INVITATION TO BID
TERMS AND CONDITIONS

SECTION 1. INTRODUCTION

1.0 ANNOUNCEMENT

The State of Oklahoma (State), by and through its designated Medicaid agency, the Oklahoma Health Care Authority (OHCA), is issuing this Invitation to Bid (ITB) for the procurement of services for the purpose of providing methods and procedures to safeguard against unnecessary utilization of care and services and to assure "efficiency, economy and quality of care as required by law pursuant to section 1902 (a)(30)(A) thru (C) of the Social Security Act (Act) and 42 U.S.C. §1320c et seq.

A State may contract with a Quality Improvement Organization (QIO) to perform medical and utilization review functions required by law, which meet the requirements of Section 1152 of the Social Security Act. Services required are as outlined under this ITB.

1.1 POINTS OF CONTACT

1.1.1 INQUIRIES

This ITB is issued by the Oklahoma Department of Central Services, Purchasing Division (DCS); and DCS is the sole point of contact from the date of release of this ITB, until the selection of the successful Bidder has been determined. DCS may be contacted at the following address:

Department of Central Services
Central Purchasing Division
2401 N. Lincoln Blvd., Suite 116
P.O. BOX 528803
Oklahoma City, Oklahoma 73152-8803
Contact: Irene Bowman
Office: (405) 521-4058
Fax: (405) 522-1077

1.1.2 AGENCY POINT OF CONTACT

The OHCA point of contact after the bid has been awarded is as follows:

Oklahoma Health Care Authority
Attn: Contracts Development
4545 North Lincoln Boulevard, Suite 124
Oklahoma City, Oklahoma 73105-3400
405-522-7431

1.2 ITB CLOSING DATE

Bids submitted in response to this ITB must be received by the State of Oklahoma, Department of Central Services (DCS), Attention: Irene Bowman, Central Purchasing Division, 2401 N. Lincoln Boulevard, Suite 116, Oklahoma City, Oklahoma 73152-8803, no later than the closing date and time referenced on the ITB instruction form. Bids delivered or received after the closing date and time will not be accepted.

1.3 ANTICIPATED CONTRACT TERM AND RENEWAL OPTIONS

a. The term of this Contract shall begin on the date of award through June 30, 2006; with five one (1) year options to renew. It is understood by the parties that, under State law, a commitment of funds shall not exceed a period of twelve (12) months. The parties shall have the option to renew the Contract, or any portion thereof, for five (5) additional one (1) year periods beginning July 1, 2006.

b. It is understood and agreed by the parties hereto that all obligations of OHCA, including the continuance of payments are contingent upon the availability and continued appropriation of State and Federal funds, and in no event shall OHCA be liable for any payments in excess of such available appropriated funds. The parties shall have the option to terminate this Contract at any time during the contract term pursuant to Section 5.10 of this ITB.

1.4 COST OF PREPARING BID

a. All costs incurred by the Bidder for costs associated for bid preparation and participation in the competitive procurement process will be the sole responsibility of the Bidder. The State will not reimburse any Bidder for any such costs.

b. The State reserves the right to withdraw the ITB at any time during the procurement process. Issuance of this ITB in no way obligates the State to award or issue a contract or to pay any costs incurred by any bidder as a result of such a withdrawal.

1.5 RETENTION OF BIDS

All bids submitted in response to this ITB become the property of the State, and will not be returned. All material submitted by the bidder becomes the irrevocable and sole property of the State of Oklahoma. Proprietary information must be documented as such within the contents of the submitted bid. All bids submitted and all information contained therein, unless otherwise specified as proprietary, shall be subject to the Oklahoma Open Records Act, 51 Okla. Stat. §24A.1 et seq. (1991).

1.6 MINIMUM QUALIFICATION REQUIREMENTS:

Bidder must meet the following minimum qualifications:

a) Organization bidding on this Contract must meet all requirements in 1152 of the Social Security Act and Title 42 C.F.R. Part 475 et seq.; and must continue to meet all applicable requirements the life cycle of this contract.
b) Page limit requirements as specified in Section 9.0 (B.) of this ITB.
c) Response in correct format as specified in Section 9.2
d) All applicable affidavits must be included in the bid response.

1.7 EVALUATION

The State of Oklahoma will conduct a comprehensive and fair evaluation of Bids received in response to this ITB. Bids will be evaluated based upon Best Value Criteria, and final approval issued by the Department of Central Services, Central Purchasing Director.

1.8 CONTRACT ADMINISTRATION

The OHCA shall designate a Program Manager (PM) to coordinate activities, resolve questions, monitor Contractor's performance and function as the Contractor's primary liaison in working with other OHCA staff. The PM will receive and review all progress reports and deliverables, schedule of monitoring and other meetings, and maintain first-line administrative responsibility for the Contract. The PM shall monitor, document and evaluate the work performance of the Contractor and authorize the payment for services rendered.

1.9 BIDDERS' LIBRARY (REFERENCE INFORMATION)

The OHCA has provided a bidders' library available on the OHCA website to assist bidders in accessing current and past program information related to this ITB. The library is available at http://www.okhca.org/about/bids/bids.asp, and with additional information at http://www.okhca.org/reports/resources/resources.asp. These sites will provide general information regarding OHCA, Medicaid program and enrollment statistics, and specific examples of work and reports required of the successful contractor. In the event you have difficulty with the first site referenced, please go to the home page (www.okhca.org) and select "about us" and then "procurement", this will direct you to the bidders' library.

SECTION 2. OBJECTIVES

The QIO will perform retrospective chart review, inspection of care, and other quality improvement functions for the Oklahoma Medicaid program, as well as prior authorization of inpatient and outpatient behavioral health services, including substance abuse, case management and psychologist services.

SECTION 3. SCOPE OF WORK

This section describes the scope of work required under the terms of this ITB. The selected Bidder shall perform all of the services listed below and as further explained in the attachments to this ITB. Attachments A through L are made part of this ITB and incorporated by reference.

3.0 Post-payment Utilization Review

Contractor will conduct retrospective review on a random sample of cases to assess the appropriateness of medical services provided to Medicaid recipients. This includes:

- Review of inpatient services for fee-for-service (hereinafter referred to as FFS) recipients as further described in Attachment A.
- Review of outpatient services for FFS recipients as further described in Attachment B.
- Review of outpatient/rehabilitative behavioral health services provided in Community Mental Health Centers as further described in Attachment G.

3.1 Quality Improvement System for Managed Care (QISMC)

Contractor will conduct activities to operationally support OHCA's adoption of the federal government's QISMC. These activities include

- Quality of care reviews for providers in the *SoonerCare* managed care program as further described in Attachment D.
- Monitoring and conducting studies in particular areas of care provided to Medicaid recipients selected by OHCA as further described in Attachment E.

3.2 Client Satisfaction Surveys

Contractor will assist OHCA in conducting surveys of Medicaid recipients in the SoonerCare managed care program. This includes Consumer Assessment of Health Plan Surveys (CAHPS) for adults and Experience of Care and Health Outcomes Surveys (ECHO) as further described in Attachment F.

3.3 Inspections of Care

Contractor will assist OHCA in determining whether services are being provided appropriately in:

- Inpatient acute psychiatric care and/or residential psychiatric treatment facilities caring for Medicaid recipients under the age of 21 as fully described in Attachment H.
- Therapeutic foster care programs serving Medicaid recipients under the age of 21 as further described in Attachment K.

3.4 Prior Authorization of Behavioral Health Services

Contractor will conduct all activities related to the prior authorization of behavioral health services, including

- Outpatient, substance abuse and psychologist services as further described in Attachment I.
- Psychiatric inpatient (acute and residential treatment center) and therapeutic foster care services for Medicaid recipients under the age of 21 as further described in Attachment J.

3.5 Quality Intervention and Education

Contractor will conduct quality interventions and education for providers identified by Contractor or by OHCA as providing or possibly providing substandard care. These activities are further described in Attachment C.

3.6 Quarterly Medicaid Provider Newsletter (Optional)

Contractor will work with OHCA to write, publish and distribute a quarterly provider newsletter as further described in Attachment L. **Note:** Bidders are not required to respond to this portion of the scope of work. Responding or not responding will not influence a bidder's chance of being awarded the contract.

SECTION 4. SYSTEM REQUIREMENTS

4.0 The activities specified in this ITB may be conducted by direct batch downloads following a file transfer protocol (FTP) format (electronically and/or web-based) allowing for the possibility of the Contractor conducting activities from an out of state location. If the Contractor maintains a local office, a T-1 line may run directly to the Oklahoma Medicaid Management Information System (MMIS) for direct real time data entry of prior authorizations. In the event the selected Contractor has and/or establishes a local operation, data transmission of prior authorizations shall be transmitted over a dedicated T1 line between OHCA fiscal agent, Electronic Data Systems (EDS) and the Contractor. Contractor will maintain all systems from the T1 "d-mark" into its LAN line. The T1 line

will be maintained by OHCA. Preference may be given to bidders who have or will establish Oklahoma City locations.

4.1 Whether Contractor maintains its own system and/or works directly in the MMIS, Contractor must always verify recipient and provider eligibility. If Contractor maintains its own system for prior authorizations, Contractor must download data from the MMIS on a daily basis.

4.2 The Contractor shall supply all hardware for staff and supervisors, including desktop computer systems capable of running Microsoft Windows XP and the MMIS program. The contractor is required to maintain computer operating systems within one version of the OHCA's current operating system for the life of the contract. The Contractor is required to maintain a local file server and Local Area Network (LAN) capable of providing software applications to its staff and supervisors.

4.3 The Contractor agrees to make data available by electronic means for OHCA auditing purposes. If Contractor maintains separate databases, Contractor agrees to allow OHCA access to such databases.

4.4 Contractor agrees to provide OHCA staff access to any separate prior authorization databases and visual imaging systems in order for OHCA to conduct Care Coordination activities related to Medicaid recipients and for auditing and compliance reviews. For services described herein, the database must include agreed upon data elements including, but not limited to: Patient Medicaid ID, Patient Name, Provider ID, Provider Name, Provider demographic info, Patient DSM-IV-TR Diagnosis, Client Assessment Record scores, Reviewer Notes, Units of Service requested & authorized, Types of Service requested & authorized, Type of Request, and From-Thru Dates of authorization.

4.5 Additional system requirements can be found in Attachments A through L.

SECTION 5. STAFFING REQUIREMENTS

5.0 Subject Matter Expert (SME)

Contractor shall propose a SME who shall have day to day responsibility for supervising the performance and obligations under this Contract, as well as receive policy direction from the OHCA PM. The SME must have previous experience in a variety of peer review and utilization review activities, preferably for a Medicaid program. In addition, the SME must demonstrate an overall understanding of the technical requirements, professional clinical determinations, customer service, and quality improvement requirements requested in order to successfully fulfill the obligations of this Contract. In the event the proposed SME does not meet the requirements of OHCA, Contractor shall collaborate with the OHCA staff to provide a candidate that is acceptable to both parties. Contractor will not change its SME without prior written approval from OHCA, and such approval shall not be unreasonably delayed or withheld.

5.1 Training

OHCA will provide training to Contractor's supervisory staff in conjunction with the SME. The Contractor is responsible for developing a staff training program and providing ongoing training to staff members. OHCA shall provide additional training throughout the term of this contract as needed. Contractor shall contact the OHCA PM to schedule such requests for additional training.

