EXHIBIT 1
DATE 1/24/2011
MB

	STATE OF MONTANA **REQUEST FOR PROPOSAL (RFP)**

RFP Number: (insert RFP number)	**RFP Title:** Five County Managed Care Demonstration Project
RFP Response Due Date and Time: (insert RFP due date) (insert time), **Local Time**	**Number of Pages:** (insert number of pages)

ISSUING AGENCY INFORMATION	
Procurement Officer: (insert procurement officer name)	**Issue Date:** (insert issue date)
Department of Public Health and Human Services Medicaid Managed Care Bureau PO Box 202951 Helena MT 59620-2951	**Phone:** 406-444-4540 **Fax:** 406-444-1861 **TTY Users, Dial 711** **Website:** http://vendor.mt.gov/

INSTRUCTIONS TO OFFERORS	
Return Sealed Proposal to: (insert agency name and address)	**Mark Face of Envelope/Package:** **RFP Number:** (insert RFP number) **RFP Response Due Date:** (insert RFP due date)
	Special Instructions: (insert special instructions and/or date of pre-proposal conference, if applicable)
IMPORTANT: SEE STANDARD TERMS AND CONDITIONS	

OFFERORS MUST COMPLETE THE FOLLOWING	
Offeror Name/Address:	**Authorized Offeror Signatory:** **(Please print name and sign in ink)**
Offeror Phone Number:	**Offeror FAX Number:**
Offeror E-mail Address:	

The draft RFP is not complete and is not ready for release. It reflects the Department's work through January 19, 2011. Before release, there will be numerous changes. It has not been revised or approved by the DPHHS Management Team or the Director. Please keep in mind the draft RFP will need to be submitted to the Center for Medicare and Medicaid Services for their review and approval.

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OFFERORS MUST RETURN THIS COVER SHEET WITH RFP RESPONSE

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Instructions for Using this RFP Template

- Insert appropriate information when requested in areas that appear in red. (As you insert information, change font color from red to automatic, unbold, and delete underlining, if appropriate.) Most of the text in this RFP Template, excluding titles and section headings, is in Arial 11 point font.

- Decide which optional paragraphs are needed and delete those not needed. **DO NOT USE THE AUTONUMBERING OR TABLE OF CONTENTS GENERATION FEATURES.** Change paragraph numbering and page numbers throughout the document, including the Table of Contents, as necessary to accommodate material that has been added or deleted.

- **Delete this text box and page when the RFP is ready to issue by clicking on the text box boundary, pressing delete, and deleting the section break on this page.**

TABLE OF CONTENTS

PAGE

Instructions to Offerors .....

Schedule of Events .....

Section 1: Project Overview and Instructions .....
- **1.0** Project Overview .....
- **1.1** Contract Term .....
- **1.2** Single Point of Contact .....
- **1.3** Required Review .....
- **1.4** Pre-Proposal Conference (Optional) .....
- **1.5** General Requirements .....
- **1.6** Submitting a Proposal .....
- **1.7** Cost of Preparing a Proposal .....

Section 2: RFP Standard Information .....
- **2.0** Authority .....
- **2.1** Offeror Competition .....
- **2.2** Receipt of Proposals and Public Inspection .....
- **2.3** Classification and Evaluation of Proposals .....
- **2.4** State's Rights Reserved .....

Section 3: Scope of Project .....

Fill in subsections as available

Section 4: Offeror Qualifications/Informational Requirements .....
- **4.0** State's Right to Investigate and Reject .....
- **4.1** Offeror Qualifications/Informational Requirements .....

Section 5: Cost Proposal .....

Section 6: Evaluation Process .....
- **6.0** Basis of Evaluation .....
- **6.1** Evaluation Criteria .....

Appendix A - Standard Terms and Conditions .....

Appendix B - Contract .....

Use Appendix C in conjunction with alternate Section 1.6.1 if you are issuing a "short response form" RFP.

Appendix C - RFP Response Form .....

Note to agencies:

For all solicitations for which Prevailing Wage Rates will be paid, the applicable Prevailing Wage Booklet from the Department of Labor and Industry, must be included as part of the solicitation.

Appendix D - Montana Prevailing Wages Rates for (Insert Type of Service) Services (Year) .....

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INSTRUCTIONS TO OFFERORS

It is the responsibility of each offeror to:

Follow the format required in the RFP when preparing your response. Provide point-by-point responses to all sections in a clear and concise manner.

Provide complete answers/descriptions. Read and answer **all** questions and requirements. Don't assume the State or evaluator/evaluation committee will know what your company capabilities are or what items/services you can provide, even if you have previously contracted with the State. The proposals are evaluated based solely on the information and materials provided in your response.

Use the forms provided, i.e., cover page, sample budget form, certification forms, etc.

Submit your response on time. Note all the dates and times listed in the Schedule of Events and within the document, and be sure to submit all required items on time. Late proposal responses are ***never*** accepted.

The following items MUST be included in the response to be considered responsive. Failure to include any of these items may result in a nonresponsive determination.

Signed Cover Sheet

Signed Addenda (if appropriate)

Optional if Section 1.5.3 is included: Address all mandatory requirements (per Section 1.5.3)

Point-by-Point response to all sections and subsections (per Section 1.6.1)

Response to Appendices A and B (per Section 1.6.1)

Complete answers to all requirements of Sections 3, 4, and 5

Correctly executed State of Montana "Affidavit for Trade Secret Confidentiality" form if claiming information to be confidential or proprietary (per Section 2.2.1)

Note to Agencies: Add other items as appropriate.

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SCHEDULE OF EVENTS

EVENT	DATE
RFP Issue Date	(insert date
Pre-Proposal Conference (Optional)	(insert date
Deadline for Receipt of Written Questions	(insert date
Deadline for Posting Written Responses to the State's Website	(insert date
RFP Response Due Date	(insert date
Notification of Offeror Interviews/Product Demonstrations (Optional)	(insert date
Offeror Interviews/Product Demonstrations (Optional)	(insert date
Intended Date for Contract Award (Optional)	(insert date

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SECTION 1: PROJECT OVERVIEW AND INSTRUCTIONS

1.0 PROJECT OVERVIEW

The STATE OF MONTANA, Department of Public Health and Human Services, (hereinafter referred to as "the State") is seeking a contractor to provide managed care services. A more complete description of the supplies and/or services sought for this project is provided in Section 3, Scope of Project. Proposals submitted in response to this solicitation must comply with the instructions and procedures contained herein.

1.1 CONTRACT TERM

The contract term is for a period of (insert number) years beginning (insert date) and ending (insert date). Renewals of the contract, by mutual agreement of both parties, may be made at (insert number)-year intervals, or any interval that is advantageous to the State. This contract, including any renewals, may not exceed a total of (insert number) years, at the option of the State.

1.2 SINGLE POINT OF CONTACT

From the date this Request for Proposal (RFP) is issued until an offeror is selected and the selection is announced by the procurement officer, **offerors are not allowed to communicate with any state staff or officials regarding this procurement, except at the direction of** (insert name of point of contact), the procurement officer in charge of the solicitation. Any unauthorized contact may disqualify the offeror from further consideration. Contact information for the single point of contact is as follows:

Procurement Officer: (insert name)
Address: (insert address)
Telephone Number: (insert number)
Fax Number: (insert number)
E-mail Address: (insert address)

1.3 REQUIRED REVIEW

1.3.1 Review RFP. Offerors should carefully review the instructions, mandatory requirements, specifications, standard terms and conditions, and contract set out in this RFP and promptly notify the procurement officer identified above in writing or via e-mail of any ambiguity, inconsistency, unduly restrictive specifications, or error which they discover upon examination of this RFP. This should include any terms or requirements within the RFP that either preclude the offeror from responding to the RFP or add unnecessary cost. This notification must be accompanied by an explanation and suggested modification and be received by the deadline for receipt of written or e-mailed inquiries set forth below. The State will make any final determination of changes to the RFP.

1.3.2 Form of Questions. Offerors with questions or requiring clarification or interpretation of any section within this RFP must address these questions in writing or via e-mail to the procurement officer referenced above on or before (insert date for receipt of written/e-mailed questions). Each question must provide clear reference to the section, page, and item in question. Questions received after the deadline may not be considered.

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1.3.3 State's Response. The State will provide an official written response by (insert date for posting of written answers to the State's website) to all questions received by (insert date for receipt of written/e-mailed questions). The State's response will be by formal written addendum. Any other form of interpretation, correction, or change to this RFP will not be binding upon the State. Any formal written addendum will be posted on the State's OneStop Vendor Information website with the posting of the RFP at http://svc.mt.gov/gsd/OneStop/SolicitationDefault.aspx by the close of business on the date listed. **Offerors must sign and return with their RFP response an Acknowledgment of Addendum for any addendum issued.**

Section 1.4 is optional.

1.4 PRE-PROPOSAL CONFERENCE

(An optional/A mandatory) Pre-Proposal Conference will be conducted at (insert address) on (insert date) at (insert time). Offerors are encouraged to use this opportunity to ask clarifying questions, obtain a better understanding of the project, or to notify the State of any ambiguities, inconsistencies, or errors discovered upon examination of this RFP. All responses to questions at the Pre-Proposal Conference will be oral and in no way binding on the State.

OR

An optional Pre-Proposal Telephone Conference Call will be conducted on (insert date) at (insert time) at (insert address). Offerors are encouraged to use this opportunity to ask clarifying questions, obtain a better understanding of the project, or to notify the State of any ambiguities, inconsistencies, or errors discovered upon examination of this RFP. All responses to questions at the Pre-Proposal Conference will be oral and in no way binding on the State. Participation in the conference call is optional. However, it is advisable that all interested parties participate. If calling from the Helena area, call (406) 444-(insert number). If calling from outside the Helena area, call (insert number). The password for both numbers is (insert password).

1.5 GENERAL REQUIREMENTS

1.5.1 Acceptance of Standard Terms and Conditions/Contract. *By submitting a response to this RFP, offeror agrees to acceptance of the standard terms and conditions and contract as set out in Appendices A and B of this RFP.* Much of the language included in the standard terms and conditions and contract reflects requirements of Montana law. Requests for additions or exceptions to the standard terms and conditions, contract terms, including any necessary licenses, or any added provisions must be submitted to the procurement officer referenced above by the date for receipt of written/e-mailed questions. Any request must be accompanied by an explanation of why the exception is being sought and what specific effect it will have on the offeror's ability to respond to the RFP or perform the contract. The State reserves the right to address nonmaterial requests for exceptions with the highest scoring offeror during contract negotiation. Any material exceptions requested and granted to the standard terms and conditions and contract language will be addressed in any formal written addendum issued for this RFP and will apply to all offerors submitting a response to this RFP. The State will make any final determination of changes to the standard terms and conditions and/or contract.

1.5.2 Resulting Contract. This RFP and any addenda, the offeror's RFP response, including any amendments, a best and final offer, and any clarification question responses shall be included in any resulting contract. The State's contract, attached as Appendix B, contains the contract terms and conditions which will form the basis of any contract between the State and the highest scoring offeror. In the event of a dispute as to the duties and responsibilities of the parties under this contract, the contract, along with any attachments prepared by the State, will govern in the same order of precedence as listed in the contract.

Section 1.5.3 is optional. All mandatory requirements must be clearly identified, listed here, and in "Instructions to Offerors" on page 3. A mandatory requirement is a particular condition or item that ***must*** be present for the proposal to be responsive. It is not an evaluation criterion.

1.5.3 Mandatory Requirements. To be eligible for consideration, an offeror ***must*** meet the intent of all mandatory requirements as listed in Sections (**insert the reference section numbers, e.g., 1.6.4, if used, Section 3, etc.**). The State will determine whether an offeror's RFP response complies with the intent of the requirements. RFP responses that do not meet the full intent of all requirements listed in this RFP may be deemed nonresponsive.

1.5.4 Understanding of Specifications and Requirements. By submitting a response to this RFP, offeror agrees to an understanding of and compliance with the specifications and requirements described in this RFP.

1.5.5 Prime Contractor/Subcontractors. The highest scoring offeror will be the prime contractor if a contract is awarded and shall be responsible, in total, for all work of any subcontractors. All subcontractors, if any, must be listed in the proposal. The State reserves the right to approve all subcontractors. The Contractor shall be responsible to the State for the acts and omissions of all subcontractors or agents and of persons directly or indirectly employed by such subcontractors, and for the acts and omissions of persons employed directly by the Contractor. Further, nothing contained within this document or any contract documents created as a result of any contract awards derived from this RFP shall create any contractual relationships between any subcontractor and the State.

1.5.6 Offeror's Signature. The proposals must be signed in ink by an individual authorized to legally bind the business submitting the proposal. The offeror's signature on a proposal in response to this RFP guarantees that the offer has been established without collusion and without effort to preclude the State of Montana from obtaining the best possible supply or service. Proof of authority of the person signing the RFP response must be furnished upon request.

1.5.7 Offer in Effect for 120 Days. A proposal may not be modified, withdrawn, or canceled by the offeror for a 120-day period following the deadline for proposal submission as defined in the Schedule of Events, or receipt of best and final offer, if required, and offeror so agrees in submitting the proposal.

1.6 SUBMITTING A PROPOSAL

Use these paragraphs if you are issuing an RFP that requires a "longer," more detailed response from the offeror.

1.6.1 Organization of Proposal. Offerors must organize their proposal into sections that follow the format of this RFP, with tabs separating each section. ***A point-by-point response to all numbered sections, subsections, and appendices is required.*** If no explanation or clarification is required in the offeror's response to a specific subsection, the offeror shall indicate so in the point-by-point response, or utilize a blanket response for the entire section, with the following statement:

"(Offeror's Name)" understands and will comply.

An offeror making the statement "Refer to our literature..." or "Please see www.....com" may be deemed nonresponsive or receive point deductions. If making reference to materials located in another section of the RFP response, specific page numbers and sections must be noted. **The Evaluator/Evaluation Committee is not required to search through literature or another section of the proposal to find a response.**

Use this paragraph, along with Appendix C, RFP Response Form, if you are issuing an RFP that requires a "shorter," less detailed response from the offeror.

1.6.1 Organization of Proposal. Offerors must submit a signed copy of the RFP cover sheet and the form attached as Appendix C to respond to this RFP.

1.6.2 Failure to Comply with Instructions. Offerors failing to comply with these instructions may be subject to point deductions. The State may also choose to not evaluate, may deem nonresponsive, and/or may disqualify from further consideration any proposals that do not follow this RFP format, are difficult to understand, are difficult to read, or are missing any requested information.

1.6.3 Multiple Proposals. Offerors may, at their option, submit multiple proposals, in which case each proposal shall be evaluated as a separate document.

Section 1.6.4 is optional. A sample price sheet can be found in the RFP Manual located at the following website address: http://gsd.mt.gov/ProcurementServices/rfpprocess.mcpx.

1.6.4 Price Sheets. Offerors ***must*** respond to this RFP by utilizing the RFP Price Sheets found in Section **(insert number)**. These price sheets serve as the primary representation of each offeror's cost/price, and will be used extensively during proposal evaluations. Additional information should be included as necessary to explain in detail the offeror's cost/price.

Note to agencies: If you need electronic copies of the proposal responses, you must insert that request here. Specify the format and medium you want.

1.6.5 Copies Required and Deadline for Receipt of Proposals. Offerors must submit **one original proposal and** (insert number) **copies** to the (insert agency name). The State reserves the right to request an electronic copy of the RFP response. **PROPOSALS MUST BE SEALED AND LABELED ON THE OUTSIDE OF THE PACKAGE** to clearly indicate that they are in response to RFP (insert RFP number). ***Proposals must be received at the receptionist's desk of the*** *(insert agency name)* ***prior to*** *(insert time)*, ***local time,*** *(insert date)*. ***Facsimile responses to requests for proposals are ONLY accepted on an exception basis with prior approval of the procurement officer.***

1.6.6 Late Proposals. ***Regardless of cause, late proposals will not be accepted and will automatically be disqualified from further consideration.*** It shall be the offeror's sole risk to assure delivery at the receptionist's desk at the designated office by the designated time. Late proposals will not be opened and may be returned to the offeror at the expense of the offeror or destroyed if requested.

1.7 COST OF PREPARING A PROPOSAL

1.7.1 State Not Responsible for Preparation Costs. The costs for developing and delivering responses to this RFP and any subsequent presentations of the proposal as requested by the State are entirely the responsibility of the offeror. The State is not liable for any expense incurred by the offeror in the preparation and presentation of their proposal or any other costs incurred by the offeror prior to execution of a contract.

1.7.2 All Timely Submitted Materials Become State Property. All materials submitted in response to this RFP become the property of the State and are to be appended to any formal documentation, which would further define or expand any contractual relationship between the State and offeror resulting from this RFP process.

SECTION 2: RFP STANDARD INFORMATION

2.0 AUTHORITY

This RFP is issued under the authority of section 18-4-304, MCA (Montana Code Annotated) and ARM 2.5.602 (Administrative Rules of Montana). The RFP process is a procurement option allowing the award to be based on stated evaluation criteria. The RFP states the relative importance of all evaluation criteria. Only the evaluation criteria outlined in this RFP will be used.

2.1 OFFEROR COMPETITION

The State encourages free and open competition among offerors. Whenever possible, the State will design specifications, proposal requests, and conditions to accomplish this objective, consistent with the necessity to satisfy the State's need to procure technically sound, cost-effective services and supplies.

2.2 RECEIPT OF PROPOSALS AND PUBLIC INSPECTION

2.2.1 Public Information. All information received in response to this RFP, including copyrighted material, is deemed public information and will be made available for public viewing and copying shortly after the time for receipt of proposals has passed with the following three exceptions: (1) bona fide trade secrets meeting the requirements of the Uniform Trade Secrets Act, Title 30, chapter 14, part 4, MCA, that have been properly marked, separated, and documented; (2) matters involving individual safety as determined by the State; and (3) other constitutional protections. See section 18-4-304, MCA. The State will make a copier available for interested parties to use at $0.10 per page. The interested party is responsible for the cost of copies and to provide personnel to do the copying.

2.2.2 Procurement Officer Review of Proposals. Upon opening the proposals received in response to this RFP, the procurement officer in charge of the solicitation will review the proposals and separate out any information that meets the referenced exceptions in Section 2.2.1 above, providing the following conditions have been met:

- Confidential information is clearly marked and separated from the rest of the proposal.
- The proposal does not contain confidential material in the cost or price section.
- An affidavit from an offeror's legal counsel attesting to and explaining the validity of the trade secret claim as set out in Title 30, chapter 14, part 4, MCA, is attached to each proposal containing trade secrets. Counsel must use the State of Montana "Affidavit for Trade Secret Confidentiality" form in requesting the trade secret claim. This affidavit form is available on the OneStop Vendor Information website at: http://svc.mt.gov/gsd/OneStop/GSDDocuments.aspx or by calling (406) 444-2575.

Information separated out under this process will be available for review only by the procurement officer, the evaluator/evaluation committee members, and limited other designees. Offerors must be prepared to pay all legal costs and fees associated with defending a claim for confidentiality in the event of a "right to know" (open records) request from another party.

2.3 CLASSIFICATION AND EVALUATION OF PROPOSALS

2.3.1 Initial Classification of Proposals as Responsive or Nonresponsive. All proposals will initially be classified as either "responsive" or "nonresponsive," in accordance with ARM 2.5.602. Proposals

may be found nonresponsive at any time during the procurement process if any of the required information is not provided; the submitted price is found to be excessive or inadequate as measured by criteria stated in the RFP; or the proposal is not within the plans and specifications described and required in the RFP. If a proposal is found to be nonresponsive, it will not be considered further.

2.3.2 Determination of Responsibility. The procurement officer will determine whether an offeror has met the standards of responsibility in accordance with ARM 2.5.407. Such a determination may be made at any time during the procurement process if information surfaces that would result in a determination of nonresponsibility. If an offeror is found nonresponsible, the determination must be in writing, made a part of the procurement file, and mailed to the affected offeror.

2.3.3 Evaluation of Proposals. An evaluator/evaluation committee will evaluate the remaining proposals and recommend whether to award the contract to the highest scoring offeror or, if necessary, to seek discussion/negotiation or a best and final offer in order to determine the highest scoring offeror. All responsive proposals will be evaluated based on stated evaluation criteria. In scoring against stated criteria, the State may consider such factors as accepted industry standards and a comparative evaluation of all other qualified RFP responses in terms of differing price, quality, and contractual factors. These scores will be used to determine the most advantageous offering to the State. If an evaluation committee meets to deliberate and evaluate the proposals, the public may attend and observe the evaluation committee deliberations.

2.3.4 Completeness of Proposals. Selection and award will be based on the offeror's proposal and other items outlined in this RFP. Submitted responses may not include references to information located elsewhere, such as Internet websites or libraries, unless specifically requested. Information or materials presented by offerors outside the formal response or subsequent discussion/negotiation or best and final offer, if requested, will not be considered, will have no bearing on any award, and may result in the offeror being disqualified from further consideration.

Section 2.3.5 is optional. The percent specified for a passing score must correspond to the Scoring Guide percentage for a passing score in Section 6.

2.3.5 Achieve Passing Score. Any proposal that fails to achieve ___**% of the total available points for Sections** _____ **(or a total of** ___ **points)** will be eliminated from further consideration. A "fail" for any individual evaluation criteria may result in proposal disqualification at the discretion of the procurement officer.

2.3.6 Opportunity for Discussion/Negotiation and/or Oral Presentation/Product Demonstration. After receipt of all proposals and prior to the determination of the award, the State may initiate discussions with one or more offerors should clarification or negotiation be necessary. Offerors may also be required to make an oral presentation and/or product demonstration to clarify their RFP response or to further define their offer. In either case, offerors should be prepared to send qualified personnel to (Helena), Montana, to discuss technical and contractual aspects of the proposal. Oral presentations and product demonstrations, if requested, shall be at the offeror's expense.

2.3.7 Best and Final Offer. The Best and Final Offer is an option available to the State under the RFP process, which permits the State to request a best and final offer from one or more offerors if additional information is required to make a final decision. Offerors may be contacted asking that they submit their best and final offer, which must include any and all discussed and/or negotiated changes. The State reserves the right to request a best and final offer for this RFP, if any, based on price/cost alone.

2.3.8 Evaluator/Evaluation Committee Recommendation for Contract Award. The evaluator/ evaluation committee will provide a written recommendation for contract award to the procurement officer that contains the scores, justification, and rationale for the decision. The procurement officer will review the recommendation to ensure its compliance with the RFP process and criteria before concurring in the evaluator's/evaluation committee's recommendation of the responsive and responsible offeror that achieves the highest score and is, therefore, the most advantageous to the State.

2.3.9 Request for Documents Notice. Upon concurrence with the evaluator's/evaluation committee's recommendation, the procurement officer will issue a "Request for Documents Notice" to the highest scoring offeror to obtain the required documents/information, such as insurance documents, contract performance security, an electronic copy of any requested material, i.e., RFP response, response to clarification questions, and/or best and final offer, and any other necessary documents. Receipt of the "Request for Documents Notice" does not constitute a contract and **no work may begin until a contract signed by all parties is in place**. The procurement officer will notify all other offerors of the State's selection.

2.3.10 Contract Execution. Upon receipt of all required materials requested in the "Request for Documents Notice," a formal contract utilizing the contract attached as Appendix B and incorporating the Standard Terms and Conditions attached as Appendix A, as well as the highest scoring offeror's response to the RFP, will be provided to the highest scoring offeror for signature. The highest scoring offeror will be expected to accept and agree to all material requirements contained in the contract and set out in Appendices A and B of this RFP. If the highest scoring offeror does not accept all material requirements, the State may move to the next highest scoring offeror, or cancel the RFP. Work under the contract may begin when the contract is fully executed, i.e., when the contract is signed by all parties.

2.4 STATE'S RIGHTS RESERVED

While the State has every intention to award a contract as a result of this RFP, issuance of the RFP in no way constitutes a commitment by the State of Montana to award and execute a contract. Upon a determination such actions would be in its best interest, the State, in its sole discretion, reserves the right to:

- Cancel or terminate this RFP (section 18-4-307, MCA);
- Reject any or all proposals received in response to this RFP (ARM 2.5.602);
- Waive any undesirable, inconsequential, or inconsistent provisions of this RFP which would not have significant impact on any proposal (ARM 2.5.505);
- Not award if it is in the best interest of the State not to proceed with contract execution (ARM 2.5.602); or
- If awarded, terminate any contract if the State determines adequate state funds are not available (section 18-4-313, MCA).

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SECTION 3: SCOPE OF PROJECT

3.0 MONTANA MEDICAID 5-COUNTY MANAGED CARE DEMONSTRATION PROJECT

3.1 CARE MANAGEMENT

Contractor must adhere to all rules pursuant to the Managed Care Quality Assurance and Network Adequacy for Managed Care sections as written in the Administrative Rules of Montana

3.1.1 Description of Population(s). 70% of population to voluntarily enroll in a medical home, choose their primary care provider (PCP).

3.1.2 Definitions Specific to This Population and Services

3.1.2.1 Medical home: In Montana, a patient-centered medical home is health care directed by primary care providers offering family-centered, culturally effective care that is coordinated, comprehensive, continuous, and, when possible, in the patient's community and integrated across systems. Health care is characterized by enhanced access, an emphasis on prevention, and improved health outcomes and satisfaction. Primary care providers receive payment that recognizes the value of medical home services.

3.1.3 Current Delivery System and Payment Methods

3.1.3.1 Primary care case management (PCCM) is fee-for-service with an additional per member per month (PMPM) fee for case management.

3.1.3.2 Provides referrals from PCP to specialists.

3.1.3.3 Cannot restrict access to services or emergency department.

3.1.3.4 American Indians have unrestricted access to IHS.

3.1.3.5 Provides complaint/grievance process for clients.

3.1.3.6 Enhanced primary care case management (EPCCM) is PMPM for enhanced care management by community-based nurses and health coaches, and includes telephonic and in-person visits with clients.

3.1.4 Specific Department-approved Outreach, Education, and Client Materials

3.1.4.1 Operate a toll free client helpline Monday through Friday 8am to 5pm excluding state-approved holidays. Including the following standards:

3.1.4.1.1 95% of all calls that do not "ring busy" answered on or before the fourth ring.

3.1.4.1.2 95% of all calls that are answered must be answered by a live person.

3.1.4.1.3 Hold time not to exceed 2 minutes for 95% of calls.

3.1.4.1.4 Average hold time not to exceed 30 seconds.

3.1.4.1.5 Respond to at least 90% of telephone inquiries during the initial call from the client.

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3.1.4.1.6 Average abandonment rate of less than 5% for calls holding 30 seconds or more.
3.1.4.1.7 Average service level of 85% or higher.
3.1.4.1.8 Blockage rate of 5% or less.
3.1.4.1.9 Average speed of answer must be 30 seconds or less.

3.1.4.2 Voice Mailbox will be available for after hour messages, to be responded to the following business day. Provide a voice messaging option at state-designated intervals during the queue hold time.

3.1.4.3 Provide a translation services/language line.

3.1.4.4 Establish client outreach script.

3.1.4.5 Establish secure client web with tutorial.

3.1.4.6 Establish Medicaid client capability to enroll in the managed care organization (MCO) via web.

3.1.4.7 Post frequently asked questions (FAQs) online, organized by topic.

3.1.4.8 Provider directory will be available to clients via web and mail.

3.1.4.9 Provide handbook with benefit/services outlined.

3.1.4.10 Provide a complaint/grievance process for clients.

3.1.4.11 Establish enrollment/disenrollment procedures.

3.1.4.12 Implement a Medical History portion of the web portal to assist hospitals, physicians and mid-level practitioners in the treatment of patients by allowing interactive access to clients' medical histories.

3.1.4.13 Provide for the creation and processing of online surveys by the State or the contractor.

3.1.4.14 Allow for HIPPA compliant emails and documents to be shared between the State, contractor, and providers.

3.1.4.15 Establish reenrollment processes for clients at less than 2 months, 2-9 months and over 9 months (CMS requirements).

3.1.4.16 Establish choice of providers/network adequacy.

3.1.4.17 80% of clients must be outreached about or informed of their benefits utilizing a state-approved outreach script.

3.1.4.18 Well Child/Early and Periodic Screening, Diagnosis and Treatment (EPSDT) letters must be mailed the week of the client's birth date.

3.1.4.19 All client materials will be at or below a 6th grade reading level.

3.1.4.20 100% of enrollment forms will be entered into the system within 3 business days of receipt.

3.1.4.21 100% of telephone enrollments will be entered into the system within 1 business day unless the system is down.

3.1.4.22 95% accuracy will be achieved on all enrollment forms audited for accuracy.

3.1.4.23 97% of client enrollment packets will have required components.

3.1.4.24 95% accuracy will be met on incoming and outgoing calls audited for quality.

3.1.4.25 Design, print and distribute state-approved member identification cards and a member handbook to members within five business days following the receipt of the eligibility file.

DRAFT

3.1.5 Client Transition to MCO

3.1.5.1 Provide outreach and transition plan including milestones from current PCCM program.

3.1.5.2 Provide pediatric-to-adult services plan.

3.1.6 Provider Choice

3.1.6.1 Provide choice of 2 or more age-appropriate providers for each client.

3.1.6.2 Welcome letter will be mailed to clients within 5 business days of receiving the enrollment file.

3.1.6.3 "Choose a provider' letter sent to Medicaid clients before auto assignment.

3.1.6.4 Logical algorithm approved by State for auto assignment.

3.1.6.5 Contractor must comply with 42 CFR 438.810 (a) and (b) (Appendix 2) to auto assign or enroll clients with PCP.

3.1.6.6 Contractor will attempt a minimum of 3 phone calls to the client to provide education/outreach on client choice of provider.

3.1.6.7 Contractor will allow client disenrollment when provider leaves the network and re-enrollment with a new choice of provider.

3.1.6.8 Client will be able to enroll with PCP on the web portal via secure log in.

3.1.7 Client Engagement

3.1.7.1 Develop and use client satisfaction survey.

3.1.7.2 Develop and use client self-assessments.

3.1.8 Description of Services

3.1.8.1 Establish network of PCPs to serve as medical homes for covered clients.

3.1.8.2 Provide 24/7 nurse advice line.

3.1.8.3 Fax triage report to PCP from nurse advice line.

3.1.8.4 Establish a lock-in program consistent with ARM for high utilizers/drug seeking clients.

3.1.8.5 Provide community-based nurse care management, including telephonic and in-person contact, to all Medicaid eligible clients.

3.1.8.6 Provide hospital discharge planning.

3.1.8.7 Develop individual care plans.

3.1.8.8 Utilize predictive modeling software to target high risk/cost clients.

3.1.8.9 Allow PCP referral for more intensive care management for patients other than those identified through predictive modeling.

3.1.8.10 State staff must have access to predictive modeling software to direct and approve outreach.

3.1.8.11 Clients will have access to local resources for community-based care management.

3.1.9 Provider Network

3.1.9.1 Clients will have a choice of 2 or more providers.

DRAFT

3.1.9.2 Maintain a provider network sufficient to provide all members with access to the full range of covered services required under the contract.
3.1.9.3 Provider network must be responsive to the linguistic, cultural, and other unique needs of minorities, the elderly, disabled individuals, or other special populations in the service area, including the capacity to communicate with members in who are deaf or hearing impaired.
3.1.9.4 Maintain provider exclusion lists.
3.1.9.5 Provide 24-hour care direction.
3.1.9.6 Operate a provider relations helpline Monday through Friday 8am to 5pm, excluding state-approved holidays, that meets Utilization Review Accreditation Commission (URAC) standards including:

3.1.9.6.1 95% of all calls that do not ring busy must be answered on or before the fourth ring.
3.1.9.6.2 95% of all calls that are answered must be answered by a live person.
3.1.9.6.3 Hold time must not exceed 2 minutes for 95% of calls.
3.1.9.6.4 Average hold time must not exceed thirty seconds.
3.1.9.6.5 Respond to at least 90% of telephone inquiries during the initial call from the provider.
3.1.9.6.6 Average abandonment rate of less than 5% for calls holding 30 seconds or more.
3.1.9.6.7 Average service level of 85% or higher.
3.1.9.6.8 Blockage rate of 5% or less.
3.1.9.6.9 Average speed of answer of 30 seconds or less.

3.1.9.7 Voice Mailbox will be available for after hour messages, to be responded to the following business day. Provide a voice messaging option at state-designated intervals during the queue hold time.
3.1.9.8 Respond in writing to written, faxed, or emailed inquiries within 5 business days of receipt.
3.1.9.9 Maintain client health records.
3.1.9.10 Transition client health records.
3.1.9.11 Establish and maintain network adequacy; active provider recruitment based on underserved areas.
3.1.9.12 Provider availability standards will be approved by the State.
3.1.9.13 Provide state-approved provider outreach and training.
3.1.9.14 Furnish each PCP, on first day of every month, with a current list of enrolled members assigned to the provider.
3.1.9.15 Prepare and issue a state-approved provider manual, including any necessary specialty manuals, to all existing network providers.

3.1.10 Data Collection and Reporting

3.1.10.1 80% of newly-enrolled clients must be outreached each month.
3.1.10.2 75% of clients must voluntarily enroll with PCP.

DRAFT

3.1.10.3 Predictive modeling software must stratify clients: top 5% of clients at risk eligible for more intensive care management; must allow for co-morbidities and not focus on specific disease states. PCPs allowed to refer patients not in the top 5% into more intensive care management.

3.1.10.4 State staff will have access to predictive modeling software to monitor outreach.

3.1.10.5 Provide QA reports.

3.1.10.6 Timing of reports, frequency, and due dates as spelled out in RFP will be accomplished.

3.1.10.7 Client help line data collected includes: abandonment rate, speed of answer, hours of phone coverage.

3.1.10.8 Conduct ongoing quality assurance to ensure standards are met for the client, provider, and nurse advice help lines; and that accurate information is provided to the caller.

3.1.10.9 Provide a call-tracking database of all provider and client inquiries and dispositions. Provide state access to this database.

3.1.10.10 Establish the capability to log calls with reason codes to track help line usage.

3.1.10.11 Use a recording system that provides screen capture and voice capture for 100% of all calls.

3.1.10.12 Image and store all client- and provider-related documents, including incoming/outgoing letters, emails, and agreements/contracts.

3.1.10.13 Collect HEDIS clinical measures:

3.1.10.13.1 Members (20 years and older) who had an ambulatory or preventative care visit during the measurement year. Include measure for Medicaid, Medicare and commercial members under the plan.

3.1.10.13.2 Percentage of well-child visits in the third, fourth, fifth and sixth years of life.

3.1.10.13.3 Percentage of adolescents who had a well-care visit.

3.1.10.13.4 Percentage of children and adolescents who received recommended vaccinations and lead screenings according to the standard periodicity schedule.

3.1.10.13.5 Percentage of members who had an annual dental exam.

3.1.10.13.6 Percentage of pregnant women who had comprehensive prenatal and postnatal care according to HEDIS standards. Include in this measure the week of pregnancy the beneficiary was enrolled in the plan.

3.1.10.13.7 Percentage of adults with a new episode of alcohol or other drug (AOD) dependence who received initiation of AOD treatment and/or engagement (initiation + 2 or more additional services with an AOD diagnosis) of AOD treatment.

3.1.10.13.8 Measure the number and percentage of members with an alcohol and other drug (AOD) claim who received the following chemical dependency services during the measurement year:

3.1.10.13.8.1 Any services

3.1.10.13.8.2 Inpatient

3.1.10.13.8.3 Intensive outpatient

3.1.10.13.9 Percentage of women aged 40-69 who had a mammogram to screen for breast cancer.

DRAFT

3.1.10.13.10 Percentage of members who received medical assistance with smoking and tobacco use cessation.

3.1.10.13.11 Percentage of women who received an annual exam which included screening for cervical cancer and STDs.

3.1.10.13.12 Percentage of discharges of members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner, who received follow-up within 7 days and/or follow-up within 30 days.

3.1.10.13.13 Percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:

- **3.1.10.13.13.1** Hemoglobin A1c (HbA1c) testing
- **3.1.10.13.13.2** HbA1c poor control (>9.0%)
- **3.1.10.13.13.3** HbA1c good control (<7.0%)
- **3.1.10.13.13.4** Eye exam (retinal) performed
- **3.1.10.13.13.5** LDL-C screening
- **3.1.10.13.13.6** LDL-C control (<100 mg/dL)
- **3.1.10.13.13.7** Medical attention for nephropathy
- **3.1.10.13.13.8** Blood pressure control (<130/80 mm Hg)
- **3.1.10.13.13.9** Blood pressure control (<140/90 mm Hg)

3.1.10.13.14 The percentage of members 18–75 years of age who were discharged alive for AMI, coronary artery bypass graft (CABG), or percutaneous transluminal coronary angioplasty (PTCA) from January 1–November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to measurement year, who had each of the following during the measurement year:

- **3.1.10.13.14.1** LDL-C screening
- **3.1.10.13.14.2** LDL-C control (<100 mg/dL)1

3.1.10.13.15 The percentage of members 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment for at least 84 days and/or at least 180 days.

3.1.10.13.16 The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90) during the measurement year.

3.1.10.13.17 The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.

3.1.10.13.18 The percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged alive from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.

3.1.10.13.19 The percentage of members who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease modifying anti-rheumatic drug (DMARD).

3.1.10.13.20 The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic

agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. For each product line, report each of the four rates separately and as a total rate:

3.1.10.13.20.1 Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)

3.1.10.13.20.2 Annual monitoring for members on digoxin

3.1.10.13.20.3 Annual monitoring for members on diuretics

3.1.10.13.19.4 Annual monitoring for members on anticonvulsants

3.1.10.13.19.5 Total rate (the sum of the four numerators divided by the sum of the four denominators)

3.1.10.13.21 The percentage of members 40 years of age and older with a new diagnosis or newly active COPD who received appropriate spirometry testing to confirm the diagnosis.

3.1.10.13.22 The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED encounter between January 1–November 30 of the measurement year and who were dispensed appropriate medications. Two rates are reported:

3.1.10.13.20.1 Dispensed a systemic corticosteroid within 14 days of the event

3.1.10.13.20.2 Dispensed a bronchodilator within 30 days of the event

3.1.10.13.23 The percentage of members 18–74 years of age who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year prior the measurement year.

3.1.10.14 Provide HEDIS MCO membership measures:

3.1.10.14.1 An unduplicated count and percentage of Medicaid and Medicare members enrolled at any time during the measurement year by demand for language interpreter services and spoken language.

3.1.10.14.2 An unduplicated count and percentage of members enrolled any time during the measurement year, by race and ethnicity.

3.1.10.15 Collect HEDIS utilization measurements:

3.1.10.15.1 Measure the utilization of frequently performed procedures that often show wide regional variation and have generated concern regarding potentially inappropriate utilization.

3.1.10.15.2 Measure utilization of acute inpatient care and services in the following categories:

3.1.10.15.2.1 Total inpatient

3.1.10.15.2.2 Medicine

3.1.10.15.2.3 Surgery

3.1.10.14.2.4 Maternity

3.1.10.15.3 Measure utilization of ambulatory care in the following categories:

3.1.10.15.3.1 Outpatient Visits

3.1.10.15.3.2 ED Visits

3.1.10.15.3.3 Ambulatory Surgery/Procedures

3.1.10.15.3.4 Observation Room Stays

3.1.10.15.4 Measure utilization of non-acute inpatient care in hospice, nursing home, rehabilitation, SNF, transitional care and respite.

3.1.10.15.5 The number and percentage of members receiving the following mental health services during the measurement year:

- 3.1.10.15.5.1 Any services
- 3.1.10.15.5.2 Inpatient
- 3.1.10.15.5.3 Intensive outpatient

3.1.10.15.6 Measure data on outpatient utilization of drug prescriptions, stratified by age, during measurement year. The following data are reported:

- 3.1.10.15.6.1 Total cost of prescriptions
- 3.1.10.15.6.2 Average cost of prescriptions PMPM
- 3.1.10.15.6.3 Total number of prescriptions
- 3.1.10.15.6.4 Average number of prescriptions PMPY

3.1.10.15.7 This measure summarizes the following data on outpatient utilization of antibiotic prescriptions during the measurement year, stratified by age and gender:

- 3.1.10.15.7.1 Total number of antibiotic prescriptions
- 3.1.10.15.7.2 Average number of antibiotic prescriptions per member per year (PMPY)
- 3.1.10.15.7.3 Total days supplied for all antibiotic prescriptions
- 3.1.10.15.7.4 Average days supplied per antibiotic prescription
- 3.1.10.15.7.5 Total number of prescriptions for antibiotics of concern
- 3.1.10.15.7.6 Average number of prescriptions PMPY for antibiotics of concern
- 3.1.10.15.7.7 Percentage of antibiotics of concern for all antibiotic prescriptions
- 3.1.10.15.7.8 Average number of antibiotics PMPY reported by drug class:
  - 3.1.10.15.7.8.1 For selected "antibiotics of concern"
  - 3.1.10.15.7.8.2 For all other antibiotics

3.1.11 Specific Contractor Staff Requirements, Training, Job Descriptions

3.1.11.1 Community-based care managers must be Chronic Care Professional Training certified (or similar certification). Sufficient staff must be hired to provide care management to all Medicaid clients with maximum caseloads of 75-150.

3.1.11.2 Care manager must be a RN, LPN or health coach supervised by RN.

3.1.11.3 Nurse advice line call center must be URAC accredited.

3.1.11.4 At a minimum help line staff must be:

- 3.1.11.4.1 Able to answer questions pertaining to the role of the PCP and providers in the area.
- 3.1.11.4.2 Able to answer access, benefits and covered services questions.
- 3.1.11.4.3 Trained in cultural competency.
- 3.1.11.4.4 Trained to treat all callers with dignity and respect.
- 3.1.11.4.5 Trained in telephone etiquette/customer service.

DRAFT

3.1.11.4.6 Trained in HIPPA compliance.

3.1.12 Involvement of State Staff (e.g., Specific Oversight)

3.1.12.1 Provide access to predictive modeling software.

3.1.12.2 Provide access to and understanding of logic/algorithms used to show cost savings and health outcomes.

3.1.13 System Review

3.1.13.1 Clearly define and document policies and procedures that will be followed to support day to day systems activities.

3.1.13.2 Submit for State review and approval:

3.1.13.2.1 Interface plan

3.1.13.2.2 Disaster recovery plan

3.1.13.2.3 Business continuity plan

3.1.13.2.4 Risk management plan

3.1.13.2.5 Systems quality assurance plan

3.2 PHYSICIANS AND ALLIED PROVIDERS

3.2.1 Description of Provider Types. Medicaid covers services delivered by providers listed below, within the scope of the provider's license.

3.2.1.1 Physician services are provided by individuals licensed under their state medical practice act to practice medicine or osteopathy. Montana Medicaid has 7,839 physicians in its provider network.

3.2.1.2 Mid-level practitioner services are provided by physician assistants licensed to practice medicine by the Montana Board of Medical Examiners and advanced practice registered nurses licensed to practice medicine by the Montana Board of Nursing. Advanced practice registered nurses include nurse anesthetists, nurse practitioners, clinical nurse specialists, and certified nurse-midwives. Mid-level practitioners also include practitioners outside Montana who hold appropriate licenses in their own states. Montana Medicaid has 1,846 mid-level practitioners in its provider network.

3.2.1.3 Laboratory services include pathology and laboratory tests provided by independent (non-hospital) clinical laboratories. X-ray facility services include radiology tests provided by independent (non-hospital) imaging facilities. Services are ordered and provided by physicians, dentists, or other providers licensed within the scope of their practice as defined by law. Providers of lab services are Medicare providers and have a current Clinical Laboratory Improvement Amendments (CLIA) certification number. Montana Medicaid has 97 independent laboratories and X-ray facilities in its provider network.

DRAFT

3.2.1.3 Family planning clinics deliver comprehensive family planning and related preventive health services such as contraceptive services, supplies and information. Montana Medicaid has 14 family planning clinics in its provider network.

3.2.1.4 Independent diagnostic testing facility services include diagnostic testing services provided by independent diagnostic testing facilities (IDTF) under the supervision of a physician. IDTFs are also enrolled with Medicare. Montana Medicaid has 23 IDTFs in its provider network.

3.2.1.5 Public health clinic services are physician and mid-level practitioner services provided in a clinic designated as a public health clinic. Montana Medicaid has 38 public health clinics in its provider network.

3.2.1.6 Podiatry services are delivered by individuals licensed under state law to practice podiatry. Montana Medicaid has 64 podiatrists in its provider network.

3.2.2 Provider Reimbursement. Most services are paid for on a fee-for-service basis using a Resource-based Relative Value Scale (RBRVS) schedule. Additionally, some services are paid for using the Medicaid fee schedule and Medicare prevailing fees.

3.2.3 Covered Services. Medicaid covers the following services delivered by providers listed in section 3.2.1:

3.2.3.1 Abortions are covered when certain conditions are met.

3.2.3.2 Cosmetic services are covered when a provider demonstrates that the condition has a severe detrimental effect on the client's physical and psychosocial wellbeing. Mastectomy and reduction mammoplasty services are covered when medically necessary. Medical necessity for reduction mammoplasty is related to signs and symptoms resulting from macromastia. Medicaid covers surgical reconstruction following breast cancer treatment.

3.2.3.3 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) include all medically necessary services for children ages 20 and under. Providers use a series of screening and diagnostic procedures designed to detect diseases, disabilities and abnormalities in the early stages. Some services are covered for children that are not covered for adults, such as: nutritionist services, private duty nursing, respiratory therapy, therapeutic family and group home care, substance dependency inpatient and day treatment services, and school-based services.

3.2.3.4 Family planning services covered include services and supplies described in section 1905(a)(4)(C) of the Social Security Act as well as medical diagnosis and treatment services provided pursuant to a family planning service in a family planning setting.

3.2.3.5 Home births are covered on an emergency basis by a physician or licensed midwife.

3.2.3.6 Immunizations are covered; children receive immunizations through the Vaccines for Children program.

3.2.3.7 Routine podiatric care is covered when a medical condition affecting the legs or feet requires treatment by a physician or podiatrist.

3.2.3.8 Elective sterilization is covered for men and women when these explicit requirements are met: the patient provides informed consent signed at least 30 days in advance, is at least 21 years old, is not mentally incompetent, and is not institutionalized.

DRAFT

3.2.3.9 Medically necessary sterilization is covered if resulting from a procedure performed to address another medical problem. Requirements include an acknowledgment form, informed consent, and justification.

3.2.3.10 Surgical services are covered and include surgeons, co-surgeons, assistants at surgery (mid-levels who are Medicaid providers) and team surgery.

3.2.3.11 Telemedicine services are covered when the consulting provider is enrolled in Medicaid.

3.2.3.12 Transplants that are covered by Medicare are covered by Medicaid, when the procedure is not considered experimental or investigational.

3.2.3.13 Weight reduction counseling and laboratory services are covered. Nutritionist services are covered for children.

3.2.3.14 Emergency department visits are covered. Emergency services are those services required to treat and stabilize an emergency medical condition.

3.2.4 Populations Served. All individuals enrolled in Montana Medicaid are eligible for services delivered by the providers listed in 3.2.1.

3.2.5 Additional Information Requested Specific to These Provider Types. In relation to the provider types described in 1.0, provide complete responses to the following:

3.2.5.1 How many providers of each provider type described above does the bidder have in its provider network?

3.2.5.2 Describe the bidder's provider recruitment process.

3.2.5.3 Describe the bidder's process for provider training and education.

3.2.5.4 Describe how the bidder will support provider relations functions, such as a provider help line, newsletters, etc.

3.2.5.5 How will provider satisfaction be measured?

3.2.5.6 Describe the bidder's provider complaints and appeals process.

3.2.5.7 Describe how bidder will assure access to services delivered by providers listed in 3.2.1.

3.2.5.8 Describe how and by whom immunizations will be provided.

3.2.5.9 Describe the bidder's plan to furnish EPSDT services. Identify all screening components. Define "medically necessary" for the purposes of EPSDT. Include the bidder's EPSDT periodicity schedule.

3.2.5.10 Describe the bidder's plan to collect and report EPSDT information to the State for the CMS 416 report.

3.2.5.11 Medicaid is required to seek rebates for physician administered drugs billed with certain procedure codes. Describe how bidder will collect NDCs and bill rebates for physician-administered drugs.

3.3 HOSPITAL AND CLINIC SERVICES

3.3.1 Description of providers and services provided to Medicaid clients. Medicaid covers services delivered by providers listed below, within the scope of the provider's license. As a

DRAFT

condition of participation in Medicaid, providers must meet all requirements generally applicable to Medicaid providers. The health professionals employed in the different provider types must meet the same requirements as if enrolled themselves, including licensure, certification, or registration for his/her provider type. Medicaid also provides utilization review and claim resolution services to enrolled providers.

3.3.2 Provider Types. The Hospital and Clinic Service Bureau provides services to eight different provider types to include: inpatient hospitals, outpatient hospitals, Federally Qualified Health Centers, Rural Health Clinics, Critical Access Hospitals, ambulatory surgical centers, dialysis centers and Indian Health Services.

3.3.2.1 Federally Qualified Health Centers (FQHCs) are as defined in 42 USC 1396(i) (2)(B) (Appendix...) which details certain FQHC services for purposes of the Medicaid and Medicare programs. Montana Medicaid has 20 FQHC enrolled providers.

3.3.2.2 Montana Medicaid has 64 enrolled Rural Health Clinics (RHCs) both in and out of state. Clinic services are subject to all rules, except level of reimbursement, which are applied by the Medicaid program to those services when performed in other settings. Clinics have the same limits on amount, scope and duration of services covered by the Medicaid program such as medical necessity requirements and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program requirements and restrictions.

3.3.2.3 Montana Medicaid has 46 Critical Access Hospitals (CAHs) providing inpatient and outpatient services. A CAH may maintain up to 25 inpatient beds that can be used interchangeably for acute care or swing-bed services. A CAH shall provide emergency services meeting the emergency needs of patients in accordance with acceptable standards of practice, including the following standards:

3.3.2.3.1 Emergency services must be organized under the direction of a practitioner member of the medical staff. A practitioner is a physician, physician's assistant certified or an advanced practice registered nurse.

3.3.2.3.2 The services must be integrated with other departments of the facility.

3.3.2.3.3 The medical staff must establish and assume continuing responsibility for policies and procedures governing medical care provided in the emergency services.

3.3.2.3.4 A practitioner is on duty or on call and physically available at the facility within one hour at all times.

3.3.2.3.5 Facilities with 10 or fewer beds that are located in frontier areas having fewer than six persons per square mile and who have one medical provider regularly available in the area may provide emergency services through a registered nurse if they have requested and been granted a waiver by the state survey agency for Medicare and Medicaid. In these instances:

3.3.2.3.5.1 An on call practitioner must be immediately available by phone or radio for the registered nurse to contact, following completion of a nursing assessment, to determine whether the patient requires discharge, further examination, treatment or stabilization, and transfer to a facility capable of providing the appropriate level of care;

3.3.2.3.5.2 All registered nurses providing emergency service coverage must have documented education and competency in emergency care;
3.3.2.3.5.3 A registered nurse is either on duty or on call and physically available at the facility within 30 minutes at all times; and
3.3.2.3.5.4 The facility may not use a registered nurse to provide emergency services coverage for more than a 72 hour continuous period of time.

3.3.2.4 Montana Medicaid has 14 in-state and roughly 24 out-of-state prospective payment system (PPS) hospitals that are enrolled and reimbursed under the All Patient Refined Diagnosis Related Group (APR-DRG) system. Other types of hospitals also included in this group, that are enrolled providers, are 42 Border hospitals (located within 100 miles of Montana's border), three distinct part units of Montana PPS hospitals and 11 Center of Excellence facilities.

3.3.2.5 Montana Medicaid covers services provided in an outpatient hospital setting using the Outpatient Prospective Payment System (OPPS). Medicaid covers most hospital outpatient services when they are medically necessary. The OPPS applies to all facilities that are not designated as CAHs or IHS and includes border and out-of-state facilities and birthing centers. Most services in the outpatient setting are paid using the Ambulatory Payment Classification (APC) system developed by Medicare. The Department has adopted Medicare definitions and weights for APCs for the most part with some exceptions.

3.3.2.6 Montana Medicaid covers services for 25 Ambulatory Surgical Centers (ASCs) if provided in an outpatient ASC setting incident to provisions of physician or dental services to clients.

3.3.2.7 Twenty-one dialysis clinics are enrolled in Montana Medicaid. These clinics must be licensed to provide services in the state in which the clinic is located. The clinics must be certified by the Centers of Medicare and Medicaid (CMS) to provide outpatient maintenance dialysis directly to end-stage renal disease (ESRD) clients and provide training for self-dialysis and home dialysis.

3.3.2.8 There are approximately seven service units for Indian Health Services (IHS) that are enrolled as Montana Medicaid providers.

3.3.2.9 Montana Medicaid provides utilization review (UR) services in accordance with the Administrative Rules of Montana (ARM) and other related policies and procedures. We contract with an in-state peer review organization to conduct the UR services. The UR program targets specific services and ensures easy accessibility to the contractor by providers

3.3.2.10 Montana Medicaid provides claim resolution and processing for PPS hospitals, CAHs, and Rural Health Clinics. All claims touched by the Department are logged in the claims log. Review of received claims includes but is not limited to: research of the history of the claim, investigation of previously processed claims that have been denied, suspended or paid incorrectly. Additional documentation may be requested from the provider.

3.3.3 Provider Reimbursement. Montana Medicaid has several different payment systems to reimburse enrolled providers depending on their provider type:

3.3.3.1 Critical Access Hospitals

Facilities defined as Critical Access Hospitals (CAHs) will be reimbursed on a cost-based retrospective basis. Cost of hospital services will be determined for inpatient and outpatient care separately. Allowable costs will be determined in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants. Such definition of allowable costs is further defined in accordance with the Medicare Provider Reimbursement Manual - CMS Publication 15-1, and is subject to the exceptions and limitations provided in the Department's Administrative Rules. CMS Publication 15-1 is a manual published by the United States Department of Health and Human Services, Center for Medicare and Medicaid Services, which provides guidelines and policies to implement Medicare regulations and establish principles for determining the reasonable cost of provider services furnished under the Health Insurance for Aged Act of 1965, as amended. Critical Access Hospital (CAH) facilities will be reimbursed on an interim basis during the facility's fiscal year. The interim rate for outpatient services will be a percentage of usual and customary charges. The percentage shall be the provider's outpatient cost-to-charge ratio determined by the facility's Montana contracted intermediary or by the Department under Medicare reimbursement principles, based upon the provider's most recent Medicaid cost report. If a provider fails or refuses to submit the financial information, including the Medicare cost report which is necessary to determine the outpatient cost-to-charge ratio, the provider's interim rate will be 50% of its usual and customary charges.

Critical Access Hospitals are paid on the interim on a hospital specific cost-to-charge ratio which cannot exceed 100%. By rule, CAHs are cost settled to 101% of cost. To accomplish the cost settlement the Department prepares a cost settlement summary showing the claims paid to the CAH during the hospital's fiscal year. The cost settlement summary contains a summary of the claims paid by revenue code and a summary of all interim payments paid to the hospital during the hospital's fiscal year. The Department obtains a copy of the Medicare cost report and enters the Medicaid paid claims data into this report to obtain the Medicaid cost for each CAH. The cost settlement calculates the appropriate reimbursement for the CAH and determines if an overpayment or underpayment has been made makes an additional payment or recovers fund from the hospital.

3.3.3.2 Prospective Payment Hospitals

Prospective Payment Hospitals are paid by APR-DRG for inpatient claims and OPPS for outpatient claims and the reimbursements are determined to be payment in full. Therefore, no cost settlement is made for Prospective Payment Hospitals.

Facilities designated as Prospective Payment Hospitals are reimbursed using APR-DRG. In most cases, payment equals the relative weight for the APR-DRG times the base price plus any applicable factors such as cost outliers or Disproportionate Share Hospital payments. This method is similar to Medicare payment policies. When details of the payment method differ between Medicare and Medicaid, then Medicaid policy prevails. After the client is discharged or transferred hospitals must submit a claim to Montana Medicaid. The hospital will be reimbursed a per-stay rate based on the APR-DRGs. Variables such as principal and additional diagnosis and principal and secondary procedures are submitted on the claim which then passes through the Medicaid grouper to determine the appropriate APR-DRG for each discharge.

3.3.3.3 Rural Health Clinics

All Rural Health Clinic services will be reimbursed on a prospective payment system beginning with fiscal year 2001 with respect to services furnished on or after January 1, 2001 and each succeeding fiscal year. The prospective payment system will apply equally to provider-based and independent (free-standing) RHCs. The payment limit for RHC services will be as described in Section 1905(a)(2)(C) 42 U.S.C. 1396a. For services furnished on or after January 1, 2001,

payment for services for a RHC shall be calculated on a per visit basis. This payment shall be equal to 100 percent of the average of the costs of the center or clinic of furnishing such services during the clinic's fiscal years 1999 and 2000 which are reasonable and related to the cost of furnishing such services. Reasonableness shall be determined as the Secretary prescribes in regulations under section 1 833(a)(3), or, in the case of services to which such regulations do not apply, the same methodology used under section 1 833(a)(3) of the Social Security Act, adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during fiscal year 2001.

The RHC shall report any increase or decrease in the scope of services by filing a cost report for the center's fiscal year 2001 and subsequent fiscal years within 150 days after the close of the provider's reporting period. The per visit payment rate shall include the costs of other ambulatory services. Allowable RHC costs for other ambulatory services shall be determined in accordance with Medicare reasonable cost principles as set forth in 42 CFR Part 413 and Medicare RHC allowable cost principles set forth in 42 CFR 405.2468, and HCFA manual provisions applicable to rural health clinics, including the Medicare provider reimbursement manual, HCFA Pub.15 and HCFA Pub.27.

3.3.3.4 Federally Qualified Health Centers

FQHCs will be reimbursed on a prospective payment system (all-inclusive rate per visit) as identified on the charge file within ACS. The rate for the preceding year must be adjusted by the percentage increase in the Medicare Economic Index (MEI) applicable to primary care services for that calendar year. FQHCs can be reimbursed for multiple visits on the same day providing they are with a different health professional or due to a different diagnosis. Newly funded FQHC's rates will be established by those facilities already established with similar geographical area/patient mix or by cost reports.

3.3.3.5 Ambulatory Surgical Centers

Ambulatory surgical centers cover surgical and ancillary services (including services for which the payment is packaged) require payment rates as defined under the Medicare Outpatient Prospective Payment System. CMS issues quarterly updates and retroactive mass adjustments that need to be done on a quarterly basis. Some services are separately billable according to the applicable Medicaid rules that pertain to multiple procedures that are performed at the same time on the same patient.

3.3.3.6 Dialysis Clinics

Dialysis Clinics Section 153(b) of the Medicare Improvements for Patients and Providers Act (MIPPA) requires implementation of an End Stage Renal Disease (ESRD) bundled Prospective Payment System (PPS) effective January 1, 2011. The ESRD PPS will replace the current basic case-mix adjusted composite payment system and the methodologies for the reimbursement of separately billable outpatient ESRD related items and services.

3.3.3.7 Indian Health Service

Payments to federally-recognized Indian health facilities that are either tribally-operated or operated by the Indian Health Service shall be made according to the following categories of services:

3.3.3.7.1 Outpatient hospital and clinic categories of service: Payment to IHS facilities under these categories of service shall be a per visit/encounter and based upon the approved rate published each year in the Federal Register by the U.S. Department of Health and Human Services' Indian Health Service, under authority of Sections 321(a) and 322(b) of the Public Health Service Act (42 U.S.C. 248 and 249(b)), Public Law 83-568 (42 U.S.C. 2001 (a)), and the Indian Health Care Improvement Act (25 U.S.C. 1601 seq). The Department shall accept submission of and make payment for multiple

visit/encounter claims for different types of service provided to a client on the same date of service by the Indian health facility only if the services provide are different or are for different diagnoses.

3.3.3.7.2 Payments to Indian health facilities for inpatient hospital services shall be reimbursed per date of inpatient stay and based upon the approval rates published each year in the Federal Register.

3.3.3.7.3 Reimbursement for drugs at IHS facilities shall follow the department methodology under the Outpatient Drug Services State Plan.

3.3.3.8 Hospital Upper Payment Limit

Federal regulations require that on the aggregate all payments to hospitals in the state must not exceed the hospital upper payment limit. For the State of Montana, the hospital upper payment limit has been acknowledged as 100% of cost. The Department prepares a cost settlement summary containing a summary of the claims paid by revenue code and a summary of all interim payments paid to the hospital during the hospital's fiscal year. The Department obtains a copy of the Medicare cost report and enters the Medicaid paid claims data into this report to obtain the Medicaid cost for each hospital in the state. To determine the upper payment limit the Department calculates 100% of cost for each Critical Access Hospital and prospective payment hospital during the hospital's fiscal year. The Department then summarizes the costs of all hospitals in the state and certifies that the aggregate reimbursements for all hospitals do not exceed 100%.

3.3.3.9 Hospital Disproportionate Share Payments

Hospitals that provide inpatient and outpatient services to a disproportionate share of Medicaid recipients can receive additional payments as either Routine or Supplemental Disproportionate Share Hospital (DSH) payments. Routine DSH payments are paid on a per discharge basis as an add-on to the claim and supplemental DSH payments are paid on an inpatient day basis as part of the Hospital Utilization Fee distribution. To determine which hospitals are eligible to receive DSH payments we calculate the Medicaid Inpatient Utilization Rate (MIUR) and Low Income Utilization Rate (LIUR) using paid claims data. The MIUR is a comparison of total Medicaid days compared to total inpatient days for the hospital and the LIUR is a comparison of the Medicaid revenue to total hospital revenue for the hospital. The total days are acquired for the hospital cost report and the Medicaid days are acquired for the cost settlement summary reports. When the MIUR or the LIUR exceed the specific thresholds the hospital is eligible to receive Routine DSH payments or Supplemental DSH payments or both. The data from paid claims data is used to determine the discharges and inpatient days used to calculated the amount the DSH payments.

3.3.3.10 Hospital Utilization Fee

The legislature established the Hospital Utilization Fee (HUF) payments in the 2005 legislature. The HUF is based on a hospital inpatient fee assessed on all inpatient days of each hospital which is used as the state match for the HUF and this amount matched with Federal Funds based on the Federal FMAP percentage. The HUF payments include payments for Supplemental DSH and Hospital Reimbursement Adjustors (HRA1 and HRA2) and a payment to psychiatric residential treatment facilities (PRTFs) which are attached to a psychiatric hospital. The distributions are based on claims data for the calendar year ending on the year prior to the date that the distribution is made. This distribution is made upon the formulas contained in the legislation. The payments from all sources of reimbursement must not exceed the cost of the hospital services provided to Medicaid patients.

3.3.3.11 All Patient Refined-Diagnosis Related Groups For each APR-DRG, a relative weight factor is assigned. The relative weight is applied to determine the APR-DRG base payment that

will be paid for each admittance through discharge stay. APR-DRG weights are reviewed/updated periodically and are adapted from national databases of millions of inpatient stays and then re-centered so the average Montana Medicaid stay in a base year has a weight of 1.00. Specific APR-DRGs need adjustments to relative weights to meet Medicaid's policy on access to quality care and a policy adjustor may be applied to increase or decrease those weights.

