and be actively involved in, educated about and/or directing his/her plan of care. Providers have critical voices in describing how the system is working from the point of view of service delivery and billing/reimbursement. Customer/family input is especially helpful in the early detection of problems. Providers and advocates must be vocal partners in the design, implementation and evaluation of the system's operations and impacts.

### ***Mandatory Requests for Information***

C41. Describe how the offeror proposes to incorporate the input from local collaboratives, the SCCS, the SQIC, other customers and families, providers and advocates in program development, service delivery and oversight, especially to cultivate, identify and strengthen customer and family initiatives and activities; and to identify and provide evidence-based and promising practices and treatment modalities that are culturally competent and customer/family friendly.

C42. Describe how the offeror will solicit and receive input from advocacy organizations and customers throughout the state regarding its operations.

C43. Describe any mechanism the offeror will have for identifying, reporting and responding to frequently voiced issues within each judicial district and within the state as a whole.

C44. Describe how customers and their families will have meaningful roles that make a difference in governance, design, implementation and evaluation of the new behavioral health services delivery system.

C45. Describe how the offeror will establish a mechanism to communicate with the local collaboratives regarding the needs and concerns of customers, families, advocates and providers within each judicial district, including the coordination of behavioral health care with other system service deliverers.

## **D. PHASE TWO (July 1, 2007--June 30, 2008)**

### ***Expectations***

During Phase Two, the MCO will be expected to work with the DHHS/Collaborative to identify more effective ways of combining the multiple funding sources and funding mechanisms to support the development of the local collaboratives and to facilitate the required outcomes of the DHHS/Collaborative. Funds from each fund source that requires separate reporting must be tracked separately and used only for the purposes allowed by that fund source. The MCO will be expected to achieve the performance and outcome measures and deliverables required for Phase

Two in order to evidence clear progress toward the behavioral health care service delivery system envisioned by the DHHS/Collaborative. An essential component of Phase Two is the evolution of the local collaboratives into cohesively formed and effectively functioning bodies. In addition to the above requirements, the MCO shall provide developmentally appropriate community based prevention, screening and early intervention services that are universal (targeting the general population), selective (targeting those at higher-than-average risk for substance abuse or mental illness) and indicated (targeting those already using or engaging in other high-risk behaviors to prevent chronic substance use and those who will experience adverse impacts of mental illness without intervention). The MCO shall adhere to the Maine vision for substance abuse prevention as stated below:

Goal 1: Maintain and enhance a comprehensive behavioral health prevention service system to prevent the abuse of alcohol, tobacco and other drugs (ATOD) among youth, families and communities not in need of treatment.

Objective 1: Increase protective factors and decrease risk behaviors related to alcohol, tobacco and other drug abuse through the implementation of evidence based programs as specified by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Prevention (CSAP). The MCO will be directed to purchase prevention services that include strong evaluation components and that are based on sound, local needs assessments of community risk and protective factors. The MCO prevention subcontractors will be required to participate in a state level evaluation initiative consisting of the use of a battery of standardized evaluation instruments for parents, teachers, and program participants. All providers will be required to enlist the assistance of professional evaluators to design and implement evaluation strategies. The MCO must also work in conjunction with the Collaborative to seek additional resources that will address unmet needs and identified priorities for service expansions. During Phase Two, additional funding streams and other resources not identified in the initial RFP may be included in the MCO's responsibility. Federal and foundation grants, as well as additional state and federal resources currently utilized by DHHS/ Collaborative agencies are likely to become the responsibility of the MCO. The MCO will work carefully and in consultation with the DHHS/Collaborative to bring those services and dollars into the single behavioral health delivery system without disruption in services for those customers, families, providers and state agencies affected by these funds. The MCO will also be required to work to ensure access to housing and supported employment resources for low-income individuals with mental illness or substance abuse disorders. Additional performance and outcome measures will be negotiated for Phases Two and Three during Phase One.

***Mandatory Requests for Information***

D1. Describe the offeror's plan to incorporate additional funding streams and increase coordination and flexibility of funding in Phase Two, specifically including, but not limited, to the following:

- Access to vocational rehabilitation and supported employment resources;
- Access to housing resources for low-income individuals or persons with mental illness or substance abuse disorders;
- Implementation of in-facility behavioral health services for youth incarcerated in CBHS correctional facilities;
- Utilization of forensic evaluation funds;
- Implementation of on-going and new federal/foundation grants for services and

evaluation;

- Utilization of prevention funds/services;
- Utilization of funding from transitional reporting centers;
- Utilization of federal and foundation funding for substance abuse and mental health prevention, early intervention, treatment or rehabilitation services;
- Utilization of domestic violence and sexual assault services funding;
- Utilization of behavioral health funds and services provided through public health clinics;
- Implementation of Safe and Drug-Free Schools funds for behavioral health; and
- Implementation of IEP services for school-aged children.

D2. Describe how the offeror will increase coordination with DWI prevention and treatment funding at the local county level.

D3. Describe the offeror's plan for assisting in the support and refinement of the local collaboratives, including using the local collaboratives for the revision of service area plans for the six (6) regions of the state.