5.2 Additional requirements
Additional staffing requirements are delineated in Attachments A through L.

SECTION 6. REPORTING REQUIREMENTS

6.0 Contractor shall submit all reports to OHCA electronically and securely following HIPAA guidelines.

6.1 Contractor shall review all reports and written material to ensure delivery of a professional and technically sound product prior to submitting to OHCA.

6.2 Specific report requirements are delineated in Attachments A through L. Within 30 days of award, Contractor will develop and submit to OHCA a "Reports Deliverable Matrix" showing all reports, frequency, and required delivery date. An example of this matrix can be found in the Bidders' Library. Contractor shall update this matrix as necessary based on any changes agreed upon with OHCA.

SECTION 7. CONTRACT TERMS AND CONDITIONS

7.0 CONTRACT COMPOSITION

a. This Contract, as well as the accepted bid, shall become part of any agreement between the parties. The DCS and OHCA are responsible for rendering decisions in matters of interpretation of all terms and conditions.

b. The component parts of the contract between the State and the Bidder selected from the evaluation of responses to this ITB shall consist of:
   1) This ITB;
   2) Any amendments to the ITB;
   3) ITB Questions and Answers, where applicable.
   4) The Contractor's Bid; and,
   5) The Purchase Order;

c. The order of precedence among the contract components shall be the ITB, any amendments to the ITB, questions and answers (if applicable), the Bidder's bid, and the award notice from DCS. A higher order document shall supersede a lower order document to the extent necessary to resolve any inconsistencies between them, but silence on any matter in a higher order document shall not negate or modify the provisions of a lower order document as to that matter.

d. In the event of a conflict in language between the documents referenced above, the provisions and requirements set forth in the ITB shall govern. In the event that an issue is addressed in the bid response that is not addressed in the ITB, no conflict in language shall be deemed to occur. However, the DCS State Purchasing Director reserves the right to clarify, in writing, any contractual relationship with the concurrence of the Bidder, and such written clarification shall govern in case of conflict with the applicable requirements stated in the ITB. In all other matters not affected by the written clarifications, if any, the ITB shall govern.

7.1 AMENDMENTS and/or MODIFICATIONS

a. This Contract contains all of the agreements of the parties and no verbal representations from either party that contradict the terms of this agreement are binding. Any modifications to this Contract must be in writing and signed by both parties, and approved by DCS Central Purchasing.

b. Legislative or other changes may require changes in this scope of work and/or the terms and conditions of the resulting contract. Modifications to the scope of work under this ITB shall be authorized in such cases, upon approval by the DCS State Purchasing Director. At all times the State will adhere to the overall intent of the scope of work. Additions to the program may also be necessary if dictated by State mandates and final approval by DCS State Purchasing Director.

7.2 USE OF SUBCONTRACTORS

The Bidder may use subcontractors if written consent of OHCA and the DCS State Purchasing Director is obtained prior to the effective date of any subcontract. The Bidder shall be responsible for the subcontractor's performance. The Bidder will be responsible for meeting all the terms of the contract resulting from this procurement. The Contractor shall be wholly responsible for performance and payment of all work performed by the subcontractor.

No subcontract or delegation shall relieve or discharge the Contractor from any obligation or liability under the Contract. The subcontractor is subject to the same conditions as the Contractor and subsequent contract modifications. Performance of any work by "contract employees" hired by the Contractor shall be considered the sole responsibility of the Contractor.

In the event any portion of this ITB is subcontracted to a third party vendor; the sub-contractor must submit all the requested documentation, certifications, and respond to all applicable sections of this ITB, in order to be considered and/or approved by OHCA.

7.3 LIABILITY/HOLD HARMLESS

a. The Contractor agrees to hold harmless the OHCA of any claims, demands and liabilities resulting from any act or omission on the part of the Contractors and agents, servants and employees in the performance of this contract. It is the express intention of the parties hereto that this agreement shall not be construed as, or given the effect of, creating a joint venture, partnership or affiliation or association that would otherwise render the parties liable as partners, agents, employer-employee or otherwise create any joint and several liability.

b. Contractor shall be required to submit a performance bond in the amount equal to one-half of the total contract amount. The performance bond must be submitted within forty-five days of award of the contract. Failure to provide a performance bond within the required time shall be cause for termination of the Contract.

c. In the event of termination for default, or voluntary or involuntary bankruptcy on the part of the Contractor, the performance bond shall become payable to the State for any outstanding damage assessments against the Contractor. Up to the full amount of the performance bond may also be applied to the Contractor's liability for any administrative costs or excess costs incurred by OHCA in obtaining similar equipment or services to replace those terminated as a result of the default. OHCA may seek other remedies under law in addition to this stated liability.

d. Contractor shall be required to provide a certificate of liability. The Contractor shall be in compliance with the insurance laws of the State of Oklahoma and the Federal government for the term of the Contract.

e. The insurance must be maintained throughout the contract period with annual documentation of such continued coverage sent to OHCA and DCS Contract Officer by November 1 of each subsequent period. Contractor shall require all subcontractors maintain all applicable insurance as stated herein.

f. The minimum insurance requirements are as follows:
   1. Professional liability coverage in the amount of one million dollars.
   2. Errors and Omissions insurance - may be covered under malpractice insurance,
   3. Comprehensive liability insurance in the amount of one million dollars. Certificate will state the policy number, the Contractor as the insured, the State of Oklahoma as the owner, and the insurance period and dollar amount of each covered category.

g. In the event of cancellation of any insurance coverage, the Contractor shall immediately notify the State of such cancellation. The Contractor shall provide OHCA and DCS Contracts Administrator with a written notice ten (10) calendar days prior to any change in the insurance coverage. Non-compliance with insurance requirements will result in a contract default and immediate termination.

7.4 CONFLICT OF INTEREST

The Bidder certifies that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of services required to be performed under this contract. The Bidder further certifies that, in the performance of this contract, no person having such interest shall be employed. Bids failing to meet this criterion of the ITB will be deemed non-responsive in respect to the total ITB.

7.5 AUDIT AND INSPECTION

a. The Contractor shall maintain adequate and separate accounting and fiscal records for the monies paid under this contract. The Contractor shall keep such records as are necessary to disclose fully the extent of services provided under this Contract. Upon request, Contractor shall furnish records and information regarding services provided under this contract to OHCA, the Oklahoma Attorney General's Medicaid Fraud Control Unit (MFCU), and the Secretary of the U.S. Department of Health and Human Services for six years from the date of service. The Contractor shall not destroy or dispose of records, which are under audit, review or investigation when the six-year limitation is met. The Contractor shall maintain such records until informed in writing by the auditing, reviewing or investigating agency that the audit, review or investigation is complete. The Contractor may microfilm, microfiche or optically image such documentation, so that it is accessible and readable for OHCA for any of the entities listed. Contractor shall obtain OHCA approval of file format storage prior to destroying permanent records.

b. Authorized representatives of OHCA, MFCU, and the Secretary shall have the right to make physical inspection of the Contractor's premises and to examine records relating to financial statements or claims submitted by the Contractor under this

Contract and to audit the Contractor's financial records as provided by 56 O.S. § 222 and 42 C.F.R. § 431.107.

c. Pursuant to 74 O.S. § 85.41, OHCA and the Oklahoma State Auditor and Inspector shall have the right to examine the Contractor's books, records, documents, accounting procedures, practices, or any other items relevant to this Contract.

d. In accordance with 42 C.F.R. § 455.100 et seq., the Contractor shall furnish ownership information within twenty (20) days to OHCA upon written request. Ownership information is critical for determining whether a person with an ownership interest has been convicted of a program-related crime under Titles V, XVIII, XIX, or XX of the federal Social Security Act, 42 U.S.C. § 301 et seq.

e. The Contractor shall submit, within thirty-five days of a request by OHCA, MFCU, or the Secretary of the U.S. DHHS all documents, as defined by 12 Okla. Stat. § 3234, in its possession, custody, or control concerning (i) the ownership of any subcontractor with whom the Contractor has had business transactions totaling more than twenty-five thousand dollars during the twelve months preceding the date of the request, or (ii) any significant business transactions between the Contractor and any wholly owned supplier, or between the Contractor and any subcontractor during the five years preceding the date of the request.

f. Contractor agrees to comply with the provisions of the Single Audit Act of 1984 and OMB Circular A-133. The Contractor agrees to provide a copy of the required audit report, including uniform financial statements, management letter and a formal written indirect cost allocation plan to OHCA, date to be determined by the OHCA. A certified public accountant or public accountant who has a valid and current license to practice accountancy in the State of Oklahoma shall perform this audit. The OHCA retains the right to examine all of the work papers of said auditor.

7.6 CONFIDENTIALITY

a. Contractor agrees that Medicaid recipient information (anything regarding recipient information) is confidential and is not to be released to the general public under 42 U.S.C. § 1396a(7), 42 C.F.R. § 431:300-306 and 63 O.S. § 5018 (Supp.1996). Contractor agrees not to release the information governed by these Medicaid recipient requirements to any other state agency or public citizen without the approval of OHCA.

b. Contractor agrees to comply with the Federal Privacy Regulations and the Federal Security Regulations as contained in 45 C.F.R. Part 160-164 that are applicable to such party as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 42 U.S.C. § 1320d through 1320d-8.

c. Contractor shall maintain the confidentiality all records gathered from health care providers, the Oklahoma Health Care Authority, and all records generated as a result of this contract, except as specifically provided in the contract. Such records include the data tapes sent to the Contractor to perform work under this contract and any other information obtained or abstracted by the Contractor. Contractor agrees that this documentation is confidential and not subject to the Oklahoma Open Records Act, 51 Okla. Stat. §24A.1 et seq. (1991). In the event a subpoena is made for any witness to testify in court or request for records to be produced regarding this contract, the Contractor shall immediately contact the Director of Legal Operations

by telephone and in writing before releasing any such information protected under the HIPAA regulations.