3.3.3.12 Ambulatory Payment Classification System

The Ambulatory Payment Classification (APC) system used to reimburse outpatient services are based on CPT and HCPCS procedure codes. Most procedure codes are assigned to a specific APC. Each APC is assigned a relative weight that reflects the resources required for that particular group of procedures. APC assignments and weights are reviewed several times a year. Some exceptions to the APC reimbursement methodology include: laboratory services, therapy services, partial hospitalization, dental, immunizations, screening mammography, blood draws and non-emergent visits to the ER.

3.3.4 Covered Services and Billing

3.3.4.1 FQHC providers that are Medicaid-enrolled provide the services defined in ARM 37.86.4401 (Appendix....).

3.3.4.2 RHC providers that perform services in a hospital setting must bill the service on a CMS-1500 form using their own provider number. RHC providers who perform inpatient surgeries or deliveries must unbundle the service and bill for the surgery (using modifier 54) or delivery only (procedure codes 59409 and 59514) on a CMS-1500 using their own provider number.

Pre- and post-visits at the clinic are billed by the clinic on a UB-04 as a core service.

3.3.4.3 Inpatient hospital services are provided to Medicaid clients who are formally admitted as an inpatient and whose expected hospital stay is greater than 24 hours. Inpatient services must be ordered by a licensed physician or dentist and provided in an institution maintained primarily for treatment and care of patients with disorders other than tuberculosis or mental diseases. The institution must be currently licensed by the designated state licensing authority in the state where the institution is located, must meet the requirements for participation in Medicare as a hospital, and must have in effect a utilization review plan that meets the requirements of 42 CFR 482.30, or provide inpatient psychiatric hospital services for individuals under age 21 according to ARM 37.88.1101 – 1119 (Appendix....).

3.3.4.4 Outpatient hospital services are provided to clients whose expected hospital stay is less than 24 hours. Outpatient services include preventive, diagnostic, therapeutic, rehabilitative and palliative care provided by (or under the direction of) a physician, dentist or other practitioner as permitted by federal law. Hospitals must meet all of the following criteria:

3.3.4.4.1 Licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located.

3.3.4.4.2 Meet the requirements for participation in Medicare as a hospital.

3.3.4.5 Montana Medicaid covers services as outlined in the fee schedules that are posted on the Montana Medicaid website located at www.mtmedicaid.org under "Resources by Provider Type", then "Select Your Provider Type". These fee schedules are updated regularly and posted by date and type of reimbursement.

3.3.4.6 Ambulatory surgical centers services are identified and defined in ARM 37.86.1402 (Appendix....).

3.3.4.7 The Montana Medicaid program covers services provided at dialysis clinics as defined by Medicare/CMS.

3.3.4.8 Montana Medicaid covers services provided under the IHS program as defined in the ARM and as outlined in the Federal Register.

3.3.4.9 Utilization review services using Medicare and/or Montana Medicaid established criteria including the following:

3.3.4.9.1 Pre-admit medical necessity or covered service reviews

3.3.4.9.2 Concurrent medical necessity reviews

3.3.4.9.3 Retrospective reviews

3.3.4.9.4 Consulting services

3.3.4.9.5 Research services as requested by the Department such as:

3.3.4.9.5.1 Educational/outreach services

3.3.4.9.5.2 Long-term placement

3.3.4.9.5.3 Conduct fair hearings for private duty nursing, durable medical equipment, hospitals, and physician program denials.

3.3.4.10 Complete administrative reviews as requested by Montana Medicaid-enrolled providers on claims that have been denied for any reason.

3.3.5 Populations served. The populations served are all individuals enrolled in Montana Medicaid that are eligible for services delivered by the providers listed in 3.3.2.

3.3.6 Additional information requested specific to these provider types. In relation to the provider types listed in section 3.2.2, please provide detailed responses to the following:

3.3.6.1 Describe the offeror's plan to address Montana's rural nature in terms of providing services to our residents.

3.3.6.2 Describe the offeror's plan to collect and report the necessary claims information to the State for use in determining eligibility for DSH payments.

3.3.6.3 Describe the offeror's plan to cost settle the hospitals and to determine the hospital specific cost to be used in determining the hospital upper payment limit.

3.3.6.4 Describe the offeror's plan to collect and report the necessary claims information to the State for use in calculation of the Hospital Utilization Fee.

3.4 MEDICAID UTILIZATION REVIEW

3.4.1 Program Purpose. This RFP is intended to address the Department of Public Health and Human Service's (DPHHS) need for selected utilization review (UR) services in accordance with the Administrative Rules of Montana and other related policies and procedures. The Administrative Rules of Montana can be accessed at http://www.dphhs.mt.gov under "Legal Section"; Medicaid manuals can be accessed at www.mtmedicaid.org under: "Resources by Provider Type" and then "Hospitals". The Department has a long history of UR activity related to hospital services. Currently, The Department contracts with an in-state peer review organization to conduct UR services. The current contract for utilization services expires June 30, 2011.

3.4.2 Program Goals. The primary goals of this RFP are to obtain the most cost effective UR program possible by targeting specific services, ensuring easy accessibility to the contractor by providers and the Department and prompt, medically appropriate decisions by the contractor. To control utilization, one of the goals for prior authorization review is to determine if the services can be performed in-state. The Department also utilizes the prior authorization policy to review coverage of services, such as transplants and experimental or investigational services.

3.4.3 Components and Services. Components involved in UR Services using Medicare- and/or Department-established criteria include the following:

3.4.3.1 Pre-Admit Medical Necessity or Covered Service Reviews

3.4.3.1.1 Out-of-state inpatient

3.4.3.1.2 Out-of-state inpatient rehabilitation

3.4.3.1.3 Transplants

3.4.3.1.4 New devices/procedures/services

3.4.3.1.5 Private duty nursing (school and home)

3.4.3.1.6 Durable medical equipment prior authorization using Medicare- and Department-established criteria

3.4.3.1.7 Physician prior authorization services using Medicare- and Department-established criteria

3.4.3.1.8 Case management for complex, potentially high-cost cases as identified by the Department or through the utilization review process:

3.4.3.1.8.1 Case management consists of monitoring the patient/client over the entire course of their hospital stay and to communicate with the Department's hospital case manager at least twice a month or more frequently as needed or requested.

3.4.3.1.8.2 Case management cases are selected by the Department at times and/or as brought to the attention by the Department's designated QIO/PRO utilization review nurse.

3.4.3.1.8.3 Pre-admission, continued stay, and discharge planning through the hospital, as well as episodes of care, are the main activities of case management.

3.4.3.1.8.4 Working with clients directly happens occasionally and is usually prior to hospital admissions when the client requires assistance with coordinating their care appointments.

3.4.3.1.9 Other procedures/diagnoses that require prior authorization

3.4.3.2 Concurrent Medical Necessity Reviews

3.4.3.2.1 Continued stay reviews for in-state admissions are required under certain circumstances, such as for services that are not, or may not be, covered by Montana Medicaid such as investigational or experimental, cosmetic, and new devices, procedures and services or have some specific medical criteria that need to be met.

DRAFT

High-cost, high-risk cases such as neonatal intensive care unit (NICU), pediatric intensive care unit (PICU), catastrophic illness or injury, and long lengths of stay are examples of some triggers utilized by the Department to identify in-state admissions for concurrent review, as no prior authorization is required. These types of hospital admissions may also warrant case management activities as noted above in Section 3.3.3 under "1. Pre-Admit...". Since all out-of-state admissions require prior authorization, the need for continued stay reviews are easily identified by the Department.

3.4.3.2.2 Out-of-state and in-state inpatient continued stay involving interim claims:
3.4.3.2.2.1 Interim billing is allowed for any stays equal to or greater than 30 days. A set amount will be paid for each inpatient day with the final adjusted claim paid by APR-DRG.
3.4.3.2.2.2 Prior authorization, from the contractor, is required on each interim claim.
3.4.3.2.2.3 Clinical information will be reviewed retrospectively prior to the issuing of the prior authorization span for each interim claim.
3.4.3.2.3 Out-of-state inpatient rehabilitation continued stay
3.4.3.2.4 Transplants continued stay
3.4.3.2.5 Private duty nursing (school and home)
3.4.3.2.6 Durable medical equipment prior authorization using Medicare and Department-established criteria

3.4.3.3 Retrospective Reviews

3.4.3.3.1 Out-of-state and in-state inpatient continued stay including interim claims
3.4.3.3.2 Out-of-state inpatient rehabilitation continued stay
3.4.3.3.3 Transplants continued stay
3.4.3.3.4 Private duty nursing (school and home)
3.4.3.3.5 Durable medical equipment prior authorization using Medicare and Department-established criteria

3.4.3.4 Retrospective Reviews

3.4.3.4.1 All Patient Refined Diagnosis Related Groups (APR-DRG) Coding
3.4.3.4.2 Readmits
3.4.3.4.3 Random sampling of certain APR-DRGs to be chosen by the Department by the beginning of each quarter
3.4.3.4.4 New technologies/services
3.4.3.4.5 Special requests – medical necessity reviews, new technologies/services
3.4.3.4.6 DRG payment exceeds charges/coding research
3.4.3.4.7 Transfers

3.4.3.5 Consulting Services

3.4.3.5.1 Physicians
3.4.3.5.2 Registered nurses
3.4.3.5.3 Other PEERS (therapists, physiatrists, psychiatrists, etc.)

DRAFT

3.4.3.5.4 Coding specialists such as Certified Coding Specialist (CCS), Registered Health Information Administrator (RHIA) and Certified Professional in Healthcare Quality (CPHQ)

3.4.3.6 Research Services as Requested by The Department

3.4.3.6.1 Criteria for medical and surgical procedures that do not have Medicare policy available or that Medicaid differs from Medicare policy such as:

- 3.4.3.6.1.1 Circumcision
- 3.4.3.6.1.2 Gastric bypass surgery
- 3.4.3.6.1.3 Cosmetic surgeries
- 3.4.3.6.1.4 Sensors from capillary blood glucose (CBG) monitors
- 3.4.3.6.1.5 Clinical studies
- 3.4.3.6.1.6 Umbilical cord stem cell transplant
- 3.4.3.6.1.7 Breathing pacemaker
- 3.4.3.6.1.8 Bone growth stimulators

3.4.3.7 Educational/Outreach Services

3.4.3.7.1 Educate physicians to refer to in-state facilities.

3.4.3.7.2 Provide telephonic, videoconference, and WebEx education on the prior authorization process and requirements to out-of-state and in-state hospitals.

3.4.3.8 Long-Term Placement

3.4.3.8.1 Assist hospitals, Senior and Long-Term Care Divisions (SLTC) and Child and Family Services (CFS) in hospital discharge planning to home, foster care or to another permanent setting for medically fragile patients.

3.4.3.8.2 Private duty nursing

3.4.3.8.3 Durable Medical Equipment

3.4.3.9 Conduct Fair Hearings for Private Duty Nursing, Durable Medical Equipment, Hospitals, and Physician Program Denials

3.4.3.9.1 Gather and present evidence

3.4.3.9.2 Testify

3.4.3.9.3 Administrative reviews for adverse actions for private duty nursing, durable medical equipment, hospitals, and physician programs

3.4.3.10 Review Type Activity Reports

3.4.3.10.1 As determined by the Department

3.4.3.10.2 Reviewed periodically as requested by the Department

3.4.4 Statistical Information. All statistical information provided by the Department in relation to this RFP represents the best and most accurate information available to the Department

DRAFT

at the time of the RFP preparation. The Department, however, disclaims any responsibility for the inaccuracy of such data and should any element of such data later be discovered to be inaccurate, such inaccuracy shall not constitute a basis for contract rejection by any offeror. If any gross inaccuracies are found after contract execution that significantly affect the contract, the Department and the contractor will negotiate appropriate changes.

3.4.5 Background. The Department of Public Health and Human Services (DPHHS) operates the Montana Medicaid program. Montana Medicaid serves approximately 100,000 Montana State residents each month. Programs include:

3.4.5.1 Montana Medicaid Hospital Program

Sixty (60) hospitals located within the State are enrolled in the Montana Medicaid Program, 14 of these hospitals are reimbursed under Medicaid's All Patient Refined Diagnosis Related Groups (APR-DRG) reimbursement system. The remaining 46 hospitals are reimbursed on a cost-based retrospective reimbursement system. In addition, some of the Montana hospitals have a distinct part for an inpatient rehabilitation unit. The Department requires prior authorization and continued stay review for out-of-state rehabilitation units only. There are currently rehabilitation units in five Montana hospitals: Benefis Health Care, Great Falls; Community Medical Center, Missoula; St. Vincent Hospital, Billings; St. Patrick Hospital, Missoula; and Kalispell Regional Hospital, Kalispell, and one in a long-term acute care hospital in Billings. Additional requests are received for admissions to out-of-state rehabilitation units, however, it must be demonstrated that the rehabilitation services are not available in Montana. Montana Medicaid has approximately 424 out-of-state hospital providers (including 42 border hospitals, 11 centers of excellence hospitals & 3 rehabilitation hospitals) enrolled in the Medicaid program. Out-of-state hospitals located within 100 miles of the Montana border are designated as "Border Hospitals" and are reimbursed under Medicaid's APR-DRG reimbursement system. A Center of Excellence is an out-of-state or border acute care medical hospital as defined in ARM 37.86.2901. Prior authorization is required for all out-of-state inpatient hospital admissions and out-of-state inpatient rehabilitation admissions.

3.4.5.2 Montana Durable Medical Equipment (DME) Program

Approximately 637 DME providers were enrolled in the Montana Medicaid program in SFY 2009. DME covered services apply specifically to services and supplies provided by durable medical equipment, prosthetic, orthotic and medical supply (DMEPOS) providers. DME includes enteral and parenteral formula, prosthetics, orthotics, supplies, and equipment, such as oxygen, wheelchairs, test strips, diapers, braces, diabetic shoes, etc. Montana follows the Medicare criteria, limits, local coverage determinations for adults, and national coverage determinations for those items covered by Medicare. Services and equipment not covered by Medicare such as diapers, pulse oximeters and miscellaneous supplies are reimbursed if the client has full Medicaid, and meets medically necessary and other coverage criteria. Some non-covered Medicare items are only covered for children under the EPSDT rule. If Medicare does not pay for services and equipment because of the lack of medical necessity, Medicaid does not pay. Prior authorization is required for certain items and any item that will reimburse over $1,000.

3.4.5.3 Montana Private Duty Nursing (PDN) Program

Eleven (11) PDN providers were enrolled in the Montana Medicaid program in SFY 2009. Private duty nursing services are provided by a registered or licensed practical nurse to non-institutionalized children, up to and including age 20, requiring complex care for conditions of such medical severity or complexity that skilled nursing care is required. Respite care is NOT a benefit of private duty nursing or home infusion therapy. Prior authorization is required and must be accompanied by a practitioner's prescription.

3.4.5.4 Montana Medicaid Physician Program

Approximately 10,000 physicians and mid-level practitioners in Montana and other states are enrolled in the Montana Medicaid program. Reimbursement is via the Resource-Based Relative Value Scale (RBRVS) fee-for-service-based system. Prior authorization is required for some services. The current fee schedule will disclose if a procedure requires prior authorization.

3.4.6 Agencies, Contractors, and Others Involved in Utilization Review Services

3.4.6.1 Agencies

Medicaid services are administered through different divisions of DPHHS (Organizational Chart can be found at: http://www.dphhs.mt.gov/about_us/organizational_charts/phhs_bureau_organizational_chart.pdf). Hospital-related services received in out-of-state and in-state inpatient and outpatient facilities and rehabilitation units are administered by the Hospital and Clinic Services Bureau of the Health Resources Division (HRD). The contractor is expected to coordinate prior authorizations and research services with the hospital, durable medical equipment, private duty nursing, and physician/mid-level program officers.

3.4.6.2 Contractors

DPHHS has contracts with many business associates. The contractor will be required to coordinate and interact with these associates to meet the goals of the program. The contractor must assure a seamless operation with these associates to meet the goals of the program. The contractor must assure a seamless operation with these associates and their systems.

3.4.6.2.1 Affiliated Computer Services (ACS) is our current fiscal agent, operates our Medicaid Management Information System (MMIS), provides provider relations services, and adjudicates claims. ACS is the enrollment broker for the managed care Passport to Health and Team Care programs and operates the Medicaid Help Line for clients. The Department's predictive modeling program is also administered by ACS (effective 6/1/09).

3.4.6.2.2 Northrup Grumman operates the eligibility system for many DPHHS programs including Medicaid.

3.4.6.2.3 Mountain-Pacific Quality Health is a professional review organization (PRO) that performs transportation authorization, drug utilization review, long-term care case management, etc.

DRAFT

3.4.6.2.4 Magellan Health Services is a behavioral health care management organization (HCO) that performs adult mental health prior authorization and utilization review services.

3.4.6.2.5 Nurse Response operates Medicaid's 24/7 nurse advice line.

3.4.6.2.6 Community Health Centers (CHCs) furnish health improvement and disease prevention management services to Medicaid clients.

3.4.6.3 Medical Community

For the success of UR Services it is imperative that the contractor work closely with the medical community in Montana and with out-of-state facilities enrolled in the Montana Medicaid program as providers. This will include engaging appropriate support and participation from the medical community, any other case management programs run by DPHHS, or with already existing outreach and education to the provider community.

3.4.7 Challenges Posed by Montana's Rural Nature

3.4.7.1 Size and Population

Montana's rural nature adds a level of complexity in providing health care services to our residents. Montana is the fourth largest state in the United States at 147,042 square miles. All of Pennsylvania, West Virginia, Maryland, Delaware, Virginia, and New Jersey would fit into Montana with about 10,000 Montana square miles remaining. The 2009 census population in these states is 37,599,573 compared to Montana's 974,989. Fifty (50) counties out of 56 counties total, have populations of fewer than 50,000 residents and 45 counties out of 56 are classified as frontier counties, which average six or fewer persons per square mile. Delaware, by contrast, has 410 persons per square mile.

3.4.7.2 Transportation

Many services that other states consider basic, such as mass transportation, are not available. Both inter- and intra-city bus services is very limited, and in fact, non-existent in most of the state. Montanans rely on friends, neighbors and relatives for much of their necessary transportation. It is not unusual for providers in Montana to serve several counties in one week and some travel by private aircraft to offer health care services to the most remote areas of the state.

3.4.7.3 Distances

Distances between services in Montana are sometimes extreme. It is not uncommon for someone to travel in excess of 100 miles to the nearest provider. With this in mind, the determination of how quickly someone must leave home to seek services must be adjusted. In our larger communities emergency help may be only 15 minutes away. However, in some of

DRAFT

the remote parts of Montana someone may need to be directed to seek services earlier in order to have the time to travel 100 miles.

3.4.7.4 Weather

Montana also has extreme weather conditions. During the winter months (which can be from October through March) travel to medical care is often delayed or impeded. Severe spring storms are not uncommon and can result in impassable roads even during those months.

3.4.7.5 Approaches to Utilization

These issues require unique and innovative approaches to UR services. Offerors are expected to address the management of these issues when responding to this RFP.

3.4.8 Objectives of Utilization Review Services

3.4.8.1 Utilization Review Services

This RFP is intended to address the Department's need for selected UR services for HRD in accordance with the Administrative Rules of Montana and other related policies and procedures. The scope of work envisioned by the Department in this RFP includes all express or implied functions, and activities and tasks necessary to provide the Department with a UR system tailored to the specific needs of the Medicaid program. It is essential for the contractor to be flexible and willing to deal with the Department in unforeseen and spontaneous needs that may arise during the life of the contract.

3.4.8.2 Out-of -state Inpatient Hospital Admissions

Prior authorization and continued stay reviews are required of all out-of-state inpatient hospital admissions, excluding "Border Hospitals". It is the intent of the Montana Medicaid program to require Medicaid recipients to utilize services available within the State of Montana when it is medically appropriate.

3.4.8.3 In-State and Out-of-State Inpatient Hospital Rehabilitation Admissions

Prior authorization and continued stay reviews are required of all out-of-state rehabilitation hospital admissions. In-state rehabilitation hospital admissions do not require prior authorization or continued stay reviews.

3.4.8.4 Transplant Services

Prior authorization certification and continued stay reviews are required of all organ and tissue transplant services covered by the Montana Medicaid Program. Medically necessary transplants are covered per Medicare guidelines and must be performed at Centers for Medicare and Medicaid (CMS) certified transplant program per organ type. Prior authorization is required for all organ and tissue transplants except corneal transplants.

3.4.8.5 New Devices/Procedures/Services

DRAFT

The Department also utilizes the prior authorization policy to review coverage of new devices or procedures or services. The Montana Medicaid Program does not cover medical services that are considered to be experimental or investigational in nature.

3.4.8.6 Private Duty Nursing

Prior authorization and continued stay reviews are required for the Private Duty Nursing (PDN) program of Montana Medicaid. Private duty nursing services are provided by a registered or licensed practical nurse to non-institutionalized children under age 21 requiring complex care for conditions of such medical severity or complexity that skilled nursing care is necessary. Respite, for the caregivers or services to allow a client's family or caregiver to go to work or school, is not a benefit of the Private Duty Nursing program. These services may be provided in a school or home setting. PDN services are provided by a licensed RN or LPN.

3.4.8.7 Retrospective Reviews

Retrospective reviews are performed of selected in-state and out-of-state services identified by the Department or the contractor. Such retrospective reviews may include: APR-DRG cases, readmits, one day stays, and transfers.

3.4.8.8 Consulting and Research Services

The Department may request medical consulting support and criteria development services. The scope of the work required by the Department with respect to such services shall include, but not be limited to, the review of specific cases referred to the for a determination of medical necessity of the services or for such specific determinations as "cosmetic", "experimental", or "investigational". Medical necessity must be determined in accordance with the Administrative Rules of Montana and other Medicaid policies and procedures. Medical consultants may be required to testify at department or district court hearings.

In addition, the contractor must provide coding reviews performed by a consultant certified as a CCS and RHIA, CCS and RHIT, or RHIA. Coding reviews will involve review of inpatient, outpatient and professional claims. The coder should have experience in APR-DRG, APC, and clinical coding.

3.4.8.9 Educational and Outreach Services

Medicaid costs can be controlled through prior authorization and retrospective review of admissions and education to providers. This education can consist of informing providers of health care services available in-state or comparing providers and their health care utilization in an effort to change their practice patterns. The contractor will be required to educate physicians and hospitals about prior authorization requirements. This should include an ongoing plan throughout the contract of the methods and mediums necessary to maintain public knowledge of this requirement. The contractor will be required to research and maintain a list of available services in-state, such as neonatology, pediatric oncology, orthopedics, urology, cardiology and other sub-specialty areas, etc.

3.4.8.10 Long-Term Placement

DRAFT

Assist hospitals and Child and Family Services in discharge planning to home, foster home, inpatient rehabilitation, or to another permanent setting for medically fragile patients that are no longer in need of acute care services. The contractor will be required to research and maintain a list of residences for vent-dependent patients.

3.4.8.11 Additional Functions

The contractor will participate in federal reviews and information requests as needed. This will include, but is not limited to, preparing materials, responding to findings, and participating in interviews. The contractor shall be required to assist the Department with other activities necessary to expansion and enhancement of utilization review, including, but not limited to, data development, data collection, input and advice on drafting of state plan modifications, federal waivers and administrative rules; client and provider manuals, newsletters, training and educational materials, and forms development.

3.4.9 Historical Utilization Review Data

3.4.9.1 Current Utilization Review History and Estimates of Future Case Load

The following is a list of the number of annual case reviews for state fiscal years (SFY) 2008, 2009, and 2010. State fiscal years are from July 1 through June 30. In some cases the Department is estimating utilization due to a recent or planned change in procedure or criteria or an anticipation of increase in caseload.

3.4.9.1.1 Pre-Admit and Continued Stay Medical Necessity or Covered Service Reviews

- 3.4.9.1.1.1 Out-of-state inpatient, SFY 2010 – 1004 reviews
- 3.4.9.1.1.2 Out-of-state inpatient rehabilitation, SFY2010 -- 20 reviews
- 3.4.9.1.1.3 Transplants, SFY2010 -- 89 reviews
- 3.4.9.1.1.4 Private duty nursing (school and home), SFY 2010 -- 180 reviews
- 3.4.9.1.1.5 Durable medical equipment, SFY 2010 -- 824 reviews
- 3.4.9.1.1.6 Medical/surgical procedures, SFY 2010 – 281 reviews
- 3.4.9.1.1.7 Hospital case management, SFY – 153 hours

3.4.9.1.2 Retrospective Reviews

- 3.4.9.1.2.1 DRG Coding , SFY 2010 -- 24 reviews
- 3.4.9.1.2.2 CPT Coding, SFY 2010 -- 39 reviews
- 3.4.9.1.2.3 Readmits, SFY 2010 -- 17 reviews
- 3.4.9.1.2.4 Special Requests (outliers, neonates), SFY 2010 -- 4 reviews

3.4.9.1.3 Consulting Services

- 3.4.9.1.3.1 PEERS, SFY 2010 -- 20 hours

DRAFT

3.4.9.1.4 Other

3.4.9.1.4.1 Appeals/administrative reviews, SFY 2010 – 14

3.4.9.1.4.2 DME/medical-surgical fair hearings, SFY 2010 – 3

3.4.10 Contractor Requirements

3.4.10.1 General Requirements

The contractor will be expected to begin work on _____ and will be required to maintain an office in Helena, Montana. The office will be staffed with, at a minimum, one registered nurse experienced in prior authorization and continued stay reviews. The contractor must provide for a backup registered nurse during sick or vacation days. If the contractor does not presently maintain an office in Helena, Montana, the Department is requesting the contractor to make every effort to establish the office by _____. The contractor must have an office established in Helena by _____ or the contract may be cancelled.

3.4.10.2 Communications

The contractor will be required to maintain, at a minimum, one toll-free telephone line, which will be dedicated to Montana Medicaid and accessible to providers. The contractor should be prepared to add an additional line if providers experience difficulty in obtaining access to the first line. The contractor will be required to provide 24-hour back-up services, i.e., an answering machine or voice mail, when the office is not open (evenings, weekends, and holidays). Calls received on the answering machine or voice mail must be returned within the next working day. All provider inquiries must receive a response within 48 hours of the initial call informing the provider of the status of the review. All notices and written communications to clients and providers must be on the contractor's letterhead or must clearly identify the contractor as the organization transmitting the communication. Physicians who request to speak with a physician advisor regarding a specific case must be given the opportunity to do so.

The contractor must be able to track all calls and assign an RN reviewer to each case to ensure that subsequent phone calls regarding the same case are routed to the appropriate RN reviewer. The contractor must ensure that a knowledgeable backup RN reviewer will also be assigned to each case in the event a provider cannot speak with the primary RN reviewer. The backup RN reviewer must be knowledgeable regarding the current status of the case and action that may need to be taken by the provider or the contractor.

A phone log must be maintained to track all calls including date, time, name of caller, facility, nature of call and disposition of call.

3.4.10.2 Utilization Review Standards

For the purposes of this RFP, the Department requires the contractor meet National Utilization Review Standards and complies with UR requirements as set forth in Title 33, Chapter 32, Parts I and 2, Montana Codes Annotated. Utilization criteria must incorporate the applicable

DRAFT

Department rules contained in ARMs 37.86.2801 – 204, 37.86.2918-2921 and 37.86.2947 Hospital; ARM 37.86.2217 PDN; ARM 37.86.1801-1807 DME; ARM 37.86.104 Physician; 37.86.201 Mid-level; 37.86.505 Podiatry; and 37.86.2201-2206 EPSDT; ARM 37.85.206-207 Medicaid Covered and Not Covered Services, 37.85.406 Billing and Claims; 37.86.410 Medical Necessity; and 37.86.411 Provider Rights; ARM 37.5.304, 37.5.305, 37.5.307, 37.5.310, 37.5.311, 37.5.13, 37.5.316, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.332,37.5.337; Administrative Reviews and Fair Hearings and all requirements of 42 CFR parts 475, 476, 478, and 480, 37.86.201 and 37.85.410 and MCA Chapters 32, 33-32-101, 33-32-102, 33-32-103, 33-32-104, 33-32-105, and 33-32-201.

3.4.10.3 Transportation Coordination

The contractor will be required to coordinate and cooperate with the transportation contractor. The transportation contractor often receives requests for out-of-state travel for inpatient or outpatient hospital services. The Department expects the UR contractor to review cases as requested to determine the medical necessity of the services and whether or not the service could be provided in-state.

3.4.10.4 Service Coverage Criteria

When determining whether Medicaid will pay for a specific service, the contractor will be required to utilize criteria set forth in the Administrative Rules of Montana and other policies and procedures for the Medicaid program.

Prior authorization review is required for all out-of-state inpatient hospital services wherein Medicare or another payer organization is the primary payer and for in-state inpatient hospitalizations for services that require prior authorizations as set forth in the Administrative Rules of Montana and other policies and procedures for the Medicaid program.

3.4.10.5 Interface with Fiscal Intermediary

The contractor will be required to electronically submit prior authorization and continued stay review information to the Department's fiscal intermediary on at least a daily business-day basis. Data currently must be submitted using a secured FTP to the FTP Move IT server of the Department's fiscal agent. Alternate submission methods or media must be approved by the Department. The current data interface file is a standard fixed file length, fixed field length, positional file. This interface does not allow for delimiters and cannot be customized. This interface may be revised or replaced upon implementation of the new Medicaid Management Information System (MMIS) at the end of 2010. The contractor is required to maintain the ability to transmit and receive data utilizing media and methods that conform to the State of Montana Information Technology Standards.

3.4.11 Operational Requirements

3.4.11.1 System Coordination

DRAFT

The contractor shall ensure seamless coordination between other systems (fiscal agent, eligibility agent, enrollment broker, provider's office). All costs for this system coordination will be the contractor's.

3.4.11.2 Automated Tracking System
The contractor shall provide an automated system which tracks clients and keep records of calls for follow-up, auditing and reporting purposes.

3.4.11.3 Collaboration
The contractor shall collaborate with other providers, community resources, business partners, and DPHHS.

3.4.11.4 Protocol/Guideline Review
The contractor shall have any clinical protocols/algorithms or guidelines reviewed and approved at least annually by physicians and the Department.

3.4.11.5 Appropriate Staffing
The contractor shall ensure all tasks are conducted by the appropriate person, for example, all clinical reviews must be conducted by a licensed RN, APRN, PA, MD, or DO. The contractor shall have staff qualified/licensed in the areas of the scope of work.

3.4.11.6 Complaints and Grievances
The contractor shall address complaints and grievances. The contractor shall notify the Department within five business days of the complaint or grievance and shall consult with the Department as to the intended resolution. The contractor will conduct fair hearings requested by providers or clients and presided over by the DPHHS Fair Hearings Officer.

3.4.11.7 HIPAA Compliance
The contractor shall create and maintain (and promptly supply) all records and documentation to support findings, recommendations, and actions.

3.4.11.8 Records and Documentation
The contractor shall create and maintain (and promptly supply) all records and documentation to support findings, recommendations and actions.

3.4.11.9 Daily Operation Policies and Procedures
The contractor shall provide policies and procedures related to the daily operations of the program as requested by DPHHS.

3.4.12 Reporting Requirements

3.4.12.1 Report Format

DRAFT

The format for all reports must be approved by DPHHS and are subject to revision during the contract duration to better meet the needs of DPHHS.

3.4.12.2 Report Frequency
The contractor shall provide reports on a monthly, quarterly and annual basis as negotiated with the Department.

3.4.12.3 Report Costs
The contractor shall be responsible for all costs associated with producing, delivering and disseminating reports.

3.4.12.4 Report Contents
The contractor will be required, during the term of the contract, to prepare a monthly executive summary, which summarizes each area of review activity. The executive summary should include, but is not limited to, information regarding numbers of reviews, who reviewed the cases (RN or Physician Advisor), approvals, denials, appeals and reversals.

The executive summary will include monthly detailed reports for each area of review. The detailed reports should include:

- **3.4.12.4** Pre-certification number
- **3.4.12.4** Client ID number
- **3.4.12.4** Dates reviews were conducted
- **3.4.12.4** Admission dates, including dates authorized and dates denied
- **3.4.12.4** Provider names and ID numbers
- **3.4.12.4** Principal diagnosis
- **3.4.12.4** Physician name

The contractor will also prepare a quarterly report, by review area, to calculate cost savings and/or cost avoidance as a result of the UR activity. This report will summarize the assumptions used to calculate the cost saving or cost avoidance and include quarterly calculations as well as year to date summaries.

Section 3.5 Ancillary Service Requirements

3.5.1 Ambulance. Offeror shall provide an ambulance - air or ground - and emergency medical transportation benefits. Ambulance services will be covered only when a client's medical condition requires immediate attention and when a less expensive means of transportation will endanger the patient's health.

3.5.2 Audiology. Offeror shall provide an audiology benefit. Audiology services are limited to services provided by a licensed audiologist to individuals with hearing disorders. Audiology services will be provided in accordance with 42CFR 440.110.

3.5.3 Chiropractic Services. Offeror shall provide a chiropractic benefit. Payment for chiropractic services may be limited to individuals age 20 and under, and limited to evaluation and management office visits, manual manipulation of the spine and x-rays to support diagnosis of subluxation of the spine.

DRAFT

3.5.5 Dental. Offeror shall provide a comprehensive dental benefit package. The offeror's dental program shall provide preventive and dental restoration services to eligible Medicaid clients and include services provided by dentists, dental hygienists, denturists, orthodontists and oral surgeons. The offeror shall provide dental services including but not limited to:

3.5.5.1 Diagnostic and preventative dental services:

3.5.5.1.1 Fluoride treatments are limited to six-month intervals.

3.5.5.1.2 Full mouth x-rays or panorex x-rays are limited to three-year intervals.

3.5.5.1.3 Bite-wing x-rays are limited to one-year intervals.

3.5.5.1.4 Examinations are limited to six-month intervals.

3.5.5.1.5 Prophylaxis are limited to six-month intervals.

NOTE: As per EPSDT requirements, these limits may be waived for individuals under 21 years old when medical necessity is documented or if a patient is developmentally disabled regardless of age.

3.5.5.2 Restoration:

3.5.5.2.1 Offeror may exclude gold in-lays as a benefit

3.5.5.3 Endodontic Services:

3.5.5.3.1 Offeror may exclude root canal services for third molars as a benefit.

3.5.5.4 Periodontal Services:

3.5.5.4.1 Offeror may limit gingival resections to treatment of gingival hyperplasia due to medication reaction.

3.5.5.5 Crowns:

3.5.5.5.1 For adults, offeror may limit the crown benefit to a minimum of 2 porcelain-used metal crowns annually for second molars, base metal only, but must allow for pre-fabricated stainless steel, or pre-fabricated resin crowns as needed.

3.5.5.5.2 For children under age 21, non pre-fabricated crowns are a benefit for anterior teeth.

3.5.5.6 Orthodontic services shall be limited to no less than:

3.5.5.6.1 Cases involving a possible cleft or craniofacial condition syndrome, congenital anomalies, cases related to malocclusion caused by traumatic injury, and cases related to interceptive orthodontia must receive prior authorization to determine individual eligibility for such orthodontia services.

3.5.5.6.2 Orthodontia for recipients age 20 and younger who have malocclusion caused by traumatic injury or needed as part of treatment with orthodontic implications.

3.5.5.6.3 Recipients are limited to a lifetime cap of $7000.00 for interceptive and full band orthodontia phases. Surgeries are not included in this lifetime cap.

3.5.5.6.4 Interceptive orthodontia is limited to children 12 years of age or younger with one or more of the following conditions:

3.5.5.6.4.1 Posterior crossbite with shift;

3.5.5.6.4.2 Anterior crossbite and/or anterior deep bite at 80% or greater vertical incisor overbite.

3.5.5.7 Offeror may exclude dental implants as a covered benefit.

3.5.5.8 Offeror may exclude bridges as a covered benefit for individuals age 21 and older.

DRAFT

3.5.5.9 Cosmetic Dental Services:
Dental services for conditions or ailments considered cosmetic in nature are not a benefit of the Montana Medicaid program except in such cases where it can be demonstrated the physical well-being and the psycho-social well-being of the recipient are severely affected in a detrimental manner. The offer must follow these criteria and consult with the Department to determine whether a service is cosmetic or a client's physical well-being and psycho-social wellbeing are severely affected in a detrimental manner.

3.5.6 Denture Services

3.5.6.1 Offeror shall replace dentures when one of the following circumstances occur:
3.5.6.1.1 Partial dentures that are at least five years old and full dentures that are at least 10 years old. One lifetime exception to the 10 year or 5 year replacement limit is allowed per client if one of the following exceptions exists and is authorized by the Department:
3.5.6.1.1.1 It is determined that the existing dentures are no longer serviceable and cannot be relined or rebased.
3.5.6.1.1.2 The dentures are lost, stolen or damaged beyond repair.
3.5.6.1.1.3 The existing dentures are causing serious physical health problems.

3.5.6.2 Offeror may cover rebasing for dentures older than five (5) years.

3.5.6.3 Coverage of denture services by a denturist is subject to the following requirements and limitations:
3.5.6.3.1 A denturist may provide initial immediate full prosthesis and initial immediate partial prosthesis only when prescribed by a dentist in writing.

3.5.7 Durable Medical Equipment (DME)
Offeror shall provide a durable medical equipment benefit. DME covered services apply specifically to services and supplies provided by durable medical equipment, prosthetic, orthotic and medical supply (DMEPOS) providers. DME includes enteral and parental formula; prosthetics; orthotics; supplies and equipment such as oxygen, wheelchairs, test strips, diapers, braces, diabetic shoes, etc. Montana follows Medicare criteria, limits, local coverage determinations, and national coverage determinations for those items covered by Medicare for adults.

Offeror shall provide services and equipment not covered by Medicare such as diapers, pulse oximeters and miscellaneous supplies. These shall be reimbursed if the client has full Medicaid and meets medical necessity criteria. If Medicare does not pay for services and equipment because of the lack of medical necessity, Medicaid does not pay.

3.5.8 Hearing Aids
Offeror shall provide a hearing aid benefit. The offeror may limit the benefit for adults to one hearing aid for adults who have a 40-decibel loss or greater in both ears. If an adult is working or going to school and they have a 40-decibel loss and have worn one aid for 6 months, the offeror shall pay for two. The offeror may limit hearing batteries to no less than 8 per month.

Offeror shall provide for children two aids that are paid for, and if they do not meet the 40-decibel loss requirement the requests are sent to a peer. All special aids are sent to a peer and are reimbursed at the

invoice price. All medically necessary hearing aids are approved for children under the Early Periodic Screening Diagnosis and Treatment (EPSDT) program.

3.5.9 Home Infusion Therapy (HIT)

Offeror shall provide a home infusion therapy benefit. Infusion therapy involves the administration of medication through a needle or catheter. It is prescribed when a patient's condition is so severe that it cannot be treated effectively by oral medications.

The offeror shall follow the Medicaid program such that it prohibits coverage of some infusion therapies. Therapies that are not appropriate to be performed in the home and those potential high-risk therapies that would be more appropriately performed in a controlled environment, such as a hospital, are excluded from coverage through the home infusion therapy program. These therapies include but are not limited to: anti-ulcer, aerosol pentamidine, blood products, growth hormones, biotechnology to include human insulin products, subcutaneous injections including but not limited to erythropoietin, growth hormones and filgrastim. Services that can be safely administered by the patient without the use of a home infusion therapy provider are also excluded from coverage.

3.5.10 Nutrition

Offeror shall provide a nutrition benefit. Nutritional screens are a provision under EPSDT. Providers should assess the nutritional status at each Well Child screen. Children with nutritional problems shall be referred to a licensed nutritionist or dietician for further assessment or counseling. Services shall include screening, counseling, assessment, consultation, and education.

3.5.11 Optometric & Eyeglass Programs

3.5.11.1 Offeror shall provide a comprehensive optometric benefit. Eye exams and eyeglasses shall be made available for full Medicaid coverage clients only. The offeror shall limit benefits to no less than an exam once per year (every 365 days) to clients age 21 and under; age 21 and over: an exam every 24 months (every 730 days). Medicaid will pay for an annual eye exam for clients who are diabetic due to medical condition.

3.5.11.2 Exams can be done sooner than 24 months for adults (over age 21) or sooner than 12 months for children if one of the following exists:

3.5.11.2.1 Individual has had cataract surgery

3.5.11.2.2 Client has at least a one line acuity change (on eye chart)

3.5.11.2.3 If no significant change, the client is responsible for the bill for the exam.

3.5.11.3 The eyeglass benefit shall be limited to no less than lens and frames once per year to clients age 20 and under; age 21 and over: lenses and frames every 24 months. Basic Medicaid coverage does not cover glasses for any reason, no matter what the diagnosis is. If client is eligible for the Essential for Employment program, eyeglasses shall be authorized. Client can check with their local Office of Public Assistance to see if they qualify.

3.5.11.4 Contact lenses shall only be covered if glasses will not correct the vision to 20/40 or if the client has aphakia (absence of the lens of eye); keratoconus (protrusion of the center of the cornea), or anisometropia (refractive power of one eye differs from other eye) of 2 diopters or more.

3.5.11.5 The offeror may limit the benefit of replacement of lost or stolen glasses to children (age 20 and under) to replace one set of lost or stolen glasses. The offeror shall cover initial glasses with one replacement if lost or stolen within a year. If a child loses that pair then the

DRAFT

parents are responsible for paying for the additional replacements at the Medicaid contract rate. Replacement for broken frames, because of manufacture defect, shall be covered.

3.5.11.6 The offeror may offer lens add-ons, or special features for eyeglass lenses such as:
3.5.11.6.1 Transition – if medically necessary offeror shall pay for children and not for adults
3.5.11.6.2 Round bifocals – if medically necessary offeror shall pay for children.
3.5.11.6.3 Polycarbonate (hard plastic) – offeror shall pay for both children & adults if client is sighted in one eye only.
3.5.11.4 UV & scratch resistant coating – if medically necessary offeror shall pay for children only
The offeror shall make these features available at the Medicaid contract rate or less if medical necessity has not been established.

3.5.12 Medicaid Pharmacy Program

Offeror shall provide a comprehensive pharmacy benefit which covers pharmaceuticals and pharmacist services to clients.

Offeror shall only pay for drugs considered as Medicaid covered drugs in accordance with 42 USC 1396r-8. Any drug rebates received by the offeror resulting from drug utilization under contract with the Department will be forwarded in its entirety to the Department. Drug utilization data and drug claim-level detail will be forwarded to the Department no later than the tenth calendar day of the month. Drug utilization data will be used by the Department to process drug rebates in accordance with current operation procedures. Drugs covered by the offeror shall be subject to the following limitations:

3.5.12.1 Drugs must be prescribed by a physician or other licensed practitioner who is authorized by law to prescribe drugs and is recognized by the Medicaid program.
3.5.12.2 Maintenance medications may be dispensed in quantities sufficient for a 90-day supply or 100 units, whichever is greater. Other medications may not be dispensed in quantities greater than a 34-day supply except where manufacturer packaging cannot be reduced to a smaller quantity. The Department will post a list of current drug classes which will be considered maintenance medications on the Department's web site at http://medicaidprovider.hhs.mt.gov.
3.5.12.3 Drugs shall not be covered if they:
3.5.12.3.1 Have been classified as "less than effective" by the FDA (DESI drugs).
3.5.12.3.2 Are produced by manufacturers who have not signed a rebate agreement with CMS.
3.5.12.4 Nursing facilities are responsible for providing over-the-counter laxatives, antacids, and aspirin to their residents as these items are included in the facility per diem rate determined by the Department.
3.5.12.5 The offeror shall cover vaccines administered in an outpatient pharmacy setting.
3.5.12.6 The offeror will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.
3.5.12.7 The offeror shall provide coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full-benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit –Part D. The following excluded drugs are covered:
3.15.12.7.1 Agents when used for the symptomatic relief of cough and colds

DRAFT

3.15.12.7.1 Prescription vitamins and mineral products, except prenatal vitamins and fluoride
3.15.12.7.1 Nonprescription drugs
3.15.12.7.1 Barbiturates
3.15.12.7.1 Benzodiazepines
3.15.12.7.1 Smoking cessation for non-dual eligibles, as Part D will cover

3.5.12.8 Product Restrictions
The offeror will follow the Department's drug formulary. The Medicaid program restricts coverage of certain drug products through the operation of an outpatient drug formulary. Criteria used to include/exclude drugs from the formulary is based upon safety, efficacy and clinical outcomes as provided by the product labeling of the drug. Montana's formulary committee meets the formulary requirements that are specified in section 1927(d)(4) of the Social Security Act.

3.5.12.8 Prior Authorization
The offeror may use a prior authorization program to follow the Department's drug formulary. For drugs requiring prior authorization, an automated voice response system is used to meet the requirements for providing a response within 24 hours. Up to a 72-hour supply of medication requiring prior authorization may be dispensed in an emergency.

3.5.12.9 Preferred Drug List
The offeror will follow the Department's Preferred Drug List. Certain designated therapeutic classes will be reviewed periodically to consider which products are clinically appropriate and most cost-effective. Those products within the therapeutic class that are not determined to be clinically superior and/or are not cost-effective will require prior authorization. The Department may maintain a Preferred Drug List containing the names of pharmaceutical drugs for which prior authorization will not be required under the medical assistance program. All other pharmaceutical drugs not on the Preferred Drug List, and determined by the Department to be in the same drug class and used for the treatment of the same medical condition as drug(s) placed on the Preferred Drug List, will require prior authorization.

3.5.12.10 Pharmacy Case Management
The offeror will establish and maintain a pharmacy case management program in order to prevent waste, fraud and abuse. The offeror's pharmacy case management program shall identify and establish controls for high utilizers, polypharmacy, and doctor shopping. A pharmacy lock-in program may be used. The offeror will work in conjunction with the Department's current pharmacy case management program in order to maintain consistency for clients shifting between the fee-for-service and managed care programs.

3.5.13 Private Duty Nursing
The offeror shall provide a private duty nursing benefit. Private duty nursing services are provided by a registered or licensed practical nurse to non-institutionalized children, up to and including age 20, requiring complex care for conditions of such medical severity or complexity that skilled nursing care is necessary. The offeror is not required to cover respite care under as a benefit of private duty nursing.

The offeror may apply following limits apply to private duty nursing services:
3.5.13.1 Private duty nursing services are limited to nursing services provided to a hospital inpatient when the patient requires individual and continuous skilled nursing care beyond that routinely provided by the hospital nursing staff.

3.5.13.2 Private duty nursing service must be furnished under the direction of the recipient's physician (ordered in writing by the patient's physician) and authorized by the Department.
3.5.13.3 Private duty nursing services are limited to services provided by a qualified Registered Nurse (RN) or a qualified Licensed Practical Nurse (LPN).

3.5.14 School Based Services
The offeror shall provide a school-based services benefit. The benefit shall include health-related services provided to children in a school setting that include: therapy services (physical, occupational, and speech language pathology); audiology (hearing); private duty nursing – needs to have a physician order or referral; school psychology & mental health services; personal care; comprehensive school and community treatment (CSCT)-child must have severe emotional disturbance (SED); specialized transportation

3.5.14.1 Client Qualifications

3.5.14.1.1 Be Medicaid eligible on the date of service
3.5.12.1.2 Be between the ages of 3 and 20
3.5.12.1.3 Be entitled to school district services under the Individual with Disabilities Act (IDEA)
3.5.12.1.4 Have Medicaid reimbursable services referenced in his/her Individual Educational Plan (IEP). This shows that Medicaid covered services are recommended by the school district.
3.5.12.1.5 In the case of CSCT services, the student must have an SED diagnosis.

3.5.15 Therapies (Occupational-Speech-Physical)
The offeror shall provide comprehensive therapy benefit package. At a minimum the offeror shall cover at least 40 hours of each type of therapy for adults age 21 and older during a fiscal year. Therapy services for children shall be based on medical necessity.

3.5.15.1 The offeror may apply the following limitations to occupational therapy services:
3.5.15.1.1 Occupational therapy services for individuals 21 years of age and older are limited to a maximum of 40 hours per state fiscal year. Licensed or unlicensed assistants or aids work under the supervision of a state-licensed therapist. The therapist assumes professional responsibility for the patient and uses that clinical information to evaluate and then treat (or not treat) the patient. The therapist is practicing within the state's scope of practice which permits the use of licensed or unlicensed therapy assistants or aids. Montana Medicaid does not require qualifications in addition to the Montana Code Annotated for Business and Occupations.
3.5.15.1.2 Occupational therapy services will be provided in accordance with 42CFR 440.110.

3.5.15.2 The offeror may apply the following limitations apply to physical therapy services:
3.5.15.2.1 Physical therapy services for individuals 21 years of age and older are limited to a maximum of 40 hours per state fiscal year. Licensed or unlicensed assistants, students, or aids work under the supervision of a state-licensed therapist. The therapist assumes professional responsibility for the patient and uses that clinical information to evaluate and then treat (or not treat) the patient. The therapist is practicing within the state's scope of practice which permits the use of licensed or unlicensed therapy assistants or aids. Montana Medicaid does not require qualifications in addition to the Montana Code Annotated for Business and Occupations.

3.5.15.2.2 Physical therapy Services will be provided in accordance with 42CFR 440.110.

3.5.15.3 The offeror may apply the following limitations apply to speech therapy services:

3.5.15.3.1 Speech therapy services for individuals 21 years of age and older are limited to a maximum of 40 hours per state fiscal year. Licensed or unlicensed assistants or aids work under the supervision of a state-licensed therapist. The therapist assumes professional responsibility for the patient and uses that clinical information to evaluate and then treat (or not treat) the patient. The therapist is practicing within the state's scope of practice which permits the use of licensed or unlicensed therapy assistants or aids. Montana Medicaid does not require qualifications in addition to the Montana Code Annotated for Business and Occupations.

3.5.15.3.2 Speech therapy will be provided in accordance with 42CFR 440.110.

3.5.16 Medical Transportation

The offeror shall provide a comprehensive medical transportation benefit package. Travel assistance benefits shall be funds that help Medicaid clients with transportation costs. These funds help clients get to and from medical appointments. When the client meets medical necessity requirements, he or she shall get help with mileage, meals, and lodging. These benefits are for clients who have Full or Basic Medicaid coverage. Offeror will ensure provisions are made for ensuring necessary transportation of recipients to and from providers.

Offeror will ensure that transportation services or reimbursement for transportation is available for recipients who obtain necessary medical care covered by the Medicaid program.

3.5.16.1 Required Available Services

3.5.16.1.1 Personal mileage (privately owned vehicle) and per diem (meals/hotel)

3.5.16.1.2 Commercial transportation services (taxi, bus, airplane)

3.5.16.1.3 Specialized transportation (wheelchair or stretcher van)

3.5.16.1.4 Personal mileage and per diem covered services

3.6 QUALITY ASSURANCE (QA)/ SURVEILLANCE UTILIZATION REVIEW (SUR)

3.6.1 Managed Care and Third Party Liability (TPL)

3.6.1.1 Contractor must agree to take responsibility for identifying and pursuing TPL for all managed care clients.

3.6.1.2 The contractor must make best efforts to identify and coordinate with all third parties against whom members may have a claim for payment or reimbursement for services. These third parties may include Medicare; any other group insurance; trustee; union; welfare or employer organization; employee benefit organization including preferred provider organizations or similar type organizations; any coverage under governmental programs; and any coverage required to be provided for by state law.

3.6.1.3 The State will adjust the contractor capitation payment by taking into consideration TPL cash recoveries for lien and estate, casualty, carrier billing to Medicare, and other insurance for Medicaid members. In lieu of this capitation offset, the contractor will perform TPL functions for the Medicaid clients and retain its TPL recoveries.

DRAFT

3.6.1.4 The contractor must track its TPL recovery for Medicaid members and report this recovery amount to the State according to the format and schedule specified by the State.
3.6.1.5 Data transfer of TPL information on any member shall occur according to the format and schedule specified by the State.
3.6.1.6 The contractor shall transfer to the State any new TPL information on any member that comes to their attention. The State shall transfer to the contractor any new TPL information for any member that comes to their attention.
3.6.1.7 The contractor must file third party recovery (TPR) reports in accordance with the format developed by DPHHS. TPR reports must include total dollars recovered from third party payers for the contractor's program for services to the contractor's members, and the total dollars recovered through coordination of benefits, subrogation, and worker's compensation.
3.6.1.8 The contractor has sole right of subrogation for 12 months from when they incurred the cost on behalf of the members to initiate recovery or attempt to recover any third party resources.
3.6.1.9 If the contractor has not initiated recovery or attempted to recover any third party resources within the 12 months, DPHHS will pursue those recoveries.
3.6.1.10 DPHHS administers a Health Insurance Premium Payment Program (HIPP) that provides for buying employer-based insurance. The HIPP program has proven to be cost effective to pay the monthly premiums versus paying the full cost of health care. This is primarily because employer-based insurance plans sometimes can provide coverage for any size family for the same premium. Employers typically contribute to the cost of the insurance premiums for HIPP enrollees, so the State does not have to pay the entire amount. All clients included in the managed care program that receive this benefit by Medicaid will continue to receive this benefit via the managed care plan. Thus the contractor is required to have a HIPP program for all Medicaid clients that qualify.
3.6.1.11 The State would keep lien and estate recovery programs in house. The contractor would share any information with the State on liens and estates regarding Medicaid clients.

3.6.2 QAD/SURS Minimum Procurement Requirements for Managed Care in Montana

3.6.2.1 Fraud, Waste and Abuse

3.6.2.1.1 Montana managed care is subject to all state and federal laws and regulations relating to fraud, abuse and waste in Medicaid, the Children's Health Insurance Program (CHIP), and health care programs. The contractor must cooperate, exchange data, collaborate and assist SURS or any state or federal agency charged with the duty of identifying, investigating, sanctioning or prosecuting suspected fraud, abuse or waste.

3.6.2.1.2 The contractor must provide originals and/or copies of all records and information requested and allow access to premises and provide records to SURS, the Department, the Centers for Medicare and Medicaid Services (CMS), the U.S. Department of Health and Human Services (DHHS), Federal Bureau of Investigation, DOJ/MFCU, or other units of state government. The contractor must provide all copies of records free of charge.

DRAFT

3.6.2.1.3 The contractor must submit a written fraud and abuse compliance plan to the Quality Assurance Division, SURS section supervisor for approval each year. The plan must be submitted 60 days prior to the start of the state fiscal year. If there are no changes for the upcoming year, the contractor may notify the SURS supervisor that: (1) no changes have been made to the previously approved plan, (2) the plan will remain in place for the upcoming state fiscal year. The notification must be signed and certified by an officer or director of the contractor that is responsible for carrying out the fraud and abuse compliance plan.

3.6.2.1.3.1 The plan must have provisions for SURS to provide random data/administrative audits and/or medical record review audits of the contractor, its contractors, providers and suppliers as validation of services provided and reported. The contractor must:

3.6.2.1.3.1.1 Employ industry standard medical billing taxonomies (procedure codes, diagnosis codes) to describe services delivered and encounter transactions produced.

3.6.2.1.3.1.2 Pay financial transactions to providers in compliance with federal and state laws, rules and regulations.

3.6.2.1.3.1.3 Maintain records for all claims payments, refunds and adjustment payments to providers, capitation payments, interest income and payments for administrative services or functions, and must maintain separate records for medical and administrative fees, charges, and payments; and

3.6.2.1.3.1.4 Maintain an accounting system that provides an audit trail containing sufficient financial documentation to allow for the reconciliation of billings, reports, and financial statements with all general ledger accounts;

3.6.2.1.3.2 The plan must provide materials that educate providers and beneficiaries about fraud, waste and abuse and how to report it.

3.6.2.1.3.3 The plan must define how the contractor will coordinate its audits/reviews with other entities, including what providers and services it intends to review on a yearly basis and specific completion dates for audits/reviews.

3.6.2.1.3.3.1 The findings of these audits/reviews shall be published in OIG report format and delivered to the SURS supervisor

3.6.2.1.3.4 The plan will outline areas of vulnerability and address correction.

3.6.2.1.3.5 The plan must have procedures to report suspected fraud/waste/abuse to SURS and/or the Medicaid Fraud Control Unit (MFCU).

3.6.2.1.3.5.1 The contractor's assigned officer or director must report and refer all possible acts of waste, abuse or fraud to the SURS Unit within 30 working days of discovery. The report and

DRAFT

referral must include: an investigative report identifying the allegation, statutes/regulations violated or considered, and the results of the investigation; copies of program rules and regulations violated for the time period in question; the estimated overpayment identified; a summary of the interviews conducted; the encounter data submitted by the provider for the time period in question; and all supporting documentation obtained as the result of the investigation. This requirement applies to all reports of possible acts of waste, abuse and fraud.

3.6.2.1.3.6 The plan must detail how the contractor will recover funds misspent due to fraudulent/abusive actions and have a detailed accounting and reporting process.

3.6.2.1.3.7 The plan must define appropriate staffing to ensure compliance functions are met.

3.6.2.1.3.8 The contractor will hold its subcontractors, providers and suppliers to the same level of compliance as is held by the State.

3.6.2.2 Provider Complaints. The contractor must develop, implement, and maintain a system for tracking and resolving all Medicaid provider complaints. Within this process, the contractor must respond fully and completely to each complaint and establish a tracking mechanism to document the status and final disposition of each provider complaint. The contractor must resolve provider complaints within 30 days from the date the complaint is received. If the contractor cannot resolve a complaint within the 30 days, it may submit a request to extend the deadline. Unless the Department has granted a written extension, the contractor is subject to remedies, including liquidated damages if provider complaints are not resolved by the timeframes determined by the Department.

3.6.2.3 Provider Due Process. The contractor must adhere to the due process associated with adverse actions as defined by ARM. The contractor must develop, implement and maintain a system for tracking and resolving all Medicaid provider appeals related to claims payment. Within this process, the contractor must respond fully and completely to each Medicaid provider's claims payment appeal and establish a tracking mechanism to document the status and final disposition of each Medicaid provider's claims payment appeal.

3.6.2.4 HIPAA

3.6.2.4.1 The contractor must comply with applicable certificate of coverage and data specification and reporting requirements promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, P.L. 104-191 (August 21, 1996), as amended or modified. The contractor must comply with HIPAA EDI requirements. The contractor's enrollment files must be in the 834 HIPAA-compliant format. Eligibility inquiries must be in the 270/271 format and all claims and remittance transactions in the 837/835 format.

3.6.2.4.2 The contractor must provide its members with a privacy notice as required by HIPAA. The contractor must provide the Department with a copy of its privacy notice for filing.

3.6.2.4.3 The contractor must comply with the State of Montana's HIPAA policies including training of employees, risk assessment, corrective actions, reporting, remedies and business associates.

3.6.2.5 Provider Enrollment

3.6.2.5.1 All contractor providers, both rendering and referring, must be enrolled with Montana Medicaid. The contractor's providers are subject to the same enrollment and screening procedures as regular Medicaid providers. This includes application fees as determined by CMS.

3.6.2.5.2 All contractor providers are subject to the applicable state and federal rules regarding termination of enrollment, sanctions, criminal and civil penalties.

3.6.3 Managed Care Network Adequacy Requirements (33-36-201 et seq., MCA; ARM 37.108.201 et seq.).

3.6.3.1 The highlights of the Managed Care Network Adequacy Program require that there be an adequate number of primary care providers, pharmacy, and hospital or critical access hospital (for access to emergency care 24/7) within the geographic service areas.

3.6.3.2 A geographic service area is normally a 30-mile radius of enrollee residence or place of work (exceptions are in ARM 37.108.219 and the Department may grant exceptions to geographic access criteria). Enrollee may select provider outside geographic service area.

3.6.3.3 Adequate network is one mid-level primary care provider per 1,500 projected enrollees or one physician per 2,500 projected enrollees.

3.6.3.4 Appointment wait times are as follows:

3.6.3.4.1 Urgent care - within 24 hours

3.6.3.4.1 Non-urgent care with symptoms - within 10 calendar days

3.6.3.4.1 Immunizations - 21 calendar days

3.6.3.4.1 Routine or preventive care – 45 days

3.6.3.4.1 Emergency services must be available and accessible 24/7

3.6.3.5 The access plan must identify:

3.6.3.5.1 Participating providers with contact information and if accepting new patients

3.6.3.5.2 Policy for referrals within and outside of network

3.6.3.5.3 Process for monitoring the need for and satisfaction of health care services

3.6.3.5.4 Process to address needs of those with limited English proficiency, illiteracy, cultural and ethnic background, physical and mental disability

3.6.3.5.5 Comprehensive list of covered and noncovered services

3.6.3.5.6 Policy or certificate of coverage including standards for provider credentialing and review, selecting and changing providers, enrollee responsibility for co-insurance, copayments and deductibles. transitional care

3.6.3.5.7 Procedures for specialty care and enrollee responsibility for associated fees, co-insurance, copayments and deductibles

DRAFT

3.6.3.5.8 Polices for emergency services and screening including contact information and procedure to facilitate review of emergency services
3.6.3.5.9 Grievance procedure
3.6.3.5.10 Policy for use of and payment for in-network and out-of-network services
3.6.3.5.11 Process to address and correct insufficient number or type of participating providers accessible to enrollees
3.6.3.5.12 Process for complying with geographic accessibility and service areas
3.6.3.5.13 Methods for assessing sufficiency of network and enrollee satisfaction

3.6.3.6 Supporting documentation can be found at:
3.6.3.6.1 Montana Code Annotated (MCA)
http://data.opi.mt.gov/bills/mca_toc/33_36_1.htm

3.6.3.6.2 Administrative Rules of Montana (ARM)
http://www.mtrules.org/gateway/Subchapterhome.asp?scn=37%2E108.2

3.7

NURSING FACILITY SERVICES

3.7.1 Description of services

3.7.1.1 Nursing facility services are allowed under a written agreement with the department to a provider who furnishes services to Medicaid recipients as defined in ARM 37.40.304 and ARM 37.40.305. These services must be delivered by providers within the scope of the provider's license, and includes providers of "long term care facility services."
3.7.1.2 Nursing facility services are provided in accordance with 42 CFR, part 483, subpart.
3.7.1.3 Services considered to be included in nursing facility/long term care facility services include but are not limited to:

a. medically necessary room
b. dietary services including dietary supplements used for tube feeding or oral feeding
c. nursing services
d. minor medical and surgical supplies
e. use of equipment and facilities

3.7.1.4 Payment for the services listed in ARM 37.40.304 and 37.40.305 are included in the per diem rate determined under ARM 37.40.307 and 37.40.336 and no additional reimbursement is provided for such services

3.7.2 Licensure and certification requirements (ARM 37.40.306)

3.7.2.1 A nursing facility services provider must maintain a current license issued by the department of public health and human services under Montana law for the category and level of care being provided.
3.7.2.2 A nursing facility services provider must comply with all applicable federal and state laws, rules, regulations and policies regarding nursing facilities including but not limited to 42 USC 1396r(b)(5) and 1396 r(c).