D4. Describe how the offeror plans to develop additional family and culturally relevant evidence-based and promising practices.

D5. Describe how the offeror will include additional customer or family-operated services.

D6. Describe the offeror's plan for refinement of the measurement and reporting of performance expectations and customer/family outcomes.

D7. Describe how the offeror plans to develop mechanisms for seeking additional funding resources (e.g., grants, increased state or federal funds, increased third party resources, etc.).

D8. Provide a preliminary work plan describing the issues the offeror believes will need to be addressed by the DHHS/Collaborative and the MCO before entering into Phase Two, with estimated timeframes and responsible parties.

D9. How will the offeror ensure admission and utilization of state-operated behavioral health facilities and services. What recommendations does the offeror have for beginning to move state-operated treatment facility resources to MCO responsibility while maintaining some state-operated service capacity and retaining facility staff as state employees working either within the facilities or in communities.

D10. Describe the offeror's proposed process for inventorying provider administrative costs and beginning a plan for reducing provider and MCO administrative costs in Phase Three.

D11. Describe the proportion of funds that the offeror expects to utilize for direct service related expenditures in Phase Two and Phase Three of the contract, recognizing the expectation that the proportion of direct service related expenditures will increase in each subsequent phase and that the administrative costs of both the SE and the providers will decrease at least by Phase Three.

D12. Provide the proportion of total expenditures the offeror proposes to expend for direct service related costs in Phase Two.

D13. Describe any changes in service delivery, service utilization and system performance and customer outcomes the offeror anticipates for Phase Two.

D14. Describe any changes in the interactions the offeror anticipates having with the Collaborative, the BHPC, local collaboratives or providers during Phase Two.

## **E. PHASE THREE (JULY 1, 2008—JUNE 30, 2009)**

### ***Expectations***

By the start of Phase Three, the system should be maturing, performance and outcomes should be clear and adjustments to the system can be undertaken based on those results. Better performance, better outcomes, better system interactions, and lower administrative costs at both provider and MCO levels are expected for Phase Three.

### ***Mandatory Requests for Information***

- E1. Describe how the offeror expects to meet the increasing requirements of performance and outcome measures from Phases One and Two, as well as any new measures identified for Phase Three.
- E2. Describe any anticipated changes in interactions with local collaboratives, SCCS, the SQIC, the DHHS/Collaborative and providers in Phase Three.
- E3. Describe the process the offeror will utilize to refine and revise regional service plans for Phase Three, using the input of local collaboratives.
- E4. Describe how the offeror anticipates working with DHHS/Collaborative agencies and local collaboratives to seek new funding streams to meet identified needs.
- E5. Describe the offeror's plan to seek and incorporate additional funding streams and increase coordination and flexibility of funding in Phase Three.
- E6. Describe the offeror's anticipated approach to development of additional culturally and linguistically competent evidence-based and promising practices.
- E7. What proportion of total expenditures does the offeror propose to expend for direct service related costs in Phase Three.
- E8. Describe any changes in service delivery, service utilization and system performance and customer outcomes the offeror anticipates for Phase Three.
- E9. What is the offeror's plan for refinement of the measurement and reporting of performance expectations and customer/family outcomes.
- E10. Describe how the offeror will include additional customer or family-operated services in Phase Three.
- E11. Describe the offeror's proposed process for reducing provider and MCO administrative costs in Phase Three.
- E12. Provide a preliminary work plan describing the issues the offeror believes will need to be addressed by the DHHS/Collaborative and the MCO before entering into Phase Three, with estimated timeframes and responsible parties.

## **F. RESPONSE TO TERMS AND CONDITIONS**

- F1. Explicitly indicate acceptance of the Conditions Governing the Procurement as stated in Section II of this RFP; or if unwilling to comply with any terms, conditions or other requirements of this RFP, the offeror shall clearly state any such deviation, with a complete explanation of why such deviation is proposed, and alternate language to address the deviation, in accordance with Section II of this RFP.
- F2. Describe any additional terms and conditions the offeror proposes be included in a potential contract, in accordance with Section II of this RFP.

## **G. OTHER SUPPORTING MATERIAL (OPTIONAL)**

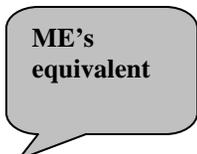
G1. Attach other materials the offeror feels may improve the quality of its responses. However, these materials must be included as items in a separate appendix, and may not substitute for required responses to Mandatory Requests for Information in subsections A through G of this section.