7.7 COMPLIANCE WITH LAW

a. The parties to this Contract acknowledge and expect that over the term of this Contract laws and regulations may change. Specifically, the parties acknowledge and expect (i) federal Medicaid statutes and regulations, (ii) State Medicaid statutes and rules, and (iii) state statutes and rules governing practice of health-care professions may change. The parties shall be mutually bound by such changes.

b. The Contractor shall comply with the following:
   - (i) the Age Discrimination in Employment Act, 29 U.S.C. § 621 et seq.;
   - (ii) the Rehabilitation Act, 29 U.S.C. § 701 et seq.;
   - (iii) the Drug-Free Workplace Act, 41 U.S.C. § 701 et seq.;
   - (iv) Title XIX of the Social Security Act (Medicaid), 42 U.S.C. § 1396 et seq.;
   - (v) the Civil Rights Act, 42 U.S.C. §§ 2000d et seq. and §§2000e et seq.;
   - (vi) the Age Discrimination Act, 42 U.S.C. § 6101 et seq.;
   - (vii) the Americans with Disabilities Act, 42 U.S.C. § 12101 et seq.;
   - (viii) the Oklahoma Worker's Compensation Act, 85 O.S. § 1 et seq.;
   - (ix) the Fair Labor Standards Act, 29 U.S.C. § 201 et seq.;
   - (x) the Equal Pay Act, Public Law 88-38, 77 Stat. 56;
   - (xi) the Vietnam Era Veterans Re-adjustment Act of 1974, Public Law 93-509; 88 Stat. 1578;
   - (xii) 31 U.S.C. § 1352 and 45 C.F.R. § 93.100 et seq., which (1) prohibit use of federal funds paid under this Agreement to lobby Congress or any federal official to enhance or protect the monies paid under this Agreement and (2) require disclosures to be made if other monies are used for such lobbying;
   - (xiii) Presidential Executive Orders 11141, 11246 and 11375, which together require certain federal Contractors and subcontractors to institute affirmative action plans to ensure absence of discrimination for employment because of race, color, religion, sex, or national origin;
   - (xiv) 45 C.F.R. §§ 76.105 and 76.110 concerning debarment, suspension and other responsibility matters;
   - (xv) 74 O.S. §§ 85.44(B)(C) and 45 C.F.R. §74.34 with regard to equipment (as defined by U.S. Office of Management and Budget Circular A-87) purchased with monies received from OHCA pursuant to this Contract;
   - (xvi) the Anti-Kickback Act of 1986, 41 U.S.C. §51 et seq., which prohibits any person from providing or attempting to provide or offering to provide any kickback; and,
   - (xvii) the Protective Services for Vulnerable Adults Act, 43A Okla. Stat. §10-101 et seq.

c. The explicit inclusion of some statutory and regulatory duties in this Contract shall not exclude other statutory or regulatory duties.

d. All questions pertaining to validity, interpretation, and administration of this Contract shall be determined in accordance with the laws of the State of Oklahoma, regardless of where any service is performed.

e. The venue for civil actions arising from this Contract shall be Oklahoma County, Oklahoma. For the purpose of Federal jurisdiction, in any action in which the State of Oklahoma is a party, venue shall be the United States District Court for the Western District of Oklahoma.

f. If any portion of this Contract is found to be in violation of State or Federal Statutes, that portion shall be stricken from this Contract and the remainder of the Contract shall remain in full force and effect.

7.8 TERMINATION

a. Either party may terminate for cause with a ninety (90) day written notice to the other party. Either party may terminate without cause with a one hundred and twenty (120) day written notice to the other party.

b. In the event funding of the Medicaid Program from State, Federal, or other sources is withdrawn, reduced, or limited in any way after the effective date of this Contract, and prior to the anticipated Contract expiration date, this Contract may be terminated immediately by OHCA.

7.9 FORCE MAJEURE

Neither party shall be deemed to be in default of any of its obligations hereunder, if and so long as it is prevented from performing such obligation by an act of war, foreign action, nuclear explosion, riot, strike, civil insurrection, earthquake, hurricane, tornado, or other catastrophic event or act of God.

7.10 PROHIBITION AGAINST ADVANCE PAYMENTS

No payment shall be made by OHCA in advance of, or in anticipation of services actually performed and/or supplies furnished under this Contract. Monthly invoices must be submitted for work performed the previous month.

7.11 TURNOVER PLAN

Contractor must assist OHCA in an orderly transition at the end of this contract should the Contractor be replaced by another entity.

A. Six months prior to the expiration date of the contract, the Contractor shall provide, at no extra charge, assistance in turning over the operations performed under this Contract to the State, or designated agent assigned by the State. The Contractor shall provide a turnover plan which includes, but is not limited to the following:

1. Proposed approach to transition operations to another vendor;
2. Identification and release of State owned documents and/or equipment/furnishing;
3. Turnover of all medical records and other necessary data to another review entity or appropriate custodian;
4. Maintenance and transition of telephone services;
5. Designation of a knowledgeable person who will be available on a daily basis to assist OHCA during the transition process; and
6. Proposed timeline delineating the transfer process.

B. Contractor shall organize and box all records for shipment to the new contractor, unless otherwise instructed by OHCA. Boxed materials must be labeled on the outside with a list of contents. Include an inventory list on each box and clearly indicate the type and date of materials. All review records should be identified and boxed (i.e. Live cases include: pending medical information, pending physician review, case pending review and re-review, or old cases: Case closed hospital adjustments (DRGs), quality review logs, documents related to cases approved where there has been an action within the last year, etc.) Contractor shall receive specific instructions from the PM regarding boxing, labeling, and shipment of all records utilized under this contract.

C. Contractor shall release all documents and records necessary to complete the transfer of operations, and will provide a final report documenting all such actions. At the option of the State, Contractor shall arrange for the removal of hardware and software, or the transfer of documents, equipment or software leases, where applicable.

D. In the event the Contractor is non-compliant or non-cooperative with the approved transfer plan, OHCA shall hold the Contractor responsible for all expenses associated with the delay of the transition and include a five (5%) penalty against the Contractor's final invoice.

7.12 TAX EXEMPT STATUS

The OHCA represents that it is exempt from federal excise, state and local taxes, and sales to the OHCA are exempted from Oklahoma sales and use taxes. If in the future the OHCA becomes subject to any such taxes, the OHCA shall reimburse the Contractor for any cost or expense incurred. Any other taxes imposed on the Contractor regarding this Contract shall be borne solely by the Contractor.

7.13 DISASTER RECOVERY PLAN

The Contractor must provide an emergency back-up system, a disaster recovery plan, and medical record storage facility to maintain business operations. Contractor must comply with all State, Federal and Oklahoma Medicaid requirements.

7.14 CONTRACT COMPLIANCE AND PENALTIES

Substantial elements of this contract are performance-based and require the Contractor to meet specific standards or metrics. The Contractor's performance may be assessed by such means as written reports, oral communication, on-site visits, audit, and data analysis.

a) Performance Improvement Plan (PIP)

If OHCA determines that the Contractor is not meeting the standards or metrics established in this ITB and that such noncompliance is impacting the performance or quality of required duties, OHCA may initiate a Performance Improvement Plan (PIP) with the Contractor. Examples of problems that may require a PIP include consistently missing deadlines, conducting activities without using required staff, using inappropriate or inadequate review criteria, and failing to act when aware of "serious risk" and "gross and flagrant violations". The Contractor will receive a written copy of the PIP.

The PIP shall clearly specify the performance deficiencies and identify specific actions required by the Contractor in order to correct the nonperformance. The Contractor shall have 30 days after receiving the PIP to successfully complete these actions. If the actions identified require more than 30 days to complete, the PIP shall specify milestones which must be met at the end of each 30-day period. The PIP shall also specify which attachments to this ITB cover the work that is affected by the noncompliance.

If the required actions are not taken or milestones are not reached at the end of the 30 days, the unit price(s) for all attachments specified in the PIP shall be reduced by 10% until the PIP is successfully completed. In the event that required actions are not taken or milestones are not reached at the end of 60 days from the Contractor's receipt of the PIP, the unit price(s) for all attachments specified in the PIP shall be reduced by 50% until the PIP is successfully completed.

OHCA shall notify the Contractor when the PIP is successfully completed and the Contractor may resume billing at 100% of the unit price(s).

b) Unacceptable reports
Attachments D and E to this ITB require specific reports to be delivered to OHCA. As noted in the attachments, Contractor will submit a draft and a final report to OHCA. If OHCA finds that the final report is unacceptable, OHCA shall provide Contractor with a written list of specific deficiencies that must be corrected in the report. Contractor must return the report to OHCA within 15 days of receiving the deficiency list. In the event that OHCA finds that the deficiencies in the report have not been corrected, OHCA shall make a determination of how much remedial work is required and/or how usable the report is in its current form. The price for the report shall be reduced proportionately by a maximum of 100%.

7.15 EQUIPMENT

Contractor agrees to and will abide by the provisions of Title 74 O.S. §85.44B and 85.44C. This contract does not provide for the direct purchase, by OHCA, of any equipment the Contractor may purchase to perform the tasks described herein. Contractor will use standard approved accounting practices to depreciate equipment and charge the depreciation to the various contracts held by the Contractor.

7.16 NOTICES

A. Whenever notice is required to be given to the other party, the notice shall be made in writing and delivered via certified mail, return receipt requested. Delivery shall be deemed to have occurred when a signed and dated return receipt is acquired by the sender. Notices shall be addressed as follows:

In case of a notice to the Contractor: Designated Program Manager
Contractor Name
Contractor Address

In case of a notice to OHCA: Oklahoma Health Care Authority
Attn: Contracts Development
4545 North Lincoln Boulevard, Suite 124
Oklahoma City, Oklahoma 73105-3400

B. In the event an address or name change is required by either party, a notice shall be provided as stated in section A above.

7.17 WORK PRODUCTS

The Contractor agrees that all data compilations, reports and work papers created and/or utilized by the Contractor to produce the work required under this contract are the property of OHCA. Nothing in this contract shall be construed to make another party a third party beneficiary to this contract.

SECTION 8. INVOICE AND PAYMENT TERMS

8.0 In consideration of payment for the performance of the services specified in this ITB, OHCA shall make monthly payments to the Contractor for completed work as stated in Pricing Schedule Bid Sheet.

8.1 A proper invoice for services must be rendered in order to receive payment. A proper invoice is one which contains, at a minimum, the following information: 1) Contractor

name; 2) FEI or vendor number; 3) invoice number; 4) purchase order number (where applicable); 5) description of service(s); 6) date(s) of service; and, 7) amount(s) billed. Contractor shall maintain documentation of all billed charges and shall make such documentation available to OHCA upon request or as otherwise stated in this Contract. Unless otherwise specified in this ITB, all travel costs shall be included in and paid against the total contract amount. Contractor shall submit invoices to the following address:

Oklahoma Health Care Authority
Division of Finance, General Accounting
P.O. Box 18299
Oklahoma City, OK 73154

8.2 Payment terms and conditions are contingent on provisions stated in Section 1.3 of this Contract. It is understood by the parties that, under state law, a commitment of funds shall not exceed a period of 12 months. Therefore, the OHCA shall issue a purchase order in 12 month increments to fund services rendered under this Contract.

8.3 OHCA shall have forty-five (45) days to pay an invoice. If OHCA fails to pay an invoice within that time, Contractor shall have the right to interest upon the invoice amount consistent with 62 O.S. § 41.4b.

8.4 Contractor shall have ninety (90) days from the expiration date of this Contract to submit invoice(s) for payment. OHCA will not be held responsible for payment of invoices submitted in excess of these time limitations. Contractor understands that all deliverables and invoices must be submitted to OHCA within ninety (90) days of the annual expiration date of this Contract.

8.5 No formal contract modification and/or amendment is required to this Contract should actual utilization of the services referenced exceed the not-to-exceed amount agreed to by the parties. The not-to-exceed amount shall be documented on the final purchase order, upon award of the contract.

SECTION 9. BID SUBMISSION CONTENT AND REQUIREMENTS

9.0 RESPONSES

A. **Language**: Responses to this ITB must be in clear and concise language suitable for inclusion in a contract with the State.

B. **Page Limitations**: Responses to this bid shall have a maximum of 100 pages, including all text, diagrams, attachments, and additional information. The type size shall not be smaller than 10 point and top, bottom, left and right margins shall be at least one inch, excluding headers and footers. The page limit does not include Attachment B, Pricing Schedule Bid Sheet. **Any pages submitted in excess of the limit will not be read, evaluated or considered in scoring the bid.**

9.1 SUBMISSION OF BIDS

A. Bidders shall be required to deliver the following number of bids to the DCS Central Purchasing, as indicated on the ITB instruction form:

- One (1) clearly identified original bid and six (6) copies of the completed bid.
- One (1) electronic file of the proposal in Microsoft Word.