DRAFT

3.7.2.3 A nursing facility services provider must maintain a current certification for Montana Medicaid issued by the department of public health and human services under applicable state and federal laws, rules, and regulations and policies for the category and level of care being provided.

3.7.2.4 A nursing facility services provider is required to operate under the direction of a licensed nursing home administrator, or other qualified supervisor for the facility, as applicable laws, regulations, rules, or policies may require.

3.7.3 Reimbursement Per Diem Rate (ARM 37.40.307)

3.7.3. 1 For nursing facility services, other than ICF/MR services, provided by nursing facilities located within the state of Montana, the Montana Medicaid program will pay a provider, for each Medicaid patient day, a per diem rate using a price based reimbursement methodology determined in accordance with The rate for each facility is determined using an operating component and a direct resident care component. The operating component is the same per diem for each nursing facility which is set at 80% of the statewide price for nursing facility services. The direct resident care component of each facility's rate is 20% of the overall statewide price for nursing facility services. This component is adjusted for the acuity of the Medicaid residents served in each facility. The acuity adjustment increases or decreases the direct resident care component in proportion to the relationship between each facility's Medicaid average case mix index and the statewide average Medicaid case mix index.

3.7.3.2 Medicaid eligibility will determine the personal resources (patient contribution) that a nursing facility resident is responsible for towards paying for the cost of care less the residents personal needs allowance as defined in ARM 37.40.302.

3.7.3.3 A provider's per diem rate for nursing facility services is effective for rate periods of July 1 through June 30 of each state fiscal year. Current nursing facility rates are listed in Appendix ___.

3.7.4 Individual Eligibility for Nursing Facility Care

3.7.4.1 Individuals eligible for Medicaid nursing facility services must:

a. meet all non-financial criteria
b. be admitted under a doctor's order
c. meet the medical criteria for needing nursing home care
d. meet the financial need requirements
e. get a pre-admission screening

3.7.4.2 In 2010 approximately 4,600 unduplicated individuals received Medicaid funded services in nursing facilities statewide, 683 in the 5 counties in the demonstration project.

3.7.5 Level Of Care; Pre Admission Screening

3.7.5.1 A nursing facility services provider must comply with regulations regarding screening for nursing facility services as defined in ARM 37.40.101 to 37.40.120, ARM 37.40.201 to 37.40.206, and 42 CFR 483.100 to 483.138.

DRAFT

3.7.5.2 A level of care determination is required to assess medical necessity and appropriateness of placement for long term care services (intermediate or skilled), and must be completed before Medicaid payment can be authorized.

3.7.5.3 All individuals seeking long term care (e.g., nursing facility or swing bed services) must have a preadmission screening before entering a facility. Currently, a Preadmission screening/level I screening is performed by the department's contractor Mountain Pacific Quality Health Foundation.

3.7.5.4 Preadmission/level I screening (also known as preadmission screening annual resident review PASAAR) will determine if a long term care applicant is approved for long term care placement, and if a Preadmission/level II screening (determines whether the applicant requires specialized services and is appropriate for long term care placement) is required for the long term care applicant.

3.7.5.5 Preadmission/level II screening is required if the Preadmission/level I screening shows indication of mental retardation or mental illness for the applicant. The department's contractor Mountain Pacific Quality Health Foundation will refer applicants to either the appropriate regional center or the regional mental retardation authority for a preadmission/level II screening.

3.7.6 Ancillaries-Separately Billable Items In addition to the amount payable to nursing facility service providers under ARM 37.40.307, the department reimburses facilities for separately billable items as defined ARM 37.40.330.

3.7.7 Resident Billable Items Items and services billable to nursing facility residents that are not paid by the department to the provider are defined in ARM 37.40.331

3.7.8 Bed Hold Payments The department reimburses nursing facility services providers for holding a bed in accordance to ARM 37.40.338 for:

a. A resident who is temporarily receiving medical services outside the facility, except in another nursing facility, and is expected to return.
b. A resident during a therapeutic home visit, limited to 24 days per state fiscal year, with prior authorization for visits over 72 hours.

3.7.9 Other Add On Payment Systems

3.7.9.1 Intergovernmental Transfer (IGT)

3.7.9 1.1 For each state fiscal year, the department provides for a one-time, lump sum distribution of funding to nursing facility providers as defined in ARM 37.40.311.

3.7.9.1.2 The mechanism for funding under an Intergovernmental Transfer program provided by the department has two components.

3.7.9.1.3 Facilities state-wide that are "at risk" county affiliated facilities who are predominately rural and are the only nursing facility in their community or county or who provide a significant share of nursing facility services in their community or county

3.7.9.1.4 All other facilities state-wide that are not "at risk" county affiliated facilities as defined above.

DRAFT

3.7.10 Direct Care Wage Program Medicaid certified nursing facilities, at the discretion of the Montana legislature, may be paid in addition to their computed Medicaid payment rate as provided in ARM 37.40.361 funds to be used only for wage and benefit increases or lump-sum distributions to direct care and ancillary services workers.

3.7.11 Reporting Requirements The following reporting is required from nursing facility service providers. [will these reports be required to be submitted to the Department by the offerer?]

3.7.11.1 Nurse aide training and testing reporting

Nursing facility services providers must provide for each quarter of the state fiscal year a *Nurse Aide Certification/Training and Competency Evaluation (Testing) Survey* form for reporting initial training and testing costs prepared in accordance with ARM 37.40.322.

3.7.11.2 Staffing Reporting

Nursing facility service providers must provide staffing at levels which are adequate to meet federal law, regulations, and requirements. Each provider must submit to the department form DPHHS-SLTC-015, *Monthly Nursing Home Staffing Report* in accordance with ARM 37.40.315.

3.7.11.3 Therapeutic Home Visits

Nursing facility service providers must submit to the department form DPHHS-SLTC-041, *Request for Therapeutic Home Visit Bed Reservation* prepared in accordance with ARM 37.40.338. For therapeutic home visits in excess of 72 hours, nursing facility service providers must submit to the department form DPHHS-SLTC-042, *Request for Bed Reservation for Therapeutic Home Visit in Excess of 72 hours* in accordance with ARM 37.40.338.

3.7.11.4 Hospital Hold

Nursing facility service providers must submit to the department form DPHHS-SLTC 052, *Request for Nursing Home Bed Reservation during Resident's Temporary Hospitalization* in accordance to 37.40.338.

3.7.11.5 Minimum Data Set submission

3.7.11.5.1 Nursing facility services providers must all minimum data set assessments and tracking documents to the Centers for Medicare and Medicaid Services (CMS) databases as defined in ARM 37.40.320.

3.7.11.5.2 Nursing facility services providers must report corrections of erroneous or missing data on resident listings distributed to facilities as defined in ARM 37.40.321

3.7.11.6 Cost reporting

Nursing facility services providers must meet the cost reporting requirements as defined in ARM 37.40.345, ARM 37.40.346, and ARM 37.40.347.

3.7.11.7 Direct care wage reporting

Nursing facility service providers are required to report to the department actual hourly wage and benefit rates (or lump sum distributions) paid to direct care and ancillary services workers as defined in ARM 37.40.361.

DRAFT

3.7.12 Out of State Nursing Facilities (ARM 37.40.337) Medicaid eligible resident for nursing facility services who requires those services from an out-of-state nursing facility under the conditions defined in ARM 37.40.337

3.7.13 Hospice The department may not pay a nursing facility provider for services provided to an eligible Medicaid/Medicare individual who has elected the Medicare hospice benefit. This applies where the hospice provider and nursing facility have made a written agreement under which the hospice provider agrees to provide professional management of the individual's hospice care and the nursing facility provider agrees to provide room and board to the individual. The department will pay the hospice provider in accordance with the department's rules governing Medicaid reimbursement to hospice providers.

3.7.14 Information requested specific to nursing facilities

3.7.14.1 Please address "network adequacy" in the five counties. In 2010, the following nursing facility services were provided to unduplicated residents in the five counties.

a. Lewis and Clark, 3 facilities, 170 residents
b. Cascade, 3 facilities, 441 residents
c. Choteau, 2 facilities, 35 residents
d. Teton, 2 facilities, 37 residents
e. Judith Basin, 0 facilities, 0 residents

3.7.14.2 The data for nursing facility services in the five county demonstration project indicates that some Medicaid eligible clients whose residency are within those five counties are currently being served in nursing facilities outside of those five counties. Please describe the impact on these Medicaid clients under this project.

3.7.14.3 Describe how a client would be affected under a "bed hold payment" as defined in ARM 37.40.338 for nursing facility services.

a. A "hospital hold payment" is provided to a nursing facility provider to hold a bed for a resident receiving hospital services
b. A "therapeutic home visit (THV)" is provided to a nursing facility provider to hold a bed for a resident receiving a therapeutic home visit.

3.7.14.4 How would a provider of nursing facility services receive one-time, lump sum distribution of funding to nursing facilities not participating in the funding for "at risk" facilities under an Intergovernmental Transfer program provided by the Department as defined in ARM 37.40.311?

3.7.14.5 How would direct care and ancillary workers providing nursing facility services be included in any legislative funded direct care wage initiative as defined in 37.40.361?

3.7.14.6 How will resident trust accounts be maintained in accordance with ARM 37.40.306, MCA 53-6-168, and 42 CFR 483.1?

3.7.14.7 How will a Medicaid eligible resident for nursing facility services requiring those services from an out of state nursing facility under the conditions defined in ARM 37.40.337 receive those services?

3.7.14.8 How will a nursing facility services provider negotiate an agreement with a hospice provider to provide professional management of hospice care for a nursing facility resident in accordance with ARM 37.40.339?

3.8 SWING BED SERVICES

3.8.1 Description of services

Swing-bed services are allowed under a written agreement with the department to a provider who furnishes services to Medicaid recipients as defined in ARM 37.40.402 and ARM 37.40.405. These services must be delivered by providers within the scope of the provider's license, and includes providers of "of acute care or extended skilled nursing care long term care facility services."

3.8.2 Licensure/certification requirements

A swing-bed hospital services provider is a licensed hospital, critical access hospital (CAH) with swing-bed approval or licensed medical assistance facility which is Medicare-certified to provide post hospital SNF care.

3.8.2.1 A swing-bed services provider is a hospital that has applied for and the department has approved enrollment as a Medicaid swing bed hospital services provider.

3.8.2.2 A swing-bed services provider that is a hospital located in a rural area of the state as defined by the department.

3.8.2.3 A swing-bed services provider that has a certificate of need from the department to provide swing-bed services.

3.8.2.4 A swing-bed hospital services provider has fewer than 50 hospital beds and has provided written assurance to the health care financing administration that the hospital will not operate over 49 hospital beds, including swing-beds, except in connection with a catastrophic event.

3.8.2.5 A swing-bed services provider who is a critical access hospital (CAH) with swing-bed approval has no more than 25 acute care inpatient beds, of which no more than 15 are used for acute care at any one time for providing inpatient care

3.8.3 Reimbursement Rate Setting

Medicaid reimbursement is described below for swing-bed facility services delivered by providers.

3.8.3.1 For swing-bed hospital services, the Montana Medicaid program will pay a provider a per diem rate as defined in ARM 37.40.406 for each Medicaid patient day.

3.8.3.2 The swing-bed hospital services per diem rate is the average Medicaid per diem rate paid to nursing facilities for routine services furnished during the calendar year immediately previous to the year in which the swing-bed hospital services are provided. Nursing facility routine services are those services included in the definition of "nursing facility services".

3.8.3.3 A provider's per diem rate for swing-bed services is effective for rate periods of January 1 through December 31 of each calendar year.

3.8.4 Eligibility for Services

Individuals eligible for swing bed placements need acute care or extended skilled nursing care, and must meet

a. All non-financial criteria
b. Be admitted under a doctor's order
c. Meet the medical criteria for needing nursing home care
d. Meet the financial need requirements
e. Get a pre-admission screening

In 2010 approximately 220 unduplicated individuals received Medicaid funded services in swing bed facilities statewide, 0 in the 5 counties in the demonstration project.

3.8.5 Ancillaries-Separately Billable Items

In addition to the amount payable to swing-bed facility service providers under ARM 37.40.406, the department reimburses facilities for separately billable items as defined ARM 37.40.406.

3.8.6 Preadmission screening and level of care determinations

3.8.6.1 A swing-bed facility services provider must comply with regulations regarding screening for nursing facility services as defined in ARM 37.40.101 to 37.40.120, ARM 37.40.201 to ARM 37.40.205, ARM 37.40.405, and 42 CFR 483.100 to 483.138.

3.8.6.2 A level of care determination is required to assess medical necessity and appropriateness of placement for long term care services (intermediate or skilled), and must be completed before Medicaid payment can be authorized.

3.8.6.3 All individuals seeking long term care (e.g., nursing facility or swing bed services) must have a preadmission screening before entering a facility. Currently, a Preadmission screening/level I screening is performed by the department's contractor Mountain Pacific Quality Health Foundation.

3.8.6.4 Preadmission/level I screening (also known as preadmission screening annual resident review PASAAR) will determine if a long term care applicant is approved for long term care placement, and if a Preadmission/level II screening (determines whether the applicant requires specialized services and is appropriate for long term care placement) is required for the long term care applicant.

3.8.6.5 Preadmission/level II screening is required if the Preadmission/level I screening shows indication of mental retardation or mental illness for the applicant. The department's contractor Mountain Pacific Quality Health Foundation will refer applicants to either the appropriate regional center or the regional mental retardation authority for a preadmission/level II screening.

3.8.7 Other Add On Payments

Medicaid certified swing bed facilities, at the discretion of the Montana legislature, may be paid in addition to their computed Medicaid payment rate as provided in ARM 37.40.422 funding to be used only for wage and benefit increases or lump-sum distributions to direct care and ancillary services workers.

3.8.8 Reporting Requirements

3.8.7.1 Direct care wage reporting

Swing Bed service providers are required to report to the department actual hourly wage and benefit rates (or lump sum distributions) paid to direct care and ancillary services workers as defined in ARM 37.40.422.

3.8.9 Information requested specific to swing bed services

3.8.9.1 How would the offeror address "network adequacy" in the five counties? In 2010, the following swing bed facility services were provided to unduplicated residents in the five counties.

a. Lewis and Clark, Cascade, Judith Basin—none
b. Choteau, 1 facility, no residents
c. Teton, 1 facility, no residents

3.8.9.2 How will direct care and ancillary workers providing swing bed services be included in any legislative funded direct care wage initiative as defined in 37.40.422?

3.9 HOME HEALTH SERVICES

3.9.1 Current home health services

3.9.1.1 Home Health Services are authorized by Section 1905 (1) () of the Social Security Act and governed by the federal regulations which define Home Health Services, who can deliver services, service requirements, and recipient eligibility. The regulations are provided in CFR 484.1-484.55.

3.9.1.2 All Home Health Services must comply with federal regulations. In addition, Montana has additional program parameters, which are referenced in this document.

3.9.2 Population To be eligible for Home Health Services, a person must meet all of the following criteria:

a. Medicaid eligible
b. Meet service criteria, which means the client's home is the most appropriate location for services based on medical reasons and the client cannot readily obtain medical services except through a Home Health agency or there is no equally effective, less costly treatment
c. Require acute skilled nursing or therapy services on a part-time, intermittent basis to prevent or postpone institutionalization
d. Not reside in a hospital, nursing facility, or ICF-MR
e. Home-bound status, which means the client is confined on a full time, part time or intermittent basis to the client's place of residence for medical reasons, is unable to obtain required medical services without demonstrated taxing effort, or cannot reasonably obtain medical services other than through a Home Health agency.

3.9.3 Provision of Home Health Services Home Health Services are provided under the following conditions:

3.9.3.1 Must be provided by a licensed Home Health agency to a client considered homebound and the services must be delivered in the client's place of residence. Place of residence means the residential setting in which the recipient generally resides, and must include client's own home, a personal care facility, a foster home, a community home or other residential setting for persons who have a developmental disability or physical disability, a rooming house or a retirement home.

3.9.3.2 Provided for the purposes of postponing or preventing institutionalization

3.9.3.3 Must be ordered by the client's attending physician

3.9.3.4 Part of a written plan of care

3.9.3.5 Reviewed and renewed by the client's attending physician at a minimum of 60 day intervals

3.9.3.6 The Home Health provider must maintain documentation that the client meets the homebound definition, as outlined earlier under the "population" section

3.9.3.7 The Home Health provider must keep written copies of the physician orders, care plans, and other client records readily available.

3.9.4 Services Description Home Health Services include:

3.9.4.1 Skilled nursing services, as defined by the Montana Nurse Practice Act, that are provided on an intermittent or part time basis to meet the medical needs of a client who needs nursing procedures. Services that can be legally performed by a paraprofessional or non-licensed individual do not qualify as skilled nursing services, even if a licensed nurse performs the task. Services must be delivered in accordance with the plan of care. Visits of licensed nurse to the home of a client solely for the purpose of supervising a Home Health aide are not reimbursable by Medicaid.

3.9.4.2 Home Health Aide services. These services must be provided under the supervision of a registered professional nurse and in accordance with the written plan of care. Services include assistance with activities of daily living and the care of the household to maintain the

client in his/her residence for a short, definite period of time. A client who is eligible for personal assistance services may not receive concurrent Home Health Aide Services.

3.9.4.3 Physical therapy services, Occupational therapy services, and Speech therapy services are services defined in scope by MCA. All therapy services must be provided by a licensed therapist. Services of a therapy assistant, therapy aide, or other person are not reimbursable. The Home Health benefit provides coverage for restorative therapy services when the particular restorative therapy services are reasonable and necessary to the client's condition and the client is unable to obtain such services through an outpatient clinic or private practice setting due to their medical status. The amount and frequency must be within the therapy's generally accepted practice.

3.9.4.3.1 Restorative therapy is defined as the following: Therapy services that are performed with a reasonable expectation that the client's function will improve significantly in a reasonable and predictable period of time, based upon an assessment of the client's restoration potential made by a physician in consultation with a licensed therapist. Therapy services are not restorative if the client's expected restoration potential would be insignificant in relation to the extent and duration of services required. Therapy services are no longer restorative if at any time after beginning treatment, it is determined that the reasonable expectation of significant improvement will not materialize.

3.9.4.3.2 The Home Health benefit does not cover maintenance therapy, which is defined as the following: Repetitive therapy services that are required to maintain functions that are performed without reasonable expectation of significant progress and that do not involve complex and sophisticated therapy services requiring the judgment and skill of a licensed therapist.

3.9.4.3.3 The establishment of a maintenance therapy plan by a licensed therapist is reimbursable. The establishment of a maintenance plan includes:

a. The initial evaluation of the client
b. Development of a plan that incorporates the treatment objectives of the prescribing physician and is appropriate for the client's capacity and tolerance
c. Instruction of others in carrying out the plan and further evaluations by a licensed therapist and required.
d. One time therapy evaluation as part of obtaining a piece of durable medical equipment is reimbursable if there is no other reasonable alternative to obtaining this service. The provider is still responsible for developing a plan of care, obtaining physician orders, and following all other applicable rules.

3.9.4.4 Medical supplies and equipment suitable for use in the home. All medical supplies must:

a. Have a therapeutic or diagnostic use,
b. Be ordered by the client's physician as part of a prescribed treatment, and
c. Be essential for agency personnel to follow the plan of care

3.9.4.4.1 The Home Health benefit excludes any item that can be classified as durable medical equipment (DME). Payment for DME may be available under the DME program.

3.9.4.4.2 Non-routine supplies may be reimbursed through this benefit under the following conditions:

a. Item following a consistent charging practice for Medicaid and non-Medicaid clients receiving the item
b. Item is directly identifiable to an individual client, and

c. Item is furnished at the direction of the client's physician and specifically identified in the plan of care.

3.9.4.4.3 Routine supplies are not reimbursable under the Home Health benefit. These supplies are customarily used during the course of most home care visits and are usually part of the staff's supplies and not designated for a particular recipient. These supplies are included in the per visit rate of Home Health Services. Routine supplies would not include those ordered by the physician that are essential to Home Health personnel to effectively carry out the plan of care. There are conditions when supplies, normally considered routine, are required in quantity, for recurring need and are included in the plan of care. These supplies would be considered non-routine and would be billable.

3.9.5 Service Exclusions: A person receiving personal care services may not receive Home Health Aide Services.

3.9.6 Client Termination: Client participation in the program terminates when either the client no longer has a medical need for services, which means that either the client no longer meets service criteria, an equally effective less costly alternative becomes available or the client requests services to terminate. The Home Health provider may discharge a client for other reasons. This is an action of the provider and the provider must provide advance notice to the client based on the provider's established policy. In all cases the provider agency must make a reasonable effort to ensure continuity and appropriateness of care through referrals to other providers.

3.9.7 Service Coordination

3.9.7.1 Developmental Disabilities

Any individual with a diagnosis of developmental disability (or a related disorder) must obtain chronic nursing services through an approved provider of the Developmental Disability Service Division. Individuals with developmental disabilities will continue to have access to skilled nursing for acute needs and home based therapies if they qualify under the Home Health benefit. This type of skilled nursing care would be for a limited time period associated with recovery from an accident, wound care, or acute hospitalization.

3.9.7.2 Adult Foster Homes

Clients residing in a home adult foster homes or may receive Medicaid Home Health Services if they meet all program conditions. The owner or staff of the adult foster care home may not do nursing tasks with the client even if the owner or staff are nurses.

3.9.7.3 Home Infusion Therapy

3.9.7.3.1 In order to bill for skilled nursing services provided in conjunction with home infusion therapy, the following must apply:

a. The individual must meet program eligibility, including service criteria; and
b. Nursing services are not available through the home infusion provider

3.9.7.3.2 If the Home Health agency is also licensed as a home infusion therapy agency and employs nurses for that purpose, it is expected that the nursing services will come through the home infusion program and not the Home Health benefit.

3.9.7.4 Services to Children

Home Health Services are not available to children who qualify for Private Duty Nursing (PDN) Services. PDN is considered equally safe and effective to and less costly than Home Health Services. If a PDN provider is not available, Home Health Services must be provided.

3.9.8 Prior Authorization of Services

Skilled nursing services and therapy services under the Home Health benefit must be prior authorized. The authorizing entity has a link to the eligibility determination database and is able to determine whether the client is Medicaid eligible, Medicaid/Medicare (dually) eligible, or TPL. The authorizing entity hires a Registered Nurse to review the required documentation and assure that the service

meets the scope and requirements of the program. Prior authorization is only provided when TPL has already been billed. The prior authorization documentation includes:

a. Client's eligibility based on service criteria
b. Order for services from the client's attending physician or PASSPORT physician
c. The attending physician or PASSPORT physician reviews the plan every 60 days (when applicable)
d. Services ordered in the plan of care are consistent with services provided by the agency as supported by visit documentation
e. Services are medically necessary and require a licensed professional
f. Services paid by Medicaid for a dually eligible individual are appropriate as the client does not met Medicare criteria or it is a service not payable by Medicare

The only service that does not need to be prior authorized is medical supplies.

3.9.9 Out of State Services

Home Health Services may be provided by providers located out of state if the service meets the Home Health Service requirements and the service is prior authorized by the Department. The out of state provider must meet the provider enrollment criteria.

3.9.10 Provider Enrollment and Participation

A Home Health agency must be:

a. Licensed by the Montana Department of Public Health and Human Services
b. Medicare certified
c. Enrolled as a Medicaid provider

All employees of an agency participating in Medicaid Home Health Services are mandatory reporters of suspected abuse, neglect, and exploitation. In addition, the Home Health agency must report all serious occurrence reports, as outlined in Community Services Bureau (CSB) Policy Manual section 305. All employees of the agency must comply with the standards of charting, as outlined in CSB Manual section 306.

The provider agency is responsible for educating contracted therapy professionals regarding general service requirements and limits under the Home Health program.

3.9.11 Reimbursement

3.9.11.1 As of July 1, 2009 the Home Health reimbursement rate for services is as follows:

a. Physical Therapy- visit charge $71.81
b. Occupational Therapy- visit charge $71.81
c. Speech Therapy- visit charge $71.81
d. Skilled Nursing- visit charge $71.81
e. Home Health Aide- visit charge $32.06
f. General Class Medical/Surgical Supplies-90% of amount allowed for the specific item under Medicare

3.9.11.2 A visit is a personal contact with the client in his/her residence to provide a covered Home Health Service.

3.9.11.3 The rate of reimbursement for Home Health Services increases according to provider rate increases as they are allocated during the Montana legislative session.

3.9.12 Cost-Sharing

The federal government allows states to require certain clients to share Medicaid costs by imposing copayments. Refer to ARM 37.85.204 for cost sharing provisions. Home Health is included under the programs where cost-sharing is allowed. A provider cannot deny services to a client solely because the client cannot pay the copayment.

Home Health copayments are:

a. $2.00 per Home Health Aide, nursing, or therapy visit

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b. $.50 per claim line of supplies

3.9.13 Reporting

Reports from the entity that conducts the prior authorizations:

a. Monthly report details # of active cases by month and year to date
b. Monthly report captures # of authorizations (both initial and extensions) by month and year to date
c. Database captures the following information
   (1) Client demographic information, diagnosis, and Home Health prior authorization history.
   (2) By prior authorization request, the requesting agency name, client name, start date, end date, service type, units requested, units approved, cost of approved units, and status of request (approved, pending, denied, or cancelled).
   (3) Comments section that displays the comments associated with prior authorization status.
   (4) Cost-savings information (for example with TPL).
   (5) Capture info on type of letter sent to agency related to each prior authorization request
   (6) Date prior authorization was sent to ACS and captures the PA #.
   (7) Document whether request resulted in an administrative review.

3.9.14 Criteria to Consider under Managed Care

3.9.14.1 Service Scope

3.9.14.1.1 Offeror must ensure that the scope of the service (i.e. type of service and service description) that is available under the current system is maintained.
3.9.14.1.2 Offeror must ensure that the provision of service under the current system is maintained.
3.9.14.1.3 Offeror must ensure that the licensure for those who perform skilled and therapy services is maintained.
3.9.14.1.4 Offeror must ensure that eligibility for service is maintained.
3.9.14.1.5 Offeror must ensure that the service authorization meets the standards for Home Health practice that are set by Medicare regulation. All authorizations should sufficiently address the client's medical necessity for service.
3.9.14.1.6 Registered nurse and/or the prescribing physician must authorize services.
3.9.14.1.7 The Offeror must identify a plan to implement inter-rater reliability to ensure consistency and quality in the authorization of services.

3.9.14.2 Service Access

3.9.14.2.1 Client must have choice of at least two providers in each of the counties (if unable to provide choice the Offeror should justify why this cannot occur).
3.9.14.2.2 Offeror must ensure that a client who has a need for Home Health Services is authorized those services
3.9.14.2.3 Offeror must ensure that a client who is authorized services receives the service from a qualified provider
3.9.14.2.4 Any individual with a diagnosis of developmental disability (or a related disorder) would receive Home Health Services under the same rules and requirements as other managed care members.

3.9.14.3 Provider Enrollment

3.9.14.3.1 Providers must meet the same enrollment criteria as currently exists.

3.9.14.3.2 Providers enrolled as Medicaid providers would automatically be enrolled in the provider network for a period of not less than one year post implementation of managed care.

3.9.14.4 Provider Complaints

3.9.14.4.1 Offeror has a plan to respond to provider concerns regarding the authorization of services.

3.9.14.4.2 Offeror provides a quarterly report to the Department on the number of complaints, by provider, by type and by resolution.

3.10 PERSONAL ASSISTANCE SERVICES

3.10.1 Current Services Personal Assistance

3.10.1.1 Personal Assistance Services (PAS) are medically necessary in-home services provided to Medicaid recipients whose health conditions cause them to be functionally limited in performing activities of daily living. PAS provides necessary long-term maintenance or supportive care in the home.

3.10.1.2 There are two options for the delivery of PAS.

a. The first option is the Agency-Based Personal Assistance Services (ABPAS).
b. The second option is Self-Direct Personal Assistance Services (SDPAS). Some service requirements are specific to each option. Unless otherwise noted the service requirements outlined below apply to both PAS options.

3.10.1.3 Under the ABPAS option, enrolled provider agencies manage the services on behalf of the client. The provider agency must employ a licensed nurse to oversee the training and supervision of all direct care attendants and monitor the client's Service Plan

3.10.1.4 As a result of grass roots legislative efforts, Montana launched the SDPAS option in October 1995. The effort established regulation in MCA 53-6-145, which dictates the parameters for the program.

3.10.1.5 The program is designed to allow clients to hire, train, manage, schedule and discharge their attendants.

3.10.1.6 Clients must demonstrate capacity to manage their care or have a personal representative manage their care.

3.10.1.7 Clients in either the agency-based or self-direct program are eligible to receive the same services; however clients in the self-direct option may direct certain health maintenance activities, as well.

3.10.1.8 There is an exemption to Montana's Nurse Practice Act that allows the client to manage their bowel care, catheter care, medication administration and wound care, with a health care professional's approval.

3.10.1.8.1 Every client has the option of selecting either the ABPAS or SDPAS option, as long as they meet the eligibility criteria.

3.10.1.8.2 If a client does not meet the eligibility criteria for SDPAS he or she is eligible to receive services under the ABPAS option.

3.10.2 Population (Reference PAS 403)

3.10.2.1 To be eligible for the ABPAS option, a client must meet all of the following criteria:

a. Meet Full Medicaid eligibility
b. Demonstrate a medical need for personal care assistance

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c. Receive all of the personal care services, aside from escort services to medical appointments and shopping, in the client's home
d. Agree to the provision of services as specified in the authorized Service Plan

3.10.2.2 In addition to the criteria outlined above, to be eligible for the SDPAS option, a client must meet the additional criteria:

3.10.2.2.1 Meet capacity for program participation, which means the client, or a personal representative, is capable of understanding the program requirements, including recruiting hiring, scheduling, training, directing and dismissing personal attendants.

3.10.2.2.2 If the client does not meet capacity the client may have an immediately involved representative assume some or all of the responsibilities. Reference SDPAS 503/701 for the capacity process and SDPAS 419 for more information on personal representatives.

3.10.2.2.3 Sign a Client Agreement or Personal Agreement form. Reference the SDPAS manual 601 for the client and personal representative responsibility and SDPAS 913 and SDPAS 914 for the form.

a. The Client Agreement outlines the client responsibilities for participation in the SDPAS program. The requirements outlined in the Agreement include:
b. Client or the client's Personal Representative is capable and willing to act as though the personal assistance is their employee for the purposes of selection, management and supervision of the personal assistance, although the personal assistant is the employee of a SDPAS provider
c. Client or the client's Personal Representative has the primary responsibility in the scheduling, training and supervision of the personal assistant.
d. Client or the client's Personal Representative will develop and maintain a Service Plan, which is based upon the completion of the client authorization profile and includes an emergency back-up plan, recruitment and training plan for personal assistants, and an oversight schedule for personal assistants.
e. Obtain authorization from a health care professional to participate in the program at least every 12 months or earlier if there is a change in health maintenance activities
f. Review, approve, sign and date all service delivery records (time sheets).
g. Accept medical and related liability regarding the delivery of PAS. According to the statutory language that created this program the client is responsible for any incidents of harm to the personal assistant.

3.10.2.2.4 Have services approved by a health care professional. Reference SDPAS 418 for more details about the approval process and paperwork and CSB 103 for a definition of health care professional.

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3.10.2.2.5 PAS must be provided for disabled children when the parent is unqualified or otherwise unable to provide the personal care and the child is at risk of institutionalization unless the services are provided.

3.10.2.2.6 A client may receive personal care services through the Medicaid Home and Community Based Services program for elderly and physically disabled, clients with developmental disabilities, or clients with severe and disabling mental illness, in addition to the PAS provided through this program.

3.10.3 Services Description (Reference PAS/SDPAS 403 and 504)

3.10.3.1 Personal Assistance Services include assistance with the following activities:

a. Activities of daily living, which are limited to bathing, grooming, transferring, walking, eating, dressing, toileting, self-administered medication, and meal preparation.

b. Household tasks, which are limited to housekeeping activities in conjunction with activities of daily living that, are directly related to the recipient's medical needs. These include only the following: cleaning the area used by the client, changing the client's bed linens, doing the client's laundry, and shopping for groceries and household items essential to the health care, nutritional needs and maintenance of the client. The attendant should, when feasible, escort the client on shopping trips, rather than do the shopping for the client.

c. Escort services, which are limited to a client who requires personal care services en-route or at the destination. The service must be provided by a personal care attendant who accompanies the client to a medical examination or treatment.

d. The Self-Direct service option includes the option to direct Health Maintenance Activities (HMA). HMA tasks are skilled tasks that are statutorily exempt from the Nurse Practice Act. HMA services include bowel program, wound care, urinary system management, and medication administration. A health care professional must sign off on the client' authorized Service Plan

3.10.3.2 PAS may only be delivered by a personal care attendant that is employed by an enrolled Medicaid provider that has met the criteria established by the Department.

3.10.3.3 PAS may be provided up to but no greater than 40 hours per week as defined by the client Service Plan. Exceptions to the 40 hour per week limit are outlined below.

3.10.3.4 Time for escort services for medical appointments is over and above what is authorized on the client Service Plan.

3.10.4 Service Exclusion (PAS/SDPAS 404)

3.10.4.1 PAS does not include any skilled services that require professional medical training unless otherwise permitted under MCA. Services provided under the delegation clause of the Nurse Practice ACT are not included as PAS. The only skilled services that can be provided under PAS are the SDPAS health maintenance activities.

3.10.4.2 PAS may not include services which maintain an entire household or family or which are not medically necessary.

3.10.4.3 PAS does not include supervision, respite care, habilitation aide, babysitting or visiting, home or outside maintenance, cleaning floors and furniture in areas the client does not use or occupy, or maintenance of animals unless the animal is a certified service animal specifically trained to meet the safety needs of the client.

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3.10.4.4 A PAS client cannot reside in a hospital, long-term care facility, intermediate care facility for the mentally retarded, or licensed personal care/assisted living facility, as defined in MCA.

3.10.4.5 An immediate family member, which means a spouse or parent of a minor child, may not be the personal care attendant to the immediate family member.

3.10.4.6 PAS may not be provided to relieve a parent of child caring or other legal responsibilities.

3.10.5 Service Limits

3.10.5.1 A maximum of 40 hours per week may be authorized for PAS. A client who needs service in excess of 40 hours on a permanent basis may receive additional service through the home and community based waiver. A client who needs service in excess of 40 hours on a temporary basis (less than three months) needs to receive prior authorization from the Department.

3.10.5.2 Household tasks may not account for more than 1/3 of the total time allocated per week for personal care services, or a maximum of 3 hours, whichever is less.

3.10.5.3 The authorizing contract entity may authorize temporary services in excess of the 40 hour limit. The contract entity may also authorize temporary services to clients who reside in licensed foster or group homes or supported living environments when the client's medical needs are beyond the scope of services normally provided. All service exceptions must be prior authorized by the contract entity. Exceptions may be made for a period of up to three months under the following circumstances:

a. As the result of an acute medical episode
b. To prevent institutionalization during the absence of the normal caregiver
c. During a post-hospitalization period

3.10.6 Client Termination

3.10.6.1 A PAS provider may terminate services to a client for any of the following reasons:

a. Client or other persons in the household subjects the personal care attendant to physical or verbal abuse, sexual harassment, exposure to the use of illegal substances or to threats of physical harm
b. Client requests termination
c. Client refuses to accept help
d. Environment of the client is unsafe to receive PAS
e. The client refuses services of a personal care attendant solely or partly on the client's race, creed, religion, sex, marital status, color, age handicap or nationality
f. Client refuses to accept services in accordance with the Service Plan

3.10.6.2 The PAS provider must give at least 10 days advance notice to the client when PAS are terminated for the reasons mentioned above. The PAS provider may immediately, but temporarily, suspend services for reasons 1-3 mentioned above. Following the temporary suspension the provider must enter into an agreement with the client to ensure that the violation does not happen again. If the client fails to agree or abide to the terms of the agreement services may be permanently terminated.

DRAFT

3.10.6.3 In all cases the provider agency must make a reasonable effort to ensure continuity and appropriateness of care through referrals to other providers.

3.10.6.4 The Department may terminate or reduce PAS when funding for services is not available. Client participation in PAS may also be terminated when the following occurs:

a. Client no longer has a medical need for services, or

b. Client refuses to participate in the required review of the contract entity or PAS provider.

3.10.6.5 The contract entity with send a notice letter to the client of program termination and provide the client with fair hearing process.

3.10.7 Prior Authorization of Services

3.10.7.1 All PAS must be prior authorized, except in the case of Temporary Authorizations, which are outlined below.

3.10.7.2 The Department has a contract with Medicare's Quality Improvement Organization to perform prior authorization for PAS. It is assumed that this function will be provided by the managed care organization.

3.10.7.3 Data and tracking are provided through a database that is specific to the PAS contract responsibilities. The contract entity must manage, respond, and report on to the following: Referral information and status of the referral; once a client is authorized for services the entity must track all paperwork, including the annual review cycle, amendments and status of amendments, change in agency, change in demographic, change in option, and discharge information.

3.10.7.4 The contract entity ensures that all PAS providers have current authorization and demographic information for every PAS client served.

3.10.7.5 Refer to PAS/SDPAS 501-506 and 415 for a complete description of the contract duties related to PAS.

3.10.7.6 The entity must staff Registered Nurses to conduct all of the authorization assessments related to the PAS program. There are three main components to the authorization process:

a. Initial Authorization

b. Annual Authorization

c. Amendments

3.10.7.7 Authorization documentation includes the following forms:

a. Client Overview/Referral (SLTC-154)

b. Client Profile (SLTC-155)

3.10.7.8 Initial Authorization

The authorizing entity has a link to the MMIS system so they can determine client eligibility prior to authorizing services.

3.10.7.8.1 The entity will also authorize services for clients in the status of Medicaid pending to ensure that services are available immediately when a client becomes eligible. The contract entity will provide written notice to all applications when services are denied due to service ineligibility.

DRAFT

3.10.7.8.2 New admissions are processed by the contract entity as outlined in PAS 411.

3.10.7.8.3 Once financial eligibility is determined the contractor has 30 working days from date the referral is received to make an onsite visit with the client.

3.10.7.8.4 The onsite visit must be conducted in the client home and it must be conducted by a RN. If the RN is unable to complete the on-site visit within 10 working days, the RN must complete a prescreen telephone review to provide initial authorization for services until an onsite can be made. The onsite still must be made within 30 working days.

3.10.7.8.5 At the time of the authorization visit the RN provides the client with a list of PAS providers to select from.

3.10.7.8.5.1 The RN's onsite visit must include:

a. An explanation of the authorization process;
b. Completion of the Client Overview and Profile; and
c. Distribution of literature explaining the program and available providers

3.10.7.9 Annual Re-Authorization

3.10.7.9.1 A prior authorization span for PAS cannot exceed a 12 month period. The span may be less, if necessary.

3.10.7.9.2 The contract entity must conduct a phone or onsite visit by the end of the month in which the authorization span ends in order to reassess the client for his/her continued need for service and authorize services accordingly.

3.10.7.9.3 An onsite visit is necessary for re-authorization if one is requested by the provider agency, by the Department, or if an onsite is determined necessary by the authorizing RN. If an onsite is not requested or deemed necessary the re-authorization can be determined over the phone.

3.10.7.10 Amendments (Reference PA/SDPAS 502 and 417)

3.10.7.10.1 Events and conditions may result in a need to change the client authorization. The provider will notify the contract entity when this event occurs.

3.10.7.10.2 All amendment requests are reviewed by a RN and entered into the database.

3.10.7.10.3 Amendments may be processed over the phone unless there is not sufficient documentation to process the request, in which case an onsite visit is necessary.

3.10.7.10.4 If the amendment results in a change to the profile a new profile is completed and sent to the provider agency.

3.10.7.11 Client Overview (Reference PAS/SDPAS 503)

3.10.7.11.1 The Client Referral/Overview form is used as the referral document by anyone interested in referring a client for PAS.

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3.10.7.11.2 It is also used by the contract entity to document the following related to the client condition: Biographical and Environmental information, Medical history, Sensory Status, Communication ability, Health status, Assistive Devices used, Factors impacting level of function, Care determination, and Client's account of quality of services received and care needs (either addressed or unresolved).

3.10.7.11.3 The complete assessment questionnaire is available upon request.

3.10.7.12 **Client Profile (Reference PAS/SDPAS 504)**

3.10.7.12.1 The profile provides a summary of information about the authorization of services for each client, specific to impairment level per tasks, tasks authorized per day and per week, time authorized per task and time authorized per week, and comments about each task that is authorized. The profile also documents whether the profile is initial, amendment, or short-term.

3.10.7.12.2 The contract entity will ensure that all PAS providers are made aware of authorizations and changes to client information.

3.10.7.12.3 The contract entity is required to send a letter to the client with notification of the results of the authorization for PAS. The letter is sent for all initial authorizations, decreases in authorization, and denials. Fair hearing rights are also provided to the client in the letter. Reference PAS 505 for more information.

3.10.7.13 **Temporary Authorization of Services:** There are two circumstances in which a PAS provider can authorize services.

3.10.7.13.1 First, a provider can authorize services for a new client who needs immediate services for the purpose of maintaining their health and safety. Reference PAS/SDPAS 414 for the paperwork and process that must be completed in order for a PAS provider to temporarily authorized services. A referral must be sent to the contract entity once a high risk intake visit has been completed so the contract entity can complete the overview and profile.

3.10.7.13.2 Second, a provider can authorize services when the client, personal representative, or agency determines that the hours and services that are currently authorized are inappropriate to meet the needs of the client. Reference PAS/SDPAS 417 for the paperwork and process that must be completed by the PAS agency in order for a PAS provider to temporarily authorize services. An amendment form must be sent to the contract entity if the change in authorization will last more than 20 days so the contract entity can update the overview and profile.

3.10.7.14 **Out of State Services:** The Department may contract with out of state agencies to provide PAS for a client who is residing out of state temporarily

3.10.7.15 **Provider Enrollment**

3.10.7.15.1 Personal Assistants cannot operate as independent contractors. A personal assistant is an employee of the provider agency. PAS providers are limited to businesses incorporated under the laws of the state of Montana.

DRAFT

3.10.7.15.2 In order to enroll as a Medicaid PAS provider the PAS providers must:

a. Demonstrate that they are paying workers' compensation and unemployment insurance.
b. Provide their articles of incorporation
c. Provide general liability insurance of $100,000
d. Provider motor vehicle insurance of $100,000
e. Provide current worker's compensation and unemployment insurance coverage
f. Submit a written contingency plan, which is approved by the Department, that addresses service delivery to clients in the event an agency is unable to deliver services in a timely manner or in the event the agency ceases operation
g. Provider proof of financial solvency, which means the agency is able to make a projected four month payroll
h. Attend a two-day PAS 101 training, which is sponsored by the Department twice each year

3.10.7.16 Provider Requirements (Reference PAS 602/SDPAS 602): PAS providers are required to follow all Department rules, policies and procedures, which include:

3.10.7.16.1 Document and verify Medicaid eligibility on a monthly basis

3.10.7.16.2 Complete the intake process with required paperwork as referenced in PAS 701/PAS 702 and SPDAS 702. Visit must be done in the client's home.

a. For ABPAS the intake process must be completed by a licensed nurse
b. For SDPAS the intake process must be completed by someone trained in SDPAS program parameters

3.10.7.16.3 Complete re-certification at intervals that do not exceed 180 days or when there is a significant change in the functional needs of the client as referenced in PAS 703 or SDPAS 602 and 703. Visit must be done in the client's home.

a. For ABPAS the intake process must be completed by a licensed nurse
b. For SDPAS the intake process must be completed by someone trained in SDPAS program parameters

3.10.7.16.4 Conduct temporary authorization and amendments, as necessary, when client condition changes

a. For ABPAS the intake process must be completed by a licensed nurse
b. For SDPAS the intake process must be completed by someone trained in SDPAS program parameters

3.10.7.16.5 Successful completion of the quality assurance process

3.10.7.16.6 Maintain a pool of trained attendants (ABPAS only)

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a. ABPAS attendants must receive 16 hours of training or have their training waiver prior to working with a client. Reference PAS 706 for more details about the training requirements
b. ABPAS attendants must receive at least 8 hours of in-service training in order to work with a client. Reference PAS 706 for more details.

3.10.7.16.7 Provide the client or personal representative with program enrollment information, program philosophy and department policies, complaint procedures, forms for ongoing participation, and procedure to have a personal assistant hired by the provider (SDPAS only)

3.10.7.16.8 Provide a grievance procedure for clients

3.10.7.16.9 Provide advance notice to clients who are being discharged

3.10.7.16.10 Timely response to contract entity regarding annual re-authorization visits

3.10.7.16.11 Complete an annual client survey as outlined in PAS 912 and SDPAS

3.10.7.16.12 Maintain required records as outlined in PAS 608 and SDPAS 608

3.10.7.16.13 Review, approve, sign and date all service delivery records (time sheets). The provider can only bill for services performed by the personal attendant if the time and tasks are authorized by the contract entity or if a temporary authorization is in place.

3.10.7.16.14 Providers that participate in direct care wage bonus funding are required to provide annual reports on the fund distribution

3.10.7.16.15 Providers that participate in health insurance funding are required to provide quarterly reports of the fund distribution

3.10.7.17 The ABPAS provider must staff a licensed nurse to supervise personal assistants in the delivery of personal assistance services.

3.10.7.18 The nurse supervisor must perform all of the intake and 180 day visits as well as all of the amendments for PAS clients. In addition, nurse must oversee and certify the initial training or waiver of training for new personal assistants, the in-service training for all current attendants, and the orientation of attendants to PAS client service plans. Reference PAS 702 and 706 for more information on the role of the nurse supervisor.

3.10.7.19 All employees of a provider participating in Medicaid PAS are mandatory reporters of suspected abuse, neglect, and exploitation. In addition, the PAS provider must report all serious occurrence reports, as outlined in Community Services Bureau (CSB) Policy Manual section 305. All employees of the agency must comply with the standards of charting, as outlined in CSB Manual section 306.

3.10.8 Provider Compliance

3.10.8.1 Providers of PAS are subject to compliance reviews to provide assurance to the Department that services are being provided within the rules and policy of the program. The reviews take place on one year to three year cycles, depending upon the outcome of

the previous review. A review may be conducted at other times as determined by the Department. The following areas are reviewed for compliance:

3.10.8.2 For ABPAS: Attendant Training Requirements, Attendant Training Records, In-Service Training Requirements, Nurse Qualifications, Serious Occurrence Reporting, Client Survey, Provider Requirements, Client Information, Provider Organizational Structure, Standard Authorization Documentation, High Risk Authorization, Amendments/Temporary Authorization, Service Delivery Records reflect service authorization, Nurse Supervision, PAS services billed correctly, Required Documentation (aside from authorization documentation), Principles of Charting, Client Interviews, Provider Reference Checks. For complete details on the review standards reference the Regional Program Office Desk Manual Sections 504(b) and 508.

3.10.8.3 For SDPAS: Serious Occurrence Reporting, Client Survey, Provider Requirements, Client Information, Provider Organizational Structure, Standard Authorization Documentation, High Risk Authorization, Amendments/Temporary Authorization, Health Care Professional Authorization, Service Delivery Records reflect service authorization, Program Oversight, PAS services billed correctly, Required Documentation (aside from authorization documentation), Principles of Charting, Client Interviews, Provider Reference Checks. For complete details on the review standards reference the Regional Program Office Desk Manual Sections 504(a) and 509.

3.10.8.4 The Department may review other areas of the program at its discretion.

3.10.8.5 The Department reviews a minimum of 3 charts or between 10-15% of the provider's caseload, whichever is greater, for the purpose of the compliance review.

3.10.8.6 Depending upon the review standard, the provider must meet at least 75%-100% of the cases to be considered compliant. If the provider does not meet the standard the provider will be given the results of the review and a second compliance review will be scheduled. The provider must meet all standards in 75%-90% of the cases in the second review or the provider will be subject to sanctions.

3.10.8.7 For information on the Department's sanction process reference ARM 37.85.501, 37.85.502, 37.85.505, 37.85.506, 37.85.507, 37.85.511, 37.85.512 and 37.85.513.

3.10.9 Reimbursement (Reference PAS 606 and SDPAS 606)

3.10.9.1 Payment for PAS is contingent on the following factors:

3.10.9.1.1 Client has received prior authorization by the contract entity and services are delivered within an authorized span or as appropriate for high risk services or a temporary authorization of an existing authorization. If services are provided without authorized span, high risk, or temporary authorization or services were initiated outside the scope of the program, repayment will be required.

3.10.9.1.2 Service are delineated in the client's service plan (profile authorization)

3.10.9.1.3 PAS provider has required necessary paperwork to deliver services. If the required paperwork is not preset, repayment will be required.

a. Intake visit
b. Re-certification (180-day visit)

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c. Health Care Professional Authorization (SDPAS only)

3.10.9.2 Payment to the PAS provider is based on a unit rate for PAS set by the Department. Reimbursement is negotiated with the Department.

3.10.9.3 The negotiated rate is determined based on two factors.

a. The first factor is whether or not the provider participated in the 2007 Direct Care Worker Funding Initiative and agreed to pay their personal assistants a minimum of $9.35 per hour.

b. The second factor is whether or not the provider participates in the Department's health insurance initiative.

3.10.9.4 Show up time is not billable to Medicaid.

3.10.9.5 Travel time is an administrative expense and has already been included in the unit rate.

3.10.9.6 Under the ABPAS option reimbursement is provided for the following categories (reference PAS 606):

a. Personal care service, which means an on-site visit to deliver PAS specific to a client Service Plan. A unit of service is 15 minutes.

b. Nurse Supervision, which means an on-site client visit or a related activity specific to that client.

c. Mileage may only be billed in conjunction with authorized escort, offsite laundry, or shopping. Odometer readings and documentation of specific destination are required to support claims for reimbursement. A unit of service is one mile.

3.10.9.7 The ABPAS rate for both personal care service and nurse supervision is $4.82. In order to receive this rate a provider must pay their personal attendants at least $9.35/hour. If a provider does not pay this minimum wage to personal attendants their rate is $4.54. The rate for mileage is $.33.

3.10.9.8 Under the SDPAS option reimbursement is provided for the following categories (reference SDPAS 606):

a. Personal care service, which means an on-site visit to deliver SDPAS specific to a client Service Plan. A unit of service is 15 minutes.

b. Program Oversight, which means an on-site client visit or a related activity specific to that client.

c. Mileage may only be billed in conjunction with authorized escort, offsite laundry, or shopping. Odometer readings and documentation of specific destination are required to support claims for reimbursement. A unit of service is one mile.

3.10.9.9 The SDPAS rate for both personal care service and nurse supervision is $4.05. In order to receive this rate a provider must pay their personal attendants at least $9.35/hour. If a provider does not pay this minimum wage to personal attendants their rate is $3.77. The rate for mileage is $.33.

3.10.9.10 An agency that participates in the health insurance for health care worker funding initiative receives a monthly gross adjustment to cover personal assistant worker health insurance premium costs, in addition to the rates outlined above.

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3.10.10 Reporting

3.10.10.1 Data provided through OPAS (the database used by the contract entity to authorize PAS and collect data):

3.10.10.1.1 Monthly authorization report- our contractor (MPQH) submits monthly reports that provide, by program option (ABPAS or SDPAS), the total number of hours authorized and number of units authorized, total # of clients, and average authorization per client.

3.10.10.1.2 The OPAS database collects data specific to each client that is authorized for PAS. Data includes demographic information, medical history, primary diagnosis, and overall health status and need for personal assistance service. In addition, data is captured specific to each of the ADL and IADL services the client needs. For each client by task there is data available to us that includes: impairment level, description of need, frequency of authorization (days per week), minutes per day

3.10.10.1.3 The annual authorization report by agency lists the names of the clients who were authorized services for an annual period of time at a specific provider agency. The report is broken apart by ABPAS and SDPAS, lists each client, and by client lists the # of amendments, high risk, discharge, etc. The Dept uses this report to select a sample of charts for PAS provider compliance review standards

3.10.10.2 Data provided by the provider agency:

3.10.10.2.1 Service Delivery Records (SDR) - every unit of service that is billed for PAS must correspond to a SDR that documents date of service, time in and out, and tasks that were performed. We do not get a report that summarizes this information, but we do review the records as part of our QAR (see below)

3.10.10.2.2 Client list with intake date, 180-day visit date and discharge date. Prior to every QAR the agency is required to submit a report that details this information.

3.11 HOSPICE SERVICES

3.11.1 General Overview; Hospice Services are authorized by Section 1905 (1) (18) of the Social Security Act and governed by the federal regulations which define home health services, who can deliver services, service requirements, and recipient eligibility. The regulations are provided in CFR 42.418.1-42.418.311.

All Hospice Services must comply with federal regulations. In addition, Montana has additional program parameters, which are referenced in this document.

The Hospice program provides health and support services to terminally ill clients and their families. These programs focus on palliative rather than curative care to help the client and those closest to the client to come to terms with the terminal condition and live the remaining life as fully as possible. When a client selects Hospice Care, he or she waives all Medicaid benefits related to curative care. The exception to this is children who are under 21 who may continue to receive curative care while on Hospice Care (reference CMS Director's Letter dated 9/9/10).

3.11.2 Population: To be eligible for Hospice Services, a person must meet all of the following criteria:

a. Medicaid eligible
b. Must be certified as being terminally ill in accordance with Medicare certification requirements set forth in ARM 37.40.808.
c. Must sign a Hospice election statement

Client may live in either his or her home in the community or in a nursing facility while receiving Hospice Services.

3.11.3 Provision of Hospice Services

3.11.3.1 Hospice Services are provided under the following conditions:

a. Must be provided by a licensed Hospice agency;
b. Must be reasonable and necessary for the palliation or management of the terminal illness as well as related conditions;
c. Individual must elect Hospice care, as outlined in ARM 37.40.815;
d. A plan of care must be established as set forth in ARM 37.40.805 and 37.40.807 before services are provided;
e. Services must be consistent with the plan of care; and
f. A certification that the individual is terminally ill must be completed as set forth in ARM 37.40.808

3.11.3.2 For covered Hospice services, Medicaid will generally pay for services covered by Medicare, as referenced in CFR 42.418.202-42.418.204 except for those provisions which apply to physicians' services. Physician Services is a covered hospice service and must be performed by a doctor of medicine or osteopathy.

3.11.4 Election and Revocation and Waiver of Benefits

3.11.4.1 A client who is eligible for Hospice Care or his representatives must file an election statement with a particular hospice agency in order to receive care. The Department follows Medicare guidelines in administering this provision. An individual waives all rights to Medicaid payments for the duration of the election of the hospice care as set forth in AMR 37.40.815.

3.11.4.2 A client or representative may revoke the individual election of hospice care at any time during an election period. After revoking Hospice election, the client may receive any Medicaid benefits previously waived when Hospice Care was chosen. A client may elect Hospice again at any time as long as the client meets the Hospice eligibility requirements. The Department follows Medicare guidelines in administering this provision.

3.11.5 Service Description

Hospice Services include:

a. Counseling services
b. Crisis services
c. Home health services
d. Inpatient hospice care
e. Inpatient respite care
f. Medical supplies
g. Nursing services
h. Physician services
i. Social worker services
j. Therapy services

3.11.6 Service Exclusions

3.11.6.1 When a client requires medication that is not related to their terminal condition and it is not curative, it will be covered by the client's Medicaid Pharmacy benefit.

3.11.6.2 A client may receive services provided by their attending physician when the services are palliative only and not related to the treatment of the terminal condition for which the hospice care was elected. In this circumstance, the physician bills Medicaid separately from Hospice for these services.

3.11.6.3 Clients who qualify for mental health services may receive mental health services during hospice care.

3.11.6.4 Services used for curative care are not covered by hospice unless the client is under 21. Curative care may be provided by the hospice when the purpose is to make the client more comfortable, but it must be included in the hospice payment.

3.11.7 Change in Agency

A client may change hospice providers once in each election period. The Department follows Medicare guidelines in administering this provision.

3.11.8 Client Termination

3.11.8.1 Client participation in the program terminates when either the client no longer has a terminal diagnosis or the clients elects off of the Hospice benefit.

3.11.8.2 The Hospice provider may discharge a client for other reasons. This is an action of the provider and the provider must provide advance notice to the client based on the provider's established policy. In all cases the provider agency must make a reasonable effort to ensure continuity and appropriateness of care through referrals to other providers.

3.11.9 Out of State Services

Hospice Services may be provided by providers located out of state if the service meets the Hospice Service requirements. The out of state provider must meet the provider enrollment criteria.

3.11.10 Provider Enrollment and Participation

3.11.10.1 A hospice agency must be:

a. Licensed by the Montana Department of Public Health and Human Services (Department)
b. Meet Medicare's conditions of participation and have a valid provider agreement with Medicare
c. Enrolled as a Medicaid provider
d. Provide the Department with a list of physician volunteers and physicians employed by the Hospice
e. Must notify the Department when the client's attending physician is not a Hospice employee
f. Comply with all form requirements, as referenced in the Hospice Care Services Manual, Section 2.3

3.11.10.2 All employees of an agency participating in Medicaid Hospice services are mandatory reporters of suspected abuse, neglect, and exploitation. In addition, the hospice agency must report all serious occurrence reports, as outlined in Community Services Bureau (CSB) Policy Manual section 305. All employees of the agency must comply with the standards of charting, as outlined in CSB Manual section 306.

3.11.10.3 The Hospice provider must use the forms outlined in section 2.3 of the Hospice Care Services manual. These forms include the plan of care, election statement, revocation statement, physician's certification statement, and physician's recertification statement.

3.11.11 Reimbursement

3.11.11.1 Medicaid payment for covered Hospice Care is made in accordance with the specific categories of covered Hospice Care (routine home care day, continuous home care day, inpatient respite day, and general inpatient care day) and the payment amounts and procedures established by Medicare detailed in CFR 42.418.302. Medicaid will not pay separately for palliative treatment, which is included in the hospice daily rate.

Reference ARM 37.40.830 and Hospice Care Services Manual section 4.3 and 4.4 for more information.

3.11.11.2 The board and room rate to be paid to a Hospice provider for a client who resides in a nursing facility is up to the Medicaid rate established by the Department for the client minus the amount the client pay towards his/her own cost of care. Payment for room and board is made to the Hospice provider who in turn reimburses the nursing facility. Reference ARM 37.40.830.

3.11.11.3 Services performed by Hospice physicians, including general supervisory services of the Hospice medical director and participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the physician member of the interdisciplinary group, are included in the Hospice rates. For other physician payments reference ARM 37.40.830. Hospice payments are subject to a cap, as detailed in federal regulations CFR 42.418.302 and ARM 37.40.830.

3.11.11.4 In most cases, the Hospice provider must bill other insurance carriers before billing Medicaid. Reference Hospice Care Services Manual section 3.1-3.3 for information on coordination of benefit coverage.

3.11.12 Reporting

Hospice providers must submit client election statements to the Department when a client selects the Hospice benefit. Reports come out of MMIS. If encounter claims use same provider type and coding we should get the data we need.

3.11.13 Requirements under Managed Care

3.11.13.1 Service Scope

3.11.13.1.1 Offeror must ensure that the scope of the service (i.e. type of service and service description) that is available under the current system is maintained.

3.11.13.1.2 Offeror must ensure that the provision of service under the current system is maintained.

3.11.13.1.3 Offeror must ensure that the licensure for those who perform skilled and therapy services is maintained.

3.11.13.1.4 Offeror must ensure that eligibility for service is maintained.

3.11.13.2 Service Access

3.11.13.2.1 Client must have choice of at least two providers in each of the counties (if unable to provide choice the Offeror should justify why this cannot occur).

3.11.13.2.2 Offeror must ensure that a client who qualifies for Hospice Services is provided the choice of this service, but is not forced to receive this service.

3.11.13.2.3 Offeror must ensure that a client who selects the service receives the service from a qualified provider.

3.11.13.2.4 Offeror must ensure that clients are able to elect out of the Hospice benefit at any time and in so doing receive curative services in a timely manner.

3.11.13.3 **Provider Enrollment**

3.11.13.3.1 Providers must meet the same enrollment criteria as currently exists.

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3.11.13.3.2 Providers enrolled as Medicaid providers would automatically be enrolled in the provider network for a period of not less than one year post implementation of managed care.

3.11.13.4 Provider Complaints

3.11.13.4.1 Offeror has a plan to respond to provider concerns regarding the authorization of services.

3.11.13.4.2 Offeror provides a quarterly report to the Department on the number of complaints, by provider, by type and by resolution.

3.12 HOME AND COMMUNITY BASED WAIVER SERVICES

3.12.1 Service Description

The Home and Community Based Services (HCBS) Waiver Program is a concurrent 1915 (c) and 1915(b) Waiver, providing services and supports in homes and communities to persons who would otherwise require placement in a nursing facility or hospital. The HCBS Waiver Program is designed to allow people with disabilities and elders to live as independently as possible in the most integrated setting available. It provides sufficient support to allow clients to achieve their goals; thereby perpetuating the intent of the ADA and ensuring compliance with Olmstead.

3.12.1.1 HCBS Waiver services are provided utilizing two distinct approaches to the provision of services:

3.12.1.1.1 Traditional waiver service model:

a. Case management is a mandatory service;
b. Case management teams (CMT's) coordinate care and services, in conjunction with the waiver client;
c. CMT's operate and manage a budget to provide the needed care to their enrolled participant's within their service area; and
d. Clients can elect to self-direct their waiver services or receive them through an agency-directed model.

3.12.1.1.2 Client–Directed service model, referred to as Big Sky Bonanza (BSB):

a. Independence Advisor and Financial Manager are mandatory services;
b. The waiver client coordinates care and services with the assistance necessary from their Independence Advisor;
c. The combined cost of State Plan Personal Assistance Services and HCBS Waiver services make up the client's individual budget;
d. The waiver client manages the individual budget to provide for their needed services, with the assistance of their Financial Manager; and
e. Client's selecting this option must self-direct their Community Support Services and their Client-Directed Goods and Services.

3.12.2 Population

3.12.2.1 Individuals receiving services in the Home and Community Based Services (HCBS) Waiver Program require nursing facility level of care, are elders 65 and older or are people with a disability, as determined by the SSA.

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3.12.2.2 A small percentage of individuals served at home are ventilator dependent and would either be in a hospital or in out-of-state facilities if it were not for the HCBS Waiver program.
3.12.2.3 The program also serves individuals with traumatic brain injuries or individuals with other more severe disabilities who would have been in out-of-state rehabilitation facilities, inpatient rehabilitation or remained inappropriately placed in nursing homes, group homes, or other institutions were it not for the specialized services available under the HCBS Waiver program.
3.12.2.4 There is no age limit with respect to access to HCBS Waiver services.

a. 60% of waiver clients are 65 or older.
b. 4% are under the age of 18.
c. Approximately 83% of recipients are dual eligible (Medicaid and Medicare eligible).
d. 35% are medically needy and must incur costs in order to be financially eligible for Medicaid services, including the HCBS Waiver.

3.12.3 Eligibility

3.12.3.1 A person is eligible to be considered for enrollment in the HCBS Waiver program if the person:

a. Is 65 years of age or older or is certified as disabled by the social security administration but does not have a primary diagnosis of mental retardation;
b. Is Medicaid eligible;
c. Requires the level of care of a nursing facility: and
d. Have needs that can be met through the program.