## **ARTICLE 1 – RECITALS**

- 1.1. All services provided pursuant to this Agreement are subject to the Procurement Code#\_\_\_\_\_ unless specifically provided otherwise herein.
- 1.2. The values and principles shall be incorporated in the provision of the service provided under this contract as follows and as set forth in the original Request for Proposals:
  - a. Individually (customer) centered and family-focused, based on principles of an individual's capacity for recovery and resiliency;
  - b. Delivered in a culturally competent, responsive and respectful manner via the most appropriate, least restrictive means, including utilization of home- and community-based settings wherever and whenever possible;
  - c. Coordinated, accessible, accountable and of high quality;
  - d. Evaluated with system performance and customer and family outcomes;
  - e. Increasing customer and family abilities to successfully manage life challenges;
  - f. Facilitating recovery and building resilience;
  - g. Providing integrated and community-based services;
  - h. Delivering services in a manner that respects community and cultural differences;
  - i. Managing care so as to utilize customer and family abilities and strengths;
  - j. Conducting treatment in consultation with the customer, his or her family or legal guardian, caregivers, and other persons critical to the customer's life and well-being, where appropriate;
  - k. Directing care with the involvement of the customer and family, to the extent possible;
  - l. Providing services that are customer and family-driven or –operated, as appropriate;
  - m. Ensuring behavioral health wellness promotion, prevention, early intervention, treatment, community support and other activities that further recovery and resiliency;
  - n. Basing services on evidence of effectiveness and the individual customer's and family's preferences;
  - o. Delivering services in a manner that evidences sensitivity to, and respect for, diversity, including race, age, gender, disability, culture, ethnicity, spirituality, sexual identity, literacy level, place of residence and primary language;
  - p. Providing the highest quality of care in a timely manner; Providing written, telephonic and electronic information that will be uniformly available to all customers and providers;
  - q. Having mechanisms in place to ensure continuous quality improvement;
  - r. Utilizing “person first” and “people who” language;

- s. Ensuring meaningful involvement of customers, family members and customer-run organizations at all levels of the decision-making processes concerning operations and oversight of the behavioral health service system; and
  - t. Moving toward the goal of using at least five percent (5%) of behavioral health expenditures for customer- and family-operated services.
- 1.3 The MCO shall work closely with the DHHS/Collaborative to ensure that:
- a. It is providing a smooth transition from the current diversified behavioral health delivery systems originating at the various State Agencies, to a single service delivery model;
  - b. That existing services continue with uninterrupted delivery; and
  - c. That contracted and subcontracted providers continue to be paid for the services they deliver
- 1.4 All MaineCare related behavioral health services purchased under this Agreement shall be subject to the following provisions for administration of the MaineCare program, which are incorporated herein by reference:
- a. The MaineCare program eligibility and provider policy manuals, including all updates, revisions, substitutions and replacements;
  - b. Title XIX and Title XXI of the Social Security Act and Code of Federal Regulations Title 42 Parts 430 to end, as revised from time to time;
  - c. The RFP; all RFP Amendments; MCO'S Questions and the DHHS/Collaborative's Answers; and the DHHS/Collaborative written Clarifications;
  - d. The MCO'S Best and Final Offer;
  - e. The MCO'S Proposal (including any and all written materials presented in the orals portion of the procurement) where not inconsistent with this Agreement and subsequent amendments to this Agreement;
  - f. All applicable statutes, regulations and rules implemented by the Federal Government, the State of Maine ("State"), and HSD, concerning MaineCare services, managed care organizations, health maintenance organizations, fiscal and fiduciary responsibilities applicable under the Insurance Code of Maine, \_\_\_\_\_, and any other applicable laws.
  - g. Any and all manuals or policies statement, including all updates and revisions thereto, or substitutions and replacements thereof, duly adopted in accordance with applicable law for the MaineCare program. All defined terms used within the Agreement shall have the meanings given them in any manual or policy statement; and
  - h. All applicable statutes, regulations and rules implemented by the Federal Government, the State of Maine, and the DHHS/Collaborative.
- 1.5 All non-MaineCare related behavioral health services purchased under this Agreement shall be subject to the applicable provisions and requirements for administration of the each of the respective programs.

1.5.1 All non-MaineCare related behavioral health services purchased under this Agreement with Federal Block Grant funds shall be subject to the Federal Block Grant Requirements defined in the SQIC Policy Manual and its appendices; specifically:



- a. Appendix \_\_: Maine Pharmacotherapy Initiative: Guidelines for the Treatment of Persons with Schizophrenia
- b. Appendix \_\_: State Funded Comprehensive Behavioral Health Standards
- c. Appendix \_\_: Developing clinical criteria for admission, continuation, and discharge
- d. Appendix \_\_: American Society of Addiction Medicine (ASAM): Patient Placement Criteria (ASAM-PPC-2) of the Treatment of Substance Abuse Disorders

For Substance Abuse Services funded by the Substance Abuse Prevention and Treatment Block Grant:

The comprehensive Alcohol and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, as amended (42 U.S.C. Section 290 dd-1, et seq. and the Public Health Service Act 42 U.S.C. Sections 300x, et seq., and 42 CFR (Code of Federal Regulations) Part 96 hereafter referred to as the "Act").

For Mental Health Services funded by the Community Mental Health Services Block Grant:

The Community Mental Health Centers Act (42 U.S.C. Section 2681, et seq., as amended), the Act (42 U.S.C. Section 300x, et seq.), and applicable federal regulations.

The following conditions apply to both federal Block Grants:

No funds shall be used to:

- a. provide inpatient services; make cash payments to intended recipients of health services; purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment; satisfy any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds; or provide financial assistance to any entity other than a public or nonprofit private entity.
- b.