B. All bids shall clearly indicate the name, title, mailing address, and telephone number of the Contractor's authorized agent with the authority to bind the firm to the provisions of the bid and to answer official questions concerning the bid. The original bid must contain an original signature by this person. Sealed bids shall be mailed or delivered to the contact person identified in Section 1.1.1 of this ITB.

C. Submitted bids are rendered as a legal offer and any bid when awarded by the State shall constitute a firm contract.

D. Submitted bids shall be in strict conformity with the instructions to the bidders and shall be submitted on the approved form. All bids, quotations, and contracts shall be typewritten or written in ink. Penciled bids shall not be accepted and shall be rejected as non-responsive. Any corrections shall be initialed in ink.

E. The State will accept all bids for evaluation that are completely and properly submitted.

F. Bidders mailing their bids or using a commercial delivery service shall allow sufficient time for delivery of their bids by the time and date specified on the ITB. **Bids received after that time will not be considered.** Delivery of the bids shall be at the bidders' expense. Any and all damage that may occur due to shipping shall be the bidders' responsibility.

G. Bids submitted in whole or in part by fax shall be rejected. **Late bids shall be rejected.** Bids shall be prepared in accordance with the requirements stated in this section of this ITB.

H. The State reserves the right to reject any bid that does not comply with the requirements and specifications of the ITB. A bid shall be rejected when the bidder imposes terms or conditions that would modify requirements of the ITB or limit the bidder's liability to the State.

I. The State reserves the right to withdraw or cancel this ITB at any time during the procurement process. Issuance of this ITB in no way obligates the State to award or issue a contract or to pay any costs incurred by any bidder as a result of such a withdrawal.

9.2 BID SUBMISSION FORMAT

Bids shall be submitted in the following format. Bidders must respond to sections and sub-sections in order and must number and label responses as shown below. If Bidder wishes to include additional information outside of the requirements below, this information should be labeled as addenda and included at the end of the response.

CHAPTER 1: FUNCTIONAL REQUIREMENTS

1.0 General Approach

In narrative terms describe Bidder's overall approach and plans to meet the requirements of this ITB. Bidder must demonstrate how they meet the requirements set forth in Section 1.6 a) of this ITB. This could include documentation such as QIO designation, QIO-like certification, etc. The content of the narrative should be designed to demonstrate that Bidder understands

OHCA's objectives, the nature of the work required and the level of effort necessary to successfully complete the project. Discuss where Bidder's facilities will be located and where the work will be performed.

1.1 Post-payment utilization review

Discuss the standard operating procedures employed in your organization for completion of retrospective and quality review (including record retrieval and physician review)? Explain any guidelines to be used – InterQual, Milliman, etc. Submit sample copies of your review worksheets and quality screens. What are the standard operating procedures employed in your organization for provider notification and follow-up when a utilization and/or quality issue is identified? (Include a description of the procedures used for the appeal and recoupement process.) Submit sample copies of letters to providers for utilization and quality issues identified. Describe the sampling method(s) your organization will utilize for the monthly identification of the cases for review as described in Attachments A and B. (Note that OHCA selects the sample in Attachment G.) Describe the methodology your organization will employ for identification and analysis of trends.

1.2 Quality Improvement for Managed Care (QISMC)

Describe the methodology you will use to audit the managed care program – onsite review, desk review, etc. Describe the methodology to be used to complete quality improvement studies. Describe your record review process (e.g., development of appropriate worksheets, staff training, hierarchy of record retrieval, qualifications of staff completing review, data entry, IQC process). Provide sample copies of worksheets for studies conducted by your organization if available. Submit a copy of a final report for a quality improvement study that your organization has completed. If such report is not available, please submit a sample report. Provide information regarding the staff available to conduct on-site record reviews as required by OHCA. Provide information regarding staff available for collaboration with OHCA staff during the various steps of study development, data collection, analysis, report finalization, etc.

1.3 Client Satisfaction Surveys

Describe the methodology and process you will use to complete the mail and telephone CAHPS and ECHO surveys required in Attachment F. Discuss the process to submit CAHPS data to the National CAHPS Benchmarking Database. If you have submitted such data to the National Database, please submit a copy of the final report. If not, please submit a sample report.

1.4 Inspections of Care

Describe the methodology and process used to conduct the onsite reviews required in Attachments H and K. Explain the forms, instruments, and reporting formats to be used. Submit samples of such forms, instruments, and reports. Discuss the staffing available to meet the staffing requirements of these attachments. Discuss plans for the annual provider meetings and other provider training or information dissemination.

1.5 Prior Authorization of Behavioral Health Services

Describe the methodology and process used to conduct the activities required for prior authorization services in Attachments I and J. Address all types of prior authorization – inpatient, outpatient, case management, psychologist, substance abuse, etc. Explain the process from the point of view of the provider –

submission, requests for more information, notification of approval/denial, etc. Discuss how information will be entered into the MMIS and how recipient and provider eligibility will be verified. Discuss provider meetings, newsletters, and any other planned provider training. Explain the process to be used to update and maintain manuals. Discuss staff available to meet the staffing requirements of these attachments. Explain internal quality assurance efforts that will be ongoing during these activities. Attach sample letters, notices, forms and reports.

1.6 **Peer Review/Quality Intervention and Education**
This section should discuss your peer review capabilities in general as well as the specific scope of work required in Attachment C. Describe the process your company utilizes in performing peer review and quality intervention and education, noting whether you utilize the CMS guidelines for peer review. Discuss your physician consultant base (i.e., number of physician consultants available, physician specialties, including dental, etc.) Identify review criteria your physician consultants will utilize when reviewing cases and your process for modifying review criteria. Describe your methods for record retrieval and case review when investigating potential quality of care cases. Describe your methods for analysis of patterns of medical review information for reporting and follow-up review. Describe your process for education intervention and corrective action including methods of monitoring compliance. Specify your average time frame for completion of case review, submission to peer review committee for review and decision-making, and conclusion of intervention and applicable corrective action plans. Note if your organization has the ability to call an ad hoc meeting of the peer review committee if necessary. If so, specify how many days, on average, would be necessary for scheduling an ad hoc meeting.

1.7 **(Optional) Quarterly Medicaid Provider Newsletter**: Describe plans for developing and producing the newsletters described in Attachment L. Discuss staff available to work on this project including Medicaid experience, technical writing abilities, graphic arts, layout and design, etc. Explain how you will effectively work with the staff of OHCA to develop content and meet deadlines. Provide samples of previous work in this area.

CHAPTER 2: TECHNICAL REQUIREMENTS

2.0 Describe Bidder's overall technical approach to information systems required for this project. Include database, Internet, telephone, fax, computer, and web-based systems required for this project. Explain whether you will use file transfer, direct entry into the MMIS or a combination of the two. Discuss how you will ensure that any separate databases will contain up-to-date recipient and provider information. Bidder must include plans outlining their emergency telecommunications back-up system and disaster recovery system. Provide any other necessary explanation of how Bidder will meet technical requirements in Attachments A through L.

2.1 Briefly discuss information systems staffing and experience in relation to this project. Contractor must describe and/or provide their 1) disaster recovery plan; 2) emergency back-up system plan, and 3) procedures for medical records storage and retrieval process.

CHAPTER 3: PROJECT MANAGEMENT

3.0 Name the Subject Matter Expert (SME) that Bidder is proposing for this project. Summarize the SME's qualifications and experience with projects of similar size

and scope and include a resume if desired. Include any additional information desired about managerial and supervisory personnel available for this project.

3.1 Provide an implementation timetable for this project. Bidder must clearly demonstrate its ability to meet the proposed timeline, and develop a contingency plan dependent upon issues that may arise. If Bidder is not established in Oklahoma, provide information on plans to set up operations. The anticipated date of award is April 1, 2006 and the program operational start date is July 1, 2006. Contractor must complete and pass all systems testing requirements by June 15, 2006.

CHAPTER 4: ORGANIZATION STABILITY AND RESOURCES

4.0 Summarize the Bidder's organizational characteristics and structure including date established, organization type (corporation, partnership, etc.), total number of full time equivalent employees, and relevant financial information. Discuss any relationship between organization and its subsidiaries and/or its parent companies. Provide any other information necessary to establish that Bidder's organization has the stability and resources to manage the project.

CHAPTER 5: ORGANIZATION PAST PERFORMANCE

5.0 **Overall experience**: Discuss Bidder's experience with all the activities described in this bid. If you have performed work of similar size, scope and nature, please briefly describe a maximum of three similar projects. If Bidder is not an Oklahoma entity, discuss any experience in serving the needs of out-of-state clients.

5.1 **Post-payment Utilization Review**: Describe your organization's experience with retrospective review of inpatient and outpatient hospital claims and include a maximum of two similar projects. Discuss guidelines that you have used such as InterQual, Milliman, etc.

5.2 **Quality Improvement for Managed Care**: Describe your organization's experience in this area and include a maximum of two similar projects. Discuss your familiarity with the federal QISMC guidelines and standards. What types of audits of a managed care plan have been completed by your organization? Describe the types of quality improvement studies your organization have completed (including the type of health plan; for example, managed care, Medicaid, etc.). What types of methodology have you used?

5.3 **Client Satisfaction Surveys**: Describe your previous experience in mail and telephone surveys and in conducting CAHPS and ECHO surveys per CAHPS specifications. Include a maximum of two similar projects. Describe your experience in completing reports of survey results for public distribution. What is the date, if any, of the most recent CAHPS/ECHO surveys completed by your company? Have you submitted CAHPS data to the National CAHPS Benchmarking Database?

5.4 **Inspections of Care**: Describe your organization's previous experience in this area and include a maximum of two similar projects.

5.5 **Prior Authorization Services**: Describe your organization's previous experience in a) prior authorization and b) prior authorization of behavioral health services. If you have previous experience in behavioral health services, please describe a

maximum of two of these projects. Otherwise, include a maximum of two previous projects involving prior authorization of any medical services.

5.6 **Peer Review/Quality Intervention and Education:** Discuss your organization's experience in this area along with a description of a maximum of two similar projects. Describe an educational intervention and corrective action plan that your peer review committee has recommended and monitored.

5.7 **Medicaid experience**: State the number of years for which Bidder has provided peer review/utilization review services for Medicaid programs in any state.

5.8 **Professional references**: Provide five (5) professional references. (References should be type written on official company letterhead from the referring company). References must be of similar size and scope of work as related to this solicitation. Provide reference names, address, telephone and/or fax number and a signed authorization from each reference to release information to OHCA.

5.9 **(Optional) Quarterly Medicaid Provider Newsletter**: Discuss your organization's experience in this area including a maximum of two similar projects. How much editing and rewriting was required of the customer?

CHAPTER 6: STAFF CAPABILITIES

6.0 List the approximate number of staff to be allocated to this project by general categories – physicians, registered and practical nurses, behavioral health licensed personnel, information systems, technical writing, layout and design, clerical and administrative. Please specify if your company is able to provide foreign language capability such as Spanish, Vietnamese, etc. Provide any other necessary information related to how Bidder will meet staffing requirements in Attachments A through L.

6.1 Discuss plans for training staff before beginning operations and plans for training updates when program, policy or system changes occur.

BID SHEET

Bidder must complete the attached Bid Sheet and attach it at the end of the bid, following responses to all sections and sub-sections above for one or both scopes of work. Bidder shall not substitute any other document or form for the Bid Sheet.