3.12.3.2 The Offices of Public Assistance verify the first two requirements.
3.12.3.3 Mountain Pacific Quality Health makes the level of care determination and completes the PASRR Level I screen (for indications of mental retardation or mental illness) using criteria set forth by the Department (LOC Criteria – Revised 2005).
3.12.3.4 Mountain Pacific Quality Health (MPQH) completes a Preadmission Determination and Functional Assessment to determine if the individual meets level of care requirements for admission to the waiver.
3.12.3.5 Medicaid financial eligibility for HCBS Waiver differs from regular Medicaid in three ways:

a. This waiver offers waiver of deeming for those under the age of 21;
b. Spousal impoverishment rules apply for community spouses; and
c. Transfers of assets are reviewed.

3.12.4 Slots: The HCBS Waiver budget is controlled via the allocation of slots and dollars. There are five types of slots each of which has a historically-determined annual dollar amount attached to it. These dollar amounts change as the cost of providing the services changes.

3.12.4.1 Basic Slot $17,500: An individual in a basic slot typically received the following HCBS Waiver services: case management, personal care supervision/socialization, respite, personal emergency response system, transportation, meals, private duty nursing, and homemaker. Basic slots allocated within the 5 county project area = 161
3.12.4.2 Adult Residential Slot $27,000: A person in an AR slot receives case management and is either in an assisted living facility or an adult foster home. 34 percent of waiver recipients are served in adult residential care facilities. AR slots allocated within the 5 county project area = 141
3.12.4.3 Supported Living Slot $61,500: These slots are for individuals with a traumatic brain injury or other severe physical disability who require supports beyond those available in the above two slots. They typically have someone on-call 24/7 in addition to the hands on care and supervision. Supported Living slots allocated within the 5 county project area = 11

3.12.4.4 Group Home/Beehive/Liberty Place $60,000: There are two group homes and three specialized assisted living facilities that serve individuals with brain injuries and severe disabilities. The ratio of staff to clients as well as staff training requirements exceeds that of other facilities. 51 individuals are currently in these slots. Specialized residential slots within the 5 county project area = 5

3.12.4.5 Ventilator Dependent Heavy Care Slot $250,000: There are 11 individuals in these slots who require someone at their side 24/7. Sometimes family members are available to assist; but mostly HCBS Waiver covers around-the-clock private duty nursing. Heavy care slots within the 5 county project area = 2

3.12.4.6 Big Sky Bonanza (BSB) Slots: These are slots for those clients who have indicated a desire and completed the training to direct their services and manage an individual budget. The budgets vary for each individual based on their HCBS Waiver cost plan and authorized State Plan hours. BSB slots within the 5 county project area = 10

Case Management Teams manage their case load of basic and adult residential slots (with minor exceptions). Clients and Financial Managers manage their BSB slots and the remaining three categories of slots are managed by the Community Services Bureau (CSB) staff. The latter comprise about 6% of the total caseload.

3.12.5 Waiting List. Open waiver slots must be equally available to all eligible individuals in the Case Management Team's (CMT) service area. When all waiver slots are filled, a waiting list must be established by the CMT to select individuals most in need of services.

3.12.5.1 Entry into the waiver is based on prioritized need as established by the criteria in the Waiting List Tool.

3.12.5.2 The Waiting List Tool scores individuals eligible for the waiver according to 10 criteria, including cognitive impairment, risk of medical deterioration without services, risk of institutional placement or death, need for formal paid services, need for adaptive aids or environmental modifications, and health and safety issues that place the individual at risk.

3.12.5.3 This tool was developed to assist CMT's in prioritizing each applicant's needs. The instrument is designed to compliment professional judgment in determining which applicant is in most need of services.

3.12.5.4 Individuals placed on the waiting list must be assessed in person within 60 days of the date of the formal referral.

3.12.5.5 The traditional elderly/disabled HCBS waiver case managers manage the waitlist.

3.12.5.6 The CMT assists applicants in securing needed support or other available services until the individual can be admitted to HCBS waiver services.

3.12.5.7 Individuals or family members of an individual on the waiting list must be contacted quarterly to ensure that the waiting list is up-to-date. Waiting list reports must be continually reviewed to ensure that individuals on the list are still in need of services.

3.12.6 Expenditures/Reimbursement

3.12.6.1 The 1915(c) HCBS waivers are required by statute to be cost-neutral relative to institutional care. The program was designed to provide a cost-neutral alternative to institutional care, requiring the States to keep waiver costs at or below those of comparable institution-based service. States can choose to do so on the aggregate or by limiting individual cost plans. Montana has selected the former to allow service provision to individuals with higher cost plans.

3.12.6.2 The total budget for FY 09 was $31,445,000. This waiver has provided LTC services to individuals at an aggregated average per capita cost of approximately $52/day or

$1,560/month in FY 09. The average per capita cost including all Medicaid services (non-waiver state plan services) was about $66/day or $1,980/month in FY 09. This includes all the types of slots listed above.

3.12.6.3 Fees for services have an upper limit and are negotiated by the CMT's or BSB clients. However some rates are non-negotiable and many others are routinely reimbursed at the upper limit. (See HCBS Fee Schedule on ACS web page).

3.12.7 Quality Assurance and Improvement

3.12.7.1 The HCBS/BSB waiver programs have a system in place to provide for continuous quality assurance and improvement. This system includes activities of discovery, remediation and quality improvement so that the State Medicaid Agency learns of critical incidents or events that affect individuals, corrects shortcomings and pursues opportunities for system improvement. The State Medicaid Agency also has overall responsibility for monitoring the system performance measures and individual outcome measures.

3.12.7.2 The Community Services Bureau, as a part of the quality assurance system, conducts annual comprehensive evaluations of the Case Management Teams and Independence Advisor and Financial Manager services to meet the Bureau's quality improvement requirements for a federally approved waiver program. The purpose of these reviews is to insure that optimal services are being provided to clients and that program rules and policies are being followed. Quality improvement results are utilized to improve programs and services. The quality assurance reviews include:

a. Provider prepared standards;
b. On-site record reviews;
c. Client interviews

3.12.7.3 Detailed information about the Quality Improvement Review process and standards can be referenced in HCBS policy 608 and BSB policy 615, 616, 617.

3.12.8 HCBS Traditional Waiver Option

3.12.8.1 The Home and Community Based Services (HCBS) Waiver Program for elderly and disabled is a concurrent 1915(b)/(c) waiver. It offers an alternative to institutional level of care while restricting freedom of choice of CMT's.

3.12.8.2 The program makes available a wide range of non-traditional medical and non-medical services that are otherwise either not covered or limited under state plan. The menu of services is necessarily extensive to ensure that the most appropriate and beneficial supports can be provided. (See HCBS Manual 700 Section).

3.12.8.3 Individualized service plans are developed by clients in conjunction with their case management team. Services are selected based upon the client's needs, preferences, desired outcomes, goals, and the services and supports that will assist him/her in achieving desired outcomes. The client will have the authority to determine who is included in the process of service and support plan development. Individuals who have not chosen the participant directed option must have a case management team. The team's function is:

a. Development and review of the service plan with the client
b. Reevaluation of the service plan including a functional assessment and service delivery
c. Coordination of services
d. Linking clients to other programs
e. Monitoring implementation of service plan
f. Ensuring health and safety
g. Addressing problems with respect to services and providers
h. Responding the crises

i. Being financially accountable for waiver expenditures for their client caseload.

3.12.8.4 HCBS Waiver Case Management Teams are the cornerstone of this program. They not only assist clients in gaining access to needed HCBS Waiver and State Plan services; but they also coordinate medical, social, educational and other services funded through other sources. The case managers help ensure that there is a network of qualified providers to meet the needs of the program. They participate in the creation and development of new services; and provide outreach to educate their communities on issues affecting individuals with disabilities and elders.

3.12.9 Big Sky Bonanza Client-Directed Waiver Option:

3.12.9.1 The Big Sky Bonanza (BSB) client-directed option is authorized under Section 1915 (c) of the Social Security Act and governed by the federal regulations which define waiver services, delivery of services, service requirements and recipient eligibility. The regulations are provided in CFR 42 441.300, et. seq.

3.12.9.2 All BSB waiver services must comply with the federally approved waiver MT.0442.R01.00

3.12.9.3 Client-directed Medicaid services means that participants, or their representatives, have decision-making authority over certain services and take direct responsibility to manage their services with the assistance of a system of available supports. The client-directed service delivery model is an alternative to traditionally delivered and managed services and allows participants to have the responsibility for managing all aspects of service delivery in a person-centered planning process.

3.12.9.4 Client-direction promotes personal choice and control over the delivery of waiver and State plan services, including who provides the services and how services are provided. Participants are afforded the decision-making authority to recruit, hire, train and supervise the individuals who furnish their services (employer authority) and have decision-making authority over how the Medicaid funds in a budget are spent (budget authority).

3.12.9.5 Requirements of client-directed waiver services:

3.12.9.5.1 Client Training: Clients or their personal representative must participate in a state developed training and pass a readiness review, prior to their enrollment in the BSB waiver option.

3.12.9.5.2 Support Broker Training: Support broker service provider with BSB (Independence Advisors and Financial Managers) must attend state developed client-direct training and receive certification before providing services.

3.12.9.5.3 Person Centered Planning Process: A person-centered planning process and assessment must be used to develop a person-centered plan. The process is directed by the individual, with assistance as needed or desired from a representative of the individual's choosing and their support broker (BSB Independence Advisor). This process identifies strengths, capacities, preferences, needs and desired measurable outcomes for the individual. Details of this planning process are referenced in BSB policy 907 and 911.

3.12.9.5.4 Service Plan: A service plan (BSB Support Services and Spending (SSSP)) is the written document that specifies the services and supports that are to be furnished to meet the preferences, choices, abilities and needs of the client and that assist the client to direct those services and supports and remain in the community. The client develops their SSSP, with the assistance of their Independence Advisor, to describe their needs, the services required to meet those needs and the cost to cover the needs. The SSSP form is referenced in BSB policy 911.

3.12.9.5.5 Individualized Budget: An individualized budget specifies how the funds, which are under the control and direction of the individual, will be utilized. The Individual Budget is based on the client's need for services and support and becomes the total amount of money they may spend for the services outlined in the SSSP. The BSB budget is determined using historic HCBS waiver service plan costs and State plan personal assistance service authorization. Reference BSB policy 912.

3.12.9.5.6 Information and Assistance in Support of Client-Direction: BSB provides a system of supports that are responsive to clients needs and desires for assistance in developing the person-centered service plan and budget, managing the individual's services and workers and performing the responsibilities of an employer. Client-directed supports include, but are not limited to:

a. Information regarding system processes;
b. Individual rights and responsibilities;
c. Available resources;
d. Counseling;
e. Training
f. Assistance

3.12.9.5.7 The amount and frequency with which an individual uses the available supports varies from person to person and circumstance to circumstance. BSB support services include:

3.12.9.5.8 Independence Advisor (IA): This is a mandatory service for clients enrolled in the BSB waiver.

3.12.9.5.9 Financial Manager (FM): This is a mandatory service for clients enrolled in the BSB waiver and must be available to assist individuals in exercising budget authority.

3.12.9.6 Benefits of client-direction for the enrollees

3.12.9.6.1 Control: participant direction lets participants decide who provides their services, when the services are delivered, and what assistance they need.

3.12.9.6.2 Flexibility: Participant direction lets participants buy things they really need, when they need them.

3.12.9.6.3 Independence: Participant direction helps participants who need daily assistance maintain their independence at home.

3.12.9.7 Individual Election of Client-Direction

3.12.9.7.1 The Community Services Bureau (CSB) provides information and counseling to participants about self-direction so they can make an informed choice whether to self-direct. CSB also allows participants to voluntarily terminate self-direction and return to receiving provider-managed services.

3.12.9.7.2 When a person voluntarily ends self-direction (or the CSB determines that self-direction should be terminated involuntarily), the CSB ensures that the individual continues to receive critical services during the transition period.

3.12.9.8 Risk Assessment and Mitigation

3.12.9.8.1 Training will be provided to every potential BSB client to prepare them for playing a greater role in the support and service planning and delivery process. The training includes information on health and safety factors, emergency back-up planning and risk identification, assessment and management.

3.12.9.8.2 Clients conduct a self-assessment to determine how informed they feel regarding the planning and implementation process.

3.12.9.8.3 Emergency back-up plans and risk identification and management are included in the client's service and support plan and are defined and developed on

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an individual basis. The emergency back-up plan may include an assessment of critical services and a back up strategy for each identified critical service. Back up may include:

a. Client back up (peer support) incorporated into the plan;
b. Informal back up (family, friends, neighbors);
c. Enrolled Medicaid provider network (personal assistance agencies)
d. System level back up (local emergency response).

3.12.9.8.4 Clients will be able to access money in their self-direct budget to pay for back up services. The IA and client will track and monitor back up utilization as part of the service and support plan quality management process.

3.12.9.8.5 The Regional Program Officer (RPO) reviews every service and support plan to assure that it meets health care needs and that there is proper documentation for emergency backup and risk management procedures.

3.12.9.8.6 The CSB Waiver Program manager reviews every initial service and support plan.

3.12.9.9 **BSB Services**: The approved menu of services provided under the BSB waiver option includes client-directed services and traditional services. Full detail of the BSB services can be referenced in the BSB 700 section of policy. ARM references, as appropriate, are referenced within each policy.

3.12.9.9.1 **Client Directed Services**

3.12.9.9.1.1 Community Support Services: Service provided by individuals recruited, selected, trained, hired and managed by the BSB client to perform a variety of tasks and include personal assistance, homemaking, chores, transportation and respite. These services differ from traditional waiver services in two ways:

a. They do not need to be provided by a Medicaid-enrolled agency;
b. The service provider does not bill Medicaid directly for services. Instead the client bills for their services through a Financial Manager (FM). The FM pays these providers using the client's monthly budget.

The client directs the support services and is responsible for submitting time sheets and invoices to the FM for payment. Providers of this service must accept the client's negotiated rate and agree to never charge the client additional money. Full details of Community Support Services can be referenced in BSB 705 policy.

3.12.9.9.1.2 Client-directed Goods and Services: BSB allows for clients to select services and goods that are unique to meet their needs and preferences. These are services, equipment, supplies, or goods not otherwise provided through this waiver or Medicaid State Plan. Items must address an identified need in the client's Support Services and Spending Plan and meet the following requirements:

a. Decrease the client's need for other Medicaid services;
b. Promote the client's inclusion in the community;
c. Promote the client's independence;
d. Fulfill a medical, social, or functional need based on unique cultural approaches; or
e. Increase the client's safety at home.

These goods and services cover a wide range based on individual needs and preferences and are reviewed and approved by the

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Community Services Bureau on an individual basis. Approved goods can range from small appliances or communication aids to a wheelchair accessible van. Approved services can include non-traditional services, such as, massage for chronic pain or muscle contractures, hippotherapy for improved balance or muscle tone, clarinet lessons for increasing lung capacity or cranio-sacral therapy to help prevent seizures. The variety of theses goods and services is as unique as each individual receiving BSB services and a vital component of the self-directed philosophy. Full details of Client-Directed Goods and Services can be referenced in BSB 706 policy.

3.12.9.9.1.3 Financial Management: Includes full bookkeeping, payroll, accounting and human resource activities for BSB clients or their personal representative. The FM agency is the employer of record for the client's employees. These services assure that the funds to provide services and supports outlined in the client's plan are implemented through a client-directed approach and are managed and paid appropriately as authorized. This is a mandatory service for client-direction. BSB 708

3.12.9.9.1.4 Independence Advisor: Includes a full array of client-directed support activities to ensure the ability of BSB clients to direct their care successfully. Clients can choose from any qualified and enrolled provider. This is a mandatory service for client-direction. Individual IA employees cannot also provide financial management services to the same clients. BSB 710

3.12.9.9.1.5 Private Duty Nursing: Medically necessary services provided to clients who require continuous in-home nursing care that is unavailable from a home health agency or under the Medicaid EPSDT program for children. These services may be client-directed or provided as a traditional waiver service. BSB 715, 909

3.12.9.9.2 Traditional Waiver Services. BSB Clients can access certain traditional waiver services. Providers of traditional waiver services must:

a. Be enrolled in the Montana Medicaid Program through ACS;
b. Meet the requirements in ARM 37.85.401 through 37.85.512; and
c. Meet all specific provider qualifications as listed in the pertinent BSB 700 Policy sections.

3.12.10 Managed Care Requirements for Home and Community Based Services

A wide range of community-based long term care services will be available under the managed care plan. The services are designed to keep people as independent as possible in the community for as long as possible. These services range from home chore services or assistance with activities of daily living (like eating, bathing, etc.) to comprehensive or intensive services like those available under the Home and Community-Based Waiver Program. Below is an explanation of the community-based services that will be available to those who are eligible for the managed care pilot project.

3.12.10.1 Personal Assistance Services

Personal assistance services (PAS) are in-home services provided to individuals whose chronic health problems cause them to need help in performing activities of daily living. PAS will be available to people on an entitlement basis. The following must be included as part of PAS.

3.12.10.1.1 Personal Care - Activities related to a person's physical health and personal hygiene. Examples of personal care activities include bathing, eating, dressing, grooming, routine hair and skin care, toileting, help with self-administered

medication and transfer/ambulation.
3.12.10.1.2 Meal Preparation - Activities related to the provision of food according to a person's needs and wishes. Meal preparation activities include: planning menus; shopping for groceries; and storing, preparing and serving food.
3.12.10.1.3 Household Tasks - Performing incidental household tasks essential to the maintenance of a person's health and safety in the home. Examples of household tasks include housecleaning, laundering, washing dishes, hanging bed linens, shopping for essential health related items and arranging furniture. The household tasks do not include basic homemaker services that maintain an entire household or family. It is expected that when a person lives with a family that the family will provide most homemaker services. Household tasks are available only in conjunction with personal care services and are limited.
3.12.10.1.4 Escort - Accompanying a person on trips to obtain Medicaid reimbursable medical services when the person requires personal care services en route or at the destination, and a family member or caregiver is not available

3.13 CHILDREN'S MENTAL HEALTH SERVICES

3.13.1 Description of Population(s) All Montana youth (see ARM 37.87.102(15) for definition of youth) for whom mental health services are medically necessary and whose families/guardians meet the financial and/or other criteria for Medicaid eligibility are eligible to receive necessary and appropriate mental health services. Access to publicly-funded mental health services is determined both by the level of income of the youth's family, and the youth's qualifying diagnosis accompanied by functional impairment.

The demonstration project should provide eligible youth with a comprehensive, coordinated continuum of care. The system must emphasize effective and efficient assessment, treatment, and rehabilitation in settings that are as close to the youth's home and community as possible and which subject the youth to the least possible restriction consistent with treatment objectives.
The service system should be versatile and responsive to each youth and family's unique needs. The treatment system must provide for the participation of the youth and/or the youth's family in planning, implementation of treatment, and in outcome evaluation.

3.13.2 Definitions Specific to This Population and Services

3.13.2.1 The MCO chosen under this RFP will be responsible for furnishing medically necessary short- and long-term services for the treatment of symptoms and conditions related to a primary diagnosis and functional impairment included in the definition of "serious emotional disturbance" in ARM 37.87.303 The following are the qualifying diagnoses as defined in the ICD-9-CM:

Diagnosis	Code
Childhood schizophrenia	295
Oppositional disorder	313.81
Autistic disorder	299
Pervasive developmental disorder (NOS)	299.80
Asperger's disorder	299.80
Separation anxiety disorder	309.21

Reactive attachment disorder of infancy or early childhood	313.89
Schizo-affective disorder	295.70
Mood disorder	296
Obsessive compulsive disorder	300.3
Dysthymic disorder	300.4
Cyclothymic disorder	301.13
Generalized anxiety disorder (overanxious disorder)	300.02
Posttraumatic stress disorder (chronic)	309.81
Dissociative identity disorder	300.14
Sexual and gender identity disorder	302
Anorexia nervosa (severe)	307.1
Bulimia nervosa (severe)	307.4
Intermittent explosive disorder	312.34
Attention deficit/hyperactivity disorder when accompanied by at least one of the diagnoses listed above.	314

3.13.2.2 In addition to having a qualifying diagnosis, the youth must also consistently and persistently demonstrate behavioral abnormalities in two or more spheres, to a significant degree, well outside normal developmental expectations for a period of at least six months or for a predictable period of six months. With respect to youth under the age of six, severe behavioral abnormality not attributable to intellectual, sensory, or health factors must be exhibited for six months or be predictable for at least six months. Both sets of these qualifying behaviors are defined in ARM 37.87.303

3.13.2.3 Services for a covered diagnosis cannot be denied solely on the basis of an individual also having a non-covered diagnosis. The MCO will be responsible for providing services necessary in the behavioral care and treatment of the covered diagnoses listed above for eligible persons who are dually diagnosed with a covered diagnosis and a non-covered diagnosis.

The MCO will be responsible for detoxification and drug and alcohol treatment and rehabilitation services, for eligible individuals with a covered diagnosis.

Current delivery system and payment method

3.13.2.4 Mental health services currently available on a fee-for-services basis to Medicaid eligible youth when medically necessary include the following list:

3.13.2.4.1 Acute inpatient hospitalization for stabilization and treatment of psychiatric conditions;

3.13.2.4.2 Outpatient hospital care for psychiatric conditions, including emergency room care;

3.13.2.4.3 Psychiatric Residential Treatment Facility (PRTF) services;

3.13.2.4.4 Psychiatric physician services;

3.13.2.4.5 Partial hospitalization services;

3.13.2.4.6 Therapeutic group home services;

3.13.2.4.7 Licensed mental health center services (*outpatient individual and group and family therapy, youth day treatment, therapeutic foster care, therapeutic family care, community based psychiatric rehabilitation services (CBPRS), assessment, consultation, and targeted case management);

3.13.2.4.8 *Private outpatient services from licensed psychologists, social workers, and professional counselors (individual, family, and group therapy; assessment; and consultation);

3.13.2.4.9 Home and Community Based Waiver Services for youth with SED (in lieu of care in a PRTF)

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*Youth and their families can receive up to 24 sessions of outpatient therapy annually without being seriously emotionally disturbed if they have a DSM diagnosis and therapy is medically necessary.

3.13.2.5 Some services may not be reimbursed when they are provided concurrently, either on the same day or at the same time as another service. The chart that outlines what is currently permitted is available on the CMHB website at: www.dphhs.mt.gov/mentalhealth/children/index.shtml.

3.13.2.6 The MCO must give all eligible youth access to all available mental health services in the amount and duration that is medically necessary when the clinical management guidelines are met. The current guidelines are provided in the Children's Mental Health Bureau Provider Manual and Clinical Guidelines for Utilization Management which is posted on the website referenced above under " forms and manuals". While the MCO can change the current clinical guidelines, it is the state's expectation that access to services will not be reduced under this contract.

3.13.3 Specific Outreach, Education, Client Materials

3.13.3.1 The MCO must implement and maintain an assertive outreach and education program in order to ensure that appropriate and needed mental health services are made available through this program to all eligible youth and families. The MCO must also provide written material to each eligible youth/family regarding their rights under this program and the recourse available to them.

The proposal must, at a minimum, address the following areas.

3.13.3.1.1 Seriously Emotionally Disturbed (SED) youth and their families: The State has a particular responsibility to serve youth and their families who have a serious emotional disturbance. The proposal must address how these individuals will be identified and provide assurances that the full range of medically necessary services, including the availability of high fidelity wraparound facilitation and appropriate community-based services will be made available to eligible individuals.

3.13.3.1.2 Access to Services: The MCO must provide eligible members with information sufficient to allow them to easily and appropriately access needed services or assessment, including crisis/emergency services. It must also provide information about the range of available services, the appropriateness of various services, and the procedures for determining when and how services will be available to an individual. It must also provide clear and concise information about how members may appeal treatment decisions or denials.

3.13.4 Client Transition to MCO It is expected that members will need to transition into and out of the managed care plan in the selected counties when their home location changes. The home location of a youth is considered to be the residence of their parent(s) and/or legal guardian. The MCO must provide information describing the process of enrolling or disenrolling members who move, and how the continuity of their care and services will be preserved.

3.13.5 Provider Choice The legal guardians of an eligible member (youth) has optimal freedom in the choice of providers consistent with the state's and the MCO's credentialing standards and the member's treatment needs. The proposal must provide that members will have a choice of mental health providers

within the scope of the treatment plan and the available provider network and should specify under what circumstances a member's choice of providers will be limited and the criteria or standards to be used for restricting a member to a particular provider or set of providers.

3.13.6 Client Engagement It is a generally accepted principle that the treatment of a youth requires the engagement of that person's family, either biological or substitute. The proposal must describe the MCO's strategies of engagement with family members of eligible youth. Engagement should begin with the development of the individual treatment plan and include family involvement in the discharge planning process.

3.13.7 Client satisfaction Measures of family satisfaction and dissatisfaction with the administration, providers, and services of the MCO must be made using survey instruments of demonstrated reliability and validity developed or chosen with the advice and assistance of family members and youth, and approved by the State. Survey instruments should be appropriately structured and worded for the population to which they will be administered. These surveys should be administered to a representative sample of family members of youth and capable youth who are receiving or have recently received services. The survey should include items designed to identify areas of and reasons for dissatisfaction with the MCO. A survey must be administered and reported semiannually. If or when the survey results fall below a minimum threshold in areas identified by the state in cooperation with an organization of family members and youth, a plan of correction must be developed, approved by the state and implemented within the next six week period.

3.13.8 Description of services The array of services contained in the Service Plan must include, but is not limited to the following:

3.13.8.1 Crisis stabilization and emergency services available 24 hours per day each day of the year, to include toll-free telephone access;

3.13.8.2 Evaluation and assessment;

3.13.8.3 Treatment planning and service coordination;

3.13.8.4 Community inpatient hospitalization for stabilization of psychiatric conditions;

3.13.8.5 Services provided on a 24/7 basis under the direction of a physician in a residential psychiatric treatment facility (PRTF) to stabilize the youth's psychiatric condition;

3.13.8.6 Therapeutic group home care provided on a 24/7 basis and staffed with at least one licensed professional in a community setting;

3.13.8.7 Therapeutic foster care provided by specially trained foster parents who receive additional supports in the home setting;

3.13.8.8 Therapeutic family care provided in the youth's permanent home with additional supports for the day to day caregiver(s);

3.13.8.9 Day treatment services which are therapeutic supports provided in a school or non-school setting during the day for youth with serious emotional disturbance (does not include educational resources which are the school's responsibility);

3.13.8.10 Comprehensive School and Community Services (CSCT) which is mental health services of a licensed professional and a behavioral aide provided primarily in a school setting to address the youth's and family's behavioral needs during the day;

3.13.8.11 Community based psychiatric rehabilitation and support (CBPRS) which is a one-to-one aide whose focus is to increase/improve the youth's functional and is provided along with other mental health services;

DRAFT

3.13.8.12 Physician, Advance Practice Nurse, and Physician Assistant services for screening and identifying psychiatric conditions and for medication management;
3.13.8.13 Outpatient hospital care for psychiatric conditions, to include appropriate emergency room care for covered diagnoses;
3.13.8.14 A psychotropic drug formulary
3.13.8.15 Medication management;
3.13.8.16 Assessments; individual, group, and family therapy; and consultations performed by licensed psychologists, licensed clinical social workers, and licensed professional counselors for treatment of specified diagnoses in private practice or in licensed mental health centers;
3.13.8.17 Targeted case management services for individuals with serious emotional disturbance;
3.13.8.18 Family information and education services;
3.13.8.19 Intensive home and community based waiver services in lieu of care in a PRTF in Cascade and Lewis and Clark counties only.

3.13.9 The Department believes that community-based services are essential for youth with SED. Community-based services are those that permit the youth to remain in a home (including foster or group homes) and to continue established educational, social, and personal activities and family relationships while receiving treatment. The Department is committed to treatment in the least restrictive and most appropriate setting consistent with the needs of the individual.

3.13.10 The Department requires sustainability of rehabilitation and supportive services for SED youth. Rehabilitation services should include functional assessment, skills training, behavior management, and additional supports necessary to allow the individual to live independently in the community.

3.13.11 Access to Services

3.13.11.1 The proposal must include a strategy to assure local access to basic mental health services to the greatest extent possible.
3.13.11.2 The proposal must contain an explicit commitment to standards of promptness for contact by a mental health professional following an initial notification, telephone contact or other contact that are no greater than the following:

3.13.11.2.1 Crisis/Emergency situations:

3.13.11.2.1.1 Within communities having a population of 10,000 or more persons (i.e., Great Falls and Helena, for the purpose of this demonstration project): face-to-face contact must occur within one (1) hour; .
3.13.11.2.1.2 Within one hundred road miles of a community of 10,000 or more persons: face-to-face contact must occur within four (4) hours;
3.13.11.2.1.3 Otherwise, face-to-face contact must occur within eight (8) hours.

3.13.11.2.2 Urgent situations:

3.13.11.2.2.1 Face-to-face contact must occur within twenty-four (24) hours.

3.13.11.2.3 Routine situations:

3.13.11.2.1 The individual must have the opportunity to see an appropriate professional within five (5) business days.

DRAFT

3.13.11.3 The proposal must acknowledge that the MCO will be responsible for providing assessment or evaluation consistent with the presenting symptoms for any individual who is eligible and who presents to the MCO or to any provider on the MCO's network with symptoms which would lead a mental health professional to reasonably suspect the presence of a covered diagnosis covered. The proposal should specify whether there will be multiple levels of assessment or evaluation, and if so, the circumstances which would trigger each level. Psychological evaluations which are performed at the request of, or authorized by, the MCO must be reimbursed to the provider regardless of the diagnosis, if any, resulting from the evaluation.

3.13.11.2.1 The proposal must describe the MCO's criteria for prior authorization of any services which will require prior authorization and the procedures to be used in obtaining prior authorization. Services which will not require prior authorization and the authorization threshold for services which will not require initial authorization must be delineated.

3.13.11.2.1.1 Inpatient Certification: The proposal must present a clear and specific process for reviewing, and criteria for authorizing, inpatient admissions including to a PRTF. The MCO must perform all inpatient certification activities required by federal regulation.

3.13.11.2.1.2 Discharge Planning: The proposal must contain an explicit commitment to support active discharge planning for any youth in a psychiatric inpatient or residential treatment facility. Active discharge planning includes family involvement and agreement (and youth when appropriate) in developing the discharge plan, and scheduled appointments for follow-up and continuing treatment in the community after the discharge when needed.

3.13.12 Special Considerations

3.13.12.1 The proposal must take into consideration the fact that no state plan service can be billed directly while a youth is in a PRTF. Eligible services, including emergency care, dental care, eyeglasses can be provided and billed to the PRTF who recovers these costs through an ancillary rate. Eligible state plan services will be outlined in the Administrative Rules of Montana (ARM).

3.13.12.2 The proposal must provide for crisis response procedures capable of effectively responding to youth and families undergoing a psychiatric crisis in order to avoid inappropriate hospitalization.

3.13.12.3 The proposal must include an explicit strategy for recognizing substance abuse or chemical dependency problems among covered youth and for providing or referring them for appropriate evaluation and treatment. It must also include a specific strategy for the identification of eligible or potentially eligible individuals needing mental health services who are receiving treatment for substance abuse. The MCO must commit to the development of written memoranda of agreement with substance abuse treatment programs and providers that explicitly establish linkage mechanisms, delineate joint and separate responsibilities, and define mutual expectations.

3.13.12.4 The proposal must include a specific strategy for identifying youth who may be eligible for services in the Developmental Disabilities Program (DDP) including how and by whom they will be referred to that program for a determination of eligibility. Should the youth be found eligible for DD services, the MCO will be expected to coordinate mental health services with those provided by DDP.

3.13.12.5 The proposal must specify how and in what circumstances case management services are to be provided. The proposal must also delineate the nature of those services,

any differences in type or level of case management, and the criteria to be used in determining who will receive case management services.

3.13.12.6 The proposal must include a provision for prescribing and monitoring the effects of effective and necessary psychotropic medications. Provisions for monitoring the effects of psychotropic medications must include the use of widely accepted measurement scales and/or inventories and must provide for cooperation with appropriate physicians to avoid duplication of services and drug interactions. The proposal must also propose a mechanism or process for regularly and systematically modifying or updating the formulary. This process should involve providers and family members. Any modification of the formulary must be subject to Department approval.

3.13.13 Coordination of Physical and Behavioral Health Services

3.13.13.1 The proposal must include an explicit strategy for recognizing physical health problems of youth and referring them to appropriate physical health providers. It must also include a specific strategy for the identification of eligible or potentially eligible individuals needing mental health services who present at either emergency rooms or to primary care physicians. The strategy for physical health care linkage must include the following elements:

3.13.13.2 A commitment to work with physical health providers to:

3.13.13.2.1 Coordinate care for patients, and

3.13.13.2.2 Develop procedures for health care providers used by both systems (e.g., hospital) with special attention to emergency services.

3.13.13.3 The proposal must include an explicit strategy for coordinating services for Medicare/Medicaid dual-eligible individuals.

3.13.14 Out of state services

3.13.14.1 The State expects that services will be provided by out-of-state providers only under limited and specified circumstances. Acceptable circumstances could include emergency or crisis treatment for eligible members when traveling outside the state or intensive, short-term treatment of conditions when specialty services are not available within Montana. The MCO must define the circumstances or criteria under which the MCO would authorize out-of-state services and delineate the criteria for adding out-of-state providers to the network.

3.13.14.2 .CMHB must provide a report to the Legislature every six months about Montana youth who receive treatment out of state (SB 399- from 2009 session). The following information must be reported every six months about Medicaid eligible youth from the 5 county area who receive treatment out of state in PRTFs or TGH:

3.13.14.2.1 Number of youth in 5 county area placed out of state

3.13.14.2.2 Reasons each child was placed out of state

3.13.14.2.3 The costs for each child placed out of state

3.13.14.1 The efforts made to avoid out-of-state placements, include the number of providers contacted about developing alternatives and whether an instate providers submitted a place for service alternatives for the child, and if the plan was not implemented, and if not, why not, and if so did the plan result in the child staying in state or returning to the state. Include other planning efforts to prepare for the child's return to the state.

3.13.15 Utilization Review

DRAFT

The proposal must provide for a standard, objective, and consistent method of assessing the mental health needs of all eligible members who present for services that ensures service needs are identified sufficiently promptly and accurately to allow for services to be provided at the lowest effective level of intensity and preclude avoidable crises or inpatient services.

It must also describe all proposed utilization management structures, criteria, and procedures in sufficient detail to allow the State to determine that utilization management decisions will be appropriate, fair, timely, and consistent. These criteria and procedures must be objective and based upon current scientific understanding and demonstrated clinical results. The proposal should address the degree to which the proposed utilization management system conforms to the Standards for Utilization Management contained in National Council for Quality Assurance (NCQA) Standards.

Transition to adult services

The MCO must provide for a method to identify and plan for the orderly transition to adult services for older youth in treatment, whether or not the youth will be eligible for services as an adult. This must include, at a minimum, provisions for the development of a written plan for transition to adult services or exit from services, if appropriate, for all members who have reached sixteen years of age; criteria to be used to determine which youth will be eligible for adult services; and development of treatment plans for youth sixteen years of age or older that include goals and objectives related to developing skills necessary for transition to adult services or independent living. All transition planning should ensure the maximum continuity of appropriate service that will preserve and build upon gains made in prior treatment.

All transition planning must include coordination with any agency or agencies to which the youth will be referred, and should include the designation of a lead agency for those persons who are eligible for services from more than one agency.

Community resources and coordination

Currently CMHB has 5 regional staff that assist families and agencies with the identification of community resources. Care is coordinated by case managers. Regional staff will assist the MCO in this role if invited. The MCO must propose how appropriate community resources will be identified and coordinated for youth and families with extraordinary care needs.

Service denial

When services are denied to Medicaid eligible youth, the member (and his/her family) has the right to due process which includes an administrative review and a fair hearing on the issue. The MCO's due process for denied services must meet federal requirements and be clearly described in its proposal.

Provider network

- Acute Care Psychiatric Hospitals for youth
- Licensed Psychiatric Residential Treatment Facilities (PRTF)
- Licensed Therapeutic Group Homes (TGH)
- Licensed Mental Health Centers (MHC)
- Psychiatrists
- Licensed Psychologists

DRAFT

- Licensed Clinical Social Workers
- Licensed Professional Counselor
- Primary Care Physicians
- Advanced Practice Registered Nurses
- Physician Assistants
- Federally Qualified Health Centers (FQHCs) that currently provide mental health services.
- PRTF Waiver Providers including agencies that employ the wraparound staff such as facilitator, family specialist, and family partner.
-

The proposal must clearly indicate the MCO's understanding that the above required array of providers is not an exhaustive listing of appropriate provider types. This plan should disclose the MCO's intentions, if any, to use other provider types and specify what they are and the specific services they would be considered qualified to provide.

Network development, adequacy, and management

The MCO will be expected to have an adequate provider network to meet the services needs of all eligible youth in the five counties served. Some of these providers may be outside the geographical region designated but must be engaged in order to have network adequacy and a continuum of care available.

Provider recruitment

The MCO must describe how it will develop and maintain network adequacy, including how it will recruit providers when needed for this purpose.

Existing providers—transition

The MCO must delineate a clear and explicit strategy to avoid unnecessary disruption and confusion to individuals who will receive services from the IMCO and who are receiving mental health treatment at the time of implementation from a provider that will not be included in the MCO's provider network. The CMHB recommends the MCO implement a policy of "Do No Harm" for the first twelve months of the contract.

New providers

The MCO must provide for a process by which the MCO will recommend that the State approve the proposed licensure, certification, educational or experiential standards for providers of any new services which the MCO may propose to implement.

Provider training and education

The proposal must describe the MCO's plan to offer provider training and education to providers offering services to the five county area.

Provider relations

The proposal must explain the MCO's plan to develop and maintain provider relations

Provider incentives

If provider incentives are utilized, these must be explained in detail.

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Continuity of care

It is expected that the MCO will provide for continuity of care when members transition from one service to another. How this will occur and who is responsible must be explained in the proposal.

Coordination with community based providers

Currently CMHB holds monthly case management calls for the purpose of coordination and training with case management providers. The proposal must describe any coordination activities that will be in place with community based providers during this contract.

Provider satisfaction

Measures of provider satisfaction and dissatisfaction with the MCO must be made using an instrument developed or chosen in cooperation with relevant provider associations and approved by the State. The survey must be administered to all providers on the MCO's panel of providers and reported semiannually.

Provider complaints and appeals

The proposal must describe the how providers complaints will be handled and what appeal process will be in place.

Data collection and reporting

The proposal must provide for an annual written evaluation of the MCO's quality assurance activities for this project. Documentation of the contributions of quality assurance activities, which should be substantially comparable to the specifications in the NCQA Standards, must be reported to the State. The proposal must also provide for continuing, periodic reports of quality assurance activities and improvements to all providers of services provided by the MCO.

Service levels and performance measurement

If the MCO plans to use performance measurement, please describe in detail in the proposal.

Clinical indicators
If the MCO plans to use clinical indicators, please describe in detail in the proposal.

Outcomes

The CMHB will implement at least one outcome measure before 12/31/2012. Others will be implemented after that time as the result of a statewide implementation of the wraparound model. The MCO will be required to collect and report specific data whenever credentialed wraparound staff provide services. If the MCO intends to initiate additional outcome measures during the contract period, these must be fully described in the proposal.

Specific MCO staff requirements, job descriptions

The Proposer must document experience in managing a comprehensive system of mental health services for youth and their families. Experience with Medicaid or other public-sector programs and with populations

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including substantial proportions of children and youth is essential. Please include a description/organizational chart of MCO staffing for this project, including staff position descriptions and requirements.

Subcontractor requirements (We assume these will be boiler plate language)

Specific TPL requirements (We assume these will be boiler plate language)

Involvement of state staff (e.g. specific oversight)

The proposal must provide for State monitoring of and access to all activities of the MCO's quality assurance and quality improvement activities. Specifically it must address the following areas.

- Program Oversight: The proposal must stipulate that the MCO and all providers with which it subcontracts or whom it employs will comply with all existing, applicable program standards and with any standards subsequently developed. The proposal must explicitly acknowledge the State's right and obligation to oversee the quality of all MCO services.

- Inspections and record reviews: The State will maintain and exercise the right to conduct inspections of any and all facilities and records pertaining to services delivered by the MCO. The proposal must state that the MCO and any service providers which it employs or with which it contracts will permit reasonable access to all clinical records, facilities, operations, staff, and systems by the State, its employees and its contractors for the purpose of monitoring services delivered. The State must be given access to all records concerning MCO quality assurance activities.

Role of Local Partnerships

The MCO must involve the System of Care Planning Committee (SOC Committee) in planning and monitoring quality assurance activities. The proposal must specify ways in which that involvement and planning will occur.

Community Alternatives for Children and Youth (Grant and Demonstration Waiver to serve youth in the community in lieu of admission to a PRTF)

In Lewis and Clark and Cascade County, CMHB is operating a 1915c Demonstration waiver. Each county has up to 20 waiver slots available. While operating as a waiver, this is actually a demonstration grant with data collection requirements. It began October 1, 2008 and enrollment of new members will end September 30, 2012 unless it becomes a 1915c waiver which would require the state to reapply. All youth enrolled as of October 1, 2012 can remain in the waiver until they no longer meet level of care if the state chooses to continue offering waiver services.

(Terry- I will add to this section and provide the rest of the information about the waiver tomorrow)

Resources for the Proposer

Children's Mental Health Bureau Provider Manual and Clinical Guidelines for Utilization Management (available on the CMHB website)
Montana Medicaid Children's Mental Health Manual (available on the DPHHS website)

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PRTF Waiver Proposal (available on the CMHB website)

3.14 Community Alternatives for Children and Youth (Grant and Demonstration Waiver to serve youth in the community in lieu of admission to a PRTF)

In Lewis and Clark and Cascade County, CMHB is operating a 1915c HCBS Demonstration waiver. Each county has up to 20 waiver slots available. While operating as a waiver, this is actually a demonstration grant with data collection requirements. It began October 1, 2007 and enrollment of new members will end September 30, 2012 unless the project becomes a 1915c waiver which will require the state to reapply. All youth enrolled in the waiver as of October 1, 2012 can remain in the waiver until they no longer meet level of care if the state chooses to continue offering waiver services. Otherwise, each youth in the waiver on October 1, 2012 will need a plan to transition back to state plan services when youth no longer meets level of care criteria.

It is assumed that waiver services will be included as part of the MCO's proposal to serve the 5 counties. However, if the MCO wants to contract management responsibilities of the waiver back to the state, that request must be stated in the proposal and will be considered by the state.

In order for the state to meet its obligations to CMS, the following items must be described:

1. Enrollment in this waiver is based on meeting level of care criteria described in the waiver application available online at the CMHB website. How and by whom will level of care be determined? How and by whom will the other criteria for enrollment be determined?
2. Currently the state employs a plan manager in each site to enroll youth, to oversee plan development, to conduct QA activities, to enroll providers, and to authorize payment for waiver and other services in the plan. How and by whom will the individual plan of care be developed for each youth enrolled in the waiver? How and by whom will the duties currently performed by the plan managers be accomplished?
3. A principle of wraparound is that the individual treatment plan reflects the needs and choices of the family and youth being served. How will the MCO ensure that families and youth have a choice of services and of providers in the plan of care that is developed?
4. It is a requirement that all wraparound staff (facilitator, family support peron, and family partner have received high fidelity wraparound training. How and by whom will that be provided?
5. This demonstration waiver requires that certain data be submitted to the evaluation contractor on a regular basis. One requirement is that a child behavior checklist (CBCL) is completed for each youth upon admission and periodically thereafter. There are other minimum data set requirements as well. In addition, specific financial information must be reported quarterly and annually. Who will be responsible for gathering and providing the required data for each youth enrolled in the waiver?
6. Providers must enroll separately as a waiver provider to serve youth in this waiver. In addition, wraparound facilitators, and the family partner must be certified or working towards certification in order to be paid. Who will be responsible for provider enrollment and training?
7. This project requires that families have access to all of the approved waiver services at all waiver locations. How will the MCO ensure network adequacy?
8. Will the MCO agree to use only state credentialed wraparound facilitators, family support specialists and peer specialists?

9. How will the MCO provide information about the waiver opportunity to family members of eligible youth and to those who could make referrals?
10. Cascade County has 20 waiver slots available and Lewis and Clark County shares 20 waiver slots with Broadwater County and Jefferson County. How will the MCO manages these slots and will the MCO establish a waiting list if all of the waiver slots are filled? If so, how and by whom will the wait list be managed? Will there be criteria developed for moving youth from the waiting list when an available slot opens up?
11. The waiver allows for a youth and family to be exited from the waiver if the cost of care is too high for cost neutrality to be maintained. However, cost neutrality is calculated in the aggregate and not for each individual youth. How will the MCO maintain cost neutrality with the waiver slots allowed in these counties and under what circumstances would a family and youth be exited from the waiver?
12. Will there be any caps on services in the amount or in the cost? If yes, please describe.
13. Will the MCO work within the parameters of the CMHB's approved waiver?
14. How quickly can providers expect reimbursement?
15. There are numerous quality assurance activities described in the 3.5 version of the waiver application (most recent). How will the MCO carry out all of the quality assurance activities required in the waiver?
16. Unless this demonstration project turns into a 1915© waiver, youth will have to be transitioned back to state plan services after 10/1/2012 when the youth no longer meets level of care critieria. Please describe the specific policies or practices the MCO will use when discharging youth and families from the waiver and transitioning them back to state plan services.

3.15 DEVELOPMENTAL DISABILITIES PROGRAM

The Developmental Disabilities Program (DDP) delivers services to over 4000 individuals. Most of those individuals are served in one of our three Medicaid HCBS waivers. The remainder are served in the IDEA Part C early intervention program or in our FES non Medicaid program.

All of the program components and service descriptions listed in the document are for the Medicaid reimbursed services.

One item not listed in this write up is wait lists. Depending on the type of Medicaid waiver Montana is interested in pursuing wait lists may or may not be a factor. If the waiver pursued allows wait lists then additional questions should be asked regarding how wait lists will be managed.

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3.16 Case Management Services for High Risk Pregnant Women, High Risk Infants, and Infants Identified at Risk for Special Health Care Needs/ Montana's Initiative for the Abatement of Mortality in Infants (MIAMI)/ Public Health Home Visiting

3.16.1 Description of Population(s). Montana state general funds, tobacco settlement, and tobacco interest funds support local tribal and public health departments to provide home visiting service to high-risk pregnant women, their infants, and infants identified at risk for special health care needs. These services are part of the comprehensive efforts to improve maternal child health status in the state as provided for in Montana's Initiative for the Abatement of Mortality in Infants (MIAMI), as outlined in Section 50-19-311, Montana Annotated Code.

The contractor must provide eligible pregnant women, their infants, and infants identified at risk for special health care needs the services currently provided by the Public Health Home Visiting (PHHV) Program contractors. The current PHHV contractors have elected to use the Health District Information Software (HDIS) by CHC Software, Inc., a Windows-based application that was procured by individual county health departments.

3.16.2 Definitions Specific to This Population and Services

3.16.2.1 High-Risk Pregnant Women (HRPW) Are Defined as Those Who:

3.16.2.1.1 Are age 17 or younger.
3.16.2.1.2 Have medical factors, including mental illness or depression, which indicate the potential for a poor pregnancy outcome.
3.16.2.1.3 Abuse alcohol, tobacco or drugs.
3.16.2.1.4 Currently are in an abusive relationship.
3.16.2.1.5 Are homeless or have had multiple residences (>3 during pregnancy).
3.16.2.1.6 Demonstrate an inability to obtain necessary resources and services and meet 3 of the following criteria. The woman:
3.16.2.1.6.1 Has a history of physical or sexual abuse
3.16.2.1.6.2 Lacks a support system
3.16.2.1.6.3 Is not educated beyond 12th grade or does not have a GED
3.16.2.1.6.4 Has a physical or developmental disability
3.16.2.1.6.5 Has had no prenatal care before or during the first 20 weeks of gestation
3.16.2.1.6.6 Has not had a dental cleaning in the past year
3.16.2.1.6.7 Is age 18 or 19
3.16.2.1.6.8 Is age 35 or over
3.16.2.1.6.9 Has limited English proficiency
3.16.2.1.6.10 Is a migrant worker or has refugee status

3.16.2.2 A High-Risk Infant (HRI) Is Defined as One Who:

3.16.2.2.1 Is age birth through 12 months
3.16.2.2.2 Is diagnosed with special health care needs as designated by qualified
ICD9 CM code and/or confirmed in utero exposure to alcohol

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3.16.2.2.3 Is at increased risk for chronic physical, developmental, behavioral, or
emotional conditions

3.16.2.2.4 Is less than one year of age and was born to a woman who received
public health home visiting services

3.16.3 Current Delivery System. Public health home visiting services are those services, based in the client's home or place of residence, that can improve pregnancy outcomes and decrease infant mortality by providing care coordination which includes education, case management, referrals and advocacy. Home visiting services are part of comprehensive efforts to improve the health of the maternal and child health population. Montana has approximately 12,500 births per year and approximately 15-20% of births may be considered "high risk" due to medical, social and economic reasons. Public health home visiting augments medical interventions, and provides essential support and guidance to families who may not be able to understand or comply with medical regimes, and/or access services that would improve the potential for healthy outcomes. Home visiting takes the service to populations that may not receive services in "traditional" settings.

In SFY 2011, MIAMI/PHHV services are provided through Department contracts with 14 county and one tribal health department who responded to a State of Montana Request for Proposal, RFP05-971J: Public Home Visiting-Montana's Initiative for the Abatement of Mortality in Infants (MIAMI). These entities contract amount is based on a formula that allows for a base amount and "client costs" calculated on the number of clients who should be served by the contractor. The anticipated target population is based on average births (per vital statistics) with 15% of the pregnant women and their infants to receive services from the contractor and 25% of infants born to non-PHHV mothers that are anticipated to need PHHV.

In state fiscal year 2011, approximately $651,639 was allocated to the 15 contractors. Contract payments are made quarterly pending Department approval of required deliverables.

3.16.4 Description of Services The contractor will be required to:

3.16.4.1 Provide public health home visiting services to the target population, defined as high-risk pregnant women, their infants, and additional infants requiring public health home visiting (designated as high risk/CSHCN) for the purposes of addressing the following outcomes as agreed upon by the PHHV Reassessment Project:

3.16.4.1.1 Increase the percent of PHHV clients served by the PHHV program who receive adequate prenatal care as measured by the Kotelchuck Index.

3.16.4.1.2 Increase the percentage of PHHV clients who abstain from smoking and other tobacco use during pregnancy.

3.16.4.1.3 Increase the percentage of PHHV infants who are born at a healthy birth weight (2500 to 4000 grams).

3.16.4.1.4 Increase the percentage of eligible PHHV infants who are exclusively breastfed through 6 months of age.

3.16.4.2 Identify high-risk populations from the population of pregnant women and infants born in the community.

3.16.4.3 Establish and maintain a mechanism for identifying high-risk pregnant women and infants including, but not limited to referrals from:

3.16.4.3.1 Hospitals, emergency rooms and clinics

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3.16.4.3.2 Physician and mid-level providers practices
3.16.4.3.3 Family planning providers,
3.16.4.3.4 WIC programs
3.16.4.3.5 Programs serving high-risk families including homeless shelters, food banks, TANF or AFDC, child protection services, and other appropriate sources.

3.16.4.4 Provide public health home visiting services to 15% of the pregnant women in the community who are high risk, and their infants.

3.16.4.5 Provide public health home visiting services to 25% of the infants in the community who are at risk for poor outcomes (designated high risk/CSHCN).

3.16.4.6 Conduct 75% of the visits in the home, with 25% out of the home. Documentation for the reason for conducting a visit outside of the home shall be provided to the Department.

3.16.4.7 Provide no fewer than four face-to-face contacts in the HRPW client's home during the prenatal and postpartum period (through the end of the month of the 60th day after pregnancy ends) and no fewer than four face-to-face home visits for each HRI and each infant with special health care needs through their first birthday.

3.16.4.8 Employ a team of providers, including a public health nurse, social worker and dietician who are eligible to provide targeted case management services as described in Administrative Rules of Montana (ARM) 37.86.3410. As described in ARM 37.86,3410 (4), the contractor shall provide the services of at least one of the professional disciplines directly (through employment), while the other disciplines may be provided through subcontracts.

3.16.4.9 Administer to each HRPW client the following required, standardized screening and/or assessment tools, and enter the results into the client's HRPW HDIS electronic record:

3.16.4.9.1 The American College of Obstetricians and Gynecologists (ACOG) Violence Against Women Screening Tool administered at intake for HRPW and HRI. The American College of Obstetricians and Gynecologists (ACOG) Violence Against Women Screening Tool is located at: http://www.acog.org/departments/dept_notice.cfm?recno=17&bulletin=585

3.16.4.9.2 The 5P's Prenatal Substance Abuse Screen for Alcohol and Drugs administered at intake for HRPW and HRI. The 5P's Prenatal Substance Abuse Screen for Alcohol and Drugs is located at: http://www.dphhs.mt.gov/PHSD/family-health/home-visiting/documents/5p.pdf

3.16.4.9.3 The Edinburgh Postnatal Depression Scale (EPDS). The EPDS is required within 60 days postpartum or at admission of the infant. The EPDS is located at: http://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf

3.16.4.9.4 The U.S. Preventive Services Task Force Tobacco Cessation Counseling Guide Sheet Assessment Tool at least at intake for the HRPW and HRI. The U.S. Preventive Services Task Force Tobacco Cessation Counseling Guide Sheet Assessment Tool is located at: http://www.ahrq.gov/clinic/uspstf09/tobacco/tobaccosum2.htm

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3.16.4.10 Administer to each HRI client the following required assessments and enter the results into the client's HDIS electronic record:

3.16.4.10.1 The Ages and Stages Developmental Questionnaire (ASQ) by 8 months of age

3.16.4.10.2 The Ages and Stages Questionnaire Social Emotional (ASQ:SE) by 10 months of age

3.16.4.11 Attend a minimum of two on-site and/or video training sessions relevant to PHHV, including sessions sponsored by the Department.

3.16.4.12 Provide unduplicated HDIS case report(s) to the Department as requested.

3.16.4.13 Distribute a copy of the shaken baby syndrome educational materials developed under MCA 50-16-10 to a child's parent during visits.

3.16.4.14 Bill for targeted case management services provided to the target populations to Medicaid and third party providers.

3.16.4.15 Agree to purchase and maintain the Health District Information Software (HDIS) by CHC Software, Inc., a Windows-based application that was procured by individual county health departments and is currently being used as the data collection instrument. The Department reserves the right to consider an alternative data collection instrument(s).

3.16.4.16 Bill for targeted case management services as described in ARM 37.86.3401 through 37.86.3415 (Subchapter 34) and ARM 37.86.3901 through 37.86.3910 (Subchapter 39).

3.16.5 The Department Will:

3.16.5.1 Calculate the minimum number of high-risk pregnant women and their infants (15% of the total births in the county) and the minimum number of infants with special health care needs (25% of the total births in the county) that the contractor must provide home visiting services to.

3.16.5.2 Provide the contractor with technical assistance, training opportunities and program guidance on, but not limited to the HDIS/PHHV electronic data system; the required PHHV screening and assessment tools; the PHHV program components; the Targeted Case Management (TCM) Administrative Rules for Montana; how to submit TCM billing; and program implementation and administration to enable the contractor to complete task order requirements.

3.16.5.3 Communicate as necessary with the contractor through on-site meetings, phone, e-mail, and fax.

3.16.5.4 Organize and facilitate training opportunities for PHHV contractors at least twice during the contract period.

3.16.5.5 Conduct an on-site visit for the purposes of completing a PHHV quality assurance review and to provide on-site consultation, if requested by the contractor or as deemed necessary by the Department during this contract period.

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3.16.6 Continuity of Care. The Maternal and Child Health Coordination (MCHC) Section, within the Family and Community Health Bureau in the Public Health and Safety Division provides contractual oversight and technical assistance to the 14 local health departments and one tribal health department who provide PHHV services. The contractor is encouraged to collaborate with the existing PHHV contractors to ensure the continuation of services to the target populations who are currently receiving PHHV services.

3.16.7 Coordination with Community-Based Partners.

3.16.7.1 The contractor will be expected to establish and maintain a mechanism for identifying high-risk pregnant women and infants including, but not limited to referrals from:

- **3.16.7.1.1** Hospitals, emergency rooms and clinics
- **3.16.7.1.2** Physician and mid-level providers practices
- **3.16.7.1.3** Family planning providers, WIC programs
- **3.16.7.1.4** Programs serving high-risk families including homeless shelters, food banks, TANF or AFDC, child protection services, and other appropriate sources

3.16.7.2 The contractor will be expected to provide referral services and follow up to these services to the clients to include, but not be limited to:

- **3.16.7.2.1** MT Tobacco Quit Line
- **3.16.7.2.2** Other tobacco cessation resources
- **3.16.7.2.3** Substance use cessation resources
- **3.16.7.2.4** Domestic violence resources
- **3.16.7.2.5** Mental health or support services
- **3.16.7.2.6** Resources to obtain housing
- **3.16.7.2.7** WIC
- **3.16.7.2.8** Other food resources, e.g., SNAP
- **3.16.7.2.9** Children With Special Health Care Needs Section
- **3.16.7.2.10** Healthy Montana Kids and Healthy Montana Kids *Plus* (Medicaid/CHIP)
- **3.16.7.2.11** Resources identified by the client, e.g., family planning

3.16.7.3 The contractor will record their client referral(s) in the client's electronic record.

3.16.8 Data Collection and Reporting

3.16.8.1 The MIAMI/PHHV contractors have elected to use the Health District Information Software (HDIS) by CHC Software, Inc for the purposes of data collection and reporting. HDIS collects the following data for all high-risk pregnant women. Therefore, the contractor will be required to collect and report the following data, for all high-risk pregnant women, to the Department:

1) County/reservation
2) Social Security number
3) Last name
4) First name
5) Middle name
6) Maiden name
7) Intake date
8) Date of birth
9) White

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10) Black
11) Asian
12) Native American/Alaska Native
13) Native Hawaiian/Pacific Islander
14) Other race
15) Unknown race
16) Hispanic
17) Education
18) Marital status
19) Smoked during pregnancy
20) Quit smoking during pregnancy
21) Tobacco use during pregnancy
22) Tobacco use last 3 months of pregnancy
23) Quit tobacco during pregnancy
24) Alcohol use during pregnancy
25) Quit alcohol use during pregnancy
26) Drug use during pregnancy
27) Quit drug use during pregnancy
28) Three or more residences or homeless during pregnancy

29) In violent/abusive relationship during pregnancy
30) Intake Edinburgh Depression Screen Score
31) Postpartum Edinburgh Depression Screen Score
32) Insurance carrier
33) Month of first prenatal medical visit
34) Enrolled in WIC at outcome
35) Enrolled in Medicaid at outcome
36) Date of delivery
37) Gestational stage
38) Infant A pregnancy outcome
39) Infant A sex
40) Infant A weight
41) Infant B pregnancy outcome
42) Infant B sex
43) Infant B weight
44) Infant C pregnancy outcome
45) Infant C sex
46) Infant C weight
47) Prenatal medical visits – total #
48) Home visits – total # face to face
49) Office visits – total # face to face
50) Other visits – total # face to face
51) MTUPP Quit Line referral
52) Tobacco cessation referral
53) Substance use cessation referral
54) Mental health or support services referral
55) Housing referral
57) Food resources referral (non-WIC)
58) Medicaid referral
59) WIC referral

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60) Other referrals made
61) No referrals made
62) PHHV program outcome
63) Date of client discharge

3.16.8.2 The MIAMI/PHHV contractors have elected to use the Health District Information Software (HDIS) by CHC Software, Inc for the purposes of data collection and reporting. HDIS collects the following data for all high risk infants. Therefore, the contractor will be required to collect and report the following data, for all high-risk infants, to the Department:

1) County/reservation
2) Social security number
3) Last name
4) First name
5) Middle name
6) Intake date
7) Date of birth
8) White
9) Black
10) Asian
11)Native American/Alaska Native
12) Native Hawaiian/Pacific Islander
13) Other race
14) Unknown race
15) Hispanic
16) Gestational age
17) Birth weight
18) Mother's first name
19) Mother's middle name
20) Mother's maiden name
21) Mother's date of birth
22) Infant of a PHHV client
23) Infant with special care needs
24) Sex
25) Breastfeeding at zero months
26) Breastfeeding at one month
27) Breastfeeding at two months
28) Breastfeeding at three months
29) Breastfeeding at four months
30) Breastfeeding at five months
31) Breastfeeding at six months
32) Enrolled in WIC at outcome
33) Enrolled in Medicaid at outcome
34) ASQ - age
35) ASQSE - age
36) Immunizations current
37) Number of calls made for suspected child abuse
38) Three or more residences or homeless during pregnancy
39) Edinburgh Depression Screen Score
40) Domestic Violence Screen (ACOG)

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41) Insurance carrier
42) Weight for length
43) Home visits – total # face to face
44) Office visits – total # face to face
45) Other visits – total # face to face
46) MTUPP Quit Line referral
47) Tobacco cessation referral
48) Substance use cessation referral
49) Mental health or support services referral
50) Housing referral
51) Food resources referral (non-WIC)
52) Medicaid referral
53) WIC referral
54) No referrals made
56) PHHV program outcome
57) Date of client discharge

3.16.8.3 The Department will consider alternative data collection software if it provides the same data as currently being collected by the contractors.

3.16.9 Service levels and performance measurement

3.16.9.1 The contractor is expected to provide public health home visiting services to at least 15% of the high-risk pregnant women and their infants (15% of the total births in the county) and to at least 25% to infants with special health care needs (25% of the total births in the county).

3.16.9.2 The Department reserves the right to reassess the outcomes, currently required of the contractors, based on future Public Health Home Visiting Reassessments or as needed. The current outcomes that must be addressed by the contractors are:

3.16.9.2.1 Increase the percent of PHHV clients served by the PHHV program who receive adequate prenatal care as measured by the Kotelchuck Index.

3.16.9.2.2 Increase the percentage of PHHV clients who abstain from smoking and other tobacco use during pregnancy.

3.16.9.2.3 Increase the percentage of PHHV infants who are born at a healthy birth weight (2500 to 4000 grams).

3.16.9.2.4 Increase the percentage of eligible PHHV infants who are exclusively breastfed through 6 months of age.

3.16.9.3 The contractor will provide the required data elements to the Department as requested.

3.16.9.4 The contractor will adhere to the ARM 37.86.3401 through 37.86.3415 (Subchapter 34) and ARM 37.86.3901 through 37.86.3910 (Subchapter 39), which includes references to the staffing requirements, services to be provided, etc.

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3.8 NURSING FACILITY SERVICES

3.7.1 Description of services

3.7.1.1 Nursing facility services are allowed under a written agreement with the department to a provider who furnishes services to Medicaid recipients as defined in ARM 37.40.304 and ARM 37.40.305. These services must be delivered by providers within the scope of the provider's license, and includes providers of "long term care facility services."