For Substance Abuse Services funded by the Substance Abuse Prevention and Treatment Block Grant, 45 CFR (Code of Federal Regulations), Part 96, applies.

The MCO shall comply with the provisions of Titles II and III of the Americans with Disabilities Act of 1990, P.L. 101-336 (42 U.S.C. Section 12101, et seq.) and Section 504 of the Rehabilitation Act (29 U.S.C. Section 794).

The MCO shall comply with the requirements of the Pro-Children Act of 1994 (20 U.S.C. Sections 6083, et seq.) that prohibits smoking in any portion of any indoor facility used routinely or regularly for the provision of health services to children under the age of 18 funded by federal grants. The law does not apply to children's services provided in private residences, portions of facilities used for inpatient drug or alcohol treatment, to

service providers whose sole source of federal funding is Medicare or MaineCare or facilities where WIC coupons are redeemed.

- 1.6 The DHHS/Collaborative is responsible for administering Maine’s statewide Behavioral health systems and shall comply with all applicable requirements for the administration, delivery, and operation of the statewide behavioral health care systems.
- 1.7 The MCO possesses the required authorization and expertise to meet the terms of this Agreement.
- 1.8 The parties to this contract acknowledge the need to work cooperatively to address and resolve problems that may arise in the administration and performance of this contract. The parties agree to document agreements in writing prior to implementation for any new contract requirements.
- 1.9 The DHHS/Collaborative may, in the administration of this contract, seek input on health care related issues from any advisory group or steering committee. The DHHS/Collaborative may seek the input of the SE on issues raised by advisory groups or steering committees that may affect the SE. Specifically, the following advisory groups or steering committees structure is acknowledged as the vehicle for directing and coordinating the behavioral health delivery system in Maine through the MCO:
  - a. The MCO shall be advised by the Statewide Quality Improvement Council (SQIC). The SQIC is a body created to meet federal advisory council requirements and to provide consistent, coordinated input to the behavioral health service delivery system in Maine. The membership of the Council includes representatives of the following groups: customers and family members; providers of both children and adult mental health and substance abuse services; State Agencies responsible for behavioral health, education and vocational services, housing, corrections or justice, MaineCare and social services, health policy planning, developmental disabilities planning, disabilities issues and advocacy; mental health and substance abuse service advocates; and other individuals necessary to assure appropriate geographic and cultural representation.
  - b. Contract oversight of the MCO shall be through the interagency MCO oversight team (OT) as established by the DHHS/Collaborative.
  - c. The DHHS/Collaborative shall establish an interagency team to address quality issues and other program development issues that may arise and this team will advise and direct the MCO.
  - d. The \_\_\_\_\_ shall establish interagency staff teams to work with locally designated staff of the MCO in the \_\_\_\_\_ # geographic areas of the state used by multiple state health and human services agencies for planning and service provision and a \_\_\_\_\_ # “area” addressing Native American issues. These interagency staff teams will be responsible for translating state policy to local areas and with Native American tribes within their designated area. These interagency staff teams will work

If needed in ME

with MCO staff and Local Systems of Care within that area to identify needs and develop programmatic recommendations, and to resolve problems or issues that may arise regarding services, service delivery, customer and family or provider concerns, and issues affecting service quality within that geographic area. The staff teams will advise the MCO.

- e. The DHHS/ Collaborative shall designate local collaboratives for each of the \_\_\_\_\_ # Judicial Districts in Maine and for Native American tribes. The local collaboratives shall act as advisors to the MCO. These systems may include schools, justice, faith-based organizations, public health entities, local housing and jobs organizations, and representatives of business or community organizations. The MCO shall share information with local collaboratives and consult with and consider their input on service delivery issues in their geographic or cultural area.

NOW, THEREFORE, in consideration of the mutual promises contained herein, the DHHS/Collaborative and the MCO agree as follows:

**ARTICLE 2. SCOPE OF WORK**

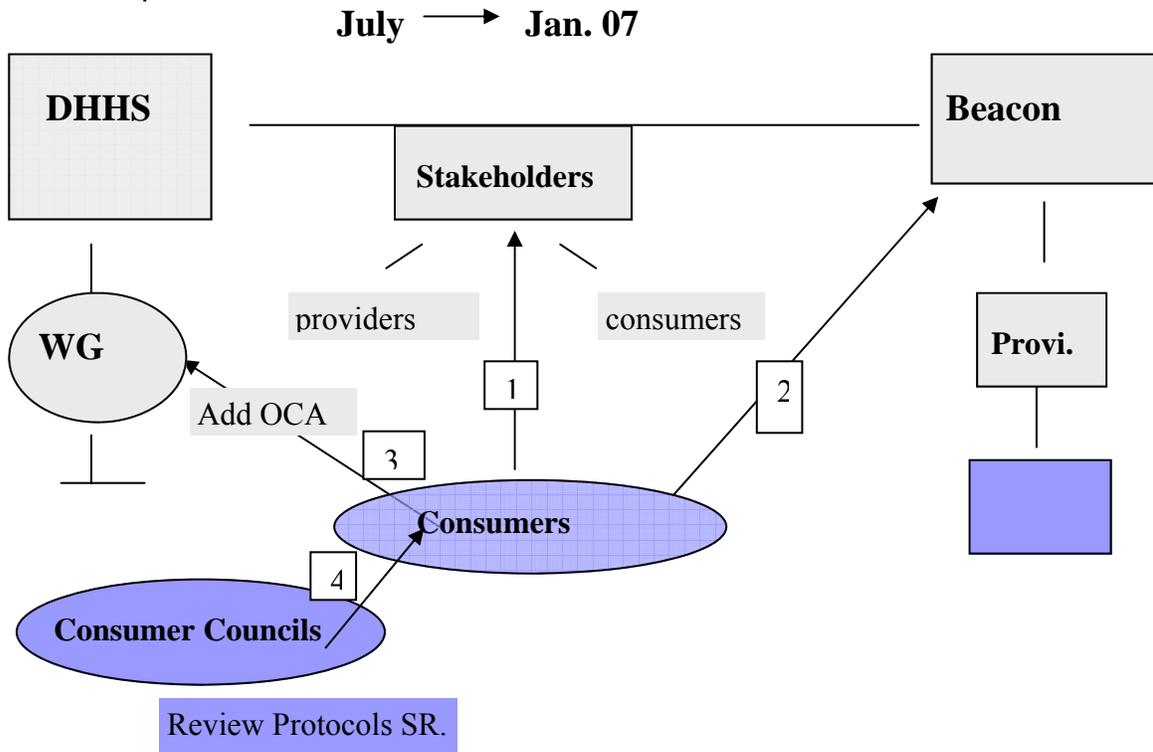
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# Appendix

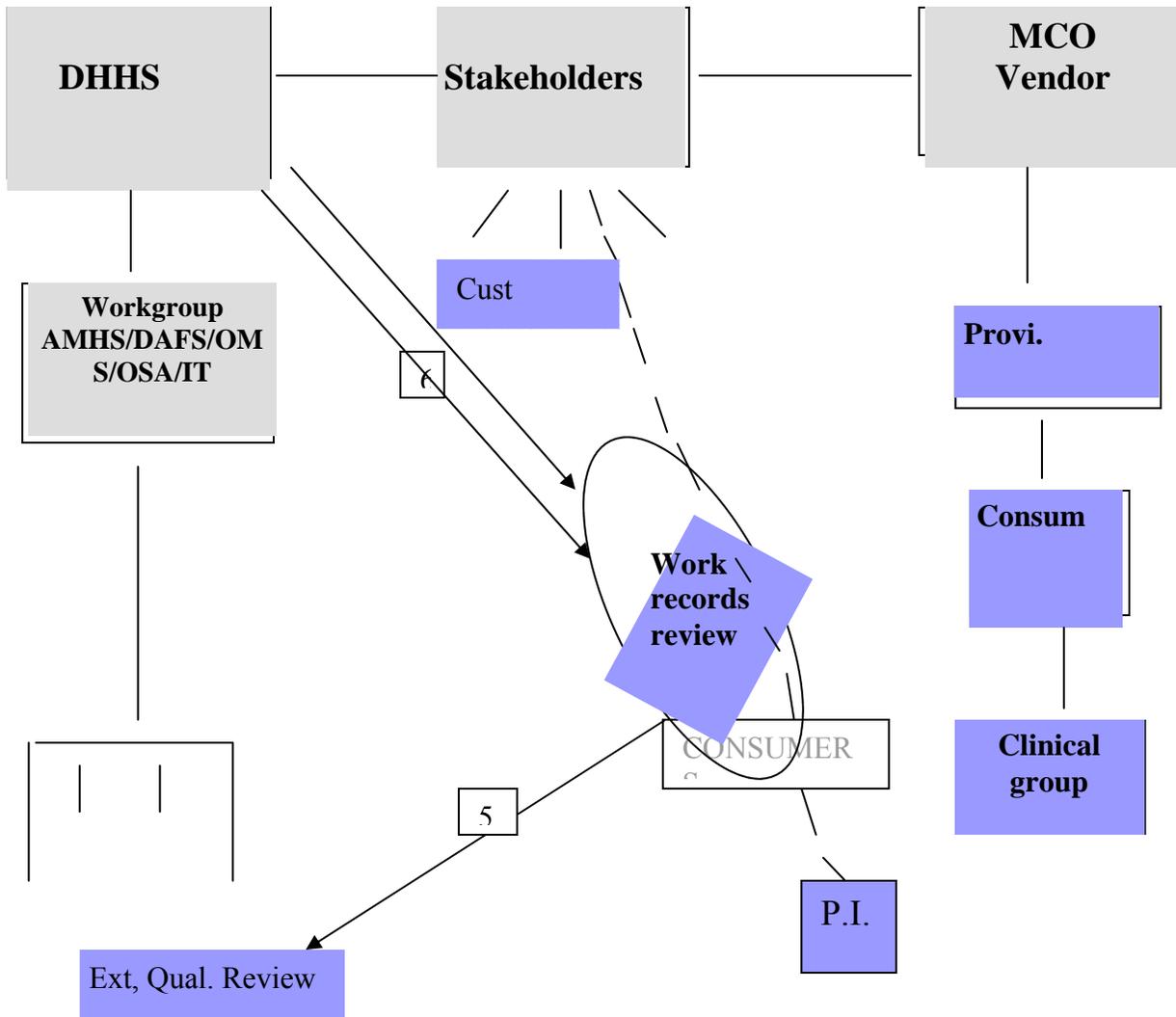
The group asked for an outline/organizational chart to better understand and focus their input to the correct entity or line of authority.