ATTACHMENT A
INPATIENT HOSPITAL RETROSPECTIVE REVIEWS
FEE-FOR-SERVICE PROGRAM

A.1. Purpose: The parties agree that the purpose of this portion of the activities is to assess the use of inpatient hospital services in Oklahoma's Medicaid Fee-for-Service Program through post-payment utilization review.

A.2. The OHCA, through its Medicaid Management Information Systems (MMIS) fiscal agent, shall send a tape of all paid inpatient hospital claims between the 5th and 10th business day of each month during this contract. OHCA agrees that the paid claims tape shall be readable in a format agreed upon by the parties.

A.3. Within 15 calendar days of the receipt of the tape, Contractor shall utilize a statistically sound methodology so that a total of 710 hospital admissions (or cases) are randomly selected from all of the medical admissions contained on the monthly paid claims tape (a hospital stay that is less than three (3) days in duration for a healthy mother (normal delivery stay) or for a healthy newborn (normal newborn stay) is excluded from this sample). A separate sub-sample of adult psychiatric levels of care admissions shall be selected and reviewed. The sub-sample size shall be forty (40) admissions. These 750 records will be reviewed using the standard format as described in A.5.

In addition to these records, Contractor shall utilize a statistically sound methodology so that a total of 150 additional cases are selected for a focused review that will include a review using the standard format as described in A.5. and a focused review of quality of care trending. These 150 cases must have a discharge date (and discharge code) within ninety (90) days of the last day of the month represented on the paid claims tape. These cases will include representative subsets of the following admission types:

- A.3 (a) NICU stay,
- A.3 (b) Delivery or newborn (excluding NICU) stay equal to or greater than three (3) days,
- A.3 (c) Hospital stay less than three (3) days excluding those discharges involving a normal delivery or normal newborn stay.
- A.3 (d) Facility transfers from one acute care hospital to another acute care hospital,
- A.3 (e) Re-admission within 15 days of prior acute care admission for a related condition,
- A.3 (f) DRG cost-outliers

All admission samples must be selected within 15 calendar days of Contractor's receipt of the tape. Contractor may adjust the ratio of medical level of care to psychiatric level of cases to account for changes in inpatient hospital types in collaboration with OHCA and as determined appropriate based on monthly admission data documented by Contractor and submitted to OHCA. Medicare cases are excluded from the hospital review. The OHCA Medical Director and Contractor shall collaborate to establish any additional On a monthly basis, Contractor agrees to provide OHCA with a list of the records excluded from the sample due to an inability to match the sample record with the hospital medical record (using the established procedure of a match to 3 of 4 criteria: recipient ID, recipient Social Security Number, recipient name, and recipient date of birth). This list will include the month the record was sampled, the date of exclusion determination, and all elements that do not match.

A.5. After up to 900 admissions (or cases) are selected, Contractor shall analyze these cases with the first level of review being completed within sixty (60) calendar days from receipt of the tape. Contractor agrees that it will use its best professional judgment to review the admissions based upon InterQual and/or community guidelines. These guidelines shall be used prospectively throughout the term of the contract.

Contractor understands that two payment methodologies are currently in place: per diem reimbursement and diagnosis-related groups (DRGs) reimbursement. Contractor will, receive a claims extract that includes paid claims utilizing both reimbursement methodologies.

The result of the review of admissions utilizing a per diem reimbursement methodology shall identify: (1) medically unnecessary admissions, (2) medically unnecessary length of stay, (3) inappropriate procedures performed, (4) inappropriate billing of the level of care submitted on the claim, and (5) quality of care issues.

The result of the review of admissions utilizing a DRG reimbursement methodology shall identify: (1) medically unnecessary or inappropriate admissions and/or readmissions, (2) medically unnecessary transfers, (3) inappropriate procedures performed, (4) inappropriately billed DRGs, (5) DRG cost outliers for determination of appropriateness of coding and grouper assignment and (6) quality of care issues.

DRG validation and record review will be based upon accepted principles of coding practice and will be consistent with guidelines established for ICD-9-CM coding, the Uniform Hospital Discharge Data Set data element definitions, and coding clarifications issued by CMS. Contractor will not change these guidelines or institute new coding requirements that do not conform to established coding rules. Contractor will verify a hospital's coding in accordance with the coding principles reflected in the current edition of the ICD-9-CM Coding Manual, Volumes 1 through 3 and the official version of the National Center for Health Statistics and CMS addenda, which update the ICD-9-CM Manual annually.

The DRG validation process will include verification that the hospital reported the principal diagnosis and all relevant diagnoses that affected DRG assignment on the claim. Principal diagnosis verification will include a determination as to whether or not the principal diagnosis listed was the diagnosis which, after review, was determined to have resulted in the beneficiary's admission to the hospital. The principal diagnosis as evidenced by the physician's entries in the beneficiary's medical record must match the principal diagnosis reported on the claim form (See 42 CFR 412.46) and the principal diagnosis must be coded to the highest level of specificity. Procedure coding validation will ensure that the hospital accurately reported all procedures affecting the DRG assignment on the claim.

As with all retrospective reviews, Contractor understands that no changes may be made to the diagnoses and/or procedures listed on the claim and that existing procedures will be maintained for provider notification of billing errors and/or denials with no changes made to the existing appeal process. Contractor will use individuals trained and experienced in ICD-9-CM coding to perform all retrospective reviews.

Using current standards of care, a generic quality screen will be completed by a registered nurse on all records reviewed and will include the physical and/or electronic signature of the reviewing nurse. Requests for copies of the entire medical record(s) will include a list of the record(s) requested and will allow the facility thirty (30) calendar days to submit the requested material. If, after thirty (30) calendar days has elapsed, the facility has failed to submit the requested medical record(s) and/or adequate record(s) to complete the review to Contractor, a

technical denial will be issued by Contractor with provider notification, appeal process and OHCA notification conducted by Contractor as per established procedure.

A.6 Contractor agrees to conduct the annual medical necessity review component of the Payment Accuracy Measurement (PAM) project as outlined in the terms prescribed by the Center for Medicare and Medicaid Services (CMS) and provided to Contractor by OHCA. These medical record reviews will be included in the number of reviews outlined in A.3 above and will incorporate the guidelines of both review types.

A.7. In the case Contractor makes a finding as referenced in A.5 above, Contractor agrees to provide up to three levels of review to the cases. Review coordinators will deliver the first level of review. The first level of review will include a review by a registered nurse to assess the quality of care received. This quality of care assessment will be completed by a registered nurse and documented on a generic quality screen form and will include the issues identified and the physical and/or electronic signature of the reviewing nurse. Physician consultants of the same peer group as the physician being reviewed will deliver the second level of review. If a second level of review is required, it will be completed within ninety (90) calendar days from receipt of the tape. The third level of review is to be provided in the case a provider appeals Contractor's decision. After reconsideration, the third level of review is to be provided by a physician consultant of like specialty of care.

A.8. Contractor agrees to issue all written notifications to providers, in a format approved by OHCA, within ten (10) calendar days from the date of the determination. Contractor agrees to administer an appeal process of all denials by Contractor. The appeals process will consist of a written notice and opportunity to respond to the denial by allowing the provider to submit additional documentation to disprove the denial. Contractor shall offer providers notice of the timeline to provide additional documentation according to OHCA policy.

A.9. Should a provider file an appeal with Contractor and submit additional documentation, Contractor agrees to decide the reconsideration within forty-five (45) calendar days of the receipt of the documentation from the provider. Contractor agrees to issue all written notifications of the reconsideration decision to providers within ten (10) calendar days from the date of the reconsideration decision. Contractor will send copies of all final decision notification letters to OHCA.

A.10 In the case Contractor makes a finding of a confirmed quality issue as referenced in A.5 above, Contractor agrees to complete a provider profile following the procedures outlined in Attachment C.

A.11. Contractor agrees to produce a bi-weekly report, a monthly report and four quarterly reports throughout the term of this contract. The bi-weekly report will be delivered no later than the 15th and 30th day of each month. The monthly report shall be postmarked or delivered no later than the 30th day of each month. The quarterly reports shall be postmarked or delivered no later than October 30th, January 30th, April 30th, and July 30th. The bi-weekly report will document the status of initial and second level of reviews. The monthly report will break out the adult psychiatric population and the quarterly report will include an analysis of any trends in the review of all cases reviewed. The psychiatric reports will be sent directly to OHCA Behavioral Health staff and will include an analysis of any trends in the review of that sub-population.

A.12. The format for the bi-weekly, monthly and quarterly reports shall be determined jointly by OHCA and Contractor.

ATTACHMENT B

OUTPATIENT HOSPITAL OBSERVATION SERVICES RETROSPECTIVE REVIEWS FEE-FOR-SERVICE PROGRAM

B.1. Purpose: The parties agree that the purpose of this portion of the activities is to assess the use of outpatient hospital observation services in Oklahoma's Medicaid Fee-for-Service Program through post-payment utilization review.

B.2. The OHCA, through its Medicaid Management Information Systems (MMIS) fiscal agent, shall send a tape of all paid outpatient hospital claims with revenue codes 76X between the 5th and 10th business day of each month during this contract. OHCA agrees that the paid claims tape shall be in a readable format agreed upon by the parties.

B.3. Within fifteen (15) calendar days of the receipt of the tape, Contractor shall utilize a statistically sound methodology so that a total of 500 cases are randomly selected from all of the observation cases contained on the monthly paid claims tape. All cases must be selected within 15 calendar days of Contractor's receipt of the tape. These 500 records will be reviewed using the standard format as described in B.5. On a monthly basis, Contractor agrees to provide OHCA with a list of the records excluded from the sample due to an inability to match the sample record with the hospital medical record (using the established procedure of a match to 3 of 4 criteria: recipient ID, recipient Social Security Number, recipient name, and recipient date of birth). This list will include the month the record was sampled, the date of exclusion determination, and all elements that do not match.

B.5. After 500 cases are selected, Contractor shall analyze these cases with the first level of review being completed within forty-five (45) calendar days from receipt of the tape. Contractor agrees that it will use its best professional judgment to review the admissions based upon CMS guidelines for qualifying observation services with the exception of diagnosis-related qualifiers. Contractor understands that the OHCA does not currently require a specified diagnosis for reimbursement of observation services. These guidelines shall be used prospectively through out the term of the contract.

The results of the observation services performed shall insure: (1) observation care was billed hourly, for a minimum of eight hours, with no separate payment up to a maximum of 48 hours; (2) observation time began at the clock time appearing on the nurse's observation admission note, and ended at the clock time documented in the physician's discharge orders, or in the absence of such documented time, the clock time when the nurse or other appropriate person signs off on the physician's discharge order; (3) the beneficiary was under the care of a physician during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes, timed, written, and signed by the physician; (4) the medical record included documentation that the physician used risk stratification criteria to determine that the beneficiary would benefit from observation care; and, (5) the hospital furnished certain other diagnostic services along with observation services to ensure that separate payment is made only for those beneficiaries truly requiring observation care.

The review will identify: (1) medically unnecessary placement in observation, (2) medically unnecessary length of stay, (3) inappropriate billing of the level of care submitted on the claim, and (4) quality of care issues.