3.7.1.2 Nursing facility services are provided in accordance with 42 CFR, part 483, subpart.

3.7.1.3 Services considered to be included in nursing facility/long term care facility services include but are not limited to:

f. medically necessary room
g. dietary services including dietary supplements used for tube feeding or oral feeding
h. nursing services
i. minor medical and surgical supplies
j. use of equipment and facilities

3.7.1.4 Payment for the services listed in ARM 37.40.304 and 37.40.305 are included in the per diem rate determined under ARM 37.40.307 and 37.40.336 and no additional reimbursement is provided for such services

3.7.2 Licensure and certification requirements (ARM 37.40.306)

3.7.2.1 A nursing facility services provider must maintain a current license issued by the department of public health and human services under Montana law for the category and level of care being provided.

3.7.2.2 A nursing facility services provider must comply with all applicable federal and state laws, rules, regulations and policies regarding nursing facilities including but not limited to 42 USC 1396r(b)(5) and 1396 r(c).

3.7.2.3 A nursing facility services provider must maintain a current certification for Montana Medicaid issued by the department of public health and human services under applicable state and federal laws, rules, and regulations and policies for the category and level of care being provided.

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3.7.2.4 A nursing facility services provider is required to operate under the direction of a licensed nursing home administrator, or other qualified supervisor for the facility, as applicable laws, regulations, rules, or policies may require.

3.7.3 Reimbursement Per Diem Rate (ARM 37.40.307)

3.7.3.1 For nursing facility services, other than ICF/MR services, provided by nursing facilities located within the state of Montana, the Montana Medicaid program will pay a provider, for each Medicaid patient day, a per diem rate using a price based reimbursement methodology determined in accordance with The rate for each facility is determined using an operating component and a direct resident care component. The operating component is the same per diem for each nursing facility which is set at 80% of the statewide price for nursing facility services. The direct resident care component of each facility's rate is 20% of the overall statewide price for nursing facility services. This component is adjusted for the acuity of the Medicaid residents served in each facility. The acuity adjustment increases or decreases the direct resident care component in proportion to the relationship between each facility's Medicaid average case mix index and the statewide average Medicaid case mix index.

3.7.3.2 Medicaid eligibility will determine the personal resources (patient contribution) that a nursing facility resident is responsible for towards paying for the cost of care less the residents personal needs allowance as defined in ARM 37.40.302.

3.7.3.3 A provider's per diem rate for nursing facility services is effective for rate periods of July 1 through June 30 of each state fiscal year. Current nursing facility rates are listed in Appendix ___.

3.7.4 Individual Eligibility for Nursing Facility Care

3.7.4.1 Individuals eligible for Medicaid nursing facility services must:

f. meet all non-financial criteria
g. be admitted under a doctor's order
h. meet the medical criteria for needing nursing home care
i. meet the financial need requirements
j. get a pre-admission screening

3.7.4.2 In 2010 approximately 4,600 unduplicated individuals received Medicaid funded services in nursing facilities statewide, 683 in the 5 counties in the demonstration project.

3.7.5 Level Of Care; Pre Admission Screening

3.7.5.1 A nursing facility services provider must comply with regulations regarding screening for nursing facility services as defined in ARM 37.40.101 to 37.40.120, ARM 37.40.201 to 37.40.206, and 42 CFR 483.100 to 483.138.

3.7.5.2 A level of care determination is required to assess medical necessity and appropriateness of placement for long term care services (intermediate or skilled), and must be completed before Medicaid payment can be authorized.

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3.7.5.3 All individuals seeking long term care (e.g., nursing facility or swing bed services) must have a preadmission screening before entering a facility. Currently, a Preadmission screening/level I screening is performed by the department's contractor Mountain Pacific Quality Health Foundation.

3.7.5.4 Preadmission/level I screening (also known as preadmission screening annual resident review PASAAR) will determine if a long term care applicant is approved for long term care placement, and if a Preadmission/level II screening (determines whether the applicant requires specialized services and is appropriate for long term care placement) is required for the long term care applicant.

3.7.5.5 Preadmission/level II screening is required if the Preadmission/level I screening shows indication of mental retardation or mental illness for the applicant. The department's contractor Mountain Pacific Quality Health Foundation will refer applicants to either the appropriate regional center or the regional mental retardation authority for a preadmission/level II screening.

3.7.6 Ancillaries-Separately Billable Items

In addition to the amount payable to nursing facility service providers under ARM 37.40.307, the department reimburses facilities for separately billable items as defined ARM 37.40.330.

3.7.7 Resident Billable Items

Items and services billable to nursing facility residents that are not paid by the department to the provider are defined in ARM 37.40.331

3.7.8 Bed Hold Payments

The department reimburses nursing facility services providers for holding a bed in accordance to ARM 37.40.338 for:

c. a resident who is temporarily receiving medical services outside the facility, except in another nursing facility, and is expected to return.
d. A resident during a therapeutic home visit, limited to 24 days per state fiscal year, with prior authorization for visits over 72 hours.

3.7.9 Other Add On Payment Systems

3.7.9.1 Intergovernmental Transfer (IGT)

3.7.9.1.1 For each state fiscal year, the department provides for a one-time, lump sum distribution of funding to nursing facility providers as defined in ARM 37.40.311.

3.7.9.1.2 The mechanism for funding under an Intergovernmental Transfer program provided by the department has two components.

3.7.9.1.3 Facilities state-wide that are "at risk" county affiliated facilities who are predominately rural and are the only nursing facility in their community or county or who provide a significant share of nursing facility services in their community or county

3.7.9.1.4 All other facilities state-wide that are not "at risk" county affiliated facilities as defined above.

3.7.10 Direct Care Wage Program

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Medicaid certified nursing facilities, at the discretion of the Montana legislature, may be paid in addition to their computed Medicaid payment rate as provided in ARM 37.40.361 funds to be used only for wage and benefit increases or lump-sum distributions to direct care and ancillary services workers.

3.7.11 Reporting Requirements

The following reporting is required from nursing facility service providers.

3.7.11.1 Nurse aide training and testing reporting

Nursing facility services providers must provide for each quarter of the state fiscal year a *Nurse Aide Certification/Training and Competency Evaluation (Testing) Survey* form for reporting initial training and testing costs prepared in accordance with ARM 37.40.322.

3.7.11.2 Staffing Reporting

Nursing facility service providers must provide staffing at levels which are adequate to meet federal law, regulations, and requirements. Each provider must submit to the department form DPHHS-SLTC-015, *Monthly Nursing Home Staffing Report* in accordance with ARM 37.40.315.

3.7.11.3 Therapeutic Home Visits

Nursing facility service providers must submit to the department form DPHHS-SLTC-041, *Request for Therapeutic Home Visit Bed Reservation* prepared in accordance with ARM 37.40.338. For therapeutic home visits in excess of 72 hours, nursing facility service providers must submit to the department form DPHHS-SLTC-042, *Request for Bed Reservation for Therapeutic Home Visit in Excess of 72 hours* in accordance with ARM 37.40.338.

3.7.11.4 Hospital Hold

Nursing facility service providers must submit to the department form DPHHS-SLTC 052, *Request for Nursing Home Bed Reservation during Resident's Temporary Hospitalization* in accordance to 37.40.338.

3.7.11.5 Minimum Data Set submission

3.7.11.5.1 Nursing facility services providers must all minimum data set assessments and tracking documents to the Centers for Medicare and Medicaid Services (CMS) databases as defined in ARM 37.40.320.

3.7.11.5.2 Nursing facility services providers must report corrections of erroneous or missing data on resident listings distributed to facilities as defined in ARM 37.40.321

3.7.11.6 Cost reporting

Nursing facility services providers must meet the cost reporting requirements as defined in ARM 37.40.345, ARM 37.40.346, and ARM 37.40.347.

3.7.11.7 Direct care wage reporting

Nursing facility service providers are required to report to the department actual hourly wage and benefit rates (or lump sum distributions) paid to direct care and ancillary services workers as defined in ARM 37.40.361.

3.7.12 Out of State Nursing Facilities (ARM 37.40.337)

Medicaid eligible resident for nursing facility services who requires those services from an out-of-state nursing facility under the conditions defined in ARM 37.40.337

3.7.13 Hospice

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The department may not pay a nursing facility provider for services provided to an eligible Medicaid/Medicare individual who has elected the Medicare hospice benefit. This applies where the hospice provider and nursing facility have made a written agreement under which the hospice provider agrees to provide professional management of the individual's hospice care and the nursing facility provider agrees to provide room and board to the individual. The department will pay the hospice provider in accordance with the department's rules governing Medicaid reimbursement to hospice providers.

3.7.14 Information requested specific to nursing facilities

3.7.14.1 Please address "network adequacy" in the five counties. In 2010, the following nursing facility services were provided to unduplicated residents in the five counties.

f. Lewis and Clark, 3 facilities, 170 residents
g. Cascade, 3 facilities, 441 residents
h. Choteau, 2 facilities, 35 residents
i. Teton, 2 facilities, 37 residents
j. Judith Basin, 0 facilities, 0 residents

3.7.14.2 The data for nursing facility services in the five county demonstration project indicates that some Medicaid eligible clients whose residency are within those five counties are currently being served in nursing facilities outside of those five counties. Please describe the impact on these Medicaid clients under this project.

3.7.14.3 Describe how a client would be affected under a "bed hold payment" as defined in ARM 37.40.338 for nursing facility services.

c. A "hospital hold payment" is provided to a nursing facility provider to hold a bed for a resident receiving hospital services
d. A "therapeutic home visit (THV)" is provided to a nursing facility provider to hold a bed for a resident receiving a therapeutic home visit.

3.7.14.4 How would a provider of nursing facility services receive one-time, lump sum distribution of funding to nursing facilities not participating in the funding for "at risk" facilities under an Intergovernmental Transfer program provided by the Department as defined in ARM 37.40.311?

3.7.14.5 How would direct care and ancillary workers providing nursing facility services be included in any legislative funded direct care wage initiative as defined in 37.40.361?

3.7.14.6 How will resident trust accounts be maintained in accordance with ARM 37.40.306, MCA 53-6-168, and 42 CFR 483.1?

3.7.14.7 How will a Medicaid eligible resident for nursing facility services requiring those services from an out of state nursing facility under the conditions defined in ARM 37.40.337 receive those services?

3.7.14.8 How will a nursing facility services provider negotiate an agreement with a hospice provider to provide professional management of hospice care for a nursing facility resident in accordance with ARM 37.40.339?

3.8 SWING BED SERVICES

3.8.1 Description of services

Swing-bed services are allowed under a written agreement with the department to a provider who furnishes services to Medicaid recipients as defined in ARM 37.40.402 and

ARM 37.40.405. These services must be delivered by providers within the scope of the provider's license, and includes providers of "of acute care or extended skilled nursing care long term care facility services."

3.8.2 Licensure/certification requirements

A swing-bed hospital services provider is a licensed hospital, critical access hospital (CAH) with swing-bed approval or licensed medical assistance facility which is Medicare-certified to provide post hospital SNF care.

3.8.2.6 A swing-bed services provider is a hospital that has applied for and the department has approved enrollment as a Medicaid swing bed hospital services provider.

3.8.2.7 A swing-bed services provider that is a hospital located in a rural area of the state as defined by the department.

3.8.2.8 A swing-bed services provider that has a certificate of need from the department to provide swing-bed services.

3.8.2.9 A swing-bed hospital services provider has fewer than 50 hospital beds and has provided written assurance to the health care financing administration that the hospital will not operate over 49 hospital beds, including swing-beds, except in connection with a catastrophic event.

3.8.2.10 A swing-bed services provider who is a critical access hospital (CAH) with swing-bed approval has no more than 25 acute care inpatient beds, of which no more than 15 are used for acute care at any one time for providing inpatient care

3.8.3 Reimbursement Rate Setting

Medicaid reimbursement is described below for swing-bed facility services delivered by providers.

3.8.3.4 For swing-bed hospital services, the Montana Medicaid program will pay a provider a per diem rate as defined in ARM 37.40.406 for each Medicaid patient day.

3.8.3.5 The swing-bed hospital services per diem rate is the average Medicaid per diem rate paid to nursing facilities for routine services furnished during the calendar year immediately previous to the year in which the swing-bed hospital services are provided. Nursing facility routine services are those services included in the definition of "nursing facility services".

3.8.3.6 A provider's per diem rate for swing-bed services is effective for rate periods of January 1 through December 31 of each calendar year.

3.8.4 Eligibility for Services

Individuals eligible for swing bed placements need acute care or extended skilled nursing care, and must meet

f. All non-financial criteria
g. Be admitted under a doctor's order
h. Meet the medical criteria for needing nursing home care
i. Meet the financial need requirements
j. Get a pre-admission screening

In 2010 approximately 220 unduplicated individuals received Medicaid funded services in swing bed facilities statewide, 0 in the 5 counties in the demonstration project.

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3.8.9 Ancillaries-Separately Billable Items

In addition to the amount payable to swing-bed facility service providers under ARM 37.40.406, the department reimburses facilities for separately billable items as defined ARM 37.40.406.

3.8.10 Preadmission screening and level of care determinations

3.8.10.1 A swing-bed facility services provider must comply with regulations regarding screening for nursing facility services as defined in ARM 37.40.101 to 37.40.120, ARM 37.40.201 to ARM 37.40.205, ARM 37.40.405, and 42 CFR 483.100 to 483.138.

3.8.10.2 A level of care determination is required to assess medical necessity and appropriateness of placement for long term care services (intermediate or skilled), and must be completed before Medicaid payment can be authorized.

3.8.10.3 All individuals seeking long term care (e.g., nursing facility or swing bed services) must have a preadmission screening before entering a facility. Currently, a Preadmission screening/level I screening is performed by the department's contractor Mountain Pacific Quality Health Foundation.

3.8.10.4 Preadmission/level I screening (also known as preadmission screening annual resident review PASAAR) will determine if a long term care applicant is approved for long term care placement, and if a Preadmission/level II screening (determines whether the applicant requires specialized services and is appropriate for long term care placement) is required for the long term care applicant.

3.8.10.5 Preadmission/level II screening is required if the Preadmission/level I screening shows indication of mental retardation or mental illness for the applicant. The department's contractor Mountain Pacific Quality Health Foundation will refer applicants to either the appropriate regional center or the regional mental retardation authority for a preadmission/level II screening.

3.8.11 Other Add On Payments

Medicaid certified swing bed facilities, at the discretion of the Montana legislature, may be paid in addition to their computed Medicaid payment rate as provided in ARM 37.40.422 funding to be used only for wage and benefit increases or lump-sum distributions to direct care and ancillary services workers.

3.8.12 Reporting Requirements

3.8.7.1 Direct care wage reporting

Swing Bed service providers are required to report to the department actual hourly wage and benefit rates (or lump sum distributions) paid to direct care and ancillary services workers as defined in ARM 37.40.422.

3.8.9 Information requested specific to swing bed services

3.8.9.1 How would the offeror address "network adequacy" in the five counties? In 2010, the following swing bed facility services were provided to unduplicated residents in the five counties.

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d. Lewis and Clark, Cascade, Judith Basin—none
e. Choteau, 1 facility, no residents
f. Teton, 1 facility, no residents

3.8.9.2 How will direct care and ancillary workers providing swing bed services be included in any legislative funded direct care wage initiative as defined in 37.40.422?

3.9 HOME HEALTH SERVICES

3.9.1 Current home health services

3.9.1.1 Home Health Services are authorized by Section 1905 (1) () of the Social Security Act and governed by the federal regulations which define Home Health Services, who can deliver services, service requirements, and recipient eligibility. The regulations are provided in CFR 484.1-484.55.

3.9.1.2 All Home Health Services must comply with federal regulations. In addition, Montana has additional program parameters, which are referenced in this document.

3.9.2 Population To be eligible for Home Health Services, a person must meet all of the following criteria:

f. Medicaid eligible
g. Meet service criteria, which means the client's home is the most appropriate location for services based on medical reasons and the client cannot readily obtain medical services except through a Home Health agency or there is no equally effective, less costly treatment
h. Require acute skilled nursing or therapy services on a part-time, intermittent basis to prevent or postpone institutionalization
i. Not reside in a hospital, nursing facility, or ICF-MR
j. Home-bound status, which means the client is confined on a full time, part time or intermittent basis to the client's place of residence for medical reasons, is unable to obtain required medical services without demonstrated taxing effort, or cannot reasonably obtain medical services other than through a Home Health agency.

3.9.3 Provision of Home Health Services Home Health Services are provided under the following conditions:

3.9.3.2 Must be provided by a licensed Home Health agency to a client considered homebound and the services must be delivered in the client's place of residence. Place of residence means the residential setting in which the recipient generally resides, and must include client's own home, a personal care facility, a foster home, a community home or other residential setting for persons who have a developmental disability or physical disability, a rooming house or a retirement home.

3.9.3.2 Provided for the purposes of postponing or preventing institutionalization

3.9.3.3 Must be ordered by the client's attending physician

3.9.3.4 Part of a written plan of care

3.9.3.5 Reviewed and renewed by the client's attending physician at a minimum of 60 day intervals

3.9.3.6 The Home Health provider must maintain documentation that the client meets the homebound definition, as outlined earlier under the "population" section

3.9.3.7 The Home Health provider must keep written copies of the physician orders, care plans, and other client records readily available.

3.9.4 Services Description Home Health Services include:

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3.9.4.1 Skilled nursing services, as defined by the Montana Nurse Practice Act, that are provided on an intermittent or part time basis to meet the medical needs of a client who needs nursing procedures. Services that can be legally performed by a paraprofessional or non-licensed individual do not qualify as skilled nursing services, even if a licensed nurse performs the task. Services must be delivered in accordance with the plan of care. Visits of licensed nurse to the home of a client solely for the purpose of supervising a Home Health aide are not reimbursable by Medicaid.

3.9.4.2 Home Health Aide services. These services must be provided under the supervision of a registered professional nurse and in accordance with the written plan of care. Services include assistance with activities of daily living and the care of the household to maintain the client in his/her residence for a short, definite period of time. A client who is eligible for personal assistance services may not receive concurrent Home Health Aide Services.

3.9.4.3 Physical therapy services, Occupational therapy services, and Speech therapy services are services defined in scope by MCA. All therapy services must be provided by a licensed therapist. Services of a therapy assistant, therapy aide, or other person are not reimbursable. The Home Health benefit provides coverage for restorative therapy services when the particular restorative therapy services are reasonable and necessary to the client's condition and the client is unable to obtain such services through an outpatient clinic or private practice setting due to their medical status. The amount and frequency must be within the therapy's generally accepted practice.

3.9.4.3.1 Restorative therapy is defined as the following: Therapy services that are performed with a reasonable expectation that the client's function will improve significantly in a reasonable and predictable period of time, based upon an assessment of the client's restoration potential made by a physician in consultation with a licensed therapist. Therapy services are not restorative if the client's expected restoration potential would be insignificant in relation to the extent and duration of services required. Therapy services are no longer restorative if at any time after beginning treatment, it is determined that the reasonable expectation of significant improvement will not materialize.

3.9.4.3.2 The Home Health benefit does not cover maintenance therapy, which is defined as the following: Repetitive therapy services that are required to maintain functions that are performed without reasonable expectation of significant progress and that do not involve complex and sophisticated therapy services requiring the judgment and skill of a licensed therapist.

3.9.4.3.3 The establishment of a maintenance therapy plan by a licensed therapist is reimbursable. The establishment of a maintenance plan includes:

e. The initial evaluation of the client
f. Development of a plan that incorporates the treatment objectives of the prescribing physician and is appropriate for the client's capacity and tolerance
g. Instruction of others in carrying out the plan and further evaluations by a licensed therapist and required.
h. One time therapy evaluation as part of obtaining a piece of durable medical equipment is reimbursable if there is no other

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reasonable alternative to obtaining this service. The provider is still responsible for developing a plan of care, obtaining physician orders, and following all other applicable rules.

3.9.4.4 Medical supplies and equipment suitable for use in the home. All medical supplies must:

d. Have a therapeutic or diagnostic use,
e. Be ordered by the client's physician as part of a prescribed treatment, and
f. Be essential for agency personnel to follow the plan of care

3.9.4.4.1 The Home Health benefit excludes any item that can be classified as durable medical equipment (DME). Payment for DME may be available under the DME program.

3.9.4.4.3 Non-routine supplies may be reimbursed through this benefit under the following conditions:

d. Item following a consistent charging practice for Medicaid and non-Medicaid clients receiving the item
e. Item is directly identifiable to an individual client, and
f. Item is furnished at the direction of the client's physician and specifically identified in the plan of care.

3.9.4.4.3 Routine supplies are not reimbursable under the Home Health benefit. These supplies are customarily used during the course of most home care visits and are usually part of the staff's supplies and not designated for a particular recipient. These supplies are included in the per visit rate of Home Health Services. Routine supplies would not include those ordered by the physician that are essential to Home Health personnel to effectively carry out the plan of care. There are conditions when supplies, normally considered routine, are required in quantity, for recurring need and are included in the plan of care. These supplies would be considered non-routine and would be billable.

3.9.5 Service Exclusions: A person receiving personal care services may not receive Home Health Aide Services.

3.9.6 Client Termination: Client participation in the program terminates when either the client no longer has a medical need for services, which means that either the client no longer meets service criteria, an equally effective less costly alternative becomes available or the client requests services to terminate. The Home Health provider may discharge a client for other reasons. This is an action of the provider and the provider must provide advance notice to the client based on the provider's established policy. In all cases the provider agency must make a reasonable effort to ensure continuity and appropriateness of care through referrals to other providers.

3.9.7 Service Coordination

3.9.7.1 Developmental Disabilities

Any individual with a diagnosis of developmental disability (or a related disorder) must obtain chronic nursing services through an approved provider of the Developmental Disability Service Division. Individuals with developmental disabilities will continue to have access to skilled nursing for acute needs and home based therapies if they qualify under the Home Health benefit. This type of skilled nursing care would be for a limited time period associated with recovery from an accident, wound care, or acute hospitalization.

3.9.7.2 Adult Foster Homes

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Clients residing in a home adult foster homes or may receive Medicaid Home Health Services if they meet all program conditions. The owner or staff of the adult foster care home may not do nursing tasks with the client even if the owner or staff are nurses.

3.9.7.3 Home Infusion Therapy

3.9.7.3.1 In order to bill for skilled nursing services provided in conjunction with home infusion therapy, the following must apply:

c. The individual must meet program eligibility, including service criteria; and
d. Nursing services are not available through the home infusion provider

3.9.7.3.2 If the Home Health agency is also licensed as a home infusion therapy agency and employs nurses for that purpose, it is expected that the nursing services will come through the home infusion program and not the Home Health benefit.

3.9.7.4 Services to Children

Home Health Services are not available to children who qualify for Private Duty Nursing (PDN) Services. PDN is considered equally safe and effective to and less costly than Home Health Services. If a PDN provider is not available, Home Health Services must be provided.

3.9.8 Prior Authorization of Services

Skilled nursing services and therapy services under the Home Health benefit must be prior authorized. The authorizing entity has a link to the eligibility determination database and is able to determine whether the client is Medicaid eligible, Medicaid/Medicare (dually) eligible, or TPL. The authorizing entity hires a Registered Nurse to review the required documentation and assure that the service meets the scope and requirements of the program. Prior authorization is only provided when TPL has already been billed. The prior authorization documentation includes:

g. Client's eligibility based on service criteria
h. Order for services from the client's attending physician or PASSPORT physician
i. The attending physician or PASSPORT physician reviews the plan every 60 days (when applicable)
j. Services ordered in the plan of care are consistent with services provided by the agency as supported by visit documentation
k. Services are medically necessary and require a licensed professional
l. Services paid by Medicaid for a dually eligible individual are appropriate as the client does not met Medicare criteria or it is a service not payable by Medicare

The only service that does not need to be prior authorized is medical supplies.

3.9.9 Out of State Services

Home Health Services may be provided by providers located out of state if the service meets the Home Health Service requirements and the service is prior authorized by the Department. The out of state provider must meet the provider enrollment criteria.

3.9.10 Provider Enrollment and Participation

A Home Health agency must be:

d. Licensed by the Montana Department of Public Health and Human Services
e. Medicare certified
f. Enrolled as a Medicaid provider

All employees of an agency participating in Medicaid Home Health Services are mandatory reporters of suspected abuse, neglect, and exploitation. In addition, the Home

Health agency must report all serious occurrence reports, as outlined in Community Services Bureau (CSB) Policy Manual section 305. All employees of the agency must comply with the standards of charting, as outlined in CSB Manual section 306.
The provider agency is responsible for educating contracted therapy professionals regarding general service requirements and limits under the Home Health program.

3.9.11 Reimbursement

3.9.11.2 As of July 1, 2009 the Home Health reimbursement rate for services is as follows:

g.	Physical Therapy- visit charge	$71.81
h.	Occupational Therapy- visit charge	$71.81
i.	Speech Therapy- visit charge	$71.81
j.	Skilled Nursing- visit charge	$71.81
k.	Home Health Aide- visit charge	$32.06
l.	General Class Medical/Surgical Supplies-90% of amount allowed for the specific item under Medicare	

3.9.11.2 A visit is a personal contact with the client in his/her residence to provide a covered Home Health Service.

3.9.11.3 The rate of reimbursement for Home Health Services increases according to provider rate increases as they are allocated during the Montana legislative session.

3.9.12 Cost-Sharing

The federal government allows states to require certain clients to share Medicaid costs by imposing copayments. Refer to ARM 37.85.204 for cost sharing provisions. Home Health is included under the programs where cost-sharing is allowed. A provider cannot deny services to a client solely because the client cannot pay the copayment.
Home Health copayments are:

c. $2.00 per Home Health Aide, nursing, or therapy visit
d. $.50 per claim line of supplies

3.9.13 Reporting

Reports from the entity that conducts the prior authorizations:

d. Monthly report details # of active cases by month and year to date
e. Monthly report captures # of authorizations (both initial and extensions) by month and year to date
f. Database captures the following information
   (1) Client demographic information, diagnosis, and Home Health prior authorization history.
   (2) By prior authorization request, the requesting agency name, client name, start date, end date, service type, units requested, units approved, cost of approved units, and status of request (approved, pending, denied, or cancelled).
   (3) Comments section that displays the comments associated with prior authorization status.
   (4) Cost-savings information (for example with TPL).
   (5) Capture info on type of letter sent to agency related to each prior authorization request
   (6) Date prior authorization was sent to ACS and captures the PA #.
   (7) Document whether request resulted in an administrative review.

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3.9.14 Criteria to Consider under Managed Care

3.9.14.2 Service Scope

3.9.14.1.1 Offeror must ensure that the scope of the service (i.e. type of service and service description) that is available under the current system is maintained.

3.9.14.1.5 Offeror must ensure that the provision of service under the current system is maintained.

3.9.14.1.6 Offeror must ensure that the licensure for those who perform skilled and therapy services is maintained.

3.9.14.1.7 Offeror must ensure that eligibility for service is maintained.

3.9.14.1.5 Offeror must ensure that the service authorization meets the standards for Home Health practice that are set by Medicare regulation. All authorizations should sufficiently address the client's medical necessity for service.

3.9.14.1.6.Registered nurse and/or the prescribing physician must authorize services.

3.9.14.1.7 The Offeror must identify a plan to implement inter-rater reliability to ensure consistency and quality in the authorization of services.

3.9.14.2 Service Access

3.9.14.2.1 Client must have choice of at least two providers in each of the counties (if unable to provide choice the Offeror should justify why this cannot occur).

3.9.14.2.2 Offeror must ensure that a client who has a need for Home Health Services is authorized those services

3.9.14.2.3 Offeror must ensure that a client who is authorized services receives the service from a qualified provider

3.9.14.2.4 Any individual with a diagnosis of developmental disability (or a related disorder) would receive Home Health Services under the same rules and requirements as other managed care members.

3.9.14.3 Provider Enrollment

3.9.14.3.1 Providers must meet the same enrollment criteria as currently exists.

3.9.14.3.2 Providers enrolled as Medicaid providers would automatically be enrolled in the provider network for a period of not less than one year post implementation of managed care.

3.9.14.4 Provider Complaints

3.9.14.4.1 Offeror has a plan to respond to provider concerns regarding the authorization of services.

3.9.14.4.2 Offeror provides a quarterly report to the Department on the number of complaints, by provider, by type and by resolution.

3.11 PERSONAL ASSISTANCE SERVICES

3.11.1 Current Services Personal Assistance

3.10.1.1 Personal Assistance Services (PAS) are medically necessary in-home services provided to Medicaid recipients whose health conditions cause them to be functionally limited in performing activities of daily living. PAS provides necessary long-term maintenance or supportive care in the home.

3.10.1.2 There are two options for the delivery of PAS.

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DRAFT

c. The first option is the Agency-Based Personal Assistance Services (ABPAS).
d. The second option is Self-Direct Personal Assistance Services (SDPAS). Some service requirements are specific to each option. Unless otherwise noted the service requirements outlined below apply to both PAS options.

3.10.2.3 Under the ABPAS option, enrolled provider agencies manage the services on behalf of the client. The provider agency must employ a licensed nurse to oversee the training and supervision of all direct care attendants and monitor the client's Service Plan

3.10.2.4 As a result of grass roots legislative efforts, Montana launched the SDPAS option in October 1995. The effort established regulation in MCA 53-6-145, which dictates the parameters for the program.

3.10.2.5 The program is designed to allow clients to hire, train, manage, schedule and discharge their attendants.

3.10.2.6 Clients must demonstrate capacity to manage their care or have a personal representative manage their care.

3.10.2.7 Clients in either the agency-based or self-direct program are eligible to receive the same services; however clients in the self-direct option may direct certain health maintenance activities, as well.

3.10.2.8 There is an exemption to Montana's Nurse Practice Act that allows the client to manage their bowel care, catheter care, medication administration and wound care, with a health care professional's approval.

3.10.1.8.1 Every client has the option of selecting either the ABPAS or SDPAS option, as long as they meet the eligibility criteria.

3.10.1.8.2 If a client does not meet the eligibility criteria for SDPAS he or she is eligible to receive services under the ABPAS option.

3.10.3 Population (Reference PAS 403)

3.10.2.3 To be eligible for the ABPAS option, a client must meet all of the following criteria:

a. Meet Full Medicaid eligibility
b. Demonstrate a medical need for personal care assistance
c. Receive all of the personal care services, aside from escort services to medical appointments and shopping, in the client's home
d. Agree to the provision of services as specified in the authorized Service Plan

3.10.2.4 In addition to the criteria outlined above, to be eligible for the SDPAS option, a client must meet the additional criteria:

3.10.2.4.1 Meet capacity for program participation, which means the client, or a personal representative, is capable of understanding the program requirements, including recruiting hiring, scheduling, training, directing and dismissing personal attendants.

3.10.2.4.2 If the client does not meet capacity the client may have an immediately involved representative assume some or all of the responsibilities. Reference SDPAS 503/701 for the capacity

DRAFT

process and SDPAS 419 for more information on personal representatives.

3.10.2.2.3 Sign a Client Agreement or Personal Agreement form. Reference the SDPAS manual 601 for the client and personal representative responsibility and SDPAS 913 and SDPAS 914 for the form.

h. The Client Agreement outlines the client responsibilities for participation in the SDPAS program. The requirements outlined in the Agreement include:

i. Client or the client's Personal Representative is capable and willing to act as though the personal assistance is their employee for the purposes of selection, management and supervision of the personal assistance, although the personal assistant is the employee of a SDPAS provider

j. Client or the client's Personal Representative has the primary responsibility in the scheduling, training and supervision of the personal assistant.

k. Client or the client's Personal Representative will develop and maintain a Service Plan, which is based upon the completion of the client authorization profile and includes an emergency back-up plan, recruitment and training plan for personal assistants, and an oversight schedule for personal assistants.

l. Obtain authorization from a health care professional to participate in the program at least every 12 months or earlier if there is a change in health maintenance activities

m. Review, approve, sign and date all service delivery records (time sheets).

n. Accept medical and related liability regarding the delivery of PAS. According to the statutory language that created this program the client is responsible for any incidents of harm to the personal assistant.

3.10.3.2.4 Have services approved by a health care professional. Reference SDPAS 418 for more details about the approval process and paperwork and CSB 103 for a definition of health care professional.

3.10.3.2.5 PAS must be provided for disabled children when the parent is unqualified or otherwise unable to provide the personal care and the child is at risk of institutionalization unless the services are provided.

3.10.3.2.6 A client may receive personal care services through the Medicaid Home and Community Based Services program for elderly and physically disabled, clients with developmental

DRAFT

disabilities, or clients with severe and disabling mental illness, in addition to the PAS provided through this program.

3.10.4 Services Description (Reference PAS/SDPAS 403 and 504)

3.10.7.10 Personal Assistance Services include assistance with the following activities:

e. Activities of daily living, which are limited to bathing, grooming, transferring, walking, eating, dressing, toileting, self-administered medication, and meal preparation.

f. Household tasks, which are limited to housekeeping activities in conjunction with activities of daily living that, are directly related to the recipient's medical needs. These include only the following: cleaning the area used by the client, changing the client's bed linens, doing the client's laundry, and shopping for groceries and household items essential to the health care, nutritional needs and maintenance of the client. The attendant should, when feasible, escort the client on shopping trips, rather than do the shopping for the client.

g. Escort services, which are limited to a client who requires personal care services en-route or at the destination. The service must be provided by a personal care attendant who accompanies the client to a medical examination or treatment.

h. The Self-Direct service option includes the option to direct Health Maintenance Activities (HMA). HMA tasks are skilled tasks that are statutorily exempt from the Nurse Practice Act. HMA services include bowel program, wound care, urinary system management, and medication administration. A health care professional must sign off on the client' authorized Service Plan

3.10.7.11 PAS may only be delivered by a personal care attendant that is employed by an enrolled Medicaid provider that has met the criteria established by the Department.

3.10.7.12 PAS may be provided up to but no greater than 40 hours per week as defined by the client Service Plan. Exceptions to the 40 hour per week limit are outlined below.

3.10.7.13 Time for escort services for medical appointments is over and above what is authorized on the client Service Plan.

3.10.8 Service Exclusion (PAS/SDPAS 404)

3.10.8.1 PAS does not include any skilled services that require professional medical training unless otherwise permitted under MCA. Services provided under the delegation clause of the Nurse Practice ACT are not included as PAS. The only skilled services that can be provided under PAS are the SDPAS health maintenance activities.

3.10.8.2 PAS may not include services which maintain an entire household or family or which are not medically necessary.

3.10.8.3 PAS does not include supervision, respite care, habilitation aide, babysitting or visiting, home or outside maintenance, cleaning floors and

DRAFT

furniture in areas the client does not use or occupy, or maintenance of animals unless the animal is a certified service animal specifically trained to meet the safety needs of the client.

3.10.8.4 A PAS client cannot reside in a hospital, long-term care facility, intermediate care facility for the mentally retarded, or licensed personal care/assisted living facility, as defined in MCA.

3.10.8.5 An immediate family member, which means a spouse or parent of a minor child, may not be the personal care attendant to the immediate family member.

3.10.8.6 PAS may not be provided to relieve a parent of child caring or other legal responsibilities.

3.10.9 Service Limits

3.10.9.1 A maximum of 40 hours per week may be authorized for PAS. A client who needs service in excess of 40 hours on a permanent basis may receive additional service through the home and community based waiver. A client who needs service in excess of 40 hours on a temporary basis (less than three months) needs to receive prior authorization from the Department.

3.10.9.2 Household tasks may not account for more than 1/3 of the total time allocated per week for personal care services, or a maximum of 3 hours, whichever is less.

3.10.9.3 The authorizing contract entity may authorize temporary services in excess of the 40 hour limit. The contract entity may also authorize temporary services to clients who reside in licensed foster or group homes or supported living environments when the client's medical needs are beyond the scope of services normally provided. All service exceptions must be prior authorized by the contract entity. Exceptions may be made for a period of up to three months under the following circumstances:

d. As the result of an acute medical episode
e. To prevent institutionalization during the absence of the normal caregiver
f. During a post-hospitalization period

3.10.10 Client Termination

3.10.10.1 A PAS provider may terminate services to a client for any of the following reasons:

g. Client or other persons in the household subjects the personal care attendant to physical or verbal abuse, sexual harassment, exposure to the use of illegal substances or to threats of physical harm
h. Client requests termination
i. Client refuses to accept help
j. Environment of the client is unsafe to receive PAS
k. The client refuses services of a personal care attendant solely or partly on the client's race, creed, religion, sex, marital status, color, age handicap or nationality

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l. Client refuses to accept services in accordance with the Service Plan

3.10.10.2 The PAS provider must give at least 10 days advance notice to the client when PAS are terminated for the reasons mentioned above. The PAS provider may immediately, but temporarily, suspend services for reasons 1-3 mentioned above. Following the temporary suspension the provider must enter into an agreement with the client to ensure that the violation does not happen again. If the client fails to agree or abide to the terms of the agreement services may be permanently terminated.

3.10.10.3 In all cases the provider agency must make a reasonable effort to ensure continuity and appropriateness of care through referrals to other providers.

3.10.10.4 The Department may terminate or reduce PAS when funding for services is not available. Client participation in PAS may also be terminated when the following occurs:

c. Client no longer has a medical need for services, or

d. Client refuses to participate in the required review of the contract entity or PAS provider.

3.10.10.5 The contract entity with send a notice letter to the client of program termination and provide the client with fair hearing process.

3.10.11 Prior Authorization of Services

3.10.11.1 All PAS must be prior authorized, except in the case of Temporary Authorizations, which are outlined below.

3.10.11.2 The Department has a contract with Medicare's Quality Improvement Organization to perform prior authorization for PAS. It is assumed that this function will be provided by the managed care organization.

3.10.11.3 Data and tracking are provided through a database that is specific to the PAS contract responsibilities. The contract entity must manage, respond, and report on to the following: Referral information and status of the referral; once a client is authorized for services the entity must track all paperwork, including the annual review cycle, amendments and status of amendments, change in agency, change in demographic, change in option, and discharge information.

3.10.11.4 The contract entity ensures that all PAS providers have current authorization and demographic information for every PAS client served.

3.10.11.5 Refer to PAS/SDPAS 501-506 and 415 for a complete description of the contract duties related to PAS.

3.10.11.6 The entity must staff Registered Nurses to conduct all of the authorization assessments related to the PAS program. There are three main components to the authorization process:

d. Initial Authorization

e. Annual Authorization

f. Amendments

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3.10.11.7 Authorization documentation includes the following forms:

c. Client Overview/Referral (SLTC-154)

d. Client Profile (SLTC-155)

3.10.11.8 Initial Authorization

The authorizing entity has a link to the MMIS system so they can determine client eligibility prior to authorizing services.

3.10.11.8.1 The entity will also authorize services for clients in the status of Medicaid pending to ensure that services are available immediately when a client becomes eligible. The contract entity will provide written notice to all applications when services are denied due to service ineligibility.

3.10.11.8.2 New admissions are processed by the contract entity as outlined in PAS 411.

3.10.11.8.3 Once financial eligibility is determined the contractor has 30 working days from date the referral is received to make an onsite visit with the client.

3.10.11.8.4 The onsite visit must be conducted in the client home and it must be conducted by a RN. If the RN is unable to complete the on-site visit within 10 working days, the RN must complete a prescreen telephone review to provide initial authorization for services until an onsite can be made. The onsite still must be made within 30 working days.

3.10.11.8.5 At the time of the authorization visit the RN provides the client with a list of PAS providers to select from.

3.10.11.8.5.1 The RN's onsite visit must include:

d. An explanation of the authorization process;

e. Completion of the Client Overview and Profile; and

f. Distribution of literature explaining the program and available providers

3.10.11.9 Annual Re-Authorization

3.10.11.9.1 A prior authorization span for PAS cannot exceed a 12 month period. The span may be less, if necessary.

3.10.7.9.2 The contract entity must conduct a phone or onsite visit by the end of the month in which the authorization span ends in order to reassess the client for his/her continued need for service and authorize services accordingly.

3.10.7.10.3 An onsite visit is necessary for re-authorization if one is requested by the provider agency, by the Department, or if an onsite is determined necessary by the authorizing RN. If an

DRAFT

onsite is not requested or deemed necessary the re-authorization can be determined over the phone.

3.10.7.11 Amendments (Reference PA/SDPAS 502 and 417)

3.10.7.16.13 Events and conditions may result in a need to change the client authorization. The provider will notify the contract entity when this event occurs.

3.10.7.16.14 All amendment requests are reviewed by a RN and entered into the database.

3.10.7.16.15 Amendments may be processed over the phone unless there is not sufficient documentation to process the request, in which case an onsite visit is necessary.

3.10.7.16.16 If the amendment results in a change to the profile a new profile is completed and sent to the provider agency.

3.10.7.17 Client Overview (Reference PAS/SDPAS 503)

3.10.7.17.1 The Client Referral/Overview form is used as the referral document by anyone interested in referring a client for PAS.

3.10.7.17.2 It is also used by the contract entity to document the following related to the client condition: Biographical and Environmental information, Medical history, Sensory Status, Communication ability, Health status, Assistive Devices used, Factors impacting level of function, Care determination, and Client's account of quality of services received and care needs (either addressed or unresolved).

3.10.7.17.3 The complete assessment questionnaire is available upon request.

3.10.7.18 Client Profile (Reference PAS/SDPAS 504)

3.10.7.18.1 The profile provides a summary of information about the authorization of services for each client, specific to impairment level per tasks, tasks authorized per day and per week, time authorized per task and time authorized per week, and comments about each task that is authorized. The profile also documents whether the profile is initial, amendment, or short-term.

3.10.7.18.2 The contract entity will ensure that all PAS providers are made aware of authorizations and changes to client information.

3.10.7.18.3 The contract entity is required to send a letter to the client with notification of the results of the authorization for PAS. The letter is sent for all initial authorizations, decreases in authorization, and denials. Fair hearing rights are also provided to the client in the letter. Reference PAS 505 for more information.

3.10.7.19 Temporary Authorization of Services: There are two circumstances in which a PAS provider can authorize services.

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3.10.7.19.1 First, a provider can authorize services for a new client who needs immediate services for the purpose of maintaining their health and safety. Reference PAS/SDPAS 414 for the paperwork and process that must be completed in order for a PAS provider to temporarily authorized services. A referral must be sent to the contract entity once a high risk intake visit has been completed so the contract entity can complete the overview and profile.

3.10.7.19.2 Second, a provider can authorize services when the client, personal representative, or agency determines that the hours and services that are currently authorized are inappropriate to meet the needs of the client. Reference PAS/SDPAS 417 for the paperwork and process that must be completed by the PAS agency in order for a PAS provider to temporarily authorize services. An amendment form must be sent to the contract entity if the change in authorization will last more than 20 days so the contract entity can update the overview and profile.

3.10.7.20 **Out of State Services:** The Department may contract with out of state agencies to provide PAS for a client who is residing out of state temporarily

3.10.7.21 **Provider Enrollment**

3.10.7.21.1 Personal Assistants cannot operate as independent contractors. A personal assistant is an employee of the provider agency. PAS providers are limited to businesses incorporated under the laws of the state of Montana.

3.10.7.21.2 In order to enroll as a Medicaid PAS provider the PAS providers must:

i. Demonstrate that they are paying workers' compensation and unemployment insurance.
j. Provide their articles of incorporation
k. Provide general liability insurance of $100,000
l. Provider motor vehicle insurance of $100,000
m. Provide current worker's compensation and unemployment insurance coverage
n. Submit a written contingency plan, which is approved by the Department, that addresses service delivery to clients in the event an agency is unable to deliver services in a timely manner or in the event the agency ceases operation
o. Provider proof of financial solvency, which means the agency is able to make a projected four month payroll
p. Attend a two-day PAS 101 training, which is sponsored by the Department twice each year

3.10.7.22 **Provider Requirements (Reference PAS 602/SDPAS 602):** PAS providers are required to follow all Department rules, policies and procedures, which include:

3.10.7.22.1 Document and verify Medicaid eligibility on a monthly basis

3.10.7.22.2 Complete the intake process with required paperwork as referenced in PAS 701/PAS 702 and SPDAS 702. Visit must be done in the client's home.

c. For ABPAS the intake process must be completed by a licensed nurse

d. For SDPAS the intake process must be completed by someone trained in SDPAS program parameters

3.10.7.22.3 Complete re-certification at intervals that do not exceed 180 days or when there is a significant change in the functional needs of the client as referenced in PAS 703 or SDPAS 602 and 703. Visit must be done in the client's home.

a. For ABPAS the intake process must be completed by a licensed nurse

b. For SDPAS the intake process must be completed by someone trained in SDPAS program parameters

3.10.7.22.4 Conduct temporary authorization and amendments, as necessary, when client condition changes

c. For ABPAS the intake process must be completed by a licensed nurse

d. For SDPAS the intake process must be completed by someone trained in SDPAS program parameters

3.10.7.22.5 Successful completion of the quality assurance process

3.10.7.22.6 Maintain a pool of trained attendants (ABPAS only)

a. ABPAS attendants must receive 16 hours of training or have their training waiver prior to working with a client. Reference PAS 706 for more details about the training requirements

b. ABPAS attendants must receive at least 8 hours of in-service training in order to work with a client. Reference PAS 706 for more details.

3.10.7.22.7 Provide the client or personal representative with program enrollment information, program philosophy and department policies, complaint procedures, forms for ongoing participation, and procedure to have a personal assistant hired by the provider (SDPAS only)

3.10.7.22.8 Provide a grievance procedure for clients

3.10.7.22.9 Provide advance notice to clients who are being discharged

3.10.7.22.10 Timely response to contract entity regarding annual re-authorization visits

DRAFT

3.10.7.22.11 Complete an annual client survey as outlined in PAS 912 and SDPAS

3.10.7.22.12 Maintain required records as outlined in PAS 608 and SDPAS 608

3.10.7.16.13 Review, approve, sign and date all service delivery records (time sheets). The provider can only bill for services performed by the personal attendant if the time and tasks are authorized by the contract entity or if a temporary authorization is in place.

3.10.8.16.14 Providers that participate in direct care wage bonus funding are required to provide annual reports on the fund distribution

3.10.8.16.15 Providers that participate in health insurance funding are required to provide quarterly reports of the fund distribution

3.10.8.17 The ABPAS provider must staff a licensed nurse to supervise personal assistants in the delivery of personal assistance services.

3.10.8.18 The nurse supervisor must perform all of the intake and 180 day visits as well as all of the amendments for PAS clients. In addition, nurse must oversee and certify the initial training or waiver of training for new personal assistants, the in-service training for all current attendants, and the orientation of attendants to PAS client service plans. Reference PAS 702 and 706 for more information on the role of the nurse supervisor.

3.10.8.19 All employees of a provider participating in Medicaid PAS are mandatory reporters of suspected abuse, neglect, and exploitation. In addition, the PAS provider must report all serious occurrence reports, as outlined in Community Services Bureau (CSB) Policy Manual section 305. All employees of the agency must comply with the standards of charting, as outlined in CSB Manual section 306.

3.10.9 Provider Compliance

3.10.8.2 Providers of PAS are subject to compliance reviews to provide assurance to the Department that services are being provided within the rules and policy of the program. The reviews take place on one year to three year cycles, depending upon the outcome of the previous review. A review may be conducted at other times as determined by the Department. The following areas are reviewed for compliance:

3.10.8.2 For ABPAS: Attendant Training Requirements, Attendant Training Records, In-Service Training Requirements, Nurse Qualifications, Serious Occurrence Reporting, Client Survey, Provider Requirements, Client Information, Provider Organizational Structure, Standard Authorization Documentation, High Risk Authorization, Amendments/Temporary Authorization, Service Delivery Records reflect service authorization, Nurse

DRAFT

Supervision, PAS services billed correctly, Required Documentation (aside from authorization documentation), Principles of Charting, Client Interviews, Provider Reference Checks. For complete details on the review standards reference the Regional Program Office Desk Manual Sections 504(b) and 508.

3.10.9.3 For SDPAS: Serious Occurrence Reporting, Client Survey, Provider Requirements, Client Information, Provider Organizational Structure, Standard Authorization Documentation, High Risk Authorization, Amendments/Temporary Authorization, Health Care Professional Authorization, Service Delivery Records reflect service authorization, Program Oversight, PAS services billed correctly, Required Documentation (aside from authorization documentation), Principles of Charting, Client Interviews, Provider Reference Checks. For complete details on the review standards reference the Regional Program Office Desk Manual Sections 504(a) and 509.

3.10.9.4 The Department may review other areas of the program at its discretion.

3.10.9.5 The Department reviews a minimum of 3 charts or between 10-15% of the provider's caseload, whichever is greater, for the purpose of the compliance review.

3.10.9.6 Depending upon the review standard, the provider must meet at least 75%-100% of the cases to be considered compliant. If the provider does not meet the standard the provider will be given the results of the review and a second compliance review will be scheduled. The provider must meet all standards in 75%-90% of the cases in the second review or the provider will be subject to sanctions.

3.10.9.7 For information on the Department's sanction process reference ARM 37.85.501, 37.85.502, 37.85.505, 37.85.506, 37.85.507, 37.85.511, 37.85.512 and 37.85.513.

3.10.10 Reimbursement (Reference PAS 606 and SDPAS 606)

3.10.9.2 Payment for PAS is contingent on the following factors:

3.10.9.1.1 Client has received prior authorization by the contract entity and services are delivered within an authorized span or as appropriate for high risk services or a temporary authorization of an existing authorization. If services are provided without authorized span, high risk, or temporary authorization or services were initiated outside the scope of the program, repayment will be required.

3.10.10.1.2 Service are delineated in the client's service plan (profile authorization)

3.10.10.1.3 PAS provider has required necessary paperwork to deliver services. If the required paperwork is not preset, repayment will be required.

c. Intake visit
d. Re-certification (180-day visit)
c. Health Care Professional Authorization (SDPAS only)

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DRAFT

3.10.10.2 Payment to the PAS provider is based on a unit rate for PAS set by the Department. Reimbursement is negotiated with the Department.

3.10.10.3 The negotiated rate is determined based on two factors.

d. The first factor is whether or not the provider participated in the 2007 Direct Care Worker Funding Initiative and agreed to pay their personal assistants a minimum of $9.35 per hour.

e. The second factor is whether or not the provider participates in the Department's health insurance initiative.

3.10.10.4 Show up time is not billable to Medicaid.

3.10.10.5 Travel time is an administrative expense and has already been included in the unit rate.

3.10.10.6 Under the ABPAS option reimbursement is provided for the following categories (reference PAS 606):

a. Personal care service, which means an on-site visit to deliver PAS specific to a client Service Plan. A unit of service is 15 minutes.

b. Nurse Supervision, which means an on-site client visit or a related activity specific to that client.

f. Mileage may only be billed in conjunction with authorized escort, offsite laundry, or shopping. Odometer readings and documentation of specific destination are required to support claims for reimbursement. A unit of service is one mile.

3.10.10.7 The ABPAS rate for both personal care service and nurse supervision is $4.82. In order to receive this rate a provider must pay their personal attendants at least $9.35/hour. If a provider does not pay this minimum wage to personal attendants their rate is $4.54. The rate for mileage is $.33.

3.10.10.8 Under the SDPAS option reimbursement is provided for the following categories (reference SDPAS 606):

a. Personal care service, which means an on-site visit to deliver SDPAS specific to a client Service Plan. A unit of service is 15 minutes.

b. Program Oversight, which means an on-site client visit or a related activity specific to that client.

c. Mileage may only be billed in conjunction with authorized escort, offsite laundry, or shopping. Odometer readings and documentation of specific destination are required to support claims for reimbursement. A unit of service is one mile.

3.10.10.9 The SDPAS rate for both personal care service and nurse supervision is $4.05. In order to receive this rate a provider must pay their personal attendants at least $9.35/hour. If a provider does not pay this minimum wage to personal attendants their rate is $3.77. The rate for mileage is $.33.

3.10.10.10 An agency that participates in the health insurance for health care worker funding initiative receives a monthly gross adjustment to cover personal

DRAFT

assistant worker health insurance premium costs, in addition to the rates outlined above.

3.10.11 Reporting

3.10.11.1 Data provided through OPAS (the database used by the contract entity to authorize PAS and collect data):

3.10.10.2.3 Monthly authorization report- our contractor (MPQH) submits monthly reports that provide, by program option (ABPAS or SDPAS), the total number of hours authorized and number of units authorized, total # of clients, and average authorization per client.

3.10.10.2.4 The OPAS database collects data specific to each client that is authorized for PAS. Data includes demographic information, medical history, primary diagnosis, and overall health status and need for personal assistance service. In addition, data is captured specific to each of the ADL and IADL services the client needs. For each client by task there is data available to us that includes: impairment level, description of need, frequency of authorization (days per week), minutes per day

3.10.10.2.5 The annual authorization report by agency lists the names of the clients who were authorized services for an annual period of time at a specific provider agency. The report is broken apart by ABPAS and SDPAS, lists each client, and by client lists the # of amendments, high risk, discharge, etc. The Dept uses this report to select a sample of charts for PAS provider compliance review standards

3.10.10.3 Data provided by the provider agency:

3.10.10.3.1 Service Delivery Records (SDR) - every unit of service that is billed for PAS must correspond to a SDR that documents date of service, time in and out, and tasks that were performed. We do not get a report that summarizes this information, but we do review the records as part of our QAR (see below)

3.10.10.3.2 Client list with intake date, 180-day visit date and discharge date. Prior to every QAR the agency is required to submit a report that details this information.

3.11 HOSPICE SERVICES

3.11.1 General Overview; Hospice Services are authorized by Section 1905 (1) (18) of the Social Security Act and governed by the federal regulations which define home health services, who can deliver services, service requirements, and recipient eligibility. The regulations are provided in CFR 42.418.1-42.418.311.

All Hospice Services must comply with federal regulations. In addition, Montana has additional program parameters, which are referenced in this document.

The Hospice program provides health and support services to terminally ill clients and their families. These programs focus on palliative rather than curative care to help the client and

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those closest to the client to come to terms with the terminal condition and live the remaining life as fully as possible.
When a client selects Hospice Care, he or she waives all Medicaid benefits related to curative care. The exception to this is children who are under 21 who may continue to receive curative care while on Hospice Care (reference CMS Director's Letter dated 9/9/10).

3.11.2 Population: To be eligible for Hospice Services, a person must meet all of the following criteria:

a. Medicaid eligible
b. Must be certified as being terminally ill in accordance with Medicare certification requirements set forth in ARM 37.40.808.
c. Must sign a Hospice election statement

Client may live in either his or her home in the community or in a nursing facility while receiving Hospice Services.

3.11.3 Provision of Hospice Services

3.11.3.2 Hospice Services are provided under the following conditions:

g. Must be provided by a licensed Hospice agency;
h. Must be reasonable and necessary for the palliation or management of the terminal illness as well as related conditions;
i. Individual must elect Hospice care, as outlined in ARM 37.40.815;
j. A plan of care must be established as set forth in ARM 37.40.805 and 37.40.807 before services are provided;
k. Services must be consistent with the plan of care; and
l. A certification that the individual is terminally ill must be completed as set forth in ARM 37.40.808

3.11.3.2 For covered Hospice services, Medicaid will generally pay for services covered by Medicare, as referenced in CFR 42.418.202-42.418.204 except for those provisions which apply to physicians' services. Physician Services is a covered hospice service and must be performed by a doctor of medicine or osteopathy.

3.11.4 Election and Revocation and Waiver of Benefits

3.11.4.1 A client who is eligible for Hospice Care or his representatives must file an election statement with a particular hospice agency in order to receive care. The Department follows Medicare guidelines in administering this provision. An individual waives all rights to Medicaid payments for the duration of the election of the hospice care as set forth in AMR 37.40.815.

3.11.4.2 A client or representative may revoke the individual election of hospice care at any time during an election period. After revoking Hospice election, the client may receive any Medicaid benefits previously waived when Hospice Care was chosen. A client may elect Hospice again at any time as long as the client meets the Hospice eligibility requirements. The Department follows Medicare guidelines in administering this provision.

3.11.5 Service Description

Hospice Services include:

k. Counseling services
l. Crisis services
m. Home health services

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n. Inpatient hospice care
o. Inpatient respite care
p. Medical supplies
q. Nursing services
r. Physician services
s. Social worker services
t. Therapy services

3.11.6 Service Exclusions

3.11.6.1 When a client requires medication that is not related to their terminal condition and it is not curative, it will be covered by the client's Medicaid Pharmacy benefit.

3.11.6.2 A client may receive services provided by their attending physician when the services are palliative only and not related to the treatment of the terminal condition for which the hospice care was elected. In this circumstance, the physician bills Medicaid separately from Hospice for these services.

3.11.6.3 Clients who qualify for mental health services may receive mental health services during hospice care.

3.11.6.4 Services used for curative care are not covered by hospice unless the client is under 21. Curative care may be provided by the hospice when the purpose is to make the client more comfortable, but it must be included in the hospice payment.

3.11.7 Change in Agency

A client may change hospice providers once in each election period. The Department follows Medicare guidelines in administering this provision.

3.11.8 Client Termination

3.11.8.1 Client participation in the program terminates when either the client no longer has a terminal diagnosis or the clients elects off of the Hospice benefit.

3.11.8.2 The Hospice provider may discharge a client for other reasons. This is an action of the provider and the provider must provide advance notice to the client based on the provider's established policy. In all cases the provider agency must make a reasonable effort to ensure continuity and appropriateness of care through referrals to other providers.

3.11.9 Out of State Services

Hospice Services may be provided by providers located out of state if the service meets the Hospice Service requirements. The out of state provider must meet the provider enrollment criteria.

3.11.10 Provider Enrollment and Participation

3.11.10.2 A hospice agency must be:

g. Licensed by the Montana Department of Public Health and Human Services (Department)
h. Meet Medicare's conditions of participation and have a valid provider agreement with Medicare
i. Enrolled as a Medicaid provider
j. Provide the Department with a list of physician volunteers and physicians employed by the Hospice
k. Must notify the Department when the client's attending physician is not a Hospice employee
l. Comply with all form requirements, as referenced in the Hospice Care Services Manual, Section 2.3

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3.11.10.2 All employees of an agency participating in Medicaid Hospice services are mandatory reporters of suspected abuse, neglect, and exploitation. In addition, the hospice agency must report all serious occurrence reports, as outlined in Community Services Bureau (CSB) Policy Manual section 305. All employees of the agency must comply with the standards of charting, as outlined in CSB Manual section 306.

3.11.10.3 The Hospice provider must use the forms outlined in section 2.3 of the Hospice Care Services manual. These forms include the plan of care, election statement, revocation statement, physician's certification statement, and physician's recertification statement.

3.11.11 Reimbursement

3.11.11.1 Medicaid payment for covered Hospice Care is made in accordance with the specific categories of covered Hospice Care (routine home care day, continuous home care day, inpatient respite day, and general inpatient care day) and the payment amounts and procedures established by Medicare detailed in CFR 42.418.302. Medicaid will not pay separately for palliative treatment, which is included in the hospice daily rate.
Reference ARM 37.40.830 and Hospice Care Services Manual section 4.3 and 4.4 for more information.

3.11.11.2 The board and room rate to be paid to a Hospice provider for a client who resides in a nursing facility is up to the Medicaid rate established by the Department for the client minus the amount the client pay towards his/her own cost of care. Payment for room and board is made to the Hospice provider who in turn reimburses the nursing facility. Reference ARM 37.40.830.

3.11.11.3 Services performed by Hospice physicians, including general supervisory services of the Hospice medical director and participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the physician member of the interdisciplinary group, are included in the Hospice rates. For other physician payments reference ARM 37.40.830.
Hospice payments are subject to a cap, as detailed in federal regulations CFR 42.418.302 and ARM 37.40.830.

3.11.11.4 In most cases, the Hospice provider must bill other insurance carriers before billing Medicaid. Reference Hospice Care Services Manual section 3.1-3.3 for information on coordination of benefit coverage.

3.11.12 Reporting

Hospice providers must submit client election statements to the Department when a client selects the Hospice benefit. Reports come out of MMIS. If encounter claims use same provider type and coding we should get the data we need.

3.11.13 Requirements under Managed Care

3.11.13.2 Service Scope

3.11.13.1.1 Offeror must ensure that the scope of the service (i.e. type of service and service description) that is available under the current system is maintained.

3.11.13.3.2 Offeror must ensure that the provision of service under the current system is maintained.

3.11.13.3.3 Offeror must ensure that the licensure for those who perform skilled and therapy services is maintained.

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3.11.13.3.4 Offeror must ensure that eligibility for service is maintained.

3.11.13.4 Service Access

3.11.13.2.1 Client must have choice of at least two providers in each of the counties (if unable to provide choice the Offeror should justify why this cannot occur).

3.11.13.4.2 Offeror must ensure that a client who qualifies for Hospice Services is provided the choice of this service, but is not forced to receive this service.

3.11.13.4.3 Offeror must ensure that a client who selects the service receives the service from a qualified provider.

3.11.13.4.4 Offeror must ensure that clients are able to elect out of the Hospice benefit at any time and in so doing receive curative services in a timely manner.

3.11.13.5 Provider Enrollment

3.11.13.4.2 Providers must meet the same enrollment criteria as currently exists.

3.11.13.3.2 Providers enrolled as Medicaid providers would automatically be enrolled in the provider network for a period of not less than one year post implementation of managed care.

3.11.13.5 Provider Complaints

3.11.13.5.1 Offeror has a plan to respond to provider concerns regarding the authorization of services.

3.11.13.4.2 Offeror provides a quarterly report to the Department on the number of complaints, by provider, by type and by resolution.

3.12 HOME AND COMMUNITY BASED WAIVER SERVICES

3.12.3 Service Description

The Home and Community Based Services (HCBS) Waiver Program is a concurrent 1915 (c) and 1915(b) Waiver, providing services and supports in homes and communities to persons who would otherwise require placement in a nursing facility or hospital. The HCBS Waiver Program is designed to allow people with disabilities and elders to live as independently as possible in the most integrated setting available. It provides sufficient support to allow clients to achieve their goals; thereby perpetuating the intent of the ADA and ensuring compliance with Olmstead.

3.12.3.1 HCBS Waiver services are provided utilizing two distinct approaches to the provision of services:

3.12.3.1.1 Traditional waiver service model:

e. Case management is a mandatory service;
f. Case management teams (CMT's) coordinate care and services, in conjunction with the waiver client;
g. CMT's operate and manage a budget to provide the needed care to their enrolled participant's within their service area; and

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h. Clients can elect to self-direct their waiver services or receive them through an agency-directed model.

3.12.3.1.2 Client–Directed service model, referred to as Big Sky Bonanza (BSB):

f. Independence Advisor and Financial Manager are mandatory services;
g. The waiver client coordinates care and services with the assistance necessary from their Independence Advisor;
h. The combined cost of State Plan Personal Assistance Services and HCBS Waiver services make up the client's individual budget;
i. The waiver client manages the individual budget to provide for their needed services, with the assistance of their Financial Manager; and
j. Client's selecting this option must self-direct their Community Support Services and their Client-Directed Goods and Services.