Marya provided the drawing below. The shaded gray areas are what is the current structure from July 06 through Jan. 07 and then Jan. 07 and beyond. Marya said nothing was set in stone and the purpose of these meetings was to gather input to change/add to this making it whatever we thought it should be.

The shaded purple areas are areas that were added as our discussion proceeded as follows with a great deal of questions:



Jan. 07 →



- July-Jan. 07 Graph: A larger circle for consumers added- (1) arrow to stakeholders indicating the need to increase consumer representation on stakeholder group (2) arrow added to indicate the need for consumer representation within Beacon. (3) arrow added to indicate need to increase consumer representation on DHHS workgroup.**

## **PRINCIPLE**

***Narrow interpretations of medical necessity must not be used to deny treatment to people who need and could benefit from that service.***

**From: Consumers' Role in Contracting for Public-Sector Managed Mental Health and Addiction Services p.40, 41, 42**

### **Medical Necessity**

**Important questions for you to ask pertaining to the MCO's proposed definition of "medically necessary" are:**

- √ Will the contract explain the public policy objectives and delineate the values on which the managed care system should be built, such as the principles established in the federal Community Support Program for adults with mental illness?
- √ Will the contract make clear the purposes for which services are delivered, such as:
  - ◆ To promote recovery and healing,
  - ◆ Prevent relapse
  - ◆ Enhance quality of life
  - ◆ To enable members to function at highest possible level, given the severity of their disorder, in the least restrictive setting of their choice
- √ Will the contract make clear what service *categories* are to be considered "medically" necessary, such as:
  - ◆ prevention,
  - ◆ identification, evaluation and assessment,
  - ◆ treatment,
  - ◆ rehabilitation,
  - ◆ stabilization,
  - ◆ addiction recovery, and
  - ◆ outreach.
- √ Will the contract require member preferences to be taken into account when determining what is a medically necessary service:
- √ Will the contract require the use of specific and recognized diagnostic and placement criteria for drug and alcohol treatment services and will it require the criteria be disclosed?
- √ Will the contract enable the purchaser to review (or approve) the MCO's mental health practice guidelines and protocols for delivery of care and will these be made available to interested parties?

- √ Will the state require the MCO to use a set of clinically based indicators (such as drug-related emergency room admissions) that would trigger a referral for an alcohol, drug abuse or mental health assessment?

**Some question you can ask about the procedures for reviewing and approving the necessity of care are:**

- √ Will the contract provide a description of the procedures the plan's reviewer must follow when making medical-necessity decision (including confidentiality protections, the procedure for making admission decisions within 24 hours, procedure for obtaining a second opinion, etc.)
- √ Will the contract require that, before any service is denied the decision that a services is not medically necessary be made by a reviewer with appropriate credentials in the specialty (mental health and/or addiction, and that denials of admission to inpatient hospital services and residential programs are made only be a specialty physician?
- √ Will the contract ensure cross-training for reviewers in both mental health and addiction

**Proposed Medically Necessary Definition presented by Jack Comart on 4/10/06 (with additions and/or edits made by Managed Care RFP Consumer Work Group)**

“Medically necessary” means behavioral and mental health services that are determined to be:

- 1) necessary to screen, assess, identify, evaluate, diagnose, prevent, prevent the progression of, stabilize, treat or diminish a behavioral health or mental health condition, including an impairment in functioning;
- 2) appropriate, in terms of type, timing, amount , frequency, duration and level;
- 3) provided in the least restrictive setting in which services can be safely and appropriately provided to meet the needs of the person;
- 4) furnished so as to include referrals to and coordination with agencies providing other relevant services to the Member, including providers of other health care services, social service providers, education providers, preschool and child care providers and vocational rehabilitation providers; peer support providers, etc.
- 5) consistent with national standards of practice, including standards of practice in community psychiatry and psychiatric rehabilitation, as defined by standard clinical references, generally accepted professional practice or empirical professional experience; and/or evidence based or promising practices .
- 6) designed to restore or maintain the person’s mental and physical health and well-being, prevent deterioration or palliate the person’s condition, diminish the adverse effects of the person behavioral or mental health condition, assist the person to achieve or maintain maximum functional capacity, and/or prevent the reasonably likely onset or relapse of a behavioral health or mental health condition;
- 7) consistent with the choices of the person to be treated (or, in the case of minor child unable to make choices, services of the family’s choice.);
- 8) safe and responsive to unique needs of linguistic and cultural minorities and furnished in a culturally relevant manner;
- 9) safe and responsive to the unique needs of people with multiple mental and physical impairments and furnished with accommodations to their needs, as required under the Americans with Disabilities Act and other applicable law;
- 10) designed (when relevant) to prevent the need for involuntary treatment or institutionalization;
- 11) provided in a manner that facilitates continuity and coordination or services within a system of care;

For children under age twenty-one(21) the services must also be designed to ameliorate or correct a condition identified during a periodic and inter-periodic screen; and provide anticipatory guidance to the parents and/or care givers of children with respect to mental health, behavioral health and emotional development.