B.6. In the case Contractor makes a finding as referenced in B.5 above, Contractor agrees to provide up to three levels of review to the cases. Review coordinators will deliver the first level of review. The first level of review will include a review by a registered nurse to assess the quality of care received. This quality of care assessment will be completed by a registered nurse and documented on a generic quality screen form and will include the issues identified and the physical and/or electronic signature of the reviewing nurse. Physician consultants of the same peer group as the physician being reviewed will deliver the second level of review. If a second level of review is required, it will be completed within sixty (60) calendar days from receipt of the tape. The third level of review is to be provided in the case a provider appeals Contractor's decision. After reconsideration, the third level of review is to be provided by a physician consultant of like specialty of care.

B.7. Contractor agrees to issue all written notifications to providers, in a format approved by OHCA, within ten (10) calendar days from the date of the determination. Contractor agrees to administer an appeal process of all denials by Contractor. The appeals process will consist of a written notice and opportunity to respond to the denial by allowing the provider to submit additional documentation to disprove the denial. Contractor shall offer providers notice of the timeline to provide additional documentation according to OHCA policy.

B.8. Should a provider file an appeal with Contractor and submit additional documentation, Contractor agrees to decide the reconsideration within forty-five (45) calendar days of the receipt of the documentation from the provider. Contractor agrees to issue all written notifications of the reconsideration decision to providers within ten (10) calendar days from the date of the reconsideration decision. Contractor will send copies of all final decision notification letters to OHCA.

B.9. In the case Contractor makes a finding of a confirmed quality issue as referenced in B.5 above, Contractor agrees to complete a provider profile following the procedures outlined in Attachment C.

B.10. Contractor agrees to produce a bi-weekly report, a monthly report and four quarterly reports throughout the term of this contract. The bi-weekly report will be delivered no later than the 15th and 30th day of each month. The monthly report shall be postmarked or delivered no later than the 30th day of each month. The quarterly reports shall be postmarked or delivered no later than October 30th, January 30th, April 30th, and July 30th. The bi-weekly report will document the status of initial and second level of reviews. The quarterly report will include an analysis of any trends in the review of all cases reviewed.

B.11. The format for the bi-weekly, monthly and quarterly reports shall be determined jointly by OHCA and Contractor.

ATTACHMENT C

QUALITY INTERVENTIONS AND EDUCATION

C.1. Purpose: The parties agree that the purpose of this portion of the activities in the contract is to identify medical providers who have provided substandard care in the Fee-for-Service and/or *SoonerCare* Programs. The parties recognize that this function is a true peer review organization function. Once identified, the purpose of the work described below is to educate the medical provider and closely monitor provider care delivery. OHCA agrees to work closely with Contractor to achieve an aggressive approach to Quality of Care Issues.

C.2. In completing the work described in this Contract and all referenced Attachments, excluding Attachment L, the Contractor agrees to use its best professional judgment while identifying medical providers who have: 1) provided substandard care; 2) have committed gross and flagrant violations; or 3) presented with confirmed quality of care deficiencies.

OHCA considers the definition of "Serious Risk" to be part of the definition of "Gross and Flagrant Violations". The final determination for "Gross and Flagrant" cases will be made through a collaboration of physicians from the two organizations, including but not limited to, the Contractor's Medical Clinical Coordinator and/or the OHCA Director of Provider Services Support Division. In addition to identifying providers, Contractor agrees to maintain a database of the confirmed quality of care issues. Further, Contractor agrees to accept referrals from OHCA relating to allegations of substandard care and review the allegations utilizing the developed standardized format. In the event a referral is received from OHCA and identified "expedited", Contractor agrees to complete the review within fifteen (15) calendar days of receipt of the referral (if the records are included with the referral); and within forty-five (45) calendar days of receipt of the referral, if the records must be obtained by Contractor. Contractor agrees to complete the review of all other referrals from OHCA within thirty (30) calendar days of receipt of the referral (if the records are included with the referral); and within sixty (60) calendar days of receipt of the referral, if the records must be obtained by Contractor. If Contractor is unable to obtain a matched specialty physician for review of the record, OHCA will be advised and will work to reach a mutually agreed-upon review deadline. Contractor agrees to work collaboratively with OHCA staff for educational interventions.

C.3. When Contractor identifies a medical provider with three (3) or more confirmed quality issues within a six (6) month period, or a single Gross and Flagrant or Serious Risk Violation, through Contractor reviews or OHCA referrals, Contractor agrees to perform the following tasks:

a) For Gross and Flagrant Violations and Serious Risk Only: Present the case to the next regularly scheduled Medical Intervention/Education Team meeting to recommend the appropriate action.
b) Within thirty (30) calendar days following the identification of the third quality issue, Contractor will present those cases to the Medical Intervention/Education Team to determine whether or not further action is necessary.
c) If a meeting is necessary, Contractor will provide the following functions:
    1. Contractor will submit, in writing, an invitation to the provider requesting a face-to-face meeting with the Intervention/Education Team (as described below in paragraph C.4) to discuss the cases involved in the pattern;
    2. Prior to the meeting, Contractor shall make its best effort to initiate a telephone contact with the medical provider to discern if a meeting is necessary and/or desired by the provider;

3. The Intervention/Education Team will discuss the cases(s) with the provider, and provide education to the provider regarding the appropriate clinical action for each case;
4. If necessary, the Intervention/Education Team shall recommend a corrective action plan (hereinafter referred to as CAP) and/or continued education to the provider;
5. Contractor shall provide in the CAP the time frame for completion for the plan; and,
6. Contractor shall monitor the compliance with the CAP.

d) If a meeting is NOT necessary, the Intervention/Education Team will determine other actions, if appropriate; including, but not limited to, a provider educational letter.

C.4. Contractor agrees that the composition of the Intervention/Education team shall be:
a) the Medical Director or designated medical staff;
b) at least one physician consultant that practices in an area of the same specialty;
c) at least one physician consultant that practices in the same area geographically;
d) Contractor staff representatives as deemed necessary by Contractor; and,
e) OHCA physician representative as deemed necessary by Contractor and OHCA.

C.5 OHCA agrees that the same physician may meet the requirements of C.4 b) and c). OHCA agrees to provide other staff representatives as resource staff as mutually agreed upon.

C.6. Contractor agrees that all of the team members will be impartial regarding the particular provider being reviewed, that none of the team's medical providers will be in economic competition with the provider being reviewed, and that none of the team's medical providers have a financial stake in the practice of the provider being reviewed or the institution being reviewed.

C.7. Contractor agrees to provide the following reports to OHCA regarding the activities in Attachment C:

a.) MONTHLY: A detailed report of providers identified by the Contractor under C.3 above. This report shall list the Medicaid program(s) the provider is contracted under, such as fee-for-service or managed care. The report shall summarize the quality issue(s), the status of the CAP, and the specific findings/outcomes of the Team meeting. This report shall detail all providers refusing to cooperate or meet with the Contractor, and will include the status of cases referred to Contractor by OHCA. Contractor agrees to produce and submit this report to OHCA by the fourteenth (14th) calendar day of each month. This report shall include a key for any Contractor abbreviations.

b.) MONTHLY: Contractor shall produce a monthly report that identifies all cases referred to Contractor by OHCA for review, and shall include a summary of the quality issues, the status of each case, and any other relevant information. Contractor agrees to produce and submit this report to OHCA by the tenth (10th) calendar day of each month. This report shall include a key for any Contractor abbreviations.

c.) IMMEDIATELY UPON COMPLETION: All CORRECTIVE ACTION PLANS. Contractor agrees to mail CAP reports to the attention: OHCA Director of Provider Services Support, within two (2) business days of completion. Each CAP shall show the date of completion, action taken, and the final determination of the Intervention/Education Team.

d.) IMMEDIATELY UPON DETERMINATION: All GROSS AND FLAGRANT AND SERIOUS RISK VIOLATIONS. Contractor will provide written notification to the OHCA Director of Provider Services Support, when a Gross and Flagrant or Serious

Risk Violation is identified. The notification shall include the specifics of the incident identified, provider information, and the date, time, and location of the scheduled Intervention/Education Team meeting. Written notification shall be provided to the OHCA Director of Provider Services documenting the specific outcome of the Intervention/Education Team meeting; including, the initial action taken and continued notification of each follow-up action concerning the specified incident. The written notification process shall cease when the Intervention/Education Team and OHCA have determined that the Provider has met all corrective requirements outlined in the CAP or a final determination has been established.

C.8. Contractor will provide the intervention as deemed necessary by the Medical Clinical Coordinator or the Intervention/Education Team and will conclude those intervention activities when determined appropriate.

C.9. Contractor will follow Medicare protocol for the sanction of Medicaid providers, should conditions outlined in C.3 warrant such action.

ATTACHMENT D

QUALITY OF CARE REVIEWS OF MEDICAID MANAGED CARE PROGRAMS (*SOONERCARE*)

D.1. Purpose: The parties agree that the purpose of this portion of the activities in the contract is to operationally support OHCA's adoption of the Federal Government's Quality Improvement System for Managed Care (hereinafter referred to as QISMC). This guide essentially describes a process by which OHCA can complete an internal and external quality assurance and/or improvement review for Oklahoma Medicaid clients enrolled in the managed care program. These guidelines provide OHCA, through Contractor, the ability to monitor and assess the effectiveness and efficiency of care being provided to the *SoonerCare* population. The parties understand that OHCA may desire to include services related to the validation of *SoonerCare* Encounter Data Claims. Should OHCA choose to exercise this option, Contractor agrees to provide encounter data claims validation services; and such services shall be incorporated under Schedule D.

SOONERCARE PROGRAM

D.2. Contractor agrees to perform a review of relevant QISMC Domains and Standards for the *SoonerCare* program. QISMC Domains and Standards to be reviewed will be jointly determined by Contractor and OHCA based upon CMS guidelines, deemed elements, and prior QARI reviews. The review will be completed by May 15th of each calendar year. Contractor will submit a narrative review draft to OHCA by May 31st of each calendar year. OHCA will submit comments by June 15th, and Contractor will complete the final documented review by June 30th of each calendar year. The specificity of the QISMC review shall be jointly established by Contractor and OHCA. Contractor agrees to collaborate with OHCA in the completion of this document with respect to the reporting format and the data reviews.

D.3. Contractor agrees that not every aspect of the reviews has been presented in this contract. The parties agree that the QISMC methodology contains the requirements of the reviews and the paragraphs above delineate the major portions of the obligation to complete the reviews.

ATTACHMENT E

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) PROJECTS

E.1. Purpose: The parties agree that the purpose of this portion of the activities in the contract is to assist OHCA in monitoring or conducting studies in particular areas of care provided to Medicaid recipients. In keeping with QISMC, the areas to be studied are selected at the discretion and as defined by the State.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program

E.2. Contractor agrees to collaborate with OHCA to facilitate the development and completion of a new EPSDT project study during the contract year. Contractor agrees to employ its best professional judgment and skills in conducting the study. A draft of the report, which documents the details and recommendations of the project shall be produced and submitted to OHCA by April 1st. OHCA shall have thirty (30) calendar days to review the document and return to Contractor with changes to its format only. The final report shall be submitted to OHCA no later than May 15th. Contractor agrees to employ its best professional judgment and skills in the development and completion of the project.

E.3. Contractor agrees to collaborate with OHCA in any revisions to the methodology and/or format for the EPSDT and diabetic project that may be indicated. Contractor agrees to facilitate the development of the project.