3.12.4 Population

3.12.2.1 Individuals receiving services in the Home and Community Based Services (HCBS) Waiver Program require nursing facility level of care, are elders 65 and older or are people with a disability, as determined by the SSA.

3.12.4.2 A small percentage of individuals served at home are ventilator dependent and would either be in a hospital or in out-of-state facilities if it were not for the HCBS Waiver program.

3.12.4.3 The program also serves individuals with traumatic brain injuries or individuals with other more severe disabilities who would have been in out-of-state rehabilitation facilities, inpatient rehabilitation or remained inappropriately placed in nursing homes, group homes, or other institutions were it not for the specialized services available under the HCBS Waiver program.

3.12.4.4 There is no age limit with respect to access to HCBS Waiver services.

e. 60% of waiver clients are 65 or older.
f. 4% are under the age of 18.
g. Approximately 83% of recipients are dual eligible (Medicaid and Medicare eligible).
h. 35% are medically needy and must incur costs in order to be financially eligible for Medicaid services, including the HCBS Waiver.

3.12.5 Eligibility

3.12.3.1 A person is eligible to be considered for enrollment in the HCBS Waiver program if the person:

e. Is 65 years of age or older or is certified as disabled by the social security administration but does not have a primary diagnosis of mental retardation;
f. Is Medicaid eligible;
g. Requires the level of care of a nursing facility: and
h. Have needs that can be met through the program.

3.12.5.2 The Offices of Public Assistance verify the first two requirements.

3.12.5.3 Mountain Pacific Quality Health makes the level of care determination and completes the PASRR Level I screen (for indications of mental retardation or

mental illness) using criteria set forth by the Department (LOC Criteria – Revised 2005).

3.12.5.4 Mountain Pacific Quality Health (MPQH) completes a Preadmission Determination and Functional Assessment to determine if the individual meets level of care requirements for admission to the waiver.

3.12.5.5 Medicaid financial eligibility for HCBS Waiver differs from regular Medicaid in three ways:

d. This waiver offers waiver of deeming for those under the age of 21;
e. Spousal impoverishment rules apply for community spouses; and
f. Transfers of assets are reviewed.

3.12.6 Slots: The HCBS Waiver budget is controlled via the allocation of slots and dollars. There are five types of slots each of which has a historically-determined annual dollar amount attached to it. These dollar amounts change as the cost of providing the services changes.

3.12.5.4 Basic Slot $17,500: An individual in a basic slot typically received the following HCBS Waiver services: case management, personal care supervision/socialization, respite, personal emergency response system, transportation, meals, private duty nursing, and homemaker. Basic slots allocated within the 5 county project area = 161

3.12.5.5 Adult Residential Slot $27,000: A person in an AR slot receives case management and is either in an assisted living facility or an adult foster home. 34 percent of waiver recipients are served in adult residential care facilities. AR slots allocated within the 5 county project area = 141

3.12.5.6 Supported Living Slot $61,500: These slots are for individuals with a traumatic brain injury or other severe physical disability who require supports beyond those available in the above two slots. They typically have someone on-call 24/7 in addition to the hands on care and supervision. Supported Living slots allocated within the 5 county project area = 11

3.12.5.7 Group Home/Beehive/Liberty Place $60,000: There are two group homes and three specialized assisted living facilities that serve individuals with brain injuries and severe disabilities. The ratio of staff to clients as well as staff training requirements exceeds that of other facilities. 51 individuals are currently in these slots. Specialized residential slots within the 5 county project area = 5

3.12.5.8 Ventilator Dependent Heavy Care Slot $250,000: There are 11 individuals in these slots who require someone at their side 24/7. Sometimes family members are available to assist; but mostly HCBS Waiver covers around-the-clock private duty nursing. Heavy care slots within the 5 county project area = 2

3.12.5.9 Big Sky Bonanza (BSB) Slots: These are slots for those clients who have indicated a desire and completed the training to direct their services and manage an individual budget. The budgets vary for each individual based on their HCBS Waiver cost plan and authorized State Plan hours. BSB slots within the 5 county project area = 10

Case Management Teams manage their case load of basic and adult residential slots (with minor exceptions). Clients and Financial Managers manage their BSB slots and the remaining three categories of slots are managed by the Community Services Bureau (CSB) staff. The latter comprise about 6% of the total caseload.

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3.12.6 Waiting List. Open waiver slots must be equally available to all eligible individuals in the Case Management Team's (CMT) service area. When all waiver slots are filled, a waiting list must be established by the CMT to select individuals most in need of services.

3.12.6.1 Entry into the waiver is based on prioritized need as established by the criteria in the Waiting List Tool.

3.12.6.2 The Waiting List Tool scores individuals eligible for the waiver according to 10 criteria, including cognitive impairment, risk of medical deterioration without services, risk of institutional placement or death, need for formal paid services, need for adaptive aids or environmental modifications, and health and safety issues that place the individual at risk.

3.12.6.3 This tool was developed to assist CMT's in prioritizing each applicant's needs. The instrument is designed to compliment professional judgment in determining which applicant is in most need of services.

3.12.5.4 Individuals placed on the waiting list must be assessed in person within 60 days of the date of the formal referral.

3.12.6.5 The traditional elderly/disabled HCBS waiver case managers manage the waitlist.

3.12.6.6 The CMT assists applicants in securing needed support or other available services until the individual can be admitted to HCBS waiver services.

3.12.6.7 Individuals or family members of an individual on the waiting list must be contacted quarterly to ensure that the waiting list is up-to-date. Waiting list reports must be continually reviewed to ensure that individuals on the list are still in need of services.

3.12.7 Expenditures/Reimbursement

3.12.6.1 The 1915(c) HCBS waivers are required by statute to be cost-neutral relative to institutional care. The program was designed to provide a cost-neutral alternative to institutional care, requiring the States to keep waiver costs at or below those of comparable institution-based service. States can choose to do so on the aggregate or by limiting individual cost plans. Montana has selected the former to allow service provision to individuals with higher cost plans.

3.12.9.6 The total budget for FY 09 was $31,445,000. This waiver has provided LTC services to individuals at an aggregated average per capita cost of approximately $52/day or $1,560/month in FY 09. The average per capita cost including all Medicaid services (non-waiver state plan services) was about $66/day or $1,980/month in FY 09. This includes all the types of slots listed above.

3.12.9.7 Fees for services have an upper limit and are negotiated by the CMT's or BSB clients. However some rates are non-negotiable and many others are routinely reimbursed at the upper limit. (See HCBS Fee Schedule on ACS web page).

3.12.10 Quality Assurance and Improvement

3.12.7.1 The HCBS/BSB waiver programs have a system in place to provide for continuous quality assurance and improvement. This system includes activities of discovery, remediation and quality improvement so that the State Medicaid Agency learns of critical incidents or events that affect individuals, corrects shortcomings and pursues opportunities for system improvement. The

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State Medicaid Agency also has overall responsibility for monitoring the system performance measures and individual outcome measures.

3.12.10.2 The Community Services Bureau, as a part of the quality assurance system, conducts annual comprehensive evaluations of the Case Management Teams and Independence Advisor and Financial Manager services to meet the Bureau's quality improvement requirements for a federally approved waiver program. The purpose of these reviews is to insure that optimal services are being provided to clients and that program rules and policies are being followed. Quality improvement results are utilized to improve programs and services. The quality assurance reviews include:

d. Provider prepared standards;
e. On-site record reviews;
f. Client interviews

3.12.10.3 Detailed information about the Quality Improvement Review process and standards can be referenced in HCBS policy 608 and BSB policy 615, 616, 617.

3.12.11 HCBS Traditional Waiver Option

3.12.8.1 The Home and Community Based Services (HCBS) Waiver Program for elderly and disabled is a concurrent 1915(b)/(c) waiver. It offers an alternative to institutional level of care while restricting freedom of choice of CMT's.

3.12.11.2 The program makes available a wide range of non-traditional medical and non-medical services that are otherwise either not covered or limited under state plan. The menu of services is necessarily extensive to ensure that the most appropriate and beneficial supports can be provided. (See HCBS Manual 700 Section).

3.12.11.3 Individualized service plans are developed by clients in conjunction with their case management team. Services are selected based upon the client's needs, preferences, desired outcomes, goals, and the services and supports that will assist him/her in achieving desired outcomes. The client will have the authority to determine who is included in the process of service and support plan development. Individuals who have not chosen the participant directed option must have a case management team. The team's function is:

j. Development and review of the service plan with the client
k. Reevaluation of the service plan including a functional assessment and service delivery
l. Coordination of services
m. Linking clients to other programs
n. Monitoring implementation of service plan
o. Ensuring health and safety
p. Addressing problems with respect to services and providers
q. Responding the crises
r. Being financially accountable for waiver expenditures for their client caseload.

3.12.11.4 HCBS Waiver Case Management Teams are the cornerstone of this program. They not only assist clients in gaining access to needed HCBS Waiver and State Plan services; but they also coordinate medical, social, educational and other services funded through other sources. The case managers help ensure that there is a network of qualified providers to meet the needs of the program. They participate in the creation and development of new

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services; and provide outreach to educate their communities on issues affecting individuals with disabilities and elders.

3.12.12 Big Sky Bonanza Client-Directed Waiver Option:

3.12.9.1 The Big Sky Bonanza (BSB) client-directed option is authorized under Section 1915 (c) of the Social Security Act and governed by the federal regulations which define waiver services, delivery of services, service requirements and recipient eligibility. The regulations are provided in CFR 42 441.300, et. seq.

3.12.12.2 All BSB waiver services must comply with the federally approved waiver MT.0442.R01.00

3.12.12.3 Client-directed Medicaid services means that participants, or their representatives, have decision-making authority over certain services and take direct responsibility to manage their services with the assistance of a system of available supports. The client-directed service delivery model is an alternative to traditionally delivered and managed services and allows participants to have the responsibility for managing all aspects of service delivery in a person-centered planning process.

3.12.12.4 Client-direction promotes personal choice and control over the delivery of waiver and State plan services, including who provides the services and how services are provided. Participants are afforded the decision-making authority to recruit, hire, train and supervise the individuals who furnish their services (employer authority) and have decision-making authority over how the Medicaid funds in a budget are spent (budget authority).

3.12.12.5 Requirements of client-directed waiver services:

3.12.12.5.1 Client Training: Clients or their personal representative must participate in a state developed training and pass a readiness review, prior to their enrollment in the BSB waiver option.

3.12.12.5.2 Support Broker Training: Support broker service provider with BSB (Independence Advisors and Financial Managers) must attend state developed client-direct training and receive certification before providing services.

3.12.9.5.3 Person Centered Planning Process: A person-centered planning process and assessment must be used to develop a person-centered plan. The process is directed by the individual, with assistance as needed or desired from a representative of the individual's choosing and their support broker (BSB Independence Advisor). This process identifies strengths, capacities, preferences, needs and desired measurable outcomes for the individual. Details of this planning process are referenced in BSB policy 907 and 911.

3.12.9.6.4 Service Plan: A service plan (BSB Support Services and Spending (SSSP)) is the written document that specifies the services and supports that are to be furnished to meet the preferences, choices, abilities and needs of the client and that assist the client to direct those services and supports and remain in the community. The client develops their SSSP, with the assistance of their Independence Advisor, to describe their needs, the services required to meet those needs and the cost to cover the needs. The SSSP form is referenced in BSB policy 911.

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3.12.9.6.5 Individualized Budget: An individualized budget specifies how the funds, which are under the control and direction of the individual, will be utilized. The Individual Budget is based on the client's need for services and support and becomes the total amount of money they may spend for the services outlined in the SSSP. The BSB budget is determined using historic HCBS waiver service plan costs and State plan personal assistance service authorization. Reference BSB policy 912.

3.12.9.6.6 Information and Assistance in Support of Client-Direction: BSB provides a system of supports that are responsive to clients needs and desires for assistance in developing the person-centered service plan and budget, managing the individual's services and workers and performing the responsibilities of an employer. Client-directed supports include, but are not limited to:

g. Information regarding system processes;
h. Individual rights and responsibilities;
i. Available resources;
j. Counseling;
k. Training
l. Assistance

3.12.9.6.7 The amount and frequency with which an individual uses the available supports varies from person to person and circumstance to circumstance. BSB support services include:

3.12.9.6.8 Independence Advisor (IA): This is a mandatory service for clients enrolled in the BSB waiver.

3.12.9.6.9 Financial Manager (FM): This is a mandatory service for clients enrolled in the BSB waiver and must be available to assist individuals in exercising budget authority.

3.12.9.7 Benefits of client-direction for the enrollees

3.12.9.7.1 Control: participant direction lets participants decide who provides their services, when the services are delivered, and what assistance they need.

3.12.9.7.2 Flexibility: Participant direction lets participants buy things they really need, when they need them.

3.12.9.7.3 Independence: Participant direction helps participants who need daily assistance maintain their independence at home.

3.12.9.8 Individual Election of Client-Direction

3.12.9.9.2 The Community Services Bureau (CSB) provides information and counseling to participants about self-direction so they can make an informed choice whether to self-direct. CSB also allows participants to voluntarily terminate self-direction and return to receiving provider-managed services.

3.12.9.9.3 When a person voluntarily ends self-direction (or the CSB determines that self-direction should be terminated involuntarily), the CSB ensures that the individual continues to receive critical services during the transition period.

3.12.9.10 Risk Assessment and Mitigation

3.12.9.10.1 Training will be provided to every potential BSB client to prepare them for playing a greater role in the support and service planning and delivery process. The training includes information on

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health and safety factors, emergency back-up planning and risk identification, assessment and management.

3.12.9.10.2 Clients conduct a self-assessment to determine how informed they feel regarding the planning and implementation process.

3.12.9.10.3 Emergency back-up plans and risk identification and management are included in the client's service and support plan and are defined and developed on an individual basis. The emergency back-up plan may include an assessment of critical services and a back up strategy for each identified critical service. Back up may include:

d. Client back up (peer support) incorporated into the plan;
e. Informal back up (family, friends, neighbors);
f. Enrolled Medicaid provider network (personal assistance agencies)
d. System level back up (local emergency response).

3.12.9.10.4 Clients will be able to access money in their self-direct budget to pay for back up services. The IA and client will track and monitor back up utilization as part of the service and support plan quality management process.

3.12.9.10.5 The Regional Program Officer (RPO) reviews every service and support plan to assure that it meets health care needs and that there is proper documentation for emergency backup and risk management procedures.

3.12.9.10.6 The CSB Waiver Program manager reviews every initial service and support plan.

3.12.9.11 BSB Services: The approved menu of services provided under the BSB waiver option includes client-directed services and traditional services. Full detail of the BSB services can be referenced in the BSB 700 section of policy. ARM references, as appropriate, are referenced within each policy.

3.12.9.11.1 Client Directed Services

3.12.9.9.1.1 Community Support Services: Service provided by individuals recruited, selected, trained, hired and managed by the BSB client to perform a variety of tasks and include personal assistance, homemaking, chores, transportation and respite. These services differ from traditional waiver services in two ways:

c. They do not need to be provided by a Medicaid-enrolled agency;
d. The service provider does not bill Medicaid directly for services. Instead the client bills for their services through a Financial Manager (FM). The FM pays these providers using the client's monthly budget. The client directs the support services and is responsible for submitting time sheets and invoices to the FM for payment. Providers of this service must accept the client's negotiated rate and agree to never charge the client additional money. Full details of Community Support Services can be referenced in BSB 705 policy.

3.12.9.9.2.2 Client-directed Goods and Services: BSB allows for clients to select services and goods that are

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unique to meet their needs and preferences. These are services, equipment, supplies, or goods not otherwise provided through this waiver or Medicaid State Plan. Items must address an identified need in the client's Support Services and Spending Plan and meet the following requirements:

f. Decrease the client's need for other Medicaid services;
g. Promote the client's inclusion in the community;
h. Promote the client's independence;
i. Fulfill a medical, social, or functional need based on unique cultural approaches; or
j. Increase the client's safety at home.

These goods and services cover a wide range based on individual needs and preferences and are reviewed and approved by the Community Services Bureau on an individual basis. Approved goods can range from small appliances or communication aids to a wheelchair accessible van. Approved services can include non-traditional services, such as, massage for chronic pain or muscle contractures, hippotherapy for improved balance or muscle tone, clarinet lessons for increasing lung capacity or cranio-sacral therapy to help prevent seizures. The variety of theses goods and services is as unique as each individual receiving BSB services and a vital component of the self-directed philosophy. Full details of Client-Directed Goods and Services can be referenced in BSB 706 policy.

3.12.9.9.2.3 Financial Management: Includes full bookkeeping, payroll, accounting and human resource activities for BSB clients or their personal representative. The FM agency is the employer of record for the client's employees. These services assure that the funds to provide services and supports outlined in the client's plan are implemented through a client-directed approach and are managed and paid appropriately as authorized. This is a mandatory service for client-direction. BSB 708

3.12.9.9.2.4 Independence Advisor: Includes a full array of client-directed support activities to ensure the ability of BSB clients to direct their care successfully. Clients can choose from any qualified and enrolled provider. This is a mandatory service for client-direction. Individual IA employees cannot also provide financial management services to the same clients. BSB 710

3.12.9.9.2.5 Private Duty Nursing: Medically necessary services provided to clients who require continuous in-home nursing care that is unavailable from a home health agency or under the Medicaid EPSDT program for children. These services may be client-directed or provided as a traditional waiver service. BSB 715, 909

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3.12.9.9.3 Traditional Waiver Services. BSB Clients can access certain traditional waiver services. Providers of traditional waiver services must:

d. Be enrolled in the Montana Medicaid Program through ACS;
e. Meet the requirements in ARM 37.85.401 through 37.85.512; and
f. Meet all specific provider qualifications as listed in the pertinent BSB 700 Policy sections.

3.12.10 Managed Care Requirements for Home and Community Based Services

A wide range of community-based long term care services will be available under the managed care plan. The services are designed to keep people as independent as possible in the community for as long as possible. These services range from home chore services or assistance with activities of daily living (like eating, bathing, etc.) to comprehensive or intensive services like those available under the Home and Community-Based Waiver Program. Below is an explanation of the community-based services that will be available to those who are eligible for the managed care pilot project.

3.12.10.1 Personal Assistance Services

Personal assistance services (PAS) are in-home services provided to individuals whose chronic health problems cause them to need help in performing activities of daily living. PAS will be available to people on an entitlement basis. The following must be included as part of PAS.

3.12.10.1.4 Personal Care - Activities related to a person's physical health and personal hygiene. Examples of personal care activities include bathing, eating, dressing, grooming, routine hair and skin care, toileting, help with self-administered medication and transfer/ambulation.

3.12.10.1.5 Meal Preparation - Activities related to the provision of food according to a person's needs and wishes. Meal preparation activities include: planning menus; shopping for groceries; and storing, preparing and serving food.

3.12.10.1.6 Household Tasks - Performing incidental household tasks essential to the maintenance of a person's health and safety in the home. Examples of household tasks include housecleaning, laundering, washing dishes, hanging bed linens, shopping for essential health related items and arranging furniture. The household tasks do not include basic homemaker services that maintain an entire household or family. It is expected that when a person lives with a family that the family will provide most homemaker services. Household tasks are available only in conjunction with personal care services and are limited.

3.12.10.1.4 Escort - Accompanying a person on trips to obtain Medicaid reimbursable medical services when the person requires personal care services en route or at the destination, and a family member or caregiver is not available

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SECTION 4: OFFEROR QUALIFICATIONS/INFORMATIONAL REQUIREMENTS

Section 4 needs to be tailored to each project. Call SPB for assistance at (406) 444-2575.

4.0 STATE'S RIGHT TO INVESTIGATE AND REJECT

The State may make such investigations as deemed necessary to determine the ability of the offeror to provide the supplies and/or perform the services specified. The State reserves the right to reject any proposal if the evidence submitted by, or investigation of, the offeror fails to satisfy the State that the offeror is properly qualified to carry out the obligations of the contract. *This includes the State's ability to reject the proposal based on negative references.*

4.1 OFFEROR QUALIFICATIONS/INFORMATIONAL REQUIREMENTS

In order for the State to determine the capabilities of an offeror to provide the supplies and/or perform the services specified in Section 3 above, the offeror must respond to the following requests for information regarding its ability to meet the State's requirements. **THE RESPONSE, "(OFFEROR'S NAME) UNDERSTANDS AND WILL COMPLY," IS NOT APPROPRIATE FOR THIS SECTION.**

NOTE: Each item must be thoroughly addressed. Offerors taking exception to any requirements listed in this section may be found nonresponsive or be subject to point deductions.

Sections 4.1.1 through 4.1.5 are optional, depending on the nature of the project and need to be tailored accordingly.

4.1.1 References. Offeror shall provide a minimum of **(insert number)** references that are using supplies and/or services of the type proposed in this RFP. The references may include state government or universities where the offeror, preferably within the last **(insert number)** years, has successfully completed **(insert language pertaining to this type of contract)**. At a minimum, the offeror shall provide the company name, the location where the supplies and/or services were provided, contact person(s), customer's telephone number, e-mail address, and a complete description of the service type, and dates the services were provided. These references may be contacted to verify offeror's ability to perform the contract. The State reserves the right to use any information or additional references deemed necessary to establish the ability of the offeror to perform the conditions of the contract. Negative references may be grounds for proposal disqualification.

4.1.2 Resumes/Company Profile and Experience. Offeror shall specify how long the individual/company submitting the proposal has been in the business of providing supplies and/or services similar to those requested in this RFP and under what company name. Offeror should provide a complete description of any relevant past projects, including the supply/service type and dates the supplies and/or services were provided. A resume or summary of qualifications, work experience, education, skills, etc., which emphasizes previous experience in this area should be provided for all key personnel who will be involved with any aspects of the contract.

4.1.3 Ability to Meet Supply Specifications. Offeror shall provide information as to its ability to meet the following supply specifications, as more specifically detailed above in Section 3.

4.1.4 Method of Providing Services. Offeror shall provide a work plan and the methods to be used that will convincingly demonstrate to the State what the offeror intends to do; the timeframes necessary to accomplish the work; and how the work will be accomplished to meet the contract requirements as more specifically detailed above in Section 3. Offeror must specifically address each of the following requirements as defined in this RFP: **(NOTE TO AGENCIES: Complete this sentence, or delete.)**

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DRAFT

Section 4.1.5 is an option **to be used only in very limited circumstances**, depending on the nature of the project and needs to be tailored accordingly. If this information is requested, agencies must be prepared to evaluate it, typically on a pass/fail basis. **Note: Financial information cannot be held confidential (section 18-4-304, MCA).**

4.1.5 Offeror Financial Stability. Offerors shall demonstrate their financial stability to supply, install and support the services specified by: (1) providing financial statements, preferably audited, for the **(insert number)** consecutive years immediately preceding the issuance of this RFP, and (2) providing copies of any quarterly financial statements that have been prepared since the end of the period reported by its most recent annual report.

DRAFT

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SECTION 5: COST PROPOSAL

Section 5 should include the estimated budget, if possible, for the project so the offeror can provide a realistic cost proposal within that range. For guidance in determining how to evaluate cost, please see examples in the RFP Manual and read the State Procurement Bureau resource document entitled "Cost Evaluation Methods for Requests for Proposals." Both are available at the following website address: http://gsd.mt.gov/ProcurementServices/rfpprocess.mcpx.

Some items you may want to consider when developing this section are:

1. How do you want costs presented?
    a) Itemized Budget
    b) Total Project Cost
    c) Task Order Basis (hourly rates)
2. How do you want to be invoiced?
3. Is there a maximum amount you cannot exceed?

DRAFT

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SECTION 6: EVALUATION PROCESS

Section 6 needs to be tailored to each project.

6.0 BASIS OF EVALUATION

The evaluator/evaluation committee will review and evaluate the offers according to the following criteria based on **a total number of** (insert number) **points.**

The **References, Resumes/Company Profile and Experience, Ability to Meet Supply Specifications, and Method of Providing Services** portions of the offer will be evaluated based on the following Scoring Guide. The **Financial Stability** portion of the offer will be evaluated on a pass/fail basis, with any offeror receiving a "fail" eliminated from further consideration. The **Cost Proposal** will be evaluated based on the formula set forth below.

Any response that fails to achieve a passing score per the requirements of Section 2.3.5 will be eliminated from further consideration. A "fail" for any individual evaluation criterion may result in proposal disqualification at the discretion of the procurement officer.

SCORING GUIDE

(NOTE: These percentages are only examples and can be tailored to fit the needs of the project.)
In awarding points to the evaluation criteria, the evaluator/evaluation committee will consider the following guidelines:

Superior Response (90-100%): A superior response is a highly comprehensive, excellent reply that meets all of the requirements of the RFP. In addition, the response may cover areas not originally addressed within the RFP and/or include additional information and recommendations that would prove both valuable and beneficial to the agency.

Good Response (75-89%): A good response meets all the requirements of the RFP and demonstrates in a clear and concise manner a thorough knowledge and understanding of the project, with no deficiencies noted.

Fair Response (60-74%): A fair response minimally meets most requirements set forth in the RFP. The offeror demonstrates some ability to comply with guidelines and requirements of the project, but knowledge of the subject matter is limited.

Failed Response (59% or less): A failed response does not meet the requirements set forth in the RFP. The offeror has not demonstrated sufficient knowledge of the subject matter.

6.1 EVALUATION CRITERIA

(NOTE TO AGENCIES: These categories need to be tailored to each project. These are only examples.)

Identify the major criteria that are critical to the success of the RFP. In most cases, this should correspond to the Offeror Qualifications/Informational Requirements set out Section 4.1 of the RFP. Some commonly used criteria are: qualifications, relevant experience, quality of work, references, service, physical facilities, human resources, cost, technical capabilities, industry standards, and proposed timelines. RFPs can only be evaluated on stated criteria, so include everything to be measured and ensure that the criteria are measurable.

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DRAFT

Once you have determined the major categories, reference those sections of the RFP that set out the specific criteria that will be evaluated and determine point assignments. Use the following as an example:

References		**____% of points for a possible __ points**
Category	**Section of RFP**	**Point Value**
A. References (Complete Contact Information Provided)	4.1.1	

Resumes/Company Profile and Experience		**____% of points for a possible __ points**
Category	**Section of RFP**	**Point Value**
A. Years of Experience	4.1.2	
B. Past Projects	4.1.2	
C. Staff Qualifications	4.1.2	

Ability to Meet Supply Specifications		**____% of points for a possible __ points**
Category	**Section of RFP**	**Point Value**
A.	4.1.3	
B.	4.1.3	
C	4.1.3	

Method of Providing Services		**____% of points for a possible __ points**
Category	**Section of RFP**	**Point Value**
A. Methods	4.1.4	
B. Work Plan	4.1.4	

Financial Stability		**Pass/Fail**
Category	**Section of RFP**	**Point Value**
A. Financial Stability	4.1.5	Pass/Fail

Cost Proposal		**20% of points for a possible __ points**
Category	**Section of RFP**	**Point Value**
A. Cost Proposal	5.0	

(NOTE TO AGENCIES: Cost Proposal must constitute 20% or more of the total available points. Exceptions to this must be documented in writing and approved by the Procurement Officer. There are several formulas that can be used to score price/cost. The most common approach is as follows. For assistance with other scoring methods, please review the State Procurement Bureau resource document entitled "Cost Evaluation Methods for Requests for Proposals" available at the following website address: http://gsd.mt.gov/ProcurementServices/rfpprocess.mcpx or contact the State Procurement Bureau. The Average Cost evaluation method requires consultation with the State Procurement Bureau before it can be used.)

Lowest overall cost receives the maximum allotted points. All other proposals receive a percentage of the points available based on their cost relationship to the lowest. Example: Total possible points for cost are 30.

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DRAFT

Offeror A's cost is $20,000. Offeror B's cost is $30,000. Offeror A would receive 30 points, Offeror B would receive 20 points ($20,000/$30,000) = 67% x 30 points = 20).

Lowest Responsive Offer Total Cost / This Offeror's Total Cost x Number of available points = Award Points

DRAFT

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APPENDIX A: STANDARD TERMS AND CONDITIONS

Insert the most recent Standard Terms and Conditions located at:
http://gsd.mt.gov/ProcurementServices/rfpprocess.mcpx.

DRAFT

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APPENDIX B: CONTRACT

1. Parties
2. Effective Date, Duration, and Renewal
3. Cost/Price Adjustments (Optional)
4. Services and/or Supplies
5. Consideration/Payment
6. Prevailing Wage Requirements (As Needed)
7. Access and Retention of Records
8. Assignment, Transfer, and Subcontracting
9. Hold Harmless/Indemnification
10. Required Insurance (Optional)
11. Compliance with Workers' Compensation Act
12. Compliance with Laws
13. Intellectual Property (Optional)
14. Patent and Copyright Protection (Optional)
15. Contract Performance Assurance (Optional)
16. Contract Termination
17. Liaison and Service of Notices
18. Meetings
19. Contractor Performance Assessments (Optional)
20. Transition Assistance
21. Choice of Law and Venue
22. Scope, Amendment, and Interpretation
23. Execution

Note to Agencies: This contract is the Department of Administration's standard contract. If your agency has a standard contract approved by your legal counsel, it should be inserted in place of this one. The contract in the RFP should be tailored to be as close to the final anticipated contract as possible.

DRAFT

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(INSERT PROJECT TITLE)
(INSERT CONTRACT NUMBER)

1. PARTIES

THIS CONTRACT is entered into by and between the State of Montana (insert agency name), (hereinafter referred to as "the State"), whose address and phone number are (insert address), (insert phone number) and (insert name of contractor), (hereinafter referred to as the "Contractor"), whose address and phone number are (insert address) and (insert phone number).

THE PARTIES AGREE AS FOLLOWS:

2. EFFECTIVE DATE, DURATION, AND RENEWAL

2.1 Contract Term. This contract shall take effect on (insert date), 20(_), (or upon contract execution) and terminate on (insert date), 20(_), unless terminated earlier in accordance with the terms of this contract. (Section 18-4-313, MCA)

2.2 Contract Renewal. This contract may, upon mutual agreement between the parties and according to the terms of the existing contract, be renewed in (insert number)-year intervals, or any interval that is advantageous to the State. This contract, including any renewals, may not exceed a total of (insert number) years. (State contracts generally may not exceed a total of seven years.)

Section 3 is optional depending on the project.

3. COST/PRICE ADJUSTMENTS

Cost Increase by Mutual Agreement. After the initial term of the contract, each renewal term may be subject to a cost increase by mutual agreement.

OR

Cost Increase by Fixed Amount. After the initial term of the contract, each renewal term may be subject to a cost increase of (insert %) %, not to exceed (insert %) %, for the entire term of the contract.

OR

Pricing Adjustments per Increase in CPI. Annual pricing adjustments to contract renewals following the contract term, if applicable, shall not exceed 75% the rate of increase in the cost of living as reflected in the Federal Bureau of Labor Statistics, Consumer Price Index (CPI) for all Urban Consumers (1982-84=100; through November 1991 = 137.8) or any other index which may be substituted in the future. The CPI for the last 12-month period of the contract will be the CPI base on which later adjustments are computed. Each time an adjustment is made, the earlier CPI base will be replaced by the adjusted CPI base. The percentage of adjustment to contract prices shall in no event exceed the percentage change in the index.

OR

Price Adjustments Negotiated Based on Changes in Contractor's Costs. Price adjustments may be permitted at the time of contract renewal through a process of negotiation with the Contractor and the State. Any price increases must be based on demonstrated industrywide or regional increases in the Contractor's costs. Publications such as the Federal Bureau of Labor Statistics and the Consumer Price Index (CPI) for all Urban Consumers may be used to determine the increased value.

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DRAFT

4. SERVICES AND/OR SUPPLIES

Contractor agrees to provide to the State the following **(insert a detailed description of the supplies, services, etc., to be provided to correspond to the requirements specified in Section 3, Scope of Project)**.

5. CONSIDERATION/PAYMENT

5.1 Payment Schedule. In consideration for the **(insert supplies or services)** to be provided, the State shall pay according to the following schedule: **(insert pay schedule)**.

5.2 Withholding of Payment. The State may withhold payments to the Contractor if the Contractor has not performed in accordance with this contract. Such withholding cannot be greater than the additional costs to the State caused by the lack of performance.

Section 6 is to be used as needed depending on the project. Call SPB for assistance at (406) 444-2575.

6. PREVAILING WAGE REQUIREMENTS

6.1 Montana Resident Preference. The nature of the work performed, or services provided, under this contract meets the statutory definition of a "public works contract" in section 18-2-401, MCA. Unless superseded by federal law, Montana law requires that contractors and subcontractors give preference to the employment of Montana residents for any public works contract in excess of $25,000 for construction or nonconstruction services in accordance with sections 18-2-401 through 18-2-432, MCA, and all administrative rules adopted in relation to these statutes.

Unless superseded by federal law, each contractor shall ensure that at least 50% of a contractor's workers performing labor on a construction project are bona fide Montana residents.

The Commissioner of the Montana Department of Labor and Industry has established the resident requirements in accordance with sections 18-2-403 and 18-2-409, MCA. Any and all questions concerning prevailing wage and Montana resident issues should be directed to the Montana Department of Labor and Industry.

6.2 Standard Prevailing Rate of Wages. In addition, unless superseded by federal law, all employees working on a public works contract shall be paid prevailing wage rates in accordance with sections 18-2-401 through 18-2-432, MCA, and all associated administrative rules. Montana law requires that all public works contracts, as defined in section 18-2-401, MCA, in which the total cost of the contract is in excess of $25,000, contain a provision stating for each job classification the standard prevailing wage rate, including fringe benefits, travel, per diem, and zone pay that the contractors, subcontractors, and employers shall pay during the public works contract. **Note to agencies: Per 18-2-417, MCA, any public works contract that, by the terms of the original contract, calls for more than 30 months to perform must include the following provision:**

The standard prevailing rate of wages paid to workers under this contract must be adjusted 12 months after the date of the award of the public works contract per section 18-2-417, MCA. The amount of the adjustment must be a 3% increase. The adjustment must be made and applied every 12 months for the term of the contract. This adjustment is the sole responsibility of the contractor and no cost adjustment in this contract will be allowed to fulfill this requirement.

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DRAFT

Furthermore, section 18-2-406, MCA, requires that all contractors, subcontractors, and employers who are performing work or providing services under a public works contract post in a prominent and accessible site on the project staging area or work area, no later than the first day of work and continuing for the entire duration of the contract, a legible statement of all wages and fringe benefits to be paid to the employees in compliance with section 18-2-423, MCA.

Section 18-2-423, MCA, requires that employees receiving an hourly wage must be paid on a weekly basis. Each contractor, subcontractor, and employer must maintain payroll records in a manner readily capable of being certified for submission under section 18-2-423, MCA, for not less than three years after the contractor's, subcontractor's, or employer's completion of work on the public works contract. **Note to agencies: If this contract is to be performed in more than one district, the highest rate for the craft, classification, or type of worker must be included in the bid specifications and contract provision per ARM 24.17.144. In this case, complete and include the following statement.** The Commissioner of the Montana Department of Labor and Industry has established the standard prevailing rate of wages in accordance with sections18-2-401 and 18-2-402, MCA, for _____ to be $_____ per hour, plus a benefit rate of $_____.

OR

If more than one craft, classification, or type of worker is included in the contract, use the following statement instead.
All contractors and employers shall classify each employee who performs labor on a public works project according to the applicable standard prevailing rate of wages for such craft, classification, or type of employee established by the Commissioner of the Montana Department of Labor and Industry, and shall pay each such employee a rate of wages not less than the standard prevailing rate as specified in the Montana Prevailing Wages Rates for **(insert type of service)** **(insert year)**.

7. ACCESS AND RETENTION OF RECORDS

7.1 Access to Records. The Contractor agrees to provide the State, Legislative Auditor or their authorized agents access to any records necessary to determine contract compliance. (Section 18-1-118, MCA)

7.2 Retention Period. The Contractor agrees to create and retain records supporting the (insert services rendered or supplies provided) for a period of three years after either the completion date of this contract or the conclusion of any claim, litigation, or exception relating to this contract taken by the State of Montana or a third party.

8. ASSIGNMENT, TRANSFER, AND SUBCONTRACTING

The Contractor shall not assign, transfer, or subcontract any portion of this contract without the express written consent of the State. (Section 18-4-141, MCA) The Contractor shall be responsible to the State for the acts and omissions of all subcontractors or agents and of persons directly or indirectly employed by such subcontractors, and for the acts and omissions of persons employed directly by the Contractor. No contractual relationships exist between any subcontractor and the State.

9. HOLD HARMLESS/INDEMNIFICATION

The Contractor agrees to protect, defend, and save the State, its elected and appointed officials, agents, and employees, while acting within the scope of their duties as such, harmless from and against all claims, demands, causes of action of any kind or character, including the cost of defense thereof, arising in favor of the Contractor's employees or third parties on account of bodily or personal injuries, death, or damage to property

arising out of services performed or omissions of services or in any way resulting from the acts or omissions of the Contractor and/or its agents, employees, representatives, assigns, subcontractors, except the sole negligence of the State, under this agreement.

Section 10 needs to be tailored to the project. Call SPB for assistance at (406) 444-2575.

10. REQUIRED INSURANCE

(Insert for commercial general liability and automobile liability only)

10.1 General Requirements. The Contractor shall maintain for the duration of the contract, at its cost and expense, insurance against claims for injuries to persons or damages to property, including contractual liability, which may arise from or in connection with the performance of the work by the Contractor, agents, employees, representatives, assigns, or subcontractors. This insurance shall cover such claims as may be caused by any negligent act or omission.

(Insert for all insurance types)

10.2 Primary Insurance. The Contractor's insurance coverage shall be primary insurance with respect to the State, its officers, officials, employees, and volunteers and shall apply separately to each project or location. Any insurance or self-insurance maintained by the State, its officers, officials, employees or volunteers shall be excess of the Contractor's insurance and shall not contribute with it.

(Insert for commercial general liability only)

10.3 Specific Requirements for Commercial General Liability. The Contractor shall purchase and maintain occurrence coverage with combined single limits for bodily injury, personal injury, and property damage of **(insert dollar amount)** per occurrence and **(insert dollar amount)** aggregate per year to cover such claims as may be caused by any act, omission, or negligence of the Contractor or its officers, agents, representatives, assigns, or subcontractors.

The State, its officers, officials, employees, and volunteers are to be covered and listed as additional insureds; for liability arising out of activities performed by or on behalf of the Contractor, including the insured's general supervision of the Contractor; products, and completed operations; premises owned, leased, occupied, or used.

(Insert for automobile liability only)

10.4 Specific Requirements for Automobile Liability. The Contractor shall purchase and maintain coverage with split limits of $500,000 per person (personal injury), $1,000,000 per accident occurrence (personal injury), and $100,000 per accident occurrence (property damage), OR combined single limits of $1,000,000 per occurrence to cover such claims as may be caused by any act, omission, or negligence of the contractor or its officers, agents, representatives, assigns, or subcontractors.

The State, its officers, officials, employees, and volunteers are to be covered and listed as additional insureds for automobiles leased, hired, or borrowed by the Contractor.

(Insert for professional liability only)

10.5 Specific Requirements for Professional Liability. The Contractor shall purchase and maintain occurrence coverage with combined single limits for each wrongful act of **(insert dollar amount)** per occurrence and **(insert dollar amount)** aggregate per year to cover such claims as may be caused by any act, omission, negligence of the Contractor or its officers, agents, representatives, assigns, or subcontractors. Note: if "occurrence" coverage is unavailable or cost prohibitive, the Contractor may provide "claims made" coverage provided the following conditions are met: (1) the commencement date of the contract must not fall outside the effective date of insurance coverage and it will be the retroactive date for insurance coverage in

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future years; and (2) the claims made policy must have a three-year tail for claims that are made (filed) after the cancellation or expiration date of the policy.

(Insert for all insurance types)

10.6 Deductibles and Self-Insured Retentions. Any deductible or self-insured retention must be declared to and approved by the state agency. At the request of the agency either: (1) the insurer shall reduce or eliminate such deductibles or self-insured retentions as respects the State, its officers, officials, employees, or volunteers; or (2) at the expense of the Contractor, the Contractor shall procure a bond guaranteeing payment of losses and related investigations, claims administration, and defense expenses.

(Insert for all insurance types)

10.7 Certificate of Insurance/Endorsements. A certificate of insurance from an insurer with a Best's rating of no less than A- indicating compliance with the required coverages, has been received by the State Procurement Bureau, P.O. Box 200135, Helena, MT 59620-0135. The Contractor must notify the State immediately, of any material change in insurance coverage, such as changes in limits, coverages, change in status of policy, etc. The State reserves the right to require complete copies of insurance policies at all times.

11. COMPLIANCE WITH WORKERS' COMPENSATION ACT

Contractors are required to comply with the provisions of the Montana Workers' Compensation Act while performing work for the State of Montana in accordance with sections 39-71-401, 39-71-405, and 39-71-417, MCA. Proof of compliance must be in the form of workers' compensation insurance, an independent contractor's exemption, or documentation of corporate officer status. Neither the contractor nor its employees are employees of the State. This insurance/exemption must be valid for the entire term of the contract. A renewal document must be sent to the State Procurement Bureau, P.O. Box 200135, Helena, MT 59620-0135, upon expiration.

12. COMPLIANCE WITH LAWS

The Contractor must, in performance of work under this contract, fully comply with all applicable federal, state, or local laws, rules, and regulations, including the Montana Human Rights Act, the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act of 1990, and Section 504 of the Rehabilitation Act of 1973. Any subletting or subcontracting by the Contractor subjects subcontractors to the same provision. In accordance with section 49-3-207, MCA, the Contractor agrees that the hiring of persons to perform the contract will be made on the basis of merit and qualifications and there will be no discrimination based upon race, color, religion, creed, political ideas, sex, age, marital status, physical or mental disability, or national origin by the persons performing the contract.

Section 13 is optional depending on project.

13. INTELLECTUAL PROPERTY

All patent and other legal rights in or to inventions created in whole or in part under this contract must be available to the State for royalty-free and nonexclusive licensing. Both parties shall have a royalty-free, nonexclusive, and irrevocable right to reproduce, publish, or otherwise use and authorize others to use, copyrightable property created under this contract.

Section 14 is optional depending on project.

14. PATENT AND COPYRIGHT PROTECTION

14.1 Third-Party Claim. In the event of any claim by any third party against the State that the products furnished under this contract infringe upon or violate any patent or copyright, the State shall promptly

notify Contractor. Contractor shall defend such claim, in the State's name or its own name, as appropriate, but at Contractor's expense. Contractor will indemnify the State against all costs, damages, and attorney's fees that accrue as a result of such claim. If the State reasonably concludes that its interests are not being properly protected, or if principles of governmental or public law are involved, it may enter any action.

14.2 Product Subject of Claim. If any product furnished is likely to or does become the subject of a claim of infringement of a patent or copyright, then Contractor may, at its option, procure for the State the right to continue using the alleged infringing product, or modify the product so that it becomes noninfringing. If none of the above options can be accomplished, or if the use of such product by the State shall be prevented by injunction, the State will determine if the Contract has been breached.

Section 15 is optional and if used must be tailored to the specific procurement. The following sample clauses are provided for consideration. Call SPB for assistance at (406) 444-2575.

15. CONTRACT PERFORMANCE ASSURANCE

15.1 Milestone Payments. Payments to the Contractor will be based on completion and acceptance of each milestone defined below.

15.2 Payment Holdbacks. ___% will be withheld from each milestone payment. The total amount withheld will be paid to the contractor at the completion and acceptance of the final milestone.

Milestone/Deliverable	Hold Back	Payment % of Total
Milestone 1:	___% of approved invoice	%
Milestone 2:	___% of approved invoice	%
Milestone 3:	___% of approved invoice	%
Milestone 4:	___% of approved invoice	%
Milestone 5:	___% of approved invoice	%
Final Acceptance		100%

Contract performance security may be used as a performance assurance tool. If used, an agency may choose to accept all forms of security or limit the security to surety bonds only. Call SPB for assistance at (406) 444-2575.

15.3 Contract Performance Security – All Forms Accepted. The Contractor must provide contract performance security based upon **(insert %)**% of the contract total.

The contract performance security must be provided by the Contractor in one of the following forms, within 10 working days from the Request for Documents Notice. ONLY THE FOLLOWING TYPES OF SECURITY ARE ACCEPTABLE AND MUST BE IN ORIGINAL FORM. FACSIMILE, ELECTRONIC, OR PHOTOCOPIES ARE NOT ACCEPTABLE. Personal or business checks are not acceptable.

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- A sufficient bond from a surety company licensed in Montana with a Best's rating of no less than A- and supplied on the State of Montana's designated form entitled "Contract Performance Bond," found at http://svc.mt.gov/gsd/OneStop/GSDDocuments.aspx; or
- Lawful money of the United States; or
- An irrevocable letter of credit from a single financial institution and supplied on the State of Montana's designated form entitled "Irrevocable Letter of Credit," found at http://svc.mt.gov/gsd/OneStop/GSDDocuments.aspx; or
- A cashier's check, certified check, bank money order, bank draft, certificate of deposit, or money market certificates drawn or issued by a federally or state-chartered bank or savings and loan association that is insured by or for which insurance is administered by the FDIC or that is drawn and issued by a credit union insured by the national credit union share insurance fund. Certificates of deposit or money market certificates will not be accepted as security for bid, proposal, or contract security unless the certificates are assigned only to the State. All interest income from these certificates must accrue only to the contractor and not the State.

See Title 18, chapter 4, part 3, MCA, Title 30, chapter 5, MCA, and ARM 2.5.502.

This contract performance security must remain in effect for the entire term of the contract. A new surety bond or irrevocable letter of credit must be issued to the State of Montana if this contract is renewed.

The contract performance security in the form of a **(insert form)** has been provided to the following address: State Procurement Bureau, P.O. Box 200135, Helena, MT 59620-0135.

OR

15.3 Contract Performance Security – Surety Bonds Only. The Contractor must provide contract performance security based upon 100% of the contract total. This security must be in the form of a surety bond licensed in Montana with a Best's rating of no less than A-. The surety bond must be supplied on the form designated by the State of Montana. The required form entitled "Contract Performance Bond," may be found at http://svc.mt.gov/gsd/OneStop/GSDDocuments.aspx. THE ORIGINAL FORM MUST BE PROVIDED. FACSIMILE, ELECTRONIC, OR PHOTOCOPIES ARE NOT ACCEPTABLE.

The contract performance security must be provided to the State of Montana within 10 working days from the Request for Documents Notice. This security must remain in effect for the entire term of the contract. A new surety bond must be issued to the State of Montana if this contract is renewed.

The original surety bond form has been provided to the following address: State Procurement Bureau, P.O. Box 200135, Helena, MT 59620-0135.

16. CONTRACT TERMINATION

The following three termination provisions are presented as options for Section 15.1. In deciding which provision to use, consideration should be given to the circumstances of each individual contract.

16.1 Termination for Cause. The State may, by written notice to the Contractor, terminate this contract in whole or in part at any time the Contractor fails to perform this contract.

OR

16.1 Termination for Cause with Notice to Cure Requirement. The State may terminate this contract for failure of the Contractor to perform any of the services, duties, or conditions contained in this contract after giving the Contractor written notice of the stated failure. The written notice must demand

performance of the stated failure within a specified period of time of not less than **(insert number of days)**. If the demanded performance is not completed within the specified period, the termination is effective at the end of the specified period.

OR

16.1 Termination for Convenience. The State may, by written notice to the Contractor, terminate this contract without cause. The State must give notice of termination to the Contractor at least **(insert numbers of days)** days prior to the effective date of termination.

16.2 Reduction of Funding. The State must terminate this contract if funds are not appropriated or otherwise made available to support the State's continuation of performance of this contract in a subsequent fiscal period. (See section 18-4-313(4), MCA.)

17. LIAISON AND SERVICE OF NOTICES

All project management and coordination on behalf of the State shall be through a single point of contact designated as the State's liaison. Contractor shall designate a liaison that will provide the single point of contact for management and coordination of Contractor's work. All work performed pursuant to this contract shall be coordinated between the State's liaison and the Contractor's liaison.

_____ will be the liaison for the State.
(Address):
(City, State, ZIP):
Telephone:
Cell Phone:
Fax:
E-mail:

_____ will be the liaison for the Contractor.
(Address):
(City, State, ZIP):
Telephone:
Cell Phone:
Fax:
E-mail:

The State's liaison and Contractor's liaison may be changed by written notice to the other party. Written notices, requests, or complaints will first be directed to the liaison.

18. MEETINGS

The Contractor is required to meet with the State's personnel, or designated representatives, to resolve technical or contractual problems that may occur during the term of the contract or to discuss the progress made by Contractor and the State in the performance of their respective obligations, at no additional cost to the State. Meetings will occur as problems arise and will be coordinated by the State. The Contractor will be given a minimum of three full working days notice of meeting date, time, and location. Face-to-face meetings are desired. However, at the Contractor's option and expense, a conference call meeting may be substituted. Consistent failure to participate in problem resolution meetings two consecutive missed or rescheduled meetings, or to make a good faith effort to resolve problems, may result in termination of the contract.

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Section 19 is optional depending on project.

19. CONTRACTOR PERFORMANCE ASSESSMENTS

The State may do assessments of the Contractor's performance. This contract may be terminated for one or more poor performance assessments. Contractors will have the opportunity to respond to poor performance assessments. The State will make any final decision to terminate this contract based on the assessment and any related information, the Contractor's response and the severity of any negative performance assessment. The Contractor will be notified with a justification of contract termination. Performance assessments may be considered in future solicitations.

20. TRANSITION ASSISTANCE

If this contract is not renewed at the end of this term, or is terminated prior to the completion of a project, or if the work on a project is terminated, for any reason, the Contractor must provide for a reasonable period of time after the expiration or termination of this project or contract, all reasonable transition assistance requested by the State, to allow for the expired or terminated portion of the services to continue without interruption or adverse effect, and to facilitate the orderly transfer of such services to the State or its designees. Such transition assistance will be deemed by the parties to be governed by the terms and conditions of this contract, except for those terms or conditions that do not reasonably apply to such transition assistance. The State shall pay the Contractor for any resources utilized in performing such transition assistance at the most current rates provided by the contract. If there are no established contract rates, then the rate shall be mutually agreed upon. If the State terminates a project or this contract for cause, then the State will be entitled to offset the cost of paying the Contractor for the additional resources the Contractor utilized in providing transition assistance with any damages the State may have otherwise accrued as a result of said termination.

21. CHOICE OF LAW AND VENUE

This contract is governed by the laws of Montana. The parties agree that any litigation concerning this bid, proposal or subsequent contract must be brought in the First Judicial District in and for the County of Lewis and Clark, State of Montana and each party shall pay its own costs and attorney fees. (See section 18-1-401, MCA.)

22. SCOPE, AMENDMENT, AND INTERPRETATION

22.1 Contract. This contract consists of (insert number) numbered pages, any Attachments as required, RFP # (insert RFP number), as amended and the Contractor's RFP response as amended. In the case of dispute or ambiguity about the minimum levels of performance by the Contractor the order of precedence of document interpretation is in the same order.

22.2 Entire Agreement. These documents contain the entire agreement of the parties. Any enlargement, alteration or modification requires a written amendment signed by both parties.

23. EXECUTION

The parties through their authorized agents have executed this contract on the dates set out below.

(INSERT AGENCY NAME)	(INSERT CONTRACTOR'S NAME)
(Insert Address)	(Insert Address)
Insert City, State, Zip)	(Insert City, State, Zip)

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FEDERAL ID #

BY: _____ BY: _____
(Name/Title) (Name/Title)

_____ _____
(Signature) (Signature)

DATE: _____ DATE: _____

Approved as to Legal Content:

_____
Legal Counsel (Date)

Approved as to Form:

_____
Procurement Officer (Date)
State Procurement Bureau

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APPENDIX C: RFP RESPONSE FORM

(USE ADDITIONAL SHEETS AS NECESSARY)

1. **Offeror must provide a signed copy of the RFP Cover Sheet.**

2. **Offeror has read, understood, and agrees to comply with the items contained in Sections 1, 2, 3, 6, and Appendices A and B of .**

Agreed _____

Offeror's Signature **Date**

OFFEROR MUST PROVIDE THE FOLLOWING INFORMATION THAT WILL BE EVALUATED BY THE RFP EVALUATOR/EVALUATION COMMITTEE:

(RFP DRAFTER INSERTS OFFEROR QUALIFICATION/INFORMATIONAL REQUIREMENTS FROM THE TEXT OF THE RFP. FOLLOWING IN RED IS AN EXAMPLE OF INFORMATION THAT MAY BE REQUESTED.)

3. **References (Section 4.1.1), page 13 of the RFP.**

4. **Resumes/Company Profile and Experience (Section 4.1.2), page 13 of the RFP.**
   - **A. Years in Business (Section 4.1.2), page 13 of the RFP.**
   - **B. Past Projects (Section 4.1.2), page 13 of the RFP.**
   - **C. Staff Qualifications (Section 4.1.2), page 13 of the RFP.**

5. **Ability to Meet Supply Specifications (Section 4.1.3), page 13 of the RFP.**

6. **Method of Providing Services (Section 4.1.4), page 13 of the RFP.**

7. **Financial Stability (Section 4.1.5), page 14 of the RFP.**

8. **Cost Proposal (Section 5.0), page 15 of the RFP.**

9. **Completeness of Proposal.** An offeror's response must be complete at the time of submittal and contain all the reference materials necessary to provide a complete response to the RFP. An offeror making the statement "Refer to our literature…" or "Please see www.……com" may be deemed nonresponsive or receive point deductions. If making reference to materials located in another section of the RFP response, specific page numbers and sections must be noted. **The Evaluator/Evaluation Committee is not required to search through literature or another section of the proposal to find a response.**

Note to agencies: If you need electronic copies of the proposal responses you must insert that request here. Specify the format and medium you want.

10. **Number of Copies and Due Date.** Offerors must submit **one original and copies** to the address listed below. The State reserves the right to request an electronic copy of the RFP response. Proposals must be received at the receptionist's desk of the State Procurement Bureau prior to **2:00 p.m., local time,** . Proposals received after this time will not be accepted for consideration. Facsimile or electronic submissions are not acceptable.

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DRAFT

State Procurement Bureau
Room 165, Mitchell Building
125 North Roberts
P.O. Box 200135
Helena, MT 59620-0135

DRAFT

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Note to agencies:

For all solicitations for which Prevailing Wage Rates will be paid, the applicable Prevailing Wage Booklet from the Department of Labor and Industry, must be included as part of the solicitation. Current Prevailing Wage Booklets are available at http://erd.dli.mt.gov/laborstandard/prevwage/Current.asp.

The booklet must be posted with the solicitation using the following or similar language:

APPENDIX D
MONTANA PREVAILING WAGES RATES FOR (INSERT TYPE OF SERVICE) SERVICES (YEAR)

The services requested in this RFP will require the Contractor to pay prevailing wages. See Contract Section 6.

Note: This document is provided in PDF format as a separate file and may be found with RFP No. (insert number) **at** (insert web address).
This appendix is a critical and necessary element of this RFP.

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Attachment 2

***The most current project management timeline with milestones and persons responsible for implementation.**

**NOTE: Revisions will be made based upon receipt and review of actuarial data and communication with CMS. We anticipate major revisions to the timeline.*

MONTANA
Department of Public Health & Human Services

January 21, 2011

Managed Care Demonstration Project Timeline

Project activity	Dates	Responsible person(s)	Progress	Resources, other entities
Phase I				
Establish DPHHS internal work group; provide project description, additional materials	09/2010	Noel	Ongoing	
Interview, select actuarial firm, define scope of work	09/2010	Noel, all divisions (for additional scope of work)		State Procurement Bureau, recent DPHHS contracts, research other states' contracts
Develop, negotiate, approve, sign contract with actuarial firm	10/15/2010	Noel, Krantz, Bell		OLA if boiler plate language changes
Initial discussions with MMIS, NG, other systems vendors on project requirements	10/15/2010	Preshinger, Baldwin		
Provide data to actuary. Sources include MMIS, AWACS, First Check, BCBS	10/2010	Preshinger (lead), Fiscal, program staff		ACS, MPQH, BCBS-MT
Consult with Insurance Commissioner's Office on managed				Insurance Commissioner Legal

Revisions will be made based upon receipt and review of actuarial data and communication with CMS. We anticipate major revisions to the timeline.

Project activity	Dates	Responsible person(s)	Progress	Resources, other entities
care statutes	10/2010	OLA		Staff
Draft request for proposal (RFP) for MCO vendor	10-12/2010	Noel (lead), staff from all divisions		State Procurement Bureau, RFPs from other states
Conversations with CMS staff on concept, vision	09/2010-04/2011	Dalton (lead)	Ongoing	CMS RO and CO staff
Submit draft RFP to CMS for review	12/31/2010	J. Thompson		
Draft federal waiver(s)	12/01/2010-02/28/2011	Noel (lead), staff from all divisions, J. Thompson		CMS staff, approved waivers from other states
Review draft feasibility study from actuary	12/15/2010	All		
Approve final feasibility study, review with Governor staff	12/31/2010	Dalton		
Phase II				

Revisions will be made based upon receipt and review of actuarial data and communication with CMS. We anticipate major revisions to the timeline.

Project activity	Dates	Responsible person(s)	Progress	Resources, other entities
Consultation with Governor staff	01/2011-01/2012	Dalton		
Authorize actuary to develop actuarially sound rates	01/03/2011	Noel		
Review draft rate report; finalize actuary work	01/15/2011	All		
RFP pre-proposal conference	01/21/2011	All		State Procurement Bureau
Develop RFP evaluation matrix and scoring guide	01/24/2011	All		State Procurement Bureau
Release RFP	01/31/2010			State Procurement Bureau
Identify systems enhancements, including MMIS, CHIMES, KIDS	11-12/2010	Baldwin (lead), Preshinger, All		
JAD sessions for systems enhancements	01-04/2011	Baldwin (lead), Preshinger, All		ACS, NG

Revisions will be made based upon receipt and review of actuarial data and communication with CMS. We anticipate major revisions to the timeline.

Project activity	Dates	Responsible person(s)	Progress	Resources, other entities
Prepare waiver for public comment	2/2011	Noel (lead)		
Submit draft waiver to CMS	2/2011	J. Thompson		
Tribal consultation: send waiver to tribes, UICs, IHS	02/01/2011-03/31/2011	J. Thompson		
Public comment period: send waiver to interested parties, post on website, publish	02/01/2011-03/31/2011	J. Thompson		
LFC review per 53.6.116(5) MCA	By 03/31/2011	Dalton		Legislative Finance Council
Respond to tribal and public comments	04/15/2011	Noel (lead), All		
Submit final waiver to CMS	04/29/2011	J. Thompson		
Receive vendor proposals	04/30/2011			State Procurement Bureau

Revisions will be made based upon receipt and review of actuarial data and communication with CMS. We anticipate major revisions to the timeline.

Project activity	Dates	Responsible person(s)	Progress	Resources, other entities
Evaluate vendor proposals, interviews, demonstrations if required	05/31/2011	Noel (lead), evaluation committee		State Procurement Bureau
Complete negotiations with successful vendor	05/30/2011	Dalton, Krantz, Noel		State Procurement Bureau
Review all MT Medicaid waivers for amendments required due to managed care waiver	06/15/2011	J. Thompson (lead), All divisions		
Obtain final vendor documents, contract signature	06/30/2011			State Procurement Bureau
Approve final systems design documents	06/30/2011	Baldwin (lead), Preshinger, All		
Draft Administrative Rule changes		Noel (lead), All		
Draft State Plan Amendment		J. Thompson, All		
Respond to CMS RAI	08/15/2011	Noel (lead), All		

Revisions will be made based upon receipt and review of actuarial data and communication with CMS. We anticipate major revisions to the timeline.

Project activity	Dates	Responsible person(s)	Progress	Resources, other entities
Submit ARM to OLA	08/20/2011	Noel		
Submit SPA to CMS	09/30/2011	J. Thompson		
File ARM of Secretary of State	10/01/2011	OLA		
ARM hearing	11/01/2011	OLA		
End of ARM comment period	11/15/2011	OLA		
Respond to ARM comments	11/25/2011	Noel (lead), All		
Final ARM filing	12/10/2011	OLA		Secretary of State
Receive CMS waiver and SPA approval	12/15/2011	Dalton		
ARM effective	12/31/2011			

Revisions will be made based upon receipt and review of actuarial data and communication with CMS. We anticipate major revisions to the timeline.

Project activity	Dates	Responsible person(s)	Progress	Resources, other entities
Systems testing	12/2011-01/2012	Baldwin (lead), Preshinger, All program staff		
Implementation	01/31/2012			

Revisions will be made based upon receipt and review of actuarial data and communication with CMS. We anticipate major revisions to the timeline.

Attachment 3

A detailed description of the public comment process that DPHHS will follow to receive comment on the draft RFP, including times proposed for public comment and how DPHHS will evaluate and potentially incorporate public input.

MONTANA
Department of Public Health & Human Services

January 21, 2011

DEPARTMENT OF ADMINISTRATION
GENERAL SERVICES DIVISION
STATE PROCUREMENT BUREAU
http://gsd.mt.gov/

BRIAN SCHWEITZER
GOVERNOR

STATE OF MONTANA

MITCHELL BUILDING, ROOM 165
PO BOX 200135

(406) 444-2575
(406) 444-2529 FAX
TTY Users-Dial 711

HELENA, MONTANA 59620-0135

QUESTIONS AND ANSWERS ON THE RFP PROCESS

Prepared by the State Procurement Bureau
Montana Department of Administration
September 2005

RE: PUBLIC MEETINGS

1. How do Montana's public meeting laws apply to RFP procurement?

Section 2-3-103, MCA, directs agencies to develop procedures that ensure adequate notice and assist public participation before a final agency action is taken that is of "significant interest to the public." The award of a contract is considered to be such an agency action. Therefore, all RFP evaluation committee meetings involving the award of a contract must be open to the public and public notice must be given.

2. At what point in the procurement process do we have to post notice of evaluation committee meetings?

Only meetings that involve an evaluation process or competing offers where the award of a contract is considered must be posted. A meeting to discuss a "best and final offer" with a company would need to be posted since the evaluation committee is still "evaluating" competing offers in considering the award of a contract. However, meetings involving the following do not need to be posted: (a) meetings to discuss and/or draft an RFP; (b) meetings to discuss a "Request for Information" unless it involves an "evaluation" or "prequalification" process; (c) meetings involving contract negotiations since the highest scoring offeror has been selected and the evaluation process is over; (d) meetings to discuss extending/renewing a contract; (e) meetings to discuss canceling an RFP or contract; and (f) meetings to review a sole source situation.

3. How much public notice must be given?

72 hours.

4. When does the clock start running on the 72-hour notice requirement?

Once it is posted. What is important is that the information be *accessible* to the public for 72 hours, which it is once it is posted electronically. Whether the time involves working days or calendar days does not matter.

5. Are we required to specifically invite people (vendors, press) to every meeting?

No, posting the meeting notice is sufficient.

6. Do evaluation committee meetings need to be advertised in a newspaper?

No. Section 2-17-532, MCA, only requires that agencies use electronic access systems such as the internet to communicate information regarding upcoming public meetings.