MSRA Title 24-A Chapter 56 §4301-A Definitions reads

10-A. Medically necessary health care. "Medically necessary health care" means health care services or products provided to an enrollee for the purpose of preventing, diagnosing or treating an illness, injury or disease or the symptoms of an illness, injury or disease in a manner that is:

- A. Consistent with generally accepted standards of medical practice; [2001, c. 288, §3 (new).]
- B. Clinically appropriate in terms of type, frequency, extent, site and duration; [2001, c. 288, §3 (new).]
- C. Demonstrated through scientific evidence to be effective in improving health outcomes; [2001, c. 288, §3 (new).]
- D. Representative of "best practices" in the medical profession; and [2001, c. 288, §3 (new).]
- E. Not primarily for the convenience of the enrollee or physician or other health care practitioner. [2001, c. 288, §3 (new).]

***Addition made by Work Group: Person denying service must have credentials equal to the person making the assessment and referral.***

***Retrospective denial can not happen except to correct errors or fraud.***

## Grievance/Appeal Process

### What do we want the Bidder to describe in their RFP response

#### I. Rights of Recipients & grievance Process for Managed Care....One process or two?

Currently the Rights of Recipients Grievance Hearings are handled through the Dept. of Labor. The process is well known not to be especially expedient causing a whole set of problems for the person waiting for resolution if there is to be one. Other issues with this process: \*If you get to the hearing stage the hearing differs from what the Rights of Recipients tells you. Ex. The Rights of Recipients says you have the right to subpoena witnesses but in actuality the Judge determines whether or not you have the right to subpoena witness.

Service grievances are handled by DHHS Hearing Officers. A consumer can go through this Grievance Process, the determination be found in their (consumer's favor) and still be overturned by the Commissioner. –**When, where, and why can this happen?** Both of these processes are flawed. The fear is if they become **One** process, all heard by DOL or all heard by DHHS how will those flaws be eliminated.

Our preference is a Uniform Grievance Process (MCO, Rights of Recipients, Provider that meets Fed and State requirements, abides by the Rights of Recipients is expedient and holds to the highest integrity throughout the process (from beginning to end.)

#### Flexibility

- MCO will not deny service until after appeal is resolved
- State gets say in what's best care that will be provided
- Single grievance process for all including people who do not have Medicaid
- Describe what the grievance process will be for those who do not fall under the MCO
- MCO will take responsibility for collaborating and take leadership role w/all systems related to grievance
- Annual Review by Consumer Council System
- Centralized office

- Language & time line for informal process

## **2. Process For Denial, Termination, transition, lack of service**

Must be a discussion (between provider, MCO & consumer) before services can be denied – Once service is denied they (services) must continue for 90 days to allow for a) transition b) appeal process and extended until final determination should the appeal process still be going on – if parties still can not agree what will be the process.

If MCO has made a serious error describe the process of how, when and where DHHS steps in and assumes control.

Timely grievance process

## **3. What is the Role of the Consumer in the grievance Process?**

Ombudsman Team – local area teams (trained)

Consumer Representation - Consumer-run point of entry

MCO – describe role peers will have in assisting consumers

Trained peers (maybe peer-supporters) to run a kind of “first-stop” for complaints and possible grievances – many could be diverted with easy resolution.

Describe how MCO will collaborate with consumer councils re: grievance process

## **4. How to Inform Members of their Rights?**

Must be a central area where information and guidance to get through a grievance process can be obtained.

If you do not get a timely response call; What happens?

## **5. Forms**

One set of forms – simple, logical, linear

Common Complaint Form & Custom Complaint Tracking

## **6. Plan for Providing Assistance to Consumers**

Clear access i.e. transportation, local venue

Customer(consumer/family) Handbook

- 6<sup>th</sup> grade language, culturally competent,
- Full description of filing grievance in handbook including special information for people under guardianship (what they can do) and guardians (what they can do)  
**#1 (ex. go directly to probate court ask for a guardian ad litem**
- Make sure Consumer/Family are made aware that mediation is available

- Pre-knowledge of grievance process before there is a problem

24 hour hotline to clarify benefits/services or rights being violated

## **7. Role of Mediation**

Make sure Consumer/Family are made aware that mediation is available #6

Pre-knowledge of grievance process before there is a problem #6

## **8. Notices**

DHHS mail service can be inefficient in regard to timeliness and impact a letter of possible grievance. Strategy needs to be developed to side step this.

Must be written and written using our language. Must be timely - notification of receipt of grievance (email – fax – mail)

All parties receive reason for denial & receive process for grievance –provider – customer (consumer)

## **9. Measures**

Who Monitors? Accountability?

How will MCO be performing in grievance process (their role?)