Diabetes Study

E.4. Contractor agrees to collaborate with OHCA to facilitate the development and completion of a new Diabetes project study during the contract year. Contractor agrees to employ its best professional judgment and skills in conducting the study. A draft of the report, which documents the details and recommendations of the project shall be produced and submitted to OHCA by April 1st. OHCA shall have thirty (30) calendar days to review the document and return to Contractor with changes to its format only. The final report shall be submitted to OHCA no later than May 15th. Contractor agrees to employ its best professional judgment and skills in the development and completion of the project.

Peri-Natal Project

E.5. Contractor agrees to collaborate with OHCA to facilitate the development and completion of a new Peri-natal project study during the contract year. Contractor agrees to employ its best professional judgment and skills in conducting the study. A draft of the report, which documents the details and recommendations of the project shall be produced and submitted to OHCA by April 1st. OHCA shall have thirty (30) calendar days to review the document and return to Contractor with changes to its format only. The final report shall be submitted to OHCA no later than May 15th. Contractor agrees to employ its best professional judgment and skills in the development and completion of the project.

E.6. Contractor agrees to produce a report documenting the status of each QAPI in a format agreeable with OHCA. A draft of each report shall be produced and submitted to OHCA by March 15th. OHCA shall have thirty (30) calendar days to review the document and return to Contractor with changes limited to formatting only. The final report for each study shall be submitted to OHCA by May 1st.

Behavioral Health Study

E.7. Contractor agrees to collaborate with OHCA to facilitate the development and completion of a new Behavioral Health Project during the contract year. Contractor agrees to employ its best professional judgment and skills in conducting the study. A draft of the report, which documents the details and recommendations of the project shall be produced and submitted to OHCA by April 1st. OHCA shall have thirty (30) calendar days to review the document and return to Contractor with changes to its format only. The final report shall be submitted to OHCA no later than May 15th. Contractor agrees to employ its best professional judgment and skills in the development and completion of the project.

Emergency Room Utilization Analysis

E.8. Contractor agrees to collaborate with OHCA to facilitate the development and completion of a new Emergency Room Utilization Project during the contract year. Contractor agrees to employ its best professional judgment and skills in conducting the study. A draft of the report, which documents the details and recommendations of the project shall be produced and submitted to OHCA by April 1st. OHCA shall have thirty (30) calendar days to review the document and return to Contractor with changes to its format only. The final report shall be submitted to OHCA no later than May 15th. Contractor agrees to employ its best professional judgment and skills in the development and completion of the project.

E.9. For all studies defined in this attachment requiring the review of medical records, Contractor agrees to document all medical record requests, including follow-up calls made to providers/clinics. Documentation of phone calls will include date, time, person contacted, and action taken. Contractor agrees to request medical records from providers' by certified mail and/or fax. Contractor agrees to conduct all aspects of record retrieval and will notify the OHCA QA/QI staff, when all avenues have been exhausted without receipt of the requested records.

E.10. Contractor agrees to produce and submit a status report in a format agreed upon by OHCA and Contractor, outlining the status of all activities included in Attachment E. Each report will be sent directly to the OHCA Quality Assurance/Quality Improvement Manager. The first report will be postmarked or delivered no later than September 30th, the second report will be postmarked or delivered no later than December 31st, and the third report will be postmarked or delivered no later than March 31st of each contract year.

E.11. Contractor agrees to collaborate with OHCA staff upon completion of the above mentioned projects, to begin new projects as specified by OHCA PM.

ATTACHMENT F

CLIENT SATISFACTION SURVEYS

F.1. Purpose: The purpose of this portion of the contract is to assist OHCA in conducting satisfaction surveys for the *SoonerCare* program. The results of the surveys will assist OHCA in improving the delivery of managed care health services in Oklahoma.

F.2. Contractor agrees to conduct one satisfaction survey for adults in the *SoonerCare* program and will include the supplemental questions provided by OHCA.

F.3. Contractor agrees that the surveys will be conducted according to the current Consumer Assessment of Health Plan Surveys (hereinafter referred to as CAHPS) methodology for sampling and administration.

F.4. Contractor agrees to collaborate with OHCA to determine the survey sample according to the CAHPS methodology. OHCA agrees to submit to Contractor the data necessary to complete the sample selection for the CAHPS survey, as per the specifications defined by Contractor. The request, including specifications, will be submitted by Contractor to the OHCA QA/QI Manager and will be completed by OHCA within forty-five (45) calendar days of receipt of the request. Contractor agrees to conduct all surveys of clients, including the production of all mailings and written instruments used in the survey. All mailings will be accomplished through first-class mail and after the second mailing, up to three (3) phone attempts will be made to households not responding to the first and second mailings. If contact is made, CAHPS survey methodology for conducting phone outreach will be followed. Following the phone outreach, Contractor agrees to conduct a third first-class mailing to all households that could not be reached by phone. If requested, the Spanish version of the CAHPS survey will be mailed to the requesting household. Contractor agrees to employ all outreach interventions needed to obtain a survey response of at least fifty (50) percent of recipients.

F.5. Contractor agrees to utilize the CAHPS software package from the Agency for Health Research and Quality (AHRQ) Contractor to compile the data. OHCA agrees to supply the most current version of the software package from the AHRQ Contractor.

F.6. The parties agree that it is both their understanding that software support to compile the data will be provided at no cost to Contractor. OHCA agrees to provide any needed administrative support to access assistance from the AHRQ Contractor regarding software support.

F.7. Contractor agrees to produce the completed CAHPS survey report for the *SoonerCare* program and submit a draft of the report to OHCA by April 1st of each calendar year. OHCA shall have thirty (30) calendar days to review the document and return to Contractor with changes to its format only. The final report shall be submitted to OHCA by May 15th of each calendar year. The report will be in a mutually agreeable format and include survey data from all survey types.

F.8. Contractor agrees to submit the CAHPS data obtained through the completion of the CAHPS child survey to the National CAHPS Benchmarking Database in accordance with NCBD guidelines and timeframes.

F.9. Contractor agrees to conduct an Experience of Care and Health Outcomes (ECHO) survey (the CAHPS survey of behavioral services) for children enrolled in the *SoonerCare* program, who have received behavioral health services as defined by the CAHPS specifications. OHCA agrees to submit the data necessary to complete the sample selection for the ECHO survey. Contractor shall request specifications from the OHCA QA/QI Manager and will be completed by OHCA within a reasonable time defined as within forty-five (45) calendar days of receipt of the request. The survey will be conducted using CAHPS methodology for sampling and administration.

F.10. Contractor agrees to collaborate with OHCA to determine the survey sample according to the CAHPS methodology. Contractor agrees to conduct all surveys of clients including the production of all mailings and written instruments used in the survey. All mailings will be accomplished using first-class mail and after the second mailing, up to three (3) phone attempts will be made to those households that did not respond to the first and second mailings. If contact is made, CAHPS survey methodology for conducting phone outreach will be followed. Following the phone outreach, Contractor agrees to conduct a third first-class mailing to all households that could not be reached by phone. If requested, the Spanish version of the ECHO survey will be mailed to the requesting household. Contractor agrees to employ all outreach interventions needed to obtain a survey response of at least forty (40) percent.

F.11. Contractor agrees to produce the completed ECHO survey report for the *SoonerCare* program and submit a draft of the report to OHCA by April 1st of each calendar year. OHCA shall have thirty (30) calendar days to review the document and return to Contractor with changes to its format only. The final report will be in a mutually agreeable format and shall be submitted to OHCA by May 15th of each calendar year.

ATTACHMENT G

RETROSPECTIVE REVIEW OF CHARTS REGARDING OUTPATIENT/REHABILITATIVE SERVICES DELIVERED IN COMMUNITY MENTAL HEALTH CENTERS (This Attachment may change dependent upon budget approval, if approved, the CMHC agencies will also go through the Prior Authorization process in Attachment I.)

G.1. Purpose: The parties agree that the purpose of this portion of the activities is to conduct on-site retrospective review of charts of those Medicaid clients receiving outpatient/rehabilitative service in facilities designated as Community Mental Health Centers (hereinafter referred to as CMHCs). The reason for the retrospective review is to assess the CMHCs internal prior-authorization process and to determine if the process results in the appropriate type(s) and unit(s) of care. In addition, Contractor will conduct on-site educational training and in-house Corrective Action Plan review with those CMHCs determined by Contractor in need of improvement. Contractor shall conduct the CMHC retrospective review in a collaborative effort with the Department of Mental Health and Substance Abuse Services' (DMHSAS') vision of CMHCs outpatient/rehabilitative services.

G.2. The sample of cases will be selected by OHCA and delivered to Contractor following a schedule developed collaboratively between the parties, as referenced in G.5. Contractor will notify the CMHC of their list of cases for review at least one week prior to the site visit. In conducting the chart review, Contractor agrees to review twenty-five (25) cases in one day with two reviewers, as designated by OHCA.

G.3. Contractor agrees to conduct on-site chart reviews of Medicaid fee-for-service cases related to those services described at OAC 317:30-5-241, OAC 317:30-5-242, OAC 317:30-5-586 and OAC 317:30-5-596.

G.4. Contractor agrees to conduct an annual on-site chart review of each Community Mental Health Center as identified and designated by the DMHSAS. The current facilities are listed in Addendum I to this ITB. In addition to the current list, Contractor agrees to conduct in-house reviews as referenced in paragraph G.2 above for all facilities identified as a CMHC by the DMHSAS during the term of this contract.

G.5. Contractor shall set a schedule of retrospective review dates with each CMHC from the facilities listed in Addendum I. This schedule shall be sent to OHCA for review. Contractor will notify the CMHCs by certified mail or fax of the sample list to be prepared for review.

G.6. In each review, Contractor agrees to perform the following services:

a) review the twenty-five (25) charts;
b) review the utilization of services defined in paragraph G.3 above;
c) compare the utilization for each patient by comparing the actual services provided to the patient as one variable, and using the standards referenced in Attachment I as the other variable; and,
d) develop reports based on comparisons as reflected in paragraph G.8 below.

G.7. The purpose of the task identified in paragraph G.6(c) is to retrospectively compare the actual utilization in CMHCs to the hypothetical utilization if each service was prior-authorized as directed in Attachment I.

G.8. Contractor agrees to provide three copies of the report regarding each CMHC facility. One report shall be to OHCA, one to DMHSAS and the other shall be to the facility reviewed.

a) The report to OHCA and the CMHC facility shall contain each of the following:

1. The number of cases selected and reviewed from each CMHC, the active Medicaid case number, recipient names, dates of service and time frame reviewed (e.g. 01/02/05-3/31/05);
2. Listing of cases Contractor is in agreement with the CMHC on level of care and types of services provided to recipients selected;
3. Listing of cases Contractor is in disagreement with the CMHC, and identification of the issues related to the disagreement; and,
4. A summary of findings and any Contractor recommendations regarding need of further action (on-site educational visit and/or corrective action plan).

b) DMHSAS will receive only number (4) above, the summary and recommendations, and will not receive the individual case reports. The OHCA has confidentiality, records and data sharing agreements with this agency that allows this information to be shared by Contractor.

G.9. On review results showing a significant deficiency rate, Contractor will decide if the CMHC facility will be required to develop a Performance Improvement Plan (PIP). Contractor will inform OHCA of this determination. OHCA will review the report referenced in G.8 above and the recommendations of Contractor in order to determine the need for any further action.