7. Can offerors make a recording of the evaluation committee meetings and oral presentations?

Yes, anyone can.

8. Should we have a sign-up sheet at every oral presentation and meeting of the evaluation committee?

Yes, in order to document attendance. However, the public is not required to sign it.

9. Can public comment be accepted at an RFP evaluation committee meeting?

No, it is not a public hearing. The public may observe the deliberations pursuant to the "right to know" provision of Montana's Constitution, Article II, § 9, and section 18-4-304, MCA, but not participate because the award of a contract must be made to the responsible and responsive offeror whose proposal best meets the evaluation criteria. Other factors or criteria may not be used in the evaluation. However, members of the public present at an RFP evaluation committee meeting may request a public hearing on the matter if so desired.

10. Can vendors offer suggestions and/or information during meetings of the evaluation committees?

No, not unless the vendor is specifically involved in a meeting to clarify parts of its own proposal.

11. Can evaluation committee members ask questions of the vendors who might be present at an evaluation committee meeting?

No, not unless representatives from *every* submitted proposal are present and available to answer questions, and then only if the chairman of the evaluation committee feels the questions would provide critical information to the committee. The exception is noted in Question 10.

12. Do we need a procedure concerning which vendor has to give their oral presentation first?

Yes. We suggest that you consider drawing names and then allowing the first vendor to have the first pick of available time slots and so forth.

13. Do we have to release the names of the evaluation committee members?

Yes, if asked.

14. Are we required to appoint an evaluation committee for every RFP we issue?

No, there is nothing in law or rule that requires it.

15. Can an interested party "listen in" to the evaluation committee meeting via a conference call?

Yes, unless the interested party is not willing to bear the cost of the phone call or if the agency is technically unable to honor the same request from multiple vendors.

16. Does it matter where the evaluation committee meets?

Yes. All evaluation committee meetings must be held in facilities that comply with the requirements of the Americans With Disabilities Act.

17. Do we have to keep minutes of evaluation committee meetings?

Yes, per section 2-3-212, MCA, minutes must be kept and available to the public. The statute lays out what must be in the minutes.

18. Are on-site visits to a vendor's business location considered a "public meeting"?

Yes. If a quorum of the evaluation committee will be participating in an on-site visit to a business location, the meeting must be treated as a "public meeting" and it must be open to the public and notice of the on-site visit provided.

19. Must a 72-hour notice be given to cancel an evaluation committee meeting?

No. All meeting times and places are subject to change. Interested parties should call the contact person to verify the time and location of the meeting.

20. Can an evaluation committee meeting be "continued" the next day without additional public notice?

Yes, if the evaluation committee was not able to complete its agenda for the originally posted date.

RE: OPEN RECORDS

21. When are proposals open for public inspection?

Only after the formal time/date set for opening of proposals, and then only *after* the proposals have been reviewed by a procurement officer to locate and remove any trade secrets.

22. Are draft documents open to the public?

Drafts do not need to be open unless the documents will be retained as part of the permanent procurement file. Generally, preliminary drafts of any report, letter, memorandum, or worksheet are considered "non-record" material that can be destroyed when they have served their purpose. See sections 2-6-202 and 2-6-401, MCA. *However, if litigation is involved, all documents are "discoverable."*

23. Are individual scoring sheets open to the public?

Yes, if the individual scoring sheets will be retained as part of the permanent procurement file.

24. Are draft scoring sheets open to the public?

Yes, if they are retained in the permanent procurement file.

25. Where is the final procurement file kept?

For all procurements managed by the State Procurement Bureau, the final procurement files are located there. If for some reason an agency handles its own proposal process, (as spelled out in a delegation agreement with SPB), then the final file is located at the agency purchasing office.

26. When are "best and final offer" documents available for public inspection?

The documents are available only after the time/date set for opening of the offers.

27. If a price sheet is requested to be submitted separately from the rest of the proposal, can the public inspect that information anyway?

No, only when it is "opened" will it become public information, and then only after the procurement officer has had time to review and copy the information for distribution to the committee members.

28. Should we request extra copies of proposals for public inspection?

Yes, one extra set should be requested for public inspection and copying.

29. Should we have a copying policy in place in the event interested vendors would like copies?

Yes. According to ARM 2.5.602(12), interested parties are responsible for making their own arrangements for making copies of proposal materials. The State Procurement Bureau allows

interested parties the use of a small photocopier at a charge of $.10 per page. Interested parties may also bring their own photocopier into the SPB office to make the photocopies.

30. Should interested parties be required to make appointments to see the documents?

Making appointments is encouraged to ensure that no one else will be trying to review/copy the documents at the same time or that the photocopier is not tied up.

31. Do we need to inform the public about who was mailed a copy of the RFP?

Yes, if asked.

32. Can we tell the public who responded to the RFP?

Yes, but only after the time/date set for receipt of proposals.

33. Can we suggest that vendors follow a "gentlemen's agreement" to not sit in on their competitors' oral presentations?

No, but we can convey the wishes of a vendor that everyone should agree to not attend their competitors oral presentations or clarification sessions.

34. Are evaluation matrices considered "public documents"? If so, when can they be released?

Yes. Evaluation matrices are public documents once they have been reviewed and approved by the procurement officer and the proposal responses have been released to a committee to begin its review.

35. What should evaluation committee members do with copies of bona fide trade secret information that they reviewed in the course of their evaluation of a proposal?

A master set of the information should be placed in a sealed envelope and retained in the official agency file. All other copies should be returned to the procurement officer to be shredded and discarded.

36. Can a company request that financial information be withheld from public inspection?

No, financial information may not be withheld from the public.

RE: RFP PROCESS

37. Should we retain the "single point of contact" policy?

Yes, it is very important that one person address all of the questions and information releases.

38. How many "best and final" offers should we permit?

Only one.

39. Can procurement officers provide information on the phone to vendors about a competitor's proposal, such as the prices and the business practices of another vendor?

It depends. First, it could only be disclosed after the time set for opening of proposals and trade secret matter has been removed. Second, all information requests should always be channeled through the established point of contact. Third, the vendor has the right to see that information, but that does not mean that the agency must spend inordinate amounts of time on the phone answering these requests when the documents are available for public inspection in the procurement office. Fourth, the procurement officer must be mindful of the need to be fair and equitable to all vendors and not neglect to promptly return calls from all inquiring vendors. The issue needs to be addressed on a case-by-case basis by the agency.

Attachment 4

*The due diligence process DPHHS plans to follow with respect to evaluation of the successful bidder, including identification of specific business processes and procedures that DPHHS will evaluate and how DPHHS will determine whether those processes and procedures are effective and meet contract requirements.

**NOTE: Information related to this request has been specifically tabbed in the attachment.*

MONTANA
Department of Public Health & Human Services

January 21, 2011

Initiating and Navigating the Request for Proposal Process

GENERAL SERVICES DIVISION
DEPARTMENT OF ADMINISTRATION
STATE OF MONTANA

OCTOBER 2003

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TABLE OF CONTENTS

1. Guardians of Public Trust 1

2. The Tools 2
   - Who's Who and What's What 2

3. What is a Request for Proposal? 3
   - When is an RFP Used? 3

4. Pros and Cons of RFPs 4

5. RFP Flowchart 5

6. Request for Proposal Process 6
   - What are Evaluation Criteria 6
   - Evaluation Criteria – How Much Detail? 8
   - How Do You Score Price? 9
   - Setting Deadlines for Clarification Questions 12
   - How Late is Late? 13
   - Trade Secret or Proprietary Information? 14
   - What is a "Responsible Offeror?" 15
   - Responsive vs. Non-responsive 16
   - Open for Public Inspection? 17
   - Outside Assistance 18
   - Tips for Handling the Clarification Process 18
   - How to Tally Final Points 20

7. Request for Proposal Format 22
   - Why So Many Subsections? 23
   - Section 1 – Project Overview and Instructions 24
   - Section 2 – RFP Standard Information 27
   - Section 3 – Scope of Project 29
   - Tips for Writing Specifications 30
   - Section 4 – Offeror Qualifications 31
   - Section 5 – Cost Proposal 32
   - Section 6 – Evaluation Criteria 33

   - Appendix A – Standard Terms and Conditions 34
   - Appendix B – Contract 35

8. Optional Specifications 36

9. Short Form Request for Proposal Format 37

10. Information Technology Request for Proposal Format 38

11. Additional RFP Tools 39
   - Sample Price Sheet 40
   - Pricing Scenario Examples 41

GUARDIANS OF PUBLIC TRUST

"Money is of no value; it cannot spend itself.
All depends on the skill of the spender."

– Ralph Waldo Emerson
1803-1882

The spending of public tax dollars is an issue close to everyone's wallet. An effective public procurement program reduces the cost of government and directly improves the quality and timeliness of services rendered by state agencies. For agencies, procurement is a service function, supporting programs by the acquisition of supplies and services. For potential offerors, it is an opportunity to provide supplies and services to government agencies.

Operating under the authority of the Montana Procurement Act, the Department of Administration has the responsibility of developing and administering a fair, legal, cost-effective procurement program. To meet this responsibility, the Department's goals are:

- ❑ To recognize our obligation to the taxpayers, the using agencies, and the offerors to institute and maintain an effective and economical program for purchasing supplies and services.

- ❑ To obtain the needed supplies and services at favorable prices without compromise of suitability, appropriate quality, and reliable offeror performance.

THE TOOLS

In order to facilitate the procurement of supplies and services for public entities, the Montana Procurement Act provides certain tools for agencies to use to obtain the desired products. These tools are outlined in Title 18, chapter 4, of the Montana Code Annotated (MCA).

These tools are:

- ✓ Invitation for Bid
- ✓ Request for Proposal
- ✓ Small Purchase
- ✓ Limited Solicitation
- ✓ Sole Source
- ✓ Exigency Purchase

In addition, the State has enhanced several of these tools with:

- ✓ Term Contracts
- ✓ Requisition Time Schedule
- ✓ Cooperative Purchasing Agreements
- ✓ Pre-Qualification of Vendors

While most of these procurement options are fairly straightforward, the Request for Proposal process is a tool that has continued to evolve since its enactment in 1983. Later legislatures and court rulings have continued to modify and define the RFP process. At its heart, however, is the premise that agencies need a procurement tool where factors other than price, such as service capabilities or technical components, may need to be considered.

WHO'S WHO?

Bidder? Offeror? Vendor? Which is which?

Bidder: A seller who submits a *bid* to an Invitation for Bid.
Offeror: A seller who is offering a *response* to a Request for Proposal.
Vendor: A seller of supplies or services.

WHAT'S WHAT?

GSD: General Services Division, Department of Administration
SPB: State Procurement Bureau, General Services Division

Invitation for Bid: A written description that completely describes what the State wants and no negotiations are necessary or permitted. Award is made solely on the basis of the lowest cost. Usually used for the purchase of supplies and equipment.

Request for Proposal: The needs of the State may not be completely clear, negotiations may be necessary, and/or cost is just one of several criteria necessary to make a

decision. Usually used for the purchase of services and information technology systems.

WHAT IS A REQUEST FOR PROPOSAL?

A Request for Proposal (RFP) is a formal invitation to a potential offeror to submit a proposal to provide a solution to a problem or a need that the agency has identified. An RFP is also a procurement process where the State has the ability to judge if an offeror's qualifications, experience, and approach will provide the best solution to the State's needs.

WHEN IS AN RFP USED?

- When the agency has defined a need and requests the offerors to propose the best method for accomplishing it;
- The agency will consider factors other than lowest price when determining whether to make an award;
- When the skills, expertise, or technical capability of the offerors will be evaluated;
- When the problem or need is fairly detailed or complex;
- The problem or need involves services or a combination of supplies and services;
- When the State may need the opportunity to ask offerors to clarify their proposals by issuing questions, or to revise their proposal through a best and final offer process; or
- Where specifications of the project cannot be clearly defined.

If your project fits any of these situations, then an RFP is most likely the procurement tool for you to utilize. Most RFPs are a direct result of an agency's desire to secure a supply or service without being limited to simply a low bid option.

PROS AND CONS OF THE RFP

Some of the advantages of using an RFP can be:

- **Creative Competition.** The RFP process exposes the problem/need to a competitive solution. The competitive process promotes quality and generally results in lower prices, more value, greater flexibility in approaches, and more creative solutions.

- **All Things Considered.** The RFP process does not confine the selection process into the lowest possible price; but rather allows for a comprehensive evaluation to usually complex problems.

- **Clear Information.** The RFP process keeps the playing field level by ensuring that all potential offerors get the same information. Getting the problem down in writing is the only way to be certain that potential offerors get the same information. It also will better protect the agency from a protest during the contract award phase.

- **Clear Solutions.** Preparing the RFP forces the agency to really think about what it wants. Sometimes a problem seems so obvious that it is easy to assume that everyone understands the needs. By going through the RFP process, the agency will be forced to define its needs in sufficient detail to allow potential offerors to provide realistic solutions at affordable prices.

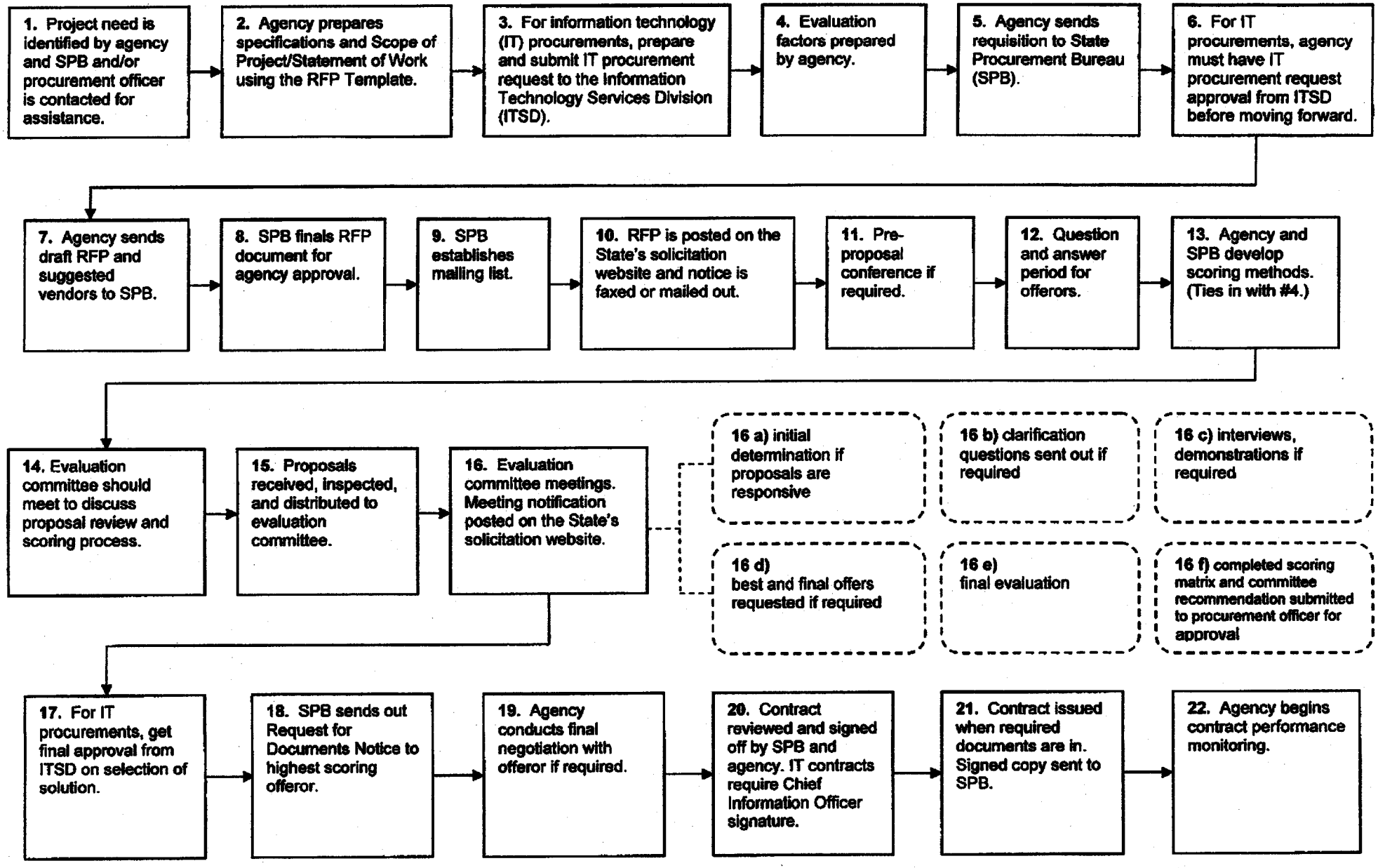
- **Straight Format.** By requiring offerors to conform to the format specified in the RFP, the agency will be better able to evaluate the proposals, without wasting time searching for information.

- **Fair Evaluations.** Formalizing the requirements and the selection process produces better results. Having predetermined evaluation criteria simplifies the selection process and ensures all offerors are evaluated fairly.

The major disadvantage of using an RFP can be:

- **Major Time Commitment.** The RFP process requires extensive time to define the requirements, prepare the RFP document, establish the evaluation process, perform the evaluations, and justify the award.

THE REQUEST FOR PROPOSAL PROCESS



THE REQUEST FOR PROPOSAL PROCESS

An RFP requires a multitude of steps – each one building toward the eventual awarding of a contract. Some of the steps are optional, depending on the nature of the project. Agencies should contact their agency purchasing officer or the State Procurement Bureau (SPB) early in the process and rely on the procurement officer assigned to their project to guide and assist them in making decisions on optional portions of the RFP process.

Initiate the Project

- Define the project goals.
- Develop a plan for reaching the goals.
- Evaluate if an RFP is the best procurement tool to use.
- Obtain necessary management approvals.
- Organize the manpower to carry out the RFP process.
- Submit a requisition to SPB.

Establish the Core Requirements

Write the core of the RFP, including every specification you want to score.

- Incorporate all special legal requirements (special licenses, certifications, etc.).
- Determine minimum standards that will be acceptable (pass/fail, must/may).
- Determine any special terms and conditions.
- Establish budgetary constraints.

Establish the Evaluation Criteria

WHAT ARE EVALUATION CRITERIA?

Evaluation criteria are the factors an agency uses to determine which of several competing proposals submitted in response to an RFP would best meet the agency's needs. In establishing effective evaluation criteria, an agency must clearly identify the factors relevant to its selection of a contractor and then prioritize or weigh these factors according to their importance in satisfying the agency's needs in the procurement. Together, the proper identification and weighing of the evaluation criteria will form an evaluation plan that will provide the agency with a common standard by which to judge the merit of competing proposals. This allows the agency to rank the proposals received while simultaneously providing offerors with a fair basis for comparison. As importantly, when evaluation criteria are properly selected and weighed, the proposals received will accurately reflect the offeror's understanding of the solicitation and the offeror's ability to deliver what the agency needs.

Establish how the proposals will be evaluated:

- Identify the major criteria that are critical for the success of the RFP.
- Commonly used criteria are:
  - Qualifications
  - Relevant experience
  - Quality of work
  - References
  - Service
  - Physical facilities
  - Human resources
  - Cost
  - Technical Capabilities
  - Proposed Timelines

TIPS TO KEEP IN MIND:

- RFPs can *only* be evaluated on the stated criteria...so include everything you want to measure.
- The evaluation criteria must be in terms that can be measured and evaluated – avoid words that are subjective, arbitrary, or too general.

Detail how much each criterion is worth.

- Each section may be stated in the form of specific points or a percentage.
- The importance of each criterion and the weight given to each criterion will largely depend on what the agency desires from the resulting contract.
- Cost does not have to be a factor, but it is rare that it will not be considered. Budget constraints may help determine the weight of the cost portion.
- Time constraints may result in increase weight for the ability and the guarantee of the contractor to complete projects by specified dates.

Include the information in the RFP.

- Explain in the RFP how points will be awarded.

EVALUATION CRITERIA: HOW MUCH DETAIL?

Identify the major criteria that are critical to the success of the RFP. In most cases, this should correspond to the Offeror Informational Requirements set out Section 4.1 of the RFP. However, in some instances, the major criteria are set out in Section 3, the Scope of Work section of the RFP. Some commonly used criteria are: qualifications, relevant experience, quality of work, references, service, physical facilities, human resources, cost, technical capabilities, industry standards and proposed timelines. RFPs can only be evaluated on stated criteria, so include everything to be measured and ensure that the criteria are measurable. Once you have determined the major categories, reference those sections of the RFP that set out the specific criteria that will be evaluated and determine point assignments. Use the following as an example:

References		**Pass/Fail**
Category	**Section of RFP**	**Point Value**
A. References Included with Offeror's Response	4.1.1	Pass/Fail

Resumes/Company Profile and Experience		**____% of points for a possible 30 points**
Category	**Section of RFP**	**Point Value**
A. Years of Experience	4.1.2	10
B. Applicability of Experience with Private/ Public Sector	4.1.2	10
C. Staff Qualifications	4.1.2	10

Method of Providing Services		**____% of points for a possible 40 points**
Category	**Section of RFP**	**Point Value**
A. Methods	4.1.3	10
B. Work Plan	4.1.3	20
C. Reporting Methods	4.1.3	10

Financial Stability		**Pass/Fail**
Category	**Section of RFP**	**Point Value**
A. Financial Stability	4.1.4	Pass/Fail

Cost Proposal		**____% of points for a possible 30 points**
Category	**Section of RFP**	**Point Value**
A. Cost Proposal	5.0	30

NOTE: *A Sample Scoring Guide is available on the GSD website at: http://discoveringmontana.com/doa/gsd/procurement/rfpprocess.asp. The Scoring Guide is an excellent tool for defining scoring assignments and it should be included in the RFP.*

HOW DO YOU SCORE PRICE?

There are several different methods to award points based on the cost set out for each proposal. If cost is included as one of the evaluation factors for a RFP, then there must be some way to convert the dollar amount into a score, or awarded points. The SPB suggests the following methods for scoring the cost portion of an RFP response.

1. **Ratio Method.**

   With this method, the proposal with the lowest cost receives the maximum points allowed. All other proposals receive a percentage of the points available based on their cost relationship to the lowest. This is determined by applying the following formula:

   $$\frac{\text{Lowest Cost}}{\text{Cost Being Evaluated}} \times \text{maximum points available} = \text{awarded points}$$

   Example: The cost for the lowest proposal is $100,000. The next lowest proposal has a cost of $125,000. The total points available for cost = 100 points.

   $$\frac{\$100,000}{\$125,000} = .80 \times 100 = 80 \text{ points}$$

2. **Best Value Method.**

   In this method, all factors, except cost, are considered and scored according to the established criteria. Once this is completed, the cost evaluation is completed by dividing the total points awarded to each proposal by its proposed cost. In this method, a value is presented in the form of a cost per point. The proposal with the lowest cost per point represents the best value to the State and would receive the award. When using this method, the SPB suggests establishing a minimum acceptable score each proposal would have to achieve in order to move forward in the process. Proposals that do not meet the minimum level would not advance to the final evaluation step.

   Example:

Category	Proposal A	Proposal B	Proposal C
Technical	400	590	700
Qualifications	240	280	230
Total Points	640	870	930
Cost	$100,000	$125,000	$150,000

(continued on next page)

Proposal	Cost	/	Points	=	Cost per point
A	$100,000		640		156
B	$125,000		870		144
C	$150,000		930		161

Proposal B would received the award because it provides the lowest cost per point, or best value to the State.

3. **Two Step Method.**

The Two Step Method is designed to reward the lowest cost proposal that meets specific qualifications. This is accomplished by first specifying the criteria that will be used to determine a "Qualified Proposal." Typically, a proposal is deemed qualified if it has passed all minimum criteria or scores established, and is within a certain percentage of the top scoring proposal, typically within 10 to 15 percent. All proposals that meet these criteria are deemed qualified, and the proposal with the lowest cost would receive the award.

Example:

A proposal will be considered to be a "Qualified Proposal" if it meets the following criteria:

a. The proposal has achieved a passing score for all parts; and
b. The total point score for the proposal is greater than or equal to 90 percent of the highest scoring proposal.

All proposals meeting these criteria will be determined to be a "finalist." The finalist proposal that results in the lowest cost to the State will receive the award.

Select an Evaluation Committee

- Select a group of subject matter experts.
- Explain time commitment.
- Explain potential conflict of interest issues.
- Have each committee member obtain necessary supervisory approval for participation and time commitment.
- Select committee chairperson.
- Decide if subcommittees will be used.

Submit Required Materials to the Procurement Officer

Items to be submitted include:

- Completed requisition.
- Electronic copy of the RFP in WORD format, Arial font.
- List of potential offerors for mailing list, if available.
- Name and phone number of committee chairperson.
- Names of committee members, if available.
- Proposed closing date (Rule of thumb: Closing dates should be at least 30 days after the release date of the RFP).

***Note:** Two weeks please! For solicitations handled by the State Procurement Bureau, the package of materials should be delivered at least two weeks in advance of the desired RFP release date.*

Final Preparation of the RFP

To prepare the RFP for release, the procurement officer will:

- Add any additional required information;
- Review RFP for compliance with laws, rules, and policies;
- Final the mailing list of potential offerors; and
- Establish the final project schedule with the project contact person.

Issue the RFP

To issue the RFP, the procurement officer will:

- Mail or fax a *notice* of the RFP to a list of up to 25 potential offerors; and
- Post the RFP to the State's website: http://discoveringmontana.com/doa/gsd/osbs/default.asp.
- On special request of the agency, the State Procurement Bureau will mail *copies of the entire RFP* to a list of up to 25 potential offerors. Agencies desiring to mail the entire document to more than 25 offerors or to send a notice to more than 25 potential offerors must pay for the additional printing and mailing costs.

Pre-proposal Conference (Optional step)

- If desired, the project contact person may conduct a face-to-face or conference call pre-proposal conference for potential offerors. This conference may either be *mandatory* or *optional* for the offerors to attend and must be stated as such in the RFP.
- The committee chairperson and the procurement officer will conduct the pre-proposal conference.
- Agencies may choose to record the conference, but it is not required.
- A sign-in sheet should be collected at the conference.
- Attendees must be aware that any oral responses to questions at a pre-proposal conference are not binding until reduced to writing.

Questions and Answers

- Typically, potential offerors are provided an opportunity to submit written questions concerning the RFP. A specific deadline for submission of questions must be set in the RFP.
- Questions are submitted to the procurement officer and forwarded to the project contact person.
- The project contact person prepares answers and submits them to the procurement officer for review.
- The procurement officer posts the information to the State's website as a formal addendum by the stated deadline.

WHEN SETTING DEADLINES FOR CLARIFICATION QUESTIONS...

When setting the deadline for questions, be sure you allow enough time for:

- offerors to have received and read the RFP;
- the project contact person to provide thoughtful answers to the questions;
- the issuance of an addendum providing the written questions and answers; and
- enough time before the deadline for receipt of proposals for the offerors to incorporate the information from the addendum into their proposals.

Final Preparation of Evaluation Process

- Prior to the deadline set for receipt of proposals, the RFP evaluation committee must make the final preparation for the evaluation process. Items to be completed include: a detailed score sheet, schedule of evaluation process, and decision on scoring method.
- The completed evaluation process must be submitted to the procurement officer for review.
- Distribution of the proposals to the evaluation committee will not take place until the final evaluation matrix has been approved by the procurement officer. See page 43 for sample scoring matrices.

Receipt of Proposals.

- The procurement officer must receive proposals by the designated deadline. *Late proposals will not be accepted, regardless of cause.* Late proposals will be destroyed or returned to the offeror at the expense of the offeror.
- The proposals will be available for public inspection: (1) after the formal due date; (2) after trade secret or other confidential information has been removed; and (3) after the procurement officer has approved the evaluation matrix and/or scoring methodology submitted by the evaluation committee.

HOW LATE IS LATE?

Any proposal not received by the designated time and date at the designated final destination will be rejected as late. Even if the proposal is only one minute late, it will be rejected regardless of cause.

Inspection of Proposals for Trade Secrets or other Protected Materials

- Upon receipt of proposals, the procurement officer will examine the proposals for any claims of trade secrets, including the required affidavit, or other protected materials.
- If such contents are present and valid, the procurement officer will remove the protected materials and make the rest of the proposal available for public inspection.
- The evaluation committee will receive its required copies, including the protected materials, after the procurement officer has discussed the implications of the presence such materials with the committee chairperson.
- Advice from agency legal counsel may be necessary in determining the validity of the trade secret claims.
- If a trade secret claim is submitted without the required affidavit, the offeror may be contacted and provided the opportunity to *either withdraw* the proposal *or release* the information for public inspection.
- If the trade secret claim is found to be invalid by agency legal counsel, the offeror will be contacted and provided the opportunity to *either withdraw* the proposal or *release* the information for public inspection.

TRADE SECRET OR PROPRIETARY INFORMATION??

According to Montana law, only "trade secrets" meeting the test of the "Uniform Trade Secrets Act," Title 30, chapter 14, part 4, MCA, are *not* open to public inspection. (Mont. Code Ann. § 18-4-304.) All other information included in a response to an RFP, including what businesses typically refer to as "proprietary business information" is open for public inspection. Offerors claiming trade secret status for parts of their responses must fill out a special affidavit *and* clearly mark and separate out any bona fide trade secret material.

The Trade Secret Affidavit is available on the GSD website at: http://discoveringmontana.com/doa/gsd/procurement/forms.asp.

A special exception to the public inspection requirement is found in section 18-4-308, MCA. This section concerns situations when the State requests specific information from an offeror to establish financial responsibility. In this instance, the requested information may not be released for public inspection without the written consent of the offeror.

Distribution of RFPs

RFPs will be distributed to the evaluation committee once:

- The procurement officer has reviewed and approved the agency's completed evaluation plan; and
- The procurement officer and the committee chairperson have discussed all issues of trade secret claims as necessary.

Non-conflict of Interest Forms

- Once the proposals have been received and it is clear which companies are involved in the RFP, each member of the evaluation committee must fill out a "Non-conflict of Interest" form. Either the committee chairperson or the procurement officer will distribute these forms to the committee members.
- If there is any question about a potential conflict of interest, legal counsel should be consulted.
- These forms must be signed, collected, and returned to the procurement officer prior to the beginning of the evaluation process.
- The "Non-conflict of Interest" form may be found on the GSD website at: http://discoveringmontana.com/doa/gsd/procurement/forms.asp.

Confidentiality Statement

- If materials are received as part of the RFP process that are protected from public view under the provisions of section 18-4-304, MCA, the procurement officer will provide the evaluation committee members with a "Confidentiality Statement."
- This form informs evaluation committee members that they must maintain the confidentiality of these documents during and after the RFP evaluation process.
- Release of confidential information may lead to disciplinary action or monetary damages against any individual who fails to keep the information confidential pursuant to section 2-2-136, MCA.
- These forms, along with any confidential material, must be signed, collected, and returned to the procurement officer prior to the beginning of the evaluation process.
- The "Confidentiality Statement" form is located on the GSD website at: http://discoveringmontana.com/doa/gsd/procurement/forms.asp.

Proposal Evaluation Process

- Prior to the initial scoring of the proposals, the evaluation committee should meet to discuss the proposal review and scoring process. Each committee member should have a clear understanding of the scoring process and how points will be assigned.
- Proposals should be distributed and reviewed individually by committee members. Committee members must be given sufficient time to read and evaluate each proposal prior to meeting as a group to score the proposals.
- Any questions regarding the scoring process should be addressed to the procurement officer or committee chairperson.

WHAT IS A "RESPONSIBLE OFFEROR"?

A responsible offeror means a person who has the capability in all respects to perform fully the contract requirements and the integrity and reliability, which will assure good faith performance. (Mont. Code Ann. § 18-4-301(8).)

RESPONSIVE OR NON-RESPONSIVE??

One of the first steps of every evaluation process is to determine if the proposals are "responsive or non-responsive" to the Request for Proposal. "Responsive" means that the proposal conforms in all material respects to the Request for Proposal. The evaluation committee will make the initial determination of whether a proposal is responsive. This determination is subject to change as information is revealed during the course of the evaluation process or anytime up to contract execution and must be corroborated by the procurement officer. The procurement officer has the final authority to find a proposal non-responsive.

What determines if a proposal is non-responsive?

At times, an evaluation committee may determine that a proposal simply does not warrant further consideration because of the inadequacy of the submitted proposal and will proceed to deem these proposals "non-responsive" with the concurrence of the procurement officer. *However, extreme care should be used when making this decision because of the time and cost that a potential offeror has put into submitting a proposal.* Proposals may be deemed "non-responsive" for the following reasons:

- If any of the required information is not provided;
- If the submitted price is found to be excessive or inadequate as measured by criteria stated in the RFP; or
- If the proposal is clearly not within the plans or specifications described and required in the RFP.

What determines if a price listed in an RFP is "excessive"?

As stated, a proposal may be found to be non-responsive due to excessive cost if the proposed price does not meet the criteria defining "excessive" in the RFP. This could be accomplished by options such as:

- Explicitly stating a budget or budget range in the RFP; or
- Stating an objective method clearly defining how proposals could be eliminated due to price.

Is there anything a potential offeror can do to make their non-responsive proposal "responsive"?

No. Proposals must be accepted "as is" by the evaluation committee and the initial screening must be conducted on that basis. The committee has the option of later requesting clarification information or a best and final offer, but only if the proposal was initially found to be "responsive."

Evaluation Committee Meetings

Once the proposals have been evaluated and scored by individual committee members, the next step is for the entire committee to get together to discuss the proposals and arrive at the final scoring. At this point, several things must be kept in mind:

- Meetings of an evaluation committee that involve an evaluation process or competing offers where the award of a contract is being considered must be electronically posted to the State's solicitation website 72 hours in advance of the meeting.
- Minutes must be kept of each meeting.
- A quorum of the committee must be present to take any official actions.
- The meetings must take place in an ADA accessible location.
- All members of the public are welcome to attend the evaluation committee meeting, however, they may not participate in the evaluation process or offer any comments. When sections of the proposals involving confidential materials are discussed, the meeting must be temporarily closed to the public.
- A master-scoring sheet should be compiled with the total score for each proposal.

OPEN FOR PUBLIC INSPECTION?

The "right to know" provision of Montana's Constitution, Article II, § 9, and section 18-4-304, MCA, allow the contents of submitted proposals to be open to public inspection, including competing offerors and the media, shortly after the time set for the receipt of proposals once the procurement officer has had the opportunity to inspect the proposals and remove any materials protected from public disclosure, i.e., trade secret materials. In addition, all meetings involving the evaluation of RFPs, are open to the public and subject to the open meeting laws. Agencies should review the latest version of the "Questions and Answers on the RFP Process" on the GSD website at: http://discoveringmontana.com/doa/gsd/procurement/rfpprocess.asp. This list of questions and answers is updated as additional issues are added.

CAN A COMMITTEE RECEIVE EVALUATION ASSISTANCE FROM OUTSIDE OF THE COMMITTEE MEMBERSHIP?

Yes. If technical assistance will enhance the decision-making of the committee, outside assistance should be used. However, only committee members may assign or vote on points.

Clarification Process (Optional step)

- The committee may choose to seek written clarification from particular offerors. A time and date for receipt of clarifications should be set.
- The procurement officer will issue any clarification questions. Responses will be returned to the procurement officer and submitted to the evaluation committee.

TIPS FOR HANDLING THE CLARIFICATION PROCESS

- Formal questions asked of offerors as part of the clarification process become a permanent part of the official procurement file; and
- It is important to establish a deadline beyond which answers to these questions will not be accepted.

Oral Presentations/Interviews/Discussions (Optional step)

- The committee may choose to ask certain offerors to make an oral presentation to the committee.
- Oral presentations by offerors must be open to the public and must be noticed to the public at least 72 hours in advance of the presentation.
- All offerors must be afforded equal time in making their presentation.
- Time slots for oral presentations should be established by the drawing of lots.
- Interviews are to be conducted and controlled by the committee chairperson. The procurement officer may attend such presentations if deemed necessary.
- All members of the evaluation committee should be present at the oral presentations.
- If oral presentations/interviews are anticipated at the outset of the RFP process, include anticipated dates, evaluation criteria and scoring methodology in the RFP.
- If a decision to hold oral presentations/interviews is made during the RFP process, the evaluation must be based solely on existing stated criteria with scores adjusted accordingly.

Site Visits (Optional step)

- The committee may choose to visit the offerors' work sites.
- Site visits must be open to the public and must be publicly noticed at least 72 hours in advance if a quorum of the evaluation committee will be attending. Offerors must be notified in the RFP that site visits may be conducted and that the visits must be open to the public if a quorum of the evaluation committee will be attending.
- If the option of requiring a site visit is pursued, evaluation criteria and/or scoring methodology must be set out for scoring the site visit in the RFP.

Best and Final Offers (Optional step)

- The committee may decide to seek best and final offers from one or more offerors if additional information is necessary or responses will be altered in order to make a final decision.
- The committee may request only one best and final offer.
- Offerors may not request an opportunity to submit a best and final offer.
- The procurement officer must be notified of the offerors who are provided the opportunity to submit best and final offers and the areas to be addressed.
- The procurement officer will send out the request for best and final offers in a letter stating the areas to be covered and the date and time in which the best and final offer must be returned.
- Proposal scores are *adjusted* in light of the new information received in the best and final offer. Additional points cannot be given.
- A best and final offer cannot be requested on price/cost alone unless so stated in the RFP. (ARM 2.5.602.)

References

- Prior to the final evaluation, references should be checked if requested in the RFP.
- The State retains the right to find the proposal non-responsive based on negative references alone.

Final Evaluation and Selection

- Final evaluation must take into consideration all submitted information and must be completed *using only the evaluation criteria defined in the RFP.*
- Final committee scores must be documented in a scoring matrix.
- The highest scoring proposal must be selected unless the agency decides to cancel the entire RFP.

HOW SHOULD THE FINAL POINT ASSIGNMENTS BE TALLIED?

Committees have several options on how to tally their final point assignments: (1) consensus score; (2) a total of all of the points given by individual committee members; or (3) an average of the individual scores. ***The SPB strongly recommends the use of consensus scoring.***

Selection Recommendation

- The chairperson of the evaluation committee must submit a written recommendation of selection to the procurement officer *prior* to the announcement of the selection.
- The selection recommendation must describe the proposal evaluation process and justify why the highest scoring offeror was selected.
- Copies of the committee's master scoring sheets and information regarding non-responsive proposals must also be submitted to the procurement officer.
- The procurement officer must approve the committee's selection process prior to notification of the highest scoring offeror.

Request for Documents

- A letter will be sent by the procurement officer to each offeror indicating the outcome of the proposal evaluation process.
- A request for documents letter will be sent to the highest scoring offeror requesting the insurance, contract security and/or worker's compensation documents required by the RFP.
- Tentative contract award will be posted to the State's website the same day as the letters are sent out. Final contract award is dependent on the receipt of a purchase order or fully executed contract.

Contract Negotiation

- Contract negotiation may begin once the highest scoring offeror has been selected and the committee's selection process has been approved by the procurement officer. Negotiation is limited to such things as the specifics of the supplies or services contained in the RFP, payment schedules or project deadlines.

Document Gathering

- The procurement officer will work with the highest scoring offeror to collect all required documents such as Workers' Compensation, insurance requirements, contract security, contractor's license, etc.
- A contract may not be signed or purchase order issued until the procurement officer indicates that all required documents have been received and are valid.
- Work may not commence until a contract is fully executed or a purchase order is issued.

Contract Signing or Issuance of Purchase Order

- If a purchase order is used, the procurement officer will issue the purchase order to the highest scoring offeror and implementation of the project may begin.
- If a contract is used, the procurement officer must approve the contract language as to form and the document must include a procurement officer signature.

THE REQUEST FOR PROPOSAL FORMAT

The State Procurement Bureau has developed a format for agencies to follow when preparing an RFP. The basis for the format is the RFP Template posted on the GSD website at the following address: http://discoveringmontana.com/doa/gsd/procurement/rfpprocess.asp.

Cover Page

Table of Contents

Offeror's RFP Checklist

Schedule of Events

- This subsection will answer several offeror questions in one concise table. However, be sure to use words like "tentative" or "anticipated" to maintain flexibility.
- The schedule should be as inclusive as possible, including:
  - ✓ RFP issue date;
  - ✓ Pre-proposal conference and/or walk-through dates (if required);
  - ✓ Deadline for receipt of written questions;
  - ✓ Deadline for issuance of State's written responses to questions;
  - ✓ Proposal submission deadline;
  - ✓ Oral presentations/interviews, if required; and
  - ✓ Tentative contract award date.

The rest of the RFP document is divided into six main parts:

- Section 1, Project Overview and Instructions, gives a brief overview of the project, names a single point of contact, and includes specific instructions on how to submit a response.
- Section 2, Standard RFP Information, contains information that covers the legal as well as the RFP process issues.
- Section 3, Scope of Project, is the core of the RFP. This is where the "scope" of the project and the specifications are detailed.
- Section 4, Offeror Qualifications, is where the specific qualifications necessary for the project are set out.
- Section 5, Cost Proposal, contains information on how much money is available for the project and/or sets out how the offeror must present its cost proposal.
- Section 6, Evaluation Criteria, states the evaluation criteria and their relative importance.

Appendix A, Standard Terms and Conditions, contains the "boilerplate" terms and conditions that apply to the solicitation and the eventual contract.

Appendix B, Contract, contains the terms and conditions that apply to the RFP and will form the basis of the resulting contract.

WHY SO MANY SUBSECTIONS?

Within each section, are numerous subsections. We are often asked why there needs to be so many subsections. Agencies must remember that the RFP is the beginning of a contract. For this reason, the RFP is written in a point-by-point manner. This is the same format commonly utilized for contracts. The subsections are a simple way to direct offerors to specific parts of the document and eliminate potential points of confusion. It is possible to condense several of the subsections, but it is important to keep in mind that each subsection represents a unique point that may or may not become a focal point of the document.

SECTION 1: PROJECT OVERVIEW AND INSTRUCTIONS

1.0 Project Overview

This subsection contains a brief narrative of agency/program missions, purpose, etc., in issuing an RFP;

- What the agency hopes to achieve through the RFP process;
- In general terms, agency's intents, goals and desires;
- In general terms, what the contractor will be required to do; and
- Why the agency is soliciting proposals.

1.1 Contract Term

- Term/duration of contract; and
- Renewal options.

1.2 Single Point of Contact

- The purpose of naming one contact person, usually the procurement officer who issues the RFP, is to:
  - ✓ Ensure that all questions will be routed through one person;
  - ✓ Provide the same information to all offerors;
  - ✓ Eliminate confusion such as "Well, someone else said I could do it this way"; and
  - ✓ Inform potential offerors that they may not contact members of the evaluation committee or agency staff.
- Provide the department and phone number where the contact person works; and
- Provide a fax number and e-mail address where questions can be sent.

1.3 Required Review

This subsection instructs offerors to carefully review the RFP and submit any questions to the procurement officer by a certain date.

- Offerors must notify the State of any ambiguity, inconsistency or error they may find.
- Questions. Things to keep in mind concerning questions posed by offerors following the release of an RFP:
  - ✓ Questions must be marked as such and identify the RFP number;
  - ✓ Establish a deadline beyond which questions will not be accepted;
  - ✓ Formal responses are posted on the State's website on or before close of business on the date stated;
  - ✓ Note that verbal answers from anyone are not legally binding.
- Addenda.
  - ✓ Any changes or corrections to the original RFP or any other information that will affect the complexion of the award must be disseminated in the form of an addendum.

- ✓ Addenda must also be posted on the State's website.

This subsection also provides information to offerors concerning standard terms and conditions, the standard contract and mandatory requirements.

1.4 Pre-Proposal Conference

This subsection contains instructions to the offeror governing the proposal submittals.

- ➢ Pre-proposal conference and walk-through (if required).
  - ✓ List the date, time, and place of the pre-proposal conference; and
  - ✓ State if the event is optional or mandatory (if mandatory, a sign-in sheet is required).

1.5 General Requirements

This subsection has standard "statements of understanding" that the offeror needs to agree to:

- ➢ Offerors are advised to notify the State of any terms and conditions that preclude them from responding or add unnecessary cost;
- ➢ The RFP, any addenda, the offeror's response, any best and final offers, and clarifications are included in the resulting contract;
- ➢ Advises offerors that they must meet the intent of all mandatory requirements;
- ➢ The offeror agrees to an understanding of and compliance with the specifications and requirements of the RFP;
- ➢ The highest scoring offeror will be the prime contractor and is responsible for any subcontractors
- ➢ The State has the right to approve all subcontractors;
- ➢ Proposals must be signed in ink; and
- ➢ The offeror's response will be valid for a stated period of time. The usual RFP time period is 120 days, but this may be adjusted to best suit the needs of the agency.

1.6 Submitting a Proposal

This subsection provides specific information on how to submit proposals noting:

- ➢ Point-by-Point Response.
  - ✓ Specify the exact format you would like the offerors to use to prepare their response to the RFP. For example, indicate where you want qualifications, resumes, price, etc., located throughout the document.
  - ✓ The specified format will assist committee members in locating certain information within each response.
  - ✓ It requires the offeror to acknowledge that they have read and will comply with all sections of the RFP.
  - ✓ It gives notice of consequences that may result from non-compliance or failure to provide all necessary information with the RFP response.

- Failure to Comply with Instructions.
  - ✓ Offerors are notified that failure to comply with instructions may be subject to point deductions.
- Multiple proposal responses (optional).
  - ✓ The project may lend itself to several solutions. This option allows the offeror submit multiple solutions for the committee to evaluate without jeopardizing or confusing one solution for another.
- RFP Price Sheet or Pricing Scenario (optional).
  - ✓ Used in instances where costs are represented in a specific format or for ease of response comparison. A Sample Price Sheet and Pricing Scenario Samples are included on pages 40 and 41.
- Copies Required and Deadline for Receipt of Proposals.
  - ✓ How many copies are required, i.e., "one original and four copies." (The number of copies should include one copy for each member of the evaluation committee, plus one copy is reserved for public inspection. The original is retained by the SPB);
  - ✓ Location, date, and time for return of proposals;
  - ✓ Include a statement that electronic or fax submittals of the RFP response are not acceptable.
- Late Proposals.
  - ✓ Regardless of cause, late proposals will not be accepted and will automatically be disqualified from further consideration. It is the offeror's sole risk to assure delivery at the receptionist's desk at the designated office by the designated time. Late proposals will not be opened and may be returned to the offeror at the expense of the offeror or destroyed if requested.

1.7 Cost of Preparing a Proposal

This subsection advises offeror that:

- Costs of preparing the proposal and possible presentations are the responsibility of the offeror;
- All materials submitted to the State become the property of the State;

SECTION 2: RFP STANDARD INFORMATION

2.0 Authority

This subsection sets out the legal authority for issuing an RFP.

2.1 Offeror Competition

This subsection provides a statement encouraging free and open competition and states that the offeror's signature on the RFP guarantees that no collusion has occurred.

2.2 Receipt of Proposals and Public Inspection

This subsection advises offeror that all information received in response to an RFP is deemed public information with few exceptions.

- ✓ The procurement officer is responsible for reviewing the proposals and separating out any information that is protected from public disclosure.

2.3 Classification and Evaluation of Proposals

This subsection contains information concerning how proposals will be evaluated and how contract award will be made as follows:

- Initial Classification;
- Determination of Responsibility;
- Evaluation;
- Completeness of Proposals;
- Achieving Passing Score (optional);
- Opportunity for Discussion/Negotiation and/or Oral Presentation/Product Demonstration;
  - ✓ This subsection notifies offerors that further presentations may be required prior to final selection. Costs of presentations are the offeror's responsibility.
- Best and Final Offer;
- Evaluation Committee Recommendation for Contract Award;
- Request for Documents Notice;
- Contract Negotiation;
- Contract Award.

2.4 State's Rights Reserved

This subsection contains a statement concerning the State's rights to:

- Cancel or terminate the RFP;
- Reject any or all proposals received;
- Waive any undesirable, inconsequential, or inconsistent provisions of the document; and

SECTION 3: SCOPE OF PROJECT

This section is the core of the RFP. It can also be entitled Statement of Work. It delineates in detail what the agency is seeking the offeror to include in their proposal in terms of the specifications and requirements necessary for the project.

Be sure to include the following items in the specifications:

- **Agency's Duties and Responsibilities**
  - ✓ What will the agency provide the contractor – guidance, oversight, office space, telephone, computers, copies, etc.
  - ✓ How often will the agency pay? Will it be based on the percentage of work completed?
  - ✓ Name the liaison for the agency.
  - ✓ Describe how the agency will monitor the ongoing performance of the contractor.
  - ✓ How will problems be communicated and resolved?

- **Contractor's Duties and Responsibilities**
  - ✓ Provide complete and specific description of the work to be performed.
  - ✓ Describe regulations and laws the contractor must follow.
  - ✓ Describe any forms the contractor must use.
  - ✓ Specify what to do in the event third parties or subcontractors are involved.
  - ✓ List deliverables, performance standards, timelines, etc.
  - ✓ Describe reporting requirements.
  - ✓ Describe sanctions for non-compliance with contract (forfeiture of contract security, liquidated damages, cancellation of contract).

- **Separation of Duties**
  - ✓ Describe any overlapping duties and responsibilities between agency and contractor.
  - ✓ Describe how contractor's scope of duties may be impacted by work that needs to be performed by the State.

TIPS FOR WRITING SPECIFICATIONS

"Don't write to be merely understood;
write so that you cannot possibly be misunderstood."
-- Robert Louis Stevenson

- Strive for clarity – use plain and simple language.
- Use layman's terms – avoid industry jargon.
- Use affirmative action words only if you mean them such as "will, shall, must";
- Don't use "would, should, may, or please."
- Do not use the term "bidder" or "contractor." An RFP is not a bid, and Montana law refers to people responding to RFPs as "offerors."
- Tell the offerors exactly what you want – if specifications are too open-ended, offerors may come back with 15 different scenarios when only one is needed.
- Don't leave room for speculation/interpretation by the offeror – you're likely to get 80 pages of questions during the question and answer period.
- Don't make the offerors re-invent the wheel – give them all of the pertinent data that you are aware of.
- Be careful to avoid unnecessarily restrictive specifications that could unfairly eliminate some offerors.
- Look ahead to the contract that will be executed. Anticipate potential problems or pitfalls and write the specifications to address and/or avoid them. Ask offerors what problems they anticipate for the project. Address the level of interaction/oversight you anticipate for the project and the performance standards you expect.

SECTION 4: OFFEROR QUALIFICATIONS

4.0 State's Right to Investigate and Reject

The State may make such investigations as deemed necessary to determine the ability of the offeror to supply the products and perform the services specified. The State reserves the right to reject any proposal if the evidence submitted by, or investigation of, the offeror fails to satisfy the State that the offeror is properly qualified to carry out the obligations of the contract. *This includes the State's ability to reject the proposal based on negative references.*

4.1 Offeror Informational Requirements

This section will determine the offeror's capabilities to provide the product and/or complete the project. The RFP must be very specific about what information the agency is seeking concerning qualifications.

4.1.1 References

- Note how many references must be supplied;
- Request the names and phone numbers for contact persons for each reference; and
- Specify if you would like public or private sector references.

4.1.2 Resumes/Company Profile and Experience

- Request pertinent information regarding company experience and/or staff qualifications;
- Request that the offerors identify previous projects they have completed of a similar nature;
- Request a list of staff people who will be working on the project, including the team leader;
- Request resumes for staff people involved in the contract;
- Specifically ask if the staff will be assigned full-time or not to the project; and
- Request a contingency plan in case key personnel become unavailable.

4.1.3 Method of Providing Services

- Ask for description of the work plan and methods to be used to accomplish the work; and
- Request a schedule of deliverables or a detailed timeline for project completion.

4.1.4 Financial Information

- Financial statements, quarterly reports, audit statements, etc.
- Should be requested in very limited circumstances.
- Should be reviewed and/or evaluated by qualified financial experts.

Ask the SPB for assistance with questions concerning this issue.

SECTION 5: COST PROPOSAL

In this section it is beneficial to the agency to include the estimated budget for the project so the offeror can provide a realistic cost proposal within that range.

This is where the agency would include information on how it wants the costs to be presented for this proposal.

If there is a maximum budget available that *cannot* be exceeded, state it here. A response cannot be disqualified for exceeding a budget ceiling unless it is so stated.

SECTION 6: EVALUATION CRITERIA

6.0 Evaluation Criteria

Include the list of criteria that will be used to score the proposals and corresponding point assignments. A list of commonly used criteria is set out in the Request for Proposal Process section of this manual.

APPENDIX A: STANDARD TERMS AND CONDITIONS

Contains the "boilerplate" terms and conditions that apply to the solicitation and the eventual contract.

APPENDIX B: CONTRACT

A contract should be attached to the RFP that reflects all the conditions and terms of the RFP. A contract is attached to the SPB's RFP Template. It is available on the GSD website at: http://discoveringmontana.com/doa/gsd/procurement/rfpprocess.asp.

OPTIONAL SPECIFICATIONS

The following sections need to be tailored to fit each RFP. Some of the sections will not be necessary for all RFPs. Standard statements are available on the General Services Division's website for each of these sections at: http://discoveringmontana.com/doa/gsd/procurement/standardcontractlanguage.asp.

Definitions

This subsection will ensure that all parties understand the terminology employed by:

- Eliminating possible equivocation of terms; and
- Eliminating cumbersome and redundant use of phrases/titles.

Prevailing Wage

By law, all bid specifications and contracts for public works projects in excess of $25,000 must contain a provision stating the standard prevailing wage rate and benefits that must be paid. (Mont. Code Ann. § 18-2-422.) Standard "Prevailing Wage Requirements" language is available on the GSD website at: http://discoveringmontana.com/doa/gsd/procurement/standardcontractlanguage.asp.

Contractor License and Registration

Construction contracts exceeding $2,500 require the contractor to be registered with the Department of Labor and Industry prior to contract execution. (Mont. Code Ann. § 39-9-401.) Standard "Contractor Registration" language is available on the GSD website at: http://discoveringmontana.com/doa/gsd/procurement/standardcontractlanguage.asp.

Contractor Withholding

Section 15-50-206, MCA, requires the state agency or department for whom a public works construction contract over $5,000 is being performed, to withhold one percent (1%) of all payments and to transmit such monies to the Department of Revenue. Standard "Contractor Withholding" language is available on the GSD website at: http://discoveringmontana.com/doa/gsd/procurement/standardcontractlanguage.asp.

SHORT FORM RFP TEMPLATE

The State Procurement Bureau has developed a Short Form RFP Template for agencies to use when working with smaller projects where a less sophisticated response is necessary. Offerors use a simplified RFP response form to respond to the RFP. The Short Form RFP Template is posted on the GSD website at the following address: http://discoveringmontana.com/doa/gsd/procurement/rfpprocess.asp.

IT RFP TEMPLATE

The State Procurement Bureau in conjunction with the Information Technology Services Division (ITSD) has developed an IT RFP Template for agencies to use when soliciting information technology projects. The IT RFP Template is posted on the GSD website at the following address:
http://discoveringmontana.com/doa/gsd/procurement/rfpprocess.asp.

ADDITIONAL RFP TOOLS

A Sample Price Sheet and Price Scenarios are provided as examples of methods that could be used to determine the price/cost for the supplies/services requested in the RFP process. These methods may be used separately or in combination to obtain price/cost information. Also provided are two Sample Evaluation Matrices or Scoring Sheets that can be tailored as necessary to meet an agency's needs.

SAMPLE PRICE SHEET

COMMUNITY REINTEGRATION OF HARD-TO-PLACE JUVENILE OFFENDERS

Complete the following pricing information, broken down by components of the total cost.

	Annual		Annual
Revenues:		**Equipment**	
Program Costs:		Vehicles	
Capital Outlay:		Telecommunications	
Debt Service		Data Processing	
Bonds		**Sub-Total**	
Loans			
TOTAL			
Personal Services, Salaries		**Total Operating Expenses**	
Administration		**External Support**	
Security		Subcontracted (Detail)	
Personnel Wages			
Personnel Benefits			
Training			
Medical			
Dental			
Mental Health			
Transportation			
Sub-Total		**Sub-Total**	
Operations		**Other (detail)**	
Training			
Transportation			
Supplies and Materials			
Client Health Services			
Medical			
Dental			
Mental Health			
Client Representation			
Legal Representation			
Contract Services			
Other (detail)			
		Sub-Total	
		GRAND TOTAL	
Sub-Total		**Offender Cost Per Day** (Total Expenditures divided by number of offenders divided by 365 days = Cost Per Day)	

PRICING SCENARIO EXAMPLES

HELICOPTER NETGUNNING SERVICES

The State of Montana, Department of Fish, Wildlife and Parks (FWP) is seeking a contractor to provide aircraft, pilot(s) and personnel for the capture, marking, transport and release of big game animals (primarily bighorn sheep, deer, elk, moose, antelope, mountain goat and wolf) on an occasional, "as needed" basis. The topography and vegetative conditions will vary from heavily timbered, mountainous terrain to sagebrush, grasslands and river breaks.

The project includes the capture of designated animals with a net fired from a hand held net gun. Agency personnel, agency contracted veterinarian and/or qualified contractor personnel may inoculate the captured animals; blood and fecal samples will be obtained. Captured animals will be marked by ear tagging and/or affixing telemetric radio collars or neckbands, and then released on site or transferred to FWP vehicles for transport to other locations. Captured animals will be handled in the most efficient and humane method possible to minimize their physiological stress. Such handling will include blind-folding, removal from the net as soon as possible, and hobbling. FWP will determine the method of slinging the captured animals for transport depending on the species of animal and distances of transport. For elk and deer, slinging by the legs will not be used for distances greater than ½ mile. All transport of sheep, goats, moose antelope and wolves will be accomplished with slinging bags that keep head in upright position or animals may be transported inside the helicopter. Contractor will ensure that any animal injured or killed during the capture operation will be immediately transported to the FWP field base of operations. Decisions as to euthanizing injured animals will be made by FWP. Contract may include air taxi or point-to-point transportation of FWP personnel but only when the project cannot be accomplished in any other way.

Based on the information provided above, please provide a fee schedule on a per animal captured, or per hour basis, for each type of animal and type of terrain that includes all anticipated costs, including personnel and miscellaneous expenses.

EXAMPLE:

The cost to perform all the requested services for one big horn sheep in mountainous terrain would be $____/animal.

The cost per hour to perform all the requested services involving deer in heavily timbered terrain would be charged at a rate of $____/hour.

LEGAL TRANSCRIPTION STENOGRAPHER SERVICES

The Department of Administration requests that your firm provide legal transcription stenographer services at a public hearing to be held in Plentywood, Montana. The hearing is scheduled from 9 a.m. to 5 p.m. on Tuesday and Wednesday, March 18 and 19, 2003, with an hour's lunch break from 12 noon to 1 p.m. Please provide a detailed listing of your costs to provide these stenographer services, including travel, lodging and per diem for the following two scenarios:

Scenario 1: One person travels to Plentywood, Montana, records the hearing and provides one original 30-page verbatim transcript of the proceedings and one computer

diskette containing the transcript in Microsoft WORD format to the Department of Administration. Please submit a detailed sample invoice for all associated costs.

Scenario 2: One person travels to Plentywood, Montana, and records the hearing. However, the Department of Administration decides it will not need a transcript of the hearing. Please submit a detailed sample invoice for all associated costs.

SAMPLE SCORING MATRICES

Scoring Matrix
Adult Non-Medicaid Mental Health Care
RFP03-720P
_____(Vendor Name or Master)

Criteria	Section	Possible Points	Assigned Points	Comments
Currently licensed as a mental health center in Montana. *If organization is not currently licensed, the proposal will be deemed non-responsive.*	**4.1.2.1**	**Pass/Fail**		
Years of providing similar service. *9-10 years - 50 points* *7-8 years - 40 points* *5-6 years - 30 points* *3-4 years - 20 points* *1-2 years -10 points* *Less than 1 year - 0 points*	**4.1.2**	**50**		
Number of adult endorsements in place at time of proposal due date. *5 - 50 points* *4 - 40 points* *3 - 30 points* *2 - 20 points* *1 - 10 points*	**4.1.2.1**	**50**		
Experience in serving MHSP adult population currently and in State Fiscal Year 2002 • *Number of clients served (combined FY02 and current)* *400 + - 20 points* *100-399 - 10 points* *0 - 99 - 0 points* • *History and scope of services* *(Use attached Scoring Guide for 80- points)*	**4.1.2.2**	**100** 20 80		

Criteria	Section	Possible Points	Assigned Points	Comments
Capacity to provide medication management services in proposed multi-country area	**4.1.2.3**	**100**		
• *Organization resources and experience in providing med management*		50		
(Use attached Scoring Guide for 50 points)				
• *Ability to cover multi-county area*		50		
(Use attached Scoring Guide for 50 points)				
Experience in working with key agencies	**4.1.2.4**	**100**		
(Use attached Scoring Guide for 100 points)				
Experience in planning discharge and aftercare for patients discharged from the Montana State Hospital for current year and State Fiscal Year 2002.	**4.1.2.5**	**100**		
• *Number of clients served in discharge or aftercare (combined FY02 and current)*		20		
76-200 clients - 20 points *26-75 clients - 10 points* *0-25 clients - 5 points*				
• *History and scope of services*		80		
(Use attached Scoring Guide for 80 points)				
Capacity and demonstrated ability to provide accurate and timely data as required by State.	**4.1.2.6**	**50**		
• *Organization resources and experience in providing data.*		25		

Criteria	Section	Possible Points	Assigned Points	Comments
(Use attached Scoring Guide for 25 points) • *Number of required data variables that will be submitted from list in Appendix C.* *71-76 variables - 25 points* *63-70 variables - 15 points* *0-62 variables - 5 points*		25		
Experience in providing 24-hour per day emergency telephone service currently and in FY 2002 • *History and Scope of service* *(Use attached Scoring Guide for 25 points)* • *Number of clients served (current and FY02 combined)* *100-200 clients - 25 points* *51-99 clients - 15 points* *0-50 clients - 5 points*	**4.1.2.7**	**50** 25 25		
Method of providing service – work plan • *Description of what services will be provided* *(Use attached Scoring Guide for 60 points)* • *Description of timeframes* *(Use attached Scoring Guide for 60 points)* • *Description of how work will be accomplished* *(Use attached Scoring Guide for 80 points)*	**4.1.3**	**200** 60 60 80		

Criteria	Section	Possible Points	Assigned Points	Comments
Proposed service area • *Number and list of counties that will be served* *22+ counties - 100 points* *18-21 counties - 80 points* *14-17 counties - 60 points* *10-13 counties - 40 points* *1-9 counties - 20 points* *Note overlapping counties with another offeror's proposal in comments column. (To be considered in Stage Two.)*	**4.1.3**	**100**		
Total Possible Points ***Offerors must obtain a passing score of at least 650 points in order to be considered for Stage Two of the evaluation.***		**900**		

Stage Two Evaluation. All proposals that obtain at least 650 points in Stage One Evaluation will be considered for contract award based on the areas of proposed service. If more than one offeror scores at least 650 points in a particular proposed service area, the contract will be awarded to the highest scoring offeror in that proposed service area.