Assistance through process measured

Time frame for data review – trends analysis & corrective action

Describe checks & balances

Describe process for how State maintains risk & control

## **10. Requirements for who reviews grievances**

Training for those who assist/review grievances

MCO, DHHS, & Outside (external review)

## **11. Hearings**

Consumer representation

Addressed promptly/uniformly without regard to payer or source of funding streams (money held in escrow by legal system to pay for representation)

Independent mediation & hearing process

MCO will take lead in describing how customers may “Review” all aspects of the “hearing” that occur and tweak the hearing process, rules, laws including DOL (dept. of labor) Consent Decree, Medicare and MaineCare All services including pharmaceuticals

## **12. Investigation**

How will the investigation or complaint be processed?

**13. Cultural Competence**

i.e. language, interpreters, etc.

**14. Monitoring & Plan for change**

Describe

**15. In State Presence of MCO**

Central office and local area locations

Supplemental Plan for Increased Consumer Involvement in the Planning, Delivery, and Evaluation of Adult Mental Health Services  
October 27, 2005

This supplemental plan is in response to the Court Master's Order Regarding Plan Approval, dated July 29, 2005, finding that the DHHS Adult Mental Health Services Plan of June 30, 2005 required additional meaningful consumer involvement in system planning and monitoring.

Although the AMHI Consent Decree predates current thinking about the importance of recovery in mental health system design, DHHS has adopted a recovery-based view of services to support a mental health services plan that will result in compliance with the AMHI Consent Decree. Recovery is an individual process in which people are supported to live, work, learn, and participate in their communities.

#### Process

AMHS invited leaders from the consumer community (AIN, Amistad, Community Support Specialists Program, Consumer Advisory Group, MAPSRC) along with a representative from NAMI and from the Maine Association of Mental Health Services to participate in two half-day discussions about how to improve consumer participation. The following plan represents the best thinking of the group with the caution that not all invitees were able to attend both days of discussion. An attendance list is attached to this report.

It is the belief of most of the stakeholders that this proposed structure and process would result in the development of a democratically chosen council of individuals who are both accountable to consumers and representative of them. These ideas are presented as an evolutionary process, recognizing that it will take time, effort and support of all involved to grow a strong and viable consumer council system.

#### Improved Consumer Involvement

Create a statewide consumer council system initially to include one statewide council and three area councils which are operational by July 2006:

--Representatives from AIN, Amistad, Community Support Specialists Program, Consumer Advisory Group, MAPSRC, NAMI, MAMHS, Office of Consumer Affairs, and the Acting Director of AMHS commit to spending a day in November 2005 to establish a framework to implement three local councils and a statewide council.

--This group will serve as the transitional advisory group until the four councils are operational and will then dissolve.

--The current Commissioner's Consumer Advisory Group will also be dissolved and the members will be encouraged to become involved in forming the area councils.

--The evolving statewide council will be chaired by a consumer elected by the council.

--The council system will include both consumer organization slots as well as at large representative slots to include the voice of individuals who are not affiliated with organized groups.

--AMHS will provide funding for these councils from existing funds.

--AMHS will continue to seek funding for the full eight area councils and statewide council, and has submitted a supplemental budget request for SFY 06 to the Governor's Office.

## Consumer Councils

The Consumer Councils will provide a review mechanism for AMHS regarding:

- Major policy and procedure development and implementation;
- Budget and program initiatives;
- Training and educational needs;
- Issues raised directly by consumers, as well as the opportunity for dialogue with DHHS staff and other stakeholders; and
- Review and direction on consumer concerns regarding managed care implementation.

AMHS will: --Involve the Councils in the selection process for key AMHS staff, including the Director;

- Present issues in as timely a manner as possible so that feedback can be meaningful;
- Present data collected for quality assurance and quality improvement to the Councils for their review;
- Work with the Councils to develop a clear "report card" for measuring system improvement;
- Work with the Councils to develop measures for recovery at the individual, program, and community level as well as monitoring the success in implementing change. DHHS had proposed in the plan dated 6/30/05 that consumers be involved in the licensing review process through participation on licensing teams. The opinion of the key stakeholders convened to review this plan was that this is not the avenue through which consumers wish to address system improvement. The councils will provide input to DHHS through a broader system perspective rather than through individual agency licensing participation. AMHS will continue this discussion with the Councils.
- Continue the support of the Statewide QIC including its role in reviewing and making recommendations regarding the Community Mental Health Block Grant.
- Inventory mental health agencies to determine their adherence with the contract requirement to include consumers on the boards of directors, and work with the Councils to assist agencies in meeting this requirement.

## Peer Services

Warm Lines The Court Master report of July 29, 2005 raises concerns about the capacity of the warm line. Amistad received the award for the statewide warm line and will begin operation on November 1, 2005. AMHS has continued to work with Amistad to support their efforts to coordinate with and publicize other existing warm lines. AMHS will continue to work with Amistad to assure that the warm line can be implemented as envisioned.

## Peer Services in Emergency Departments

AMHS would like further discussion on these services in the course of informal dispute resolution.

Managed Care RFP Consumer Work Group  
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