G.10. Contractor will notify the CMHC of a time frame required for receipt of the CMHC facility's PIP. Contractor will review the plan and make a final determination on the facility. The final determination may be either a final letter of acceptance to the facility on their PIP or a referral to the SURS department of OHCA.

G.11. For each review, Contractor agrees to use a team of two healthcare professionals consisting of a Licensed Psychiatrist, Licensed Psychologist, Licensed Marriage and Family Therapist, Licensed Social Worker (with clinical specialty), Licensed Behavioral Practitioner or a Licensed Professional Counselor with at least three years of clinical experience.

ATTACHMENT H

INSPECTIONS OF CARE IN PSYCHIATRIC FACILITIES

H.1. Purpose: The parties agree that the purpose of this portion of the activities in the contract is to determine whether psychiatric services being delivered under the Medicaid Program involve: 1) active, individualized, and appropriate treatment; 2) promote maximum physical, mental, and psychosocial functioning; and 3) whether the environment is safe and therapeutically appropriate.

H.2. Contractor agrees to provide care reviews as described in H.6 below to all facilities providing inpatient acute care, and/or residential treatment and psychiatric services to Medicaid patients under the age of 21. Please refer to Addendum II (A, B, and C) to this ITB for the current designated facilities.

H.3. Contractor agrees that should new facilities in the categories referenced in H.2., begin providing Medicaid services during the term of this Contract, Contractor shall incorporate such facilities into Addendum II (A, B, or C) and provide services without the requirement of a contract amendment. OHCA agrees to notify Contractor in writing, as soon as reasonably possible, should additional facilities be added during the term of this Contract.

H.4. For each review, Contractor agrees to use a team of one to three healthcare professionals, with at least one team member as identified below.

a) A Registered Nurse with at least three years of clinical experience, two of which must be in inpatient psychiatric services to children.

b) A Licensed Psychiatrist, Licensed Psychologist, Licensed Marriage and Family Therapist, Licensed Social Worker (with clinical specialty), Licensed Behavioral Practitioner or a Licensed Professional Counselor with at least three years of clinical experience, two of which should be inpatient psychiatric services to children.

H.5. The Contractor will identify and assign one member of the healthcare professional team, as the team coordinator for the inspection of care (IOC) process. Contractor will ensure there is maximum standardization and consistency regarding the Contractor's behavioral health services process utilized under this agreement.

H.6. Contractor agrees that the healthcare professional team will review patient chart samples of no less than five-percent (5%) of the number of Medicaid admits in the past 12 months, with a minimum of 1 and maximum of 20 charts reviews for each unit. If there are no active cases, then an IOC will not be conducted during the contract period. Contractor agrees to provide an on-site review of each facility listed in H.2 and H.3 during the term of this Contract, except as provided in H.13.

H.7. Contractor agrees to document and conduct on-site reviews that include each of the following components:

a) An annual meeting shall be conducted with the providers to review the IOC process for each contract year.
b) Chart reviews shall be performed to ensure that the appropriate and proper documentation of individualized assessments, treatment planning, treatment services (including physician care and medication practices), family involvement (in care and therapy), and discharge planning have been utilized;
c) Evaluate the appropriateness of staffing patterns;

d) Review of safety and adequacy of the facility and therapeutic environment;
e) Review the facility accreditation certification to ensure all facilities are current and in compliance with accreditation mandates; such as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), American Osteopathic Association (AOA), or the Commission on Accreditation for Rehabilitative Facilities (CARF) for Residential Treatment Centers.
f) Review of certain hospital policies (such as grievance, confidentiality, patient rights, etc.) for completeness and appropriate use and follow-up by staff;
g) Evaluate seclusion and incident reports, as well as any sentinel events (suicides on unit, other deaths, etc.);
h) Evaluate the treatment and services provided for children diagnosed with mental retardation, developmental disabilities or medical conditions; and,
i) Evaluate for adherence to any additional policy requirements for Medicaid compensation for services provided, i.e. staff credentials.
j) Exit interviews with providers shall be performed to review the overall results of the on-site review. In the event the Contractor discovered incomplete and/or missing documentation during the review, the Contractor shall provide a "missing records" letter for both parties (both parties shall sign the missing records notification, and each party shall retain an original for the permanent file).

H.8. Reports, Appeals and Penalties

a) Contractor will report to OHCA the appropriate penalties to be imposed on providers, according to the agreed upon guidelines. This initial report will be mailed to the Provider, via Certified Mail, within twenty (20) calendar days of the review.
b) If the Provider files an appeal of the Initial Decision/Report, they shall have ten (10) calendar days from the date they receive the Initial Decision/Report to respond.
c) Upon Contractor's receipt of a provider appeal, the Contractor shall submit a Final Decision/Report to the Provider, via Certified Mail, within 21 calendar days of the receipt of the appeal.
d) Based upon the findings from the process listed above, an ad hoc review may be convened by mutual agreement, between Contractor and OHCA, (see ad hoc standards below in H.14) and scheduled within 90 days.

H.9. Final Report:

a) For a review with no problems/discrepancies found, Contractor will deliver the Final Decision/Report to OHCA Behavioral Health Unit within thirty (30) calendar days of the exit interview.
b) For a review with problems identified, Contractor will deliver the Final Decision/Report to OHCA Behavioral Health Unit within thirty (30) calendar days of the exit interview, or thirty (30) calendar days from the date a final decision was rendered in regards to a provider appeal.

H.10. The forms, instruments, and reporting formats to be used in the review described in H.7 will be developed by Contractor and approved by the OHCA. The forms and instruments will be reviewed and updated as needed with agreement of both parties.

H.11 The site reviews will begin no later than September 15th, and will be conducted through June 30th of each calendar year. Payment for IOC reports shall not be issued until the final report is received and approved by the OHCA PM; with the understanding that this provision does not supersede payment provisions stated in Section 6.5 of this ITB.

H.12. Contractor agrees to provide an annual on-site review per contract year for each Acute and RTC program listed in Addendum II (A, B, and C). The Contractor also agrees to provide ad hoc reviews of facilities identified at the request of OHCA. The Contractor agrees to provide ad hoc reviews to a maximum of three (3)

Out of State facilities per contract year as designated by the OHCA. The OHCA will request an ad hoc review, when there is reason to believe a significant problem exists with the services being performed in a particular facility. In the event OHCA request an ad hoc review, the Contractor will perform a partial or full review as described in H.7 dependent upon the complaint and/or relevant issues; and, may use the evaluation instruments described in H.8 through H.10. Contractor is required to review a minimum of five (5) and a maximum of ten (10) cases, per level of care. At OHCA's discretion, an OHCA representative may accompany the team performing ad hoc reviews. Contractor agrees to send team members made up of at least 3 clinicians as identified in H. 4 above. Unless otherwise instructed by OHCA, the Contractor will attend to any difficult areas of policy and practice relevant to the specific concerns. It is agreed by Contractor, that when an ad hoc review is requested by the OHCA, Contractor shall conduct the review within 14 (fourteen) calendar days of the request.

H.13. In the case Contractor has reviewed a facility described in Addendum II A, B, or C in a prior year contract with OHCA, in addition to reviewing items in H.7, Contractor agrees compare the prior year's IOC report to the current years review findings. In this case, Contractor shall include any finding and history on this matter in the full report to OHCA.

H.14. Contractor agrees no prior notice of on-site reviews shall be provided to any facility. Contractor agrees to notify OHCA Behavioral Health Unit immediately, in any instance in which a facility refuses Contractor access to Medicaid patient records.

H.15. Contractor agrees to provide all finalized reports to OHCA concerning each facility reviewed, following the guidelines listed under H.9 above. The report shall contain the name of the facility, the team members, and all observations documented by the team during the review. Additionally, in instances where the Contractor reviews a site, program, or facility and determines the facility, environment, treatment, or practices are placing a child at risk of physical or emotional injury; the Contractor will contact the OHCA PM by telephone within twenty-four (24) hours of the review, provide a written report to the OHCA PM within four (4) calendar days of the review, and schedule a follow-up meeting with the OHCA PM.

ATTACHMENT I

OUTPATIENT BEHAVIORAL HEALTH, SUBSTANCE ABUSE AND PSYCHOLOGIST SERVICES

I.1. Purpose: The parties agree that the purpose of this portion of the contract is to utilize the services of Contractor to prior authorize certain behavioral health, substance abuse, case management, and psychologist services. This function is important as one facet of utilization control and quality improvement in the area of behavioral health and substance abuse services.

I.2. Contractor agrees to conduct all activities of prior authorization including: 1) the receipt of the prior authorization request from the provider; 2) review of the medical/psychological conditions asserted for the care; 4) verify providers eligibility through the OHCA MMIS system, and, 3) enter the prior authorization decision into the OHCA MMIS system (this action provides notification to the recipient of Contractor's decision. Contractor agrees to conduct prior authorization in the following areas: 1) outpatient behavioral health services; 2) substance abuse services; 3) case management; and, 4) psychologist's services.

General Responsibilities For Conducting All Prior Authorization Reviews

I.3. Contractor agrees to provide prior authorization (hereinafter referred to as "PA") each time a properly contracted OHCA Medicaid provider requests prior authorization of any of the services contained in OAC (Oklahoma Administrative Code) 317:30-5-241, 30-5-242, 30-5-586 and 30-5-596.

I.4. Contractor agrees to use its best professional judgment in determining both the medical necessity of the requested treatment, as well as determining the level of care required by the patient.

I.5. Contractor agrees to use the following standards to determine whether a service should be prior authorized:

a) Contractor agrees to process requests for PA, utilizing the criteria defined in the Outpatient Behavioral Health Services Provider Manual. Contractor shall work collaboratively with OHCA staff to update and modify the manual and procedures on a continuing basis.

b) In each case the level of care and the appropriate treatment modalities shall be determined through use of the Client Assessment Record (hereinafter C.A.R.), Addiction Severity Index (A.S.I hereinafter) or other appropriate assessment, the DSM-IV diagnoses, the current treatment regimen and the noted improvement or relapse of condition; patient history and/or current symptomatology;

c) In each case, Contractor agrees to utilize all OHCA regulations regarding prior authorizations, all regulations regarding eligible providers, and all regulations regarding the services noted in Paragraph I.3 above. OHCA agrees to submit an active provider file to Contractor at an agreed-upon frequency for reconciliation by Contractor. Contractor will ensure their staff verifies provider eligibility.

I.6. A request for prior authorization of outpatient Behavioral Health and/or case management services may be considered and processed for the following levels of care:

a) Children (0-36 months);
b) Children (under 21), levels I-IV;
c) Adults (over 21 years), levels I-IV;

d) ICF/MR Residents;
e) Psychological Evaluation;
f) Specialized Case Management, Child and Adult;
g) Children in Residential Behavioral Management Services
h) Substance Abuse
i) Psychologists
j) Others as mutually agreed upon.

Staffing

I.7. Contractor agrees to hire an appropriate number of professionals including: Review Coordinators, Program Managers, Clinical Consultants and Support Staff to timely handle the requests received by Contractor. Contractor agrees that licensed staff shall maintain an active license; and the educational qualifications of these professionals shall be the following:

a) Contractor agrees that team members or review coordinators shall be either a(an): (1) Licensed Professional Counselor with three or more years of clinical experience, (2) Licensed Marital & Family Therapist with three or more years of clinical experience, (3) Licensed Social Worker with a clinical specialty with three or more years of clinical experience, (4) Licensed