RFP SCORING GUIDE

A maximum total number of points available will be set out in the RFP's evaluation criteria section. Each category of evaluation criteria will be broken down further with points assigned to each. In awarding these points, please consider the following guidelines:

Superior Response (95-100%): A superior response will be a highly comprehensive, excellent reply that meets all of the requirements of the areas within that category. In addition, the response covers areas not originally addressed within the RFP category and includes additional information and recommendations that would prove both valuable and beneficial to the agency. This response is considered to be an excellent standard, demonstrating the offeror's authoritative knowledge and understanding of the project.

Very Good Response (85-94%): A very good response will provide useful information, while showing experience and knowledge within the category. The proposal is well thought out and addresses all requirements set forth in the RFP. The offeror provides insight into their expertise, knowledge and understanding of the subject matter.

Good Response (75-84%): A good response meets all the requirements and has demonstrated in a clear and concise manner a thorough knowledge and understanding of the subject matter. This response demonstrates an above average performance with no apparent deficiencies noted.

Fair Response (65-74%): A fair response meets the requirements in an adequate manner. This response demonstrates an ability to comply with guidelines, parameters, and requirements with no additional information put forth by offeror.

Poor Response (60-64%): A poor response minimally meets most requirements set forth in the RFP. The offeror has demonstrated knowledge of the subject matter only.

Failed Response (0-59%): A failed response does not meet the requirements set forth in the RFP. The offeror has not demonstrated knowledge of the subject matter.

Score	100 point scale	80 point scale	60 point scale	50 point scale	25 point scale
Superior	95-100	76-80	57-60	47-50	24-25
Very Good	85-94	68-75	51-56	43-46	22-23
Good	75-84	60-67	45-50	38-42	19-21
Fair	65-74	52-59	39-44	33-37	16-18
Poor	60-64	48-51	36-38	30-32	14-15
Failed	0-59	0-47	0-35	0-29	0-13

EARLY CHILDHOOD PUBLIC AWARENESS
AND ENGAGEMENT CAMPAIGN
RFP04-784J
Scoring Matrix

The evaluation committee will review and evaluate the offers according to the following criteria based on a **maximum of 200 total points**. If deemed necessary, the State may request additional information to determine an offeror's ability to provide the services. **Note: Points will be assigned based on the attached Scoring Guide.**

Offeror Name: _____ Points Awarded: _____

Category	Section	Possible Points	Points Awarded	Comments
EXPERIENCE	**See Table Below**			
A. Description of Purpose or Goals	4.1.1	5		
B. Description of Services Provided	4.1.1	5		
C. Staff Resumes	4.1.1	10		
D. Narrative Describing Experience	4.1.1	5		
E. Letters of Support	4.1.1	5		
F. Samples of Past Work	4.1.1	10		
G. Staff Qualifications	4.1.1	10		
REFERENCES	**References Provided = Pass; References Not Provided = Fail**			
A. References	4.1.2	Pass/Fail		
SUMMARY	**See Table Below**			
A. Principal Features of Proposal	4.1.3	10		
B. Offeror's Strengths	4.1.3	10		
DESCRIPTION OF SERVICE DELIVERY/WORK PLAN	**See Table Below**			
A. Offeror's Methods	4.1.4	30		
B. Offeror's Work Plan	4.1.4	30		
EVALUATION PLAN	**See Table Below**			
A. Offeror's Method for Collection	4.1.5	10		
B. Narrative	4.1.5	10		
ADMINISTRATION				
A. Offeror General Information	4.1.6	Pass/Fail		
RESOURCES/SUPPORT	**See Table Below**			
A. Staffing	4.1.7	10		
B. Additional Support	4.1.7	5		
C. Coordination/Subcontract Agreements	4.1.7	5		

BUDGET PROPOSAL	See Table Below -whether the budget categories are appropriate and acceptable for performance; and -whether the sums designated in the budget are appropriate for the various particulars of performance			
A. Budget Narrative	5.1	30		
B. Financial Officer	5.1	Pass/Fail		

SCORING GUIDE

Superior Response (95-100%): A superior response will be a highly comprehensive, excellent reply that meets all of the requirements of the areas within that category. In addition, the response covers areas not originally addressed within the RFP category and includes additional information and recommendations that would prove both valuable and beneficial to the agency. This response is considered to be an excellent standard, demonstrating the offeror's authoritative knowledge and understanding of the project.

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Poor Response (60-64%): A poor response minimally meets most requirements set forth in the RFP. The offeror has demonstrated knowledge of the subject matter only.

Failed Response (0-59%): A failed response does not meet the requirements set forth in the RFP. The offeror has not demonstrated knowledge of the subject matter.

Score	5 point scale	10 point scale	30 point scale
Superior	5	9-10	26-30
Very Good	4	7-8	20-25
Good	3	5-6	15-19
Fair	2	3-4	10-14
Poor	1	1-2	5-9
Failed	0	0	0-4

FOR MORE INFORMATION...

For more information or assistance regarding the RFP process:

1. Call the Montana State Procurement Bureau at (406) 444-2575.

Attachment 5

*A copy of the actuarial contract.

MONTANA
Department of Public Health & Human Services

January 21, 2011

CONTRACT FROM THE MONTANA
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

CONTRACT NUMBER 11-11-1-04-001-0

RECEIVED

SECTION 1: PARTIES

This contract is entered into between the Montana Department of Public Health and Human Services (hereinafter referred to as the "Department"), whose address and phone number are PO Box 202951, Helena MT 59620-2951 and 406-444-4540 and Mercer Health & Benefits LLC (hereinafter referred to as the "Contractor"), whose federal ID number, mailing address, fax number, and phone number are 34-2015463, 333 South 7th Street, Suite 1600, Minneapolis MN 55402-2427, 612-642-8686 and 612-642-8600.

THE PARTIES AGREE AS FOLLOWS:

SECTION 2: PURPOSE

The purpose of this contract is to obtain actuarial information the Department may use to establish rates in the implementation of a managed care program for Montana Medicaid and CHIP.

SECTION 3: TERM OF CONTRACT

A. The term of this contract for the purpose of delivery of services is from December 1, 2010 through November 30, 2011, unless terminated otherwise in accordance with the provisions of this contract. This contract may be extended for an additional twelve month period if the parties agree to the extension prior to the end of the current term of this contract.

B. The completion date of performance for purposes of issuance of final payment for services is the date upon which the Contractor submits to the Department such final reports as are required under this contract and are satisfactory in form and contents as determined by the Department.

C. The Contractor, after termination of this contract, remains subject to and obligated to comply with all legal and continuing contractual obligations arising in relation to its duties and responsibilities that may arise under the contract including, but not limited to, record retention, audits, indemnification, insurance, the protection of confidential information, recipient grievances and appeals

and property ownership and use.

SECTION 4: SERVICES TO BE PROVIDED

A. The Contractor agrees to use due care, skill, and diligence in providing the following actuarial services to the Department:

(1) A budgetary study highlighting program costs across the various Medicaid and CHIP populations and services, including physical health, behavioral health, long term care, and home and community based waiver services.
(2) A data book detailing Montana regional information as defined by the Department, including pmpm costs for each of the various services defined by provider type in aid category cohorts.
(3) Costs projected forward to the time period the rates will be effective.
(4) An actuarial opinion and fiscal impact analysis of the proposed managed care project.
(5) An estimated range of program savings.
(6) Development of methodology for an actuarially sound pmpm rate as required by CMS, including provision of Medicaid eligibility groups and rate cells.

B. Source data will include claims and payments for all Medicaid and CHIP benefits for a three year period. Data sources include:

a. MMIS for physical and behavioral health claims for Medicaid; dental, eyeglasses, and some behavioral health claims for CHIP;
b. AWACS for health claims for individuals enrolled in DD waivers;
c. First Check at Mountain Pacific Quality Health for non-emergency transportation claims; and
d. BlueCross BlueShield of Montana for physical and most behavioral health claims for CHIP.

C. Contractor will provide complete explanations of all studies, reports, opinions, and analyses to Department staff.

D. Contractor's principle actuary must be a Fellow in the Society of Actuaries (FSA) and a Member of the American Academy of Actuaries (MAAA) with proven experience with a Medicaid and/or CHIP program.

E. Non-actuaries must work under the supervision of the principle actuary to perform actuarial work.

SECTION 5: CONSIDERATION AND PAYMENTS

A. In consideration of the services to be provided through this contract, the Contractor is to receive from the Department reimbursement for services rendered in accordance with the following reimbursement fees. The Contractor may only bill for services that have been performed.

[Contractor name] 2010-2011 hourly billing rates	
Principal	**$355**
Actuary	**$355**
Assistant Actuary	**$280**
Actuarial Analyst	**$225**
Administrative	**$95**

B. The Contractor must submit invoices itemizing all services and expenses for reimbursement. Invoices must be submitted to the Department in accordance with the following schedule: Minimum 30 day intervals through contract term.

C. The Department may withhold payment at any time during the term of the contract, if the Contractor is failing to perform its duties and responsibilities in accordance with the terms of this contract.

D. In order to assure full performance by the Contractor of the duties and responsibilities of this contract, the Department is withholding 10 percent of the consideration from payment until such time as the Department determines that the Contractor has satisfactorily performed all the duties and responsibilities of this contract. The Department may retain the above stated amount if the Contractor fails to complete full performance. The exercise of the Department's right in relation to this provision does not preclude the Department from recovery of additional amounts that are owing to it.

E. The consideration provided to the Contractor under this contract may be adjusted by the Department in its discretion based on audit findings.

F. The sources of the funding for this contract are 50% from the state general fund and, for the balance, federal grants from the U.S. Department of Health and Human Services. CFDA Number is 93.778.

G. The total reimbursement provided to the Contractor for the purposes of this contract may not exceed $140,000.

H. The Contractor may not receive monies provided through this contract as reimbursement for the costs of services that are reimbursed from other sources.

SECTION 6: RELATED PARTY TRANSACTIONS PROHIBITED

The Contractor may not enter into any contract or other arrangement for the use, purchase, sale, lease or rental of real property, personal property or services funded with monies of this contact if an employee, administrator, officer or director of the Contractor may receive a financial or other valuable benefit as a result.

The Department may grant exceptions to this prohibition where it determines that the particular circumstances warrant the granting of an exception.

SECTION 7: CREATION AND RETENTION OF RECORDS

A. The Contractor must create and maintain records of the services covered by this contract, including financial records, supporting documents and such other records as are required by law or other authority.

B. The Contractor agrees to provide the Department, Legislative Auditor, or their authorized agents, access to any records necessary to determine contract compliance (section 18-1-118, MCA).

C. Records must be retained for a period of three (3) years from the completion date of this contract. If any litigation, review, claim or audit is started before the expiration of the three year period, the records must be retained until all litigation, reviews, claims or audit findings involving the records have been resolved.

D. The Contractor must provide the Department and its authorized agents with reasonable access to records the Contractor maintains for purposes of this contract. The Contractor must make the records available at all

reasonable times at the Contractor's general offices.

E. Records developed for the purposes of delivery of services to recipients under this contract are the property of the Department and must be developed, maintained, and disposed of as provided in this contract or as otherwise directed by the Department.

SECTION 8: ACCOUNTING, COST PRINCIPLES AND AUDIT

A. The Contractor, in accordance with 18-4-311, MCA and other authorities, must maintain for the purposes of this contract an accounting system of procedures and practices that conforms to Generally Accepted Accounting Principles (GAAP), as interpreted by the Department, and to any other accounting requirements the Department may require.

B. The Department or any other legally authorized governmental entity or their authorized agents may at any time during or after the term of this contract conduct, in accordance with 5-13-304 and 18-1-118, MCA and other authorities, audits for the purposes of assuring the appropriate administration and expenditure of the monies provided to the Contractor through this contract and assuring the appropriate administration and delivery of services provided through this contract.

C. The Contractor, for purposes of audit and other administrative activities, in accordance with 18-1-118, MCA and other authorities, must provide the Department and any other legally authorized governmental entity or their authorized agents access at any time to all the Contractor's records, materials and information, including any and all audit reports with supporting materials and work documents, pertinent to the services provided under this contract until the expiration of three years from the completion date of this contract.

The State and any other legally authorized governmental entity or their authorized agents may record any information and make copies of any materials necessary for the conduct of an audit or other necessary administrative activity.

D. The Contractor must comply with the accounting and audit requirements in 45 CFR §74.26(d) and the cost principles and procedures for commercial organizations in 48 Subpart CFR 31.2 concerning the use of the funds provided under this contract in the version in effect on the date this

contract is signed by both parties. Pursuant to 45 CFR §74.26(d), a "for-profit" organization may either have an audit conducted in accordance with the Federal Office of Management and Budget (OMB) Circular A-133, "Audits of States, Local Governments, and Non-Profit Organizations" or the Government Auditing Standards.

E. The Contractor must reimburse the Department or compensate the Department in any other manner as the Department may direct for any sums of monies determined by an audit to be owing to the Department.

SECTION 9: ASSIGNMENT, TRANSFER AND SUBCONTRACTING

A. The Contractor may not assign, transfer, delegate or subcontract, in whole or part, this contract or any right or duty arising under this contract unless the Department in writing approves the assignment, transfer, delegation or subcontract.

B. An assignment, transfer, delegation or subcontract entered into by the Contractor must be in writing, must be subject to the terms and conditions of this contract and must contain any further conditions as may be required by the Department.

C. The Department's approval of any assignment, transfer, delegation or subcontract neither makes the Department a party to that agreement nor creates any right, claim or interest in favor of any party to that agreement against the Department.

D. The Contractor must immediately notify the Department of any litigation concerning any assignment, transfer, delegation or subcontract.

E. The Contractor must indemnify and hold the Department harmless, in accordance with the provisions of this contract, regarding indemnification, with respect to any suit or action by any party to an assignment, transfer, delegation or subcontract.

SECTION 10: HOLD HARMLESS/INDEMNIFICATION

A. The Contractor must indemnify, defend, and hold harmless the State of Montana, its officials, agents, and employees from any breach of this contract by the Contractor, from any matters arising from the performance of this contract,

or from the Contractor's failure to comply with any federal, state, and local laws, regulations and ordinances applicable to the services or work to be provided under this contract.

B. This indemnification applies to all claims, obligations, liabilities, costs, attorney's fees, losses or suits resulting from any acts, errors, omissions or negligence, whether willful or not, of the Contractor, its employees, agents, subcontractors, or assignees and any other person, firm, or corporation performing work, services or providing materials under this contract.

SECTION 11: INSURANCE COVERAGE

A. GENERAL LIABILITY INSURANCE

1. The Contractor must maintain, at its cost, primary standard general liability insurance coverage. The general liability coverage must include claims arising out of contractual liability, the delivery of services, omissions in the delivery of services, injuries to persons, damages to property, the provision of goods or rights to intellectual property or any other liabilities which may arise in the provision of services under this contract. The insurance must cover claims as may be caused by any act, omission, or negligence of the Contractor and/or its officers, agents, employees, representatives, assigns or subcontractors.

2. The Contractor must provide general liability insurance coverage inclusive of bodily injury, personal injury and property damage. The general liability insurance coverage must be obtained with combined single limits of $500,000 per occurrence and $1,000,000 aggregate per year, from an insurer with a Best's Rating of no less than A- or through a qualified self-insurer plan, implemented in accordance with Montana law and subject to the approval of the Department.

3. The state, its officers, officials, agents, employees, and volunteers, are to be covered as additional insureds for liability arising out of activities performed by or on behalf of the Contractor, inclusive of the insured's general supervision of the Contractor, products and completed operations; and arising in relation to the premises owned, leased,

occupied or used by the Contractor.

C. PROFESSIONAL LIABILITY INSURANCE

1. The Contractor must maintain, at its cost, professional liability insurance coverage against claims for harm to persons which may arise from the professional services provided through this contract. The insurance must cover claims as may be caused by any act, omission, or negligence of the Contractor and/or its officers, agents, employees, representatives, assigns or subcontractors, assigns or employees.

2. The Contractor must provide occurrence coverage professional liability insurance with combined single limits of $1,000,000 per occurrence and $2,000,000 aggregate per year, from an insurer with a Best's Rating of no less than A-.

3. In lieu of occurrence coverage, the Contractor may provide claims made coverage with three years of additional tail coverage at the discretion of the Department and with prior approval of the Risk Management and Tort Defense Division of the Department of Administration.

D. GENERAL REQUIREMENTS

1. The Contractor must provide to the Department a copy of the certificate of insurance showing compliance with the requisite coverage. All insurance required under this contract must remain in effect for the entire contract period. The Contractor must provide to the Department copies of any new certificate or of any revisions to the existing certificate issued during the term of this contract.

2. The Department may require the Contractor to provide copies of any insurance policies pertinent to these requirements, any endorsements to those policies, and any subsequent modifications of those policies.

3. The Contractor's insurance coverage is the primary insurance in respect to the state, its officers, officials, agents, employees and volunteers. Any insurance or self-insurance maintained by the state and its officers, officials, agents, employees, and volunteers is in excess of the Contractor's insurance

and does not contribute with it.

4. Any deductible or self-insured retention must be declared to and approved by the Department. At the request of the Department, the insurer must:

   a. reduce or eliminate such deductibles or self-insured retentions in relation to the state, its officials, employees and volunteers; or

   b. the Contractor must procure a bond guaranteeing payment of losses and related investigations, claims administration and defense expenses.

SECTION 12: COMPLIANCE WITH LABOR LAWS

A. The Contractor assures the Department that the Contractor is an independent contractor providing services for the Department and that neither the Contractor nor any of the Contractor's employees are employees of the Department under this contract or any subsequent amendment.

B. The Contractor, at all times during the term of this contract, must maintain coverage for the Contractor and the Contractor's employees through workers' compensation, occupational disease, and any similar or related statutorily required insurance program. The Contractor must provide the Department with proof of necessary insurance coverage.

C. If the Contractor has received, for workers' compensation purposes, an independent contractor exemption as to the Contractor, the Contractor must provide the Department with a copy of the exemption.

D. The Contractor is solely responsible for and must meet all labor, health, safety, and other legal requirements, including payment of all applicable taxes, premiums, deductions, withholdings, overtime and other amounts, which may be legally required with respect to the Contractor and any persons providing services on behalf of the Contractor under this contract.

E. The provision of this contract regarding indemnification applies with respect to any and all claims, obligations, liabilities, costs, attorney fees, losses or suits accruing or resulting from the Contractor's failure to comply with this section, or from any finding by any legal authority that any person providing services on behalf of the

Contractor under this contract is an employee of the Department.

SECTION 13: COMPLIANCE WITH APPLICABLE LAWS, RULES AND POLICIES

The Contractor must comply with all applicable federal and state laws, executive orders, regulations and written policies, including those pertaining to licensing.

SECTION 14: FEDERAL REQUIREMENTS

A. Generally

1. The Contractor, in addition to the federal requirements specified in this contract and any attachments to this contract, must comply with the applicable federal requirements and assurances for recipients of federal grants provided in the federal OMB 424B (Rev. 7-97) form, known as "ASSURANCES - NON-CONSTRUCTION PROGRAMS", and in the Department's "CERTIFICATION OF COMPLIANCE WITH CERTAIN REQUIREMENTS FOR DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES (12-06)". Those assurance documents must be signed by the Contractor and submitted to the Department prior to the signing of this contract.

   The Contractor is responsible for determining which requirements and assurances are applicable to the Contractor.

2. The Contractor must ensure compliance of its subcontractors with the applicable federal requirements and assurances.

B. Political and Lobbying Activities

1. Federal monies received by the Contractor under the terms of this contract may not be used for any political activities by the Contractor, its employees or agents except as expressly permitted by state and federal law.

2. As required by 31 USC 1352 and 45 CFR 93.100 et seq., federally appropriated monies may not be used to influence or attempt to influence an officer or employee of any agency, a member of the U.S. Congress, an officer or employee of the U.S. Congress or an

employee of a member of the U.S. Congress, in connection with the awarding of any federal contract, grant or loan, the making of any cooperative agreement or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan or cooperative agreement.

3. If any funds other than federally appropriated funds are paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of the U.S. Congress, an officer or employee of the U.S. Congress or an employee of a member of the U.S. Congress in connection with this contract, the Contractor must complete and submit to the Department the federally required form, "STANDARD FORM LLL".

4. Federally appropriated monies received through the programs of the federal Departments of Health & Human Services, Education or Labor, as provided in Section 503 of H.R. 3424, appropriating monies for the Departments of Labor, Health and Human Services, and Education, as enacted through Division B of H.R. 3194,"The Consolidated Appropriations Act of 1999", Pub. L. No. 106-113, and as may be provided by congressional continuing resolutions or further budgetary enactments, may not be used:

   a. to fund publicity or propaganda, or for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, radio, television, or video presentation designed to support or defeat legislation pending before the U.S. Congress or a state legislature, except for presentations to the U.S. Congress or a state legislative body or one or more of its members as an aspect of normal and recognized executive-legislative relationships.

   b. to pay the salary or expenses of any grant or contract recipient, or agent acting for the recipient, related to any activity designed to influence legislation or appropriations pending before the U.S. Congress or a state or local legislative body.

5. The Contractor must cooperate with any investigation undertaken regarding the expenditure of funds for political or lobbying activities.

6. The Contractor must ensure the compliance of any

subcontractors with these restrictions and any related reporting requirements.

7. Federal monies received through Title III of the Older Americans Act for services to the aged, in accordance with 42 USC §3026, may be used for the following activities:

C. Federal Debarment Prohibition

1. The Department, in accordance with The Federal Acquisition Streamlining Act of 1994, P.L. 103-355, and Executive Orders #12549 and #12689, is prohibited from contracting with any entity that is debarred, suspended, or otherwise excluded from participating in procurement activities funded with federal monies. This prohibition also extends to contracting with an entity that has a director, officer, partner, person with beneficial ownership of more than 5 percent of the entity's equity, employee, consultant, or person otherwise providing items and services that are significant and material to the entity's obligations under its contract with the Department if that person has been debarred, suspended or otherwise excluded from participating in procurement activities funded with federal monies.

2. If the Department finds that the Contractor is not in compliance with subsection (1), the Department;

   a. must notify the federal government;

   b. may continue this contract unless the Secretary of the federal Department of Health and Human Services directs otherwise; and

   c. may only renew or otherwise extend the duration of the existing contract with the Contractor if the federal government provides to the Department and to Congress a written statement describing compelling reasons that exist for renewing or extending this contract.

SECTION 15. CIVIL RIGHTS

A. Federal and State Authorities

The Contractor must comply with the applicable provisions of the Montana Human Rights Act (49-2-101, et seq., MCA),

Governmental Code of Fair Practices (49-3-101, et seq. MCA) the federal Civil Rights Act of 1964 (42 USC 2000d, et seq.), the federal Age Discrimination Act of 1975 (42 USC 6101, et seq.),Section 504 of the federal Rehabilitation Act of 1973 (29 USC 794), and the federal Americans with Disabilities Act of 1990 (42 USC 12101, et seq.).

B. Discrimination

The Contractor, as provided at 49-3-207, MCA and other relevant authorities, may not discriminate in any manner against any person on the basis of race, color, religion, creed, political ideas, sex, age, marital status, physical or mental disability or national origin.

C. Employment

The Contractor, as provided at 49-3-207, MCA, must hire persons on the basis of merit and qualifications directly related to the requirements of the particular position being filled.

The Contractor, in accordance with federal Executive Orders 11246 and 11375 and 41 CFR Part 60, must provide for equal employment opportunities in its employment practices.

SECTION 16. CONFIDENTIALITY AND HIPAA REQUIREMENTS

A. The Contractor must, during and after the term of this Contract, protect confidential consumer and recipient information obtained and used in the performance of contractual duties and responsibilities under this Contract in accordance with applicable legal and policy authorities.

B. All material and information containing consumer and recipient personal information provided to the Contractor by the Department or acquired by the Contractor on behalf of the Department, whether verbal, written, magnetic media, or in other forms, is to be regarded as confidential information and may only be used or disseminated by the Contractor, its subcontractors, or agents for the purposes allowed for under this Contract and any governing legal and policy authorities.

C. The Contractor, in relation to individually identifiable health information, must comply with the privacy and security requirements of the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the regulations implementing those requirements at 45 CFR Part

160 and Subparts A, C, and E of Part 164 as they may be applicable to the Contractor and the services provided through this Contract. Attachment D to this contract provides information as to where the Contractor may access the relevant HIPAA legal authorities and the interpretative direction provided by the federal government. The Department's Certification Form, signed by the Contractor and incorporated as an attachment to this Contract provides for the Contractor's certification of its determination as to whether it is legally subject to the HIPAA privacy requirements and, if subject to the HIPAA, certification of its determination that it is fully in compliance with HIPAA.

D. The Contractor must notify the Department in writing within five work days in the event that 1) a complaint is lodged with the Office of Civil Rights (OCR) of the Department of Health and Human Services alleging that determines that the Contractor is not in compliance with HIPAA, 2) the Office of Civil Rights (OCR) of the Department of Health and Human Services determines that the Contractor is not in compliance with HIPAA, or 3) an administrative action or litigation is initiated against the Contractor based on any legal authority pertaining to the protection of confidential information. The Contractor must provide with any notice a copy of the relevant administrative complaint, determination or legal complaint.

E. Failure of the Contractor to be in compliance with this provision, the Department's policies protecting confidential information, or federal and state legal authorities, inclusive of HIPAA, governing the protection of confidential information is cause for termination of this Contract by the Department.

SECTION 17. BUSINESS ASSOCIATE PROVISION

A. The following definitions apply to this section:

1. Business Associate. "Business Associate" means Mercer Government Human Services Consulting.

2. Covered Entity. "Covered Entity" means the Department.

3. Individual. "Individual" has the same meaning as the term "individual" in 45 CFR §164.501 and includes a person who qualifies as a personal representative in

accordance with 45 CFR §164.502(g).

4. Minimum Necessary. "Minimum Necessary" means when using or disclosing protected health information or when requesting protected health information reasonable efforts must be made to limit the protected health information used or disclosed to the information needed to accomplish the intended purpose of the use, disclosure, or request. To the extent practicable minimum necessary means the protected health information used or disclosed will be in limited date set format as that term is defined at 45 CFR §164.514(e). The definition of the term minimum necessary in this contract is controlled by guidance issued by the Secretary of the federal Department of Health and Human Services.

5. Privacy Rule. "Privacy Rule" means the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.

6. Protected Health Information. "Protected Health Information" has the same meaning as the term "protected health information" in 45 CFR §164.501, and includes Electronic Protected Health Information ("E-PHI") as that term is used in 45 CFR Part 164, Subpart C, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

7. Required By Law. "Required By Law" has the same meaning as the term "required by law" in 45 CFR §164.501.

8. Secretary. "Secretary" means the Secretary of the Department of Health and Human Services or his designee.

9. Security Rule. "Security Rule" means the Security Standards for the Protection of Electronic Protected Health Information (E-PHI).

10. Other terms used but not otherwise defined in this Agreement have the same meaning as those terms in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as codified at 42 USC §1320d-d8, and its implementing regulations at 45 CFR Parts 160, 162 and 164 (the "HIPAA Regulations"); and the Health Information Technology for Economic and Clinical

Health Act, enacted as part of the American Recovery and Reinvestment Act of 2009, and its attendant regulations and guidance (the "HITECH Act").

B. Obligations and Activities of Business Associate.

1. Mercer Health & Benefits LLC agrees it is a Business Associate (as that term is defined at 45 CFR §160.103) of the Department and agrees to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as codified at 42 USC §1320d-d8, and its implementing regulations at 45 CFR Parts 160, 162 and 164 (the "HIPAA Regulations"); and the Health Information Technology for Economic and Clinical Health Act, enacted as part of the American Recovery and Reinvestment Act of 2009, and its attendant regulations and guidance (the "HITECH Act"). Contractor agrees to not use or disclose PHI, including E-PHI other than as permitted or required by the Agreement or as Required by Law.

2. Contractor agrees to implement appropriate administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Protected Health Information as such safeguards are set forth in the Security Rule, and to prevent use or disclose of the Protected Health Information other than as provided for by this Agreement.

3. Contractor agrees to mitigate, to the extent practicable, any harmful effect that is known to Contractor of a use or disclosure of Protected Health Information by Contractor in violation of the requirements of this Section.

4. Contractor agrees to report to the Department any use or disclosure of the Protected Health Information not provided for by this Contract of which it becomes aware, including that Contractor shall promptly report to Covered Entity any security incident of which it becomes aware, and at the request of Covered Entity shall identify: the date of the security incident, the scope of the security incident, the Contractor's response to the Security incident, and the identification of the party responsible for causing the security incident, if known.

5. Contractor agrees to ensure that any agent of Contractor including a subcontractor, to whom

Contractor provides Protected Health Information that Contractor received from, or created or received by Contractor on behalf of the Department agrees to the same restrictions and conditions that apply through this Section to Contractor with respect to such information.

6. Contractor agrees to provide access, at the request of the Department and in the time and manner specified by the Department, to Protected Health Information in a Designated Record Set, to the Department or, as directed by the Department, to an Individual in order to meet the requirements under 45 CFR §164.524 and Section 13405(e) of the HITECH Act.

7. Contractor agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Department directs or agrees to pursuant to 45 CFR §164.526 at the request of the Department or an Individual, and in the time and manner prescribed by the Department.

8. Contractor agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Contractor on behalf of, the Department available to the Department, or to the Secretary of the Federal Department of Health and Human Services, in a time and manner prescribed by the Department or designated by the Secretary, for purposes of the Secretary determining the Department's compliance with the Privacy Rule, the Security Rule and the HITECH Act.

9. Contractor agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for the Department to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR §164.528 and Section 13405(c) of the HITECH Act.

10. Contractor agrees to provide to the Department or an Individual, in time and manner prescribed by the Department information collected in accordance with subsection 9 above, to permit the Department to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR §164.528.

Contractor agrees to document such disclosures of PHI and collect information related to such disclosures as would be required for Department to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR §164.528 and Section 13405(c) of the HITECH Act. Effective for disclosures made on or after January 1, 2014, and notwithstanding 45 CFR §164.528(a)(1)(i), Contractor agrees to document disclosures of PHI made through an electronic health record to carry out treatment, payment or health care operations as provided by 45 CFR §164.506 in the three years prior to the date on which the accounting is requested, and to collect information related to such disclosures as required by the Secretary in regulation pursuant to Section 13405(c)(2) or the HITECH Act.

11. Contractor agrees to provide to Department or an Individual, within twenty days of Department's request, information collected in accordance with this paragraph, to permit Department to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR §164.528 and the HITECH Act.

12. Contractor agrees to comply with Section 13402 of the HITECH Act and the regulations implementing such provisions, currently Subpart D of Part 164 of Title 45 of the Code of Federal Regulations, or such regulations as may be in effect from time to time. Pursuant to such requirements, Contractor agrees to implement response programs that specify actions to be taken when Contractor detects or becomes aware of unauthorized access to information systems.

    i. Contractor agrees to notify Department, by facsimile or telephone, of any breach or suspected breach of its security related to areas, locations, or computer system which contain unsecured PHI, including, without limitation, any instance of theft, unauthorized access by fraud, deception, or other malfeasance or inadvertent access (an "incident") in accordance to 45 CFR §164.410 as promptly as possible, upon having reason to suspect that an Incident may have occurred or determining the scope of any such incident, but in no event later than two (2) calendar days upon having reason to suspect that an incident may have occurred.

ii. In the event of any such incident, Contractor shall further provide to Department, in writing, such details concerning the incident as Department may request, and shall cooperate with Department, its regulators and law enforcement to assist in regaining possession of such unsecured PHI and prevent its further unauthorized use, and taken any unnecessary remedial actions as may be required by Contractor to prevent other or further incidents.

iii. If Department determines that it may need to notify any individual(s) as a result of such incident that is attributable to Contractor's breach of its obligations under this Agreement, contractor shall bear all reasonable direct and indirect costs associated with such determination including, without limitation, the costs associated with providing notification to the affected individuals, providing fraud monitoring or other services to affected Individuals and any forensic analysis required to determine the scope of the incident.

iv. Contractor agrees to update the notice provided to Department under this Agreement of such incident to include, to the extent possible and as soon as possible working in cooperation with Department, the identification of each individual whose unsecured PHI has been, or is reasonably believed by Contractor to have been accessed, acquired, used or disclosed during the incident and nay of the following information Department is required to include in its notice to the individual pursuant to 45 CFR §164.404(c):

1. A brief description of what happened, including the date of the Incident and the date the discovery of the incident, if known.

2. A description of the types of unsecured PHI that were involved in the Incident (e.g., Social Security Number, full name, date of birth, address, diagnosis).

3. Any steps the Individual should take to protect themselves from potential harm resulting from the Incident.

4. A brief description of what is being done to investigate the Incident, mitigate the harm and protect against future incidents.

5. Contact procedures for Individuals to ask questions or learn additional information which shall include a toll-free number, an e-mail address, Web site, or postal address.

6. Such additional information must be submitted to Department immediately at the time the information becomes available to Contractor.

13. Effective February 17, 2010, Contractor may use and disclose PHI that is created or received by Contractor from or on behalf of Department only if such use or disclosure, respectively, complies with each applicable requirement of 45 CFR §164.504(e) and the HITECH Act. The additional requirements of Subtitle D of the HITECH Act that relate to privacy and that apply to covered entities also will apply to Contractor and are incorporated into this Agreement by reference.

14. Effective February 17, 2010, Contractor must comply with an Individual's request under 45 CFR §164.522(a)(1)(i)(A) that Contractor restrict the disclosure of PHI of the Individual.

C. Permitted Uses and Disclosures by Contractor

Except as otherwise limited in this Section, Contractor may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, the Department as specified in Section 2, provided that such use or disclosure would not violate the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as codified at 42 USC §1320d-d8, and its implementing regulations at 45 CFR Parts 160, 162 and 164 (the "HIPAA Regulations"); and the Health Information Technology for Economic and Clinical Health Act, enacted as part of the American Recovery and Reinvestment Act of 2009, and its attendant regulations and guidance (the "HITECH Act") if done by the Department or the minimum necessary policies and procedures of the Department.

D. Obligations of the Department

1. The Department shall notify Contractor of any

limitation(s) in its notice of privacy practices of the Department in accordance with 45 CFR §164.520, to the extent that such limitation may affect Contractor's use or disclosure of Protected Health Information. A copy of the Department's Notice of privacy practice is attached to this contract and incorporated herein.

2. The Department shall notify Contractor of any changes in, or revocation of, permission by an individual to use or disclose Protected Health Information, to the extent that such changes may affect Contractor's use or disclosure of Protected Health Information.

3. The Department shall notify Contractor of any restriction to the use or disclosure of Protected Health Information that the Department has agreed to in accordance with 45 CFR §164.522, to the extent that such restriction may affect Contractor's use or disclosure of Protected Health Information.

E. Permissible Requests by the Department

The Department shall not request Contractor to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by the Department

F. Term and Termination

1. Term. The Term of this Section shall be effective as of the effective date of the Contract, and shall terminate when all of the Protected Health Information provided by the Department to Contractor, or created or received by Contractor on behalf of the Department, is destroyed or returned to the Department, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this subsection.

2. Termination for Cause. Upon the Department's knowledge of a material breach by Contractor, the Department shall, at its sole discretion, either:

i. Provide an opportunity for Contractor to:

- cure the breach; or
- end the violation and terminate this Contract if Contractor does not cure the

breach; or

- end the violation within the time specified by the Department; or

ii. Or, immediately terminate this Contract if Contractor has breached a material term of this Section and cure is not possible; or

iii. Or, if neither termination nor cure are feasible, the Department shall report the violation to the Secretary.

3. Effective February 17, 2010 and upon Contractor's knowledge of a material breach by Department, contractor shall either:

i. Notify Department of such breach in reasonable detail, and provide an opportunity for Department to cure the breach or violation; or if cure is not possible, Contractor may immediately terminate this Agreement; or

ii. If neither termination nor cure is feasible, Contractor shall report the violation to the Secretary.

Department may terminate this Agreement upon thirty (30) days written notice in the event (i) Contractor does not promptly enter into negotiations to amend this Agreement when requested by Department pursuant to Section 12(B) of this Agreement, or (ii) Contractor does not enter into an amendment to this Agreement providing assurances regarding the safeguarding of PHI that department, in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA, the HIPAA Regulations and/or the HITECH Act.

4. Effect of Termination.

i. Except as provided in paragraph (ii) of this subsection, upon termination of this contract, for any reason, Contractor shall at the Department's sole discretion return or destroy all Protected Health Information received from the Department, or created or received by Contractor on behalf of the Department. This provision shall apply to Protected Health Information that is in the possession of

subcontractors or agents of Contractor. Contractor shall retain no copies of the Protected Health Information.

ii. In the event that Contractor determines that returning or destroying the Protected Health Information is infeasible, Contractor shall provide to the Department notification of the conditions that make return or destruction infeasible. Upon written agreement by the Department that return or destruction of Protected Health Information is infeasible, Contractor shall extend the protections of this Section to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Contractor maintains such Protected Health Information.

G. Miscellaneous

1. Regulatory References. A reference in this Section to a section in the Privacy Rule *or Security Rule* means the section as in effect or as amended.

2. Amendment. The Parties agree to take such action as is necessary to amend this Section from time to time as is necessary for the Department to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as codified at 42 USC §1320d-d8, and its implementing regulations at 45 CFR Parts 160, 162 and 164 (the "HIPAA Regulations"); and the Health Information Technology for Economic and Clinical Health Act, enacted as part of the American Recovery and Reinvestment Act of 2009, and its attendant regulations and guidance (the "HITECH Act").

3. Survival. The respective rights and obligations of Contractor under Section 23 of this Contract shall survive the termination of this Section.

4. Interpretation. Any ambiguity in this Section shall be resolved to permit the Department to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as codified at 42 USC §1320d-d8, and its implementing regulations at 45 CFR Parts 160, 162 and 164 (the "HIPAA Regulations"); and the Health Information Technology for Economic and

Clinical Health Act, enacted as part of the American Recovery and Reinvestment Act of 2009, and its attendant regulations and guidance (the "HITECH Act").

SECTION 18. DEPARTMENTAL GUIDANCE

The Contractor may request from the Department guidance in administrative and programmatic matters that are necessary to Contractor's performance. The Department may provide such guidance as it determines is appropriate. Guidance may include providing copies of regulations, statutes, standards and policies that are to be complied with under this contract. The Department may supply essential interpretations of such materials and this contract to assist with contract compliance by the Contractor. The Contractor is not relieved by a request for guidance of any obligation to meet the requirements of this contract. Legal services will not be provided by the Department to the Contractor in any matters relating to this contract.

SECTION 19. PROPERTY

A. For purposes of this provision the following definitions based on the pertinent federal regulations apply:

"Equipment" means tangible nonexpendable personal property, including exempt property, charged directly to the contract having a useful life of more than one year and an acquisition cost of $5,000 or more per unit unless lower limits are otherwise established.

"Intangible property" means, but is not limited to, trademarks, copyrights, patents, and patent applications and such property as loans, notes and other instruments of property ownership, whether considered tangible or intangible.

"Personal property" means property of any kind of property except real property. It may be tangible, having physical existence, such as equipment and supplies, or intangible, having no physical existence, such as data, copyrights, patents, or securities.

"Property" means, unless otherwise stated, real property, equipment, and intangible property.

"Real property" means land, including land improvements, structures, and appurtenances thereto, but excludes movable machinery and equipment.

B. Property to be used for the purposes of carrying out the duties and responsibilities provided for in this contract may be purchased with funds from this contract only if authorized by the Department through the terms of this contract.

C. Property purchased with federal funding must be purchased, managed, and disposed of in accordance with the pertinent provisions at 74 CFR §§ 74.32, 74.34, 74.35, 74.36, and 74.37 and 92 CFR §§ 92.31, 92.32,92.33 and 92.34.

D. At such time as the Contractor no longer contracts to deliver services to the Department or as directed by the Department during the term of the contract, the Contractor agrees to deliver, as may be required by law or as may be directed by the Department, title to and possession of any property purchased with contractual monies to the Department or to any entity designated by the Department.

E. All patent and other legal rights in and to inventions arising out of activities assisted by funds from this contract must be available, in accordance with 37 CFR Part 401 and any other applicable legal authority, to the public for royalty-free and nonexclusive licensing. The Contractor must notify the Department promptly in writing of any invention conceived or actually reduced to practice in the course of performance of this contract.

F. The Department and any federal agency from which funds for this contract are derived have, in accordance with 45 CFR §74.36 and 45 CFR §92.34, a royalty-free, nonexclusive, and irrevocable right to reproduce, publish or otherwise use and authorize others to use for Department and agency purposes any written, audio or video material developed under this contract.

SECTION 20. ACCESS TO PREMISES

The Contractor must provide the State of Montana and any other legally authorized governmental entity, or their authorized representatives, the right to enter at all reasonable times the Contractor's premises or other places where contractual performance occurs to inspect, monitor or otherwise evaluate contractual performance. The Contractor must provide reasonable facilities and assistance for the safety and convenience of the persons performing those duties. All inspection, monitoring and evaluation must be performed in such a manner as not to unduly interfere with contractual performance.

SECTION 21. CONTRACT TERMINATION

A. The Department may immediately terminate the whole or any part of this contract for failure to perform the contract in accordance with the terms of the contract and other governing authorities.

1. If there is no exigency or risk of harm to persons from continued performance, the Department, in its discretion, may impose penalties and/or provide notice to the Contractor of the failure to perform and allow the Contractor 30 days during which to cure the failure.

2. Failure to perform includes, but is not limited to, failure to:

   a. perform the services within the time limits specified in this contract;

   b. perform any of the requirements of this contract;

   c. perform its contractual duties or responsibilities in accordance with the terms of the contract or any other authority, including statute, rules, or policy that govern the standards for performance; or

   d. comply with any law, regulation or licensure and certification requirement.

B. The Department may terminate the whole or any part of this contract when federal or state funding for this contract becomes unavailable for any reason. The Department must give notice to the Contractor at least thirty (30) days prior to the effective date of termination.

C. Notice of termination must be given in writing.

D. Notice of termination given to the Department by the Contractor may only be revoked with the consent of the Department.

E. Upon contract termination or nonrenewal of this contract, the Contractor must allow the Department, its agents and representatives full access to the Contractor's facilities and records to arrange the orderly transfer of the contracted activities.

SECTION 22. LIAISON AND SERVICE OF NOTICES

A. Mary Noel, telephone 406-444-4146, fax 406-444-1861, manoel@mt.gov is the liaison for the Department. Tom Steiner, telephone 612-642-8884, fax 612-642-8686, tom.steiner@mercer.com is the liaison for the Contractor. These persons serve as the primary contacts between the parties regarding the performance of this contract.

B. Written notices, reports and other information required to be exchanged between the parties must be directed to the liaison at the parties' addresses set out in this contract.

SECTION 23. CHOICE OF LAW, REMEDIES AND VENUE

A. This contract is governed by the laws of the State of Montana.

B. Any remedies provided by this contract are not exclusive and are in addition to any other remedies provided by law.

C. In the event of litigation concerning this contract, venue must be in the First Judicial District in and for the County of Lewis and Clark, State of Montana.

D. In the event of a contractual dispute, the Contractor agrees to continue performance under this contract unless the Department explicitly waives performance in writing.

SECTION 24. SCOPE, AMENDMENT AND INTERPRETATION OF CONTRACT

A. This contract consists of 28 numbered pages and these attachments:

Attachment A: Assurances SF 424B
Attachment B: Certification of Compliance
Attachment C: Lobbying Activities SF LLL
Attachment D: DPHHS HIPAA Privacy Policy

This is the entire contract between the parties.

B. No statements, promises, or inducements made by either party or their agents are valid or binding if not contained herein.

C. The headings to the sections of this contract are for convenience of reference and do not modify, the terms and language of the provisions to which they are headings.

D. No contractual provisions from a prior contract of the parties are valid or binding in this contractual agreement.

E. This contract, except as may be otherwise provided by the terms of this contract, may not be enlarged, modified or altered except by written amendment signed by the parties to this contract.

F. In the event of a dispute as to the duties and responsibilities of the parties under this contract, the contract along with any attachments prepared by the Department, inclusive of request for proposal, if any, govern over the Contractor's proposal if any.

G. If any provision of this contract is determined by a court of law to be invalid legally, all other provisions of this contract remain in effect and are valid and binding on the parties.

H. If any provision of this contract, per se or as applied, is determined by the Department to be in conflict with any federal or state law or regulation then the provision is inoperative to the extent that the Department determines it is in conflict with that authority and the provision is to be considered modified to the extent the Department determines necessary to conform with that authority.

I. Waiver of any default, breach or failure to perform under this contract is not deemed to be a waiver of any subsequent default, breach or failure of performance. In addition, waiver of any default, breach or failure to perform is not construed to be a modification of the terms of this contract unless reduced to writing as an amendment to this contract.

The parties through their authorized agents have executed this contract on the dates set out below.

MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

By: _____ Date 1/5/11

Terry Krantz, Administrator
Health Resources Division

PO Box 202951
Helena MT 59620-2951
406-444-4540

MERCER HEALTH & BENEFITS LLC

By: _____ Date: December 2, 2010

Thomas J. Steiner, Partner

333 South 7th Street, Suite 1600
Minneapolis MN 55402-2427
612-642-8884

Federal ID #34-2015463

OMB Approval No. 0348-0040

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions reducing this burden, to the Office of Management and Budget, Paperwork Reduction project (0348-0040), Washington, DC 20503.

PLEASE D NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurance. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§ 4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM=s Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include, but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§ 1681-1683 and 1685-1686), which prohibit discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§ 6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§ 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. 290 dd-3 and 290 ee-3) as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. § 2601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (I) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-66), which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§ 1501-1508 and 7324-7328) which limit the

political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§ 276a to 276a-7), the Copeland Act (40 U.S.C. § 276c and 18 U.S.C. §§ 874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§ 327-333, regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard are to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approval State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§ 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955k, as amended (42 U.S.C. § 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§ 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. 470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. 2131 et seq.) pertaining to the care, handling and treatment of warm blooded animals held for research, teaching or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§ 4801 et seq.) Which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
Thomas J Sloan	Partner
APPLICANT ORGANIZATION	DATE SUBMITTED
Mercer Health & Benefits LLC	December 2, 2010

CERTIFICATION OF COMPLIANCE WITH CERTAIN REQUIREMENTS FOR DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES CONTRACTORS

The Contractor, **Mercer Health & Benefits LLC**, for the purpose of contracting with the Montana Department of Public Health & Human Services, certifies to the Department its compliance, as may be applicable to it, with the following:

A. That the Contractor does not act in collusion with other contractors for the purpose of gaining unfair advantages for it or other contractors or for the purpose of providing the services at a noncompetitive price or otherwise in a noncompetitive manner.

B. That the Contractor is an independent contractor; that it maintains necessary and appropriate workers compensation and unemployment insurance coverage; that it is solely responsible for and must meet all labor and tax law requirements pertaining to its employment and contracting activities, inclusive of insurance premiums, tax deductions, tax withholding, overtime wages and other employment obligations that may be legally required with respect to it.

C. That the Contractor, any employee of the Contractor, or any significant subcontractor in the performance of the duties and responsibilities of the proposed contract, are not currently suspended, debarred, or otherwise prohibited from entering into a federally funded contract or participating in the performance of a federally funded contract.

D. That the Contractor is in compliance with all of the privacy, electronic transmission, coding and other requirements of the Health Insurance Portability And Accountability Act of 1996 and its implementing rules as may be applicable to the Contractor.

E. That the Contractor, if receiving federal monies, does not expend federal monies in violation of federal legal authorities prohibiting expenditure of federal funds on lobbying federal and state legislative bodies or for any effort to persuade the public to support or oppose legislation.

F. That the Contractor, if receiving federal monies, prohibits smoking at any site of federally funded activities that serves youth under the age of 18. This is not applicable to sites funded with Medicaid monies only or to sites used for inpatient drug or alcohol treatment.

G. That the Contractor, if receiving federal monies, maintains drug free environments at its work sites, providing required notices, undertaking affirmative reporting, et al., as required by federal legal authorities.

H. That the Contractor manages any real, personal, or intangible property purchased or developed with federal monies in accordance with federal legal authorities.

I. That the Contractor, if receiving federal monies, is not delinquent in the repayment of any debt owed to a federal entity.

J. That the Contractor, if expending federal monies for construction purposes or otherwise for property development, complies with federal legal authorities relating to flood insurance, historic properties, relocation assistance for displaced persons, elimination of architectural barriers, metric conversion, and environmental impacts.

K. That the Contractor, if expending federal monies for research purposes, complies with federal legal authorities relating to use of human subjects, animal welfare, biosafety, misconduct in science and metric conversion.

L. That the Contractor, if receiving $100,000 or more in federal monies, complies with all applicable standards and policies relating to energy efficiency which are contained in the state energy plan issued in compliance with the federal Energy Policy and Conservation Act.

The Contractor is obligated during the duration of the contractual relationship to abide by those requirements pertinent to it in accordance with the governing legal authorities.

Not all of these assurances may be pertinent to the Contractor=s circumstances. This certification form, however, is standardized for general use and signing it is intended to encompass only provisions applicable to the circumstances of the Contractor in relation to the federal and state monies that are being received.

These assurances are in addition to those stated in the federal OMB 424B (Rev. 7-97) form, known as **"ASSURANCES - NON-CONSTRUCTION PROGRAMS"**, issued by the federal Office of Management of the Budget (OMB). Standard Form 424B is an assurances form that must be signed by the Contractor if the Contractor is to be in receipt of federal monies.

There may be program specific assurances, not appearing either in this form or in the OMB Standard Form 424B, that the Contractor may have to provide by certification.

This form, along with OMB Standard Form 424B, are to be provided with original signature to the Department=s contract liaison. The completed forms are maintained by the Department in the pertinent purchase and contract files.

Further explanation of several of the requirements certified through this form may be found in the Department=s standard Request For Proposal (RFP) format document, standard contracting requirements document, and set of standard contract provisions. In addition, detailed explanations of federal requirements may be obtained through the Internet at sites for the federal departments and programs and for Office for Management of the Budget (OMB) and the General Services Administration (GSA).

NAME OF CONTRACTOR: **Mercer Health & Benefits LLC**

By: Thomas J Steiner — 12/2/2010 (Date)

Thomas J. Steiner (Typed/Printed Name) as Partner (Title)

333 South 7th Street, Suite 1600
Address

Minneapolis, MN 55402-2427
City, State Zip

612 642 8884
Phone Number

34-2015463
Federal I.D. Number

DISCLOSURE OF LOBBYING ACTIVITIES

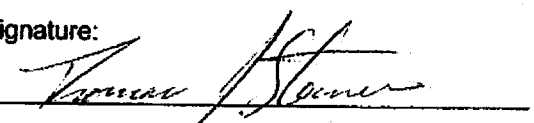
Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

Approved by OMB
0348-0046

1. **Type of Federal Action:** Γ a. contract Γ b. grant Γ c. cooperative agreement Γ d. loan Γ e. loan guarantee Γ f. loan insurance	2. **Status of Federal Action:** Γ a. bid/offer/application Γ b. initial award Γ c. post-award	3. **Report Type:** Γ a. initial filing Γ b. material change **For Material Change Only:** Year _____ quarter _____ Date of last report _____

4. **Name and Address of Reporting Entity:** Γ Prime Γ Subawardee Tier _____, if known **Congressional District, if known:**	5. **If Reporting Entity in No. 4 is a Subawardee, Enter Name and Address of Prime:** **Congressional District, if known:**
6. **Federal Department/Agency:**	7. **Federal Program Name/Description:** CFDA Number, if applicable: _____
8. **Federal Action Number, if known:**	9. **Award Amount, if known:** $ _____
10. a. **Name and Address of Lobbying Registrant** (If individual, last name, first name, MI):	b. **Individuals Performing Services** (including address if different from No. 10a) (last name, first name, MI):

11. Information requested through this form is authorized by Title 31 U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Signature: 

Print Name: Thomas J. Steiner

Title: Partner

Telephone No.: 612 642 8884

Date: December 2, 2010

Federal Use Only:

Authorized for Local Reproduction
Standard Form LLL (Rev. 7-97)

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawarded or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to Title 31 U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include, but are not limited to, subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in Item 4 checks ASubawardee≅, then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award of loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number, the contract, grant or loan award number; the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., ARFP-DE-90-001".

9. For a covered Federal action, where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying registrant under the Lobbying Disclosure Act of 1995 engaged by the reporting entity identified in Item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services and include full address if different from 10(a). Enter Last Name, First Name and Middle Initial (MI).

11. The certifying official shall sign and date the form, print his/her name, title and telephone number.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No. 0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.

SOURCES OF INFORMATION ON THE PRIVACY, TRANSACTIONS AND SECURITY REQUIREMENTS PERTAINING TO HEALTH CARE INFORMATION OF THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The following are sources of information concerning the applicability of and implementation of the privacy, transactions and security requirements of HIPAA. The Department of Public Health & Human Services requires that Contractors generating, maintaining, and using health care information in relation to recipients of State administered and funded services be compliant with the requirements of HIPAA.

There can be difficulty in interpreting the applicability of HIPAA to an entity. It is advisable to retain knowledgeable consultants or attorneys to advise concerning determinations of applicability.

Websites specified here may be changed without notice by those parties maintaining them.

FEDERAL RESOURCES:

The following are official federal resources in relation to HIPAA requirements. These are public sites.

1. U.S. Department Of Health & Human Services / Centers For Medicare & Medicaid Services

   www.cms.gov/hipaa

   The federal Department of Health & Human Services/Centers For Medicare & Medicaid Services (CMS) provides information pertaining to transactions, security and privacy requirements under HIPAA, including the adopted regulations and various official interpretative materials. CMS is responsible for the implementation nationally of the transactions and security aspects of HIPAA.

2. U.S. Department of Health & Human Services/Office Of Civil Rights

   www.hhs.gov/ocr/hipaa

   The federal Department of Health & Human Services/Office Of Civil Rights (OCR) provides information pertaining to privacy requirements under HIPAA, including the adopted regulations and various official interpretative materials. This site includes an inquiry service. OCR is responsible for the implementation of the privacy aspects of HIPAA and serves as both the official interpreter for and enforcer of the privacy requirements.

3. U.S. Department of Health & Human Services/Centers For Disease Control & Prevention

www.cdc.gov/privacyrule

The federal Department of Health & Human Services/Centers For Disease Control & Prevention (CDC) provides information pertaining to the application of privacy requirements under HIPAA to public health activities and programs.

OTHER NATIONAL PUBLIC RESOURCES:

WEDI/SNIP

www.wedi.org/snip

The Workgroup For Electronic Data Interchange is a collaborative national effort, inclusive of the federal entities, that has undertaken a broad effort at the implementation of HIPAA, in particular the electronic transactions and security aspects, known as the Strategic National Implementation Process. There are several regional and state based WEDI/SNIP efforts. There is not one, however, that covers Montana.

STATE RESOURCES:

1 Montana Collaborative Website

www.hipaamontana.com

This site is a collaborative website of several entities, including the Department of Public Health & Human Services, that provides information to the public on HIPAA as it relates to entities in Montana. The Department=s policies and forms, pertaining to implementation of HIPAA, appear at this site. This site also provides an analysis as to the interplay of HIPAA with Montana laws on confidentiality.

2. Department Website For Medicaid Providers

www.mtmedicaid.org

This site provides information for providers of services funded with medicaid monies. HIPAA requirements in relation to medicaid state plan services are described at this site.

PROVIDER ASSOCIATIONS:

Many national and state provider associations have developed extensive resources for their memberships concerning HIPAA requirements. Those are important resources in making determinations as to the applicability and implementation of HIPAA.

CONSULTANT RESOURCES:

There are innumerable consulting resources available nationally. The Department does not make recommendations or referrals as to such resources. It is advisable to pursue references before retaining any consulting resource. Some consulting resources have proven to be inappropriate for certain types of entities and circumstances and some may lack the necessary knowledge concerning the applicability and implementation of HIPAA.

Bell, Amber

From: Noel, Mary
Sent: Thursday, January 06, 2011 9:48 AM
To: Bell, Amber
Subject: FW: Professional liability coverage for Mercer
Attachments: State of Montana COI E&O.pdf

Amber, Would you please confirm this meets our requirements? Thanks—Mary

From: Steiner, Thomas [mailto:Tom.Steiner@mercer.com]
Sent: Thursday, January 06, 2011 9:44 AM
To: Noel, Mary
Subject: Fw: Professional liability coverage for Mercer

Tom Steiner
Mercer Government Human Services Consulting
333 South 7th Street, Suite 1600
Minneapolis, MN 55402-2427

Phone: +1 612 642 8884
Mailto: tom.steiner@mercer.com
www.mercerHR.com

From: Mary and Tom Steiner <steinermt@msn.com>
To: Steiner, Thomas
Sent: Thu Jan 06 11:41:21 2011
Subject: Professional liability coverage for Mercer

Mary,

Here is the Mercer professional liability coverage. Can you confirm this meets the contract specifications?

Tom
From: Berlanga, Mayra S
To: Steiner, Thomas
Cc: Goens, Terri; Hughes, Joel
Sent: Thu Jan 06 11:29:17 2011
Subject: RE: U-ZPRO-195-A.pdf - Adobe Acrobat Standard

Tom,

I'm attaching a Certificate of Insurance issued to the State of Montana evidencing Professional Liability insurance in effect for Mercer Health & Benefits LLC for a limit of $2M per claim and aggregate. Please note that the insurer is Steadfast Insurance Company (a division of Zurich) which has an AM Best rating of A+ XV.

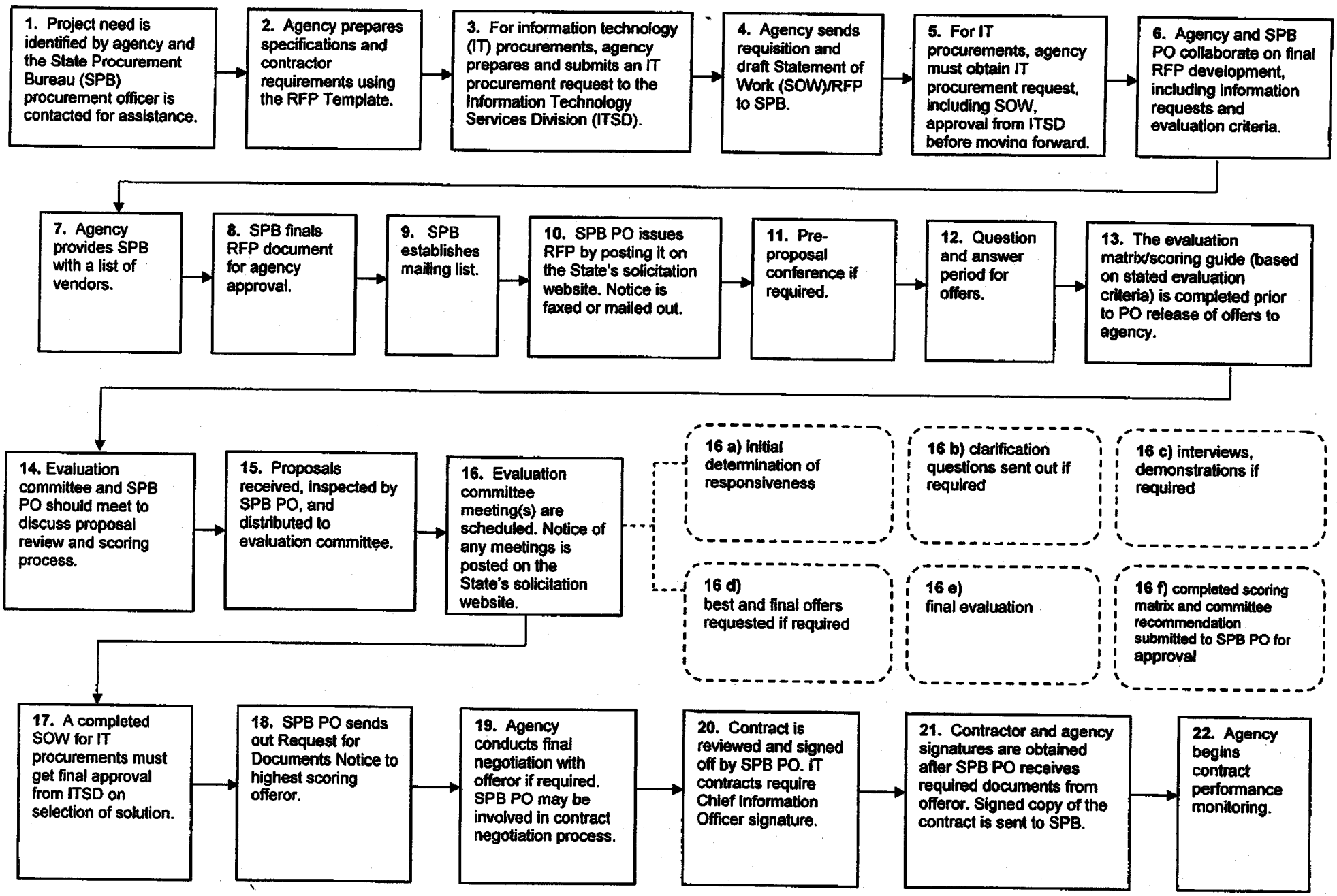
Please let us know if you have any questions or need anything else.

Kind regards,

Mayra

<<State of Montana COI E&O.pdf>>

THE REQUEST FOR PROPOSAL PROCESS



ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 01/05/2011

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER MARSH USA INC. 111 S.W. COLUMBIA FIFTH FLOOR PORTLAND, OR 97201 014026-MerHB-E&O-2011	CONTACT NAME: PHONE (A/C, No, Ext): FAX (A/C, No): E-MAIL ADDRESS: PRODUCER CUSTOMER ID #:
INSURED Mercer Health & Benefits LLC 333 South 7th Street, Suite 1600 Minneapolis, MN 55402-242	INSURER(S) AFFORDING COVERAGE — NAIC # INSURER A : Steadfast Insurance Company — 26387 INSURER B : INSURER C : INSURER D : INSURER E : INSURER F :

COVERAGES **CERTIFICATE NUMBER:** NYC-005178958-01 **REVISION NUMBER: 9**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
	☐ CLAIMS-MADE ☐ OCCUR						MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
							GENERAL AGGREGATE	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						PRODUCTS - COMP/OP AGG	$
	☐ POLICY ☐ PRO-JECT ☐ LOC							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ ALL OWNED AUTOS						BODILY INJURY (Per accident)	$
	☐ SCHEDULED AUTOS						PROPERTY DAMAGE (Per accident)	$
	☐ HIRED AUTOS							$
	☐ NON-OWNED AUTOS							$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DEDUCTIBLE							$
	☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N						☐ WC STATU-TORY LIMITS ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [N] N/A (Mandatory in NH)						E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Professional Liability			EOC 6725020-00	09/01/2010	09/01/2011	Per Claim and Aggregate	2,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)
Re: Contract Number 11-11-1-04-001-0.
SIR: $10,000 Each Claim.

CERTIFICATE HOLDER

Montana Department of Public Health
and Human Services
P.O. Box 202951
Helena, MT 59620-2951

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.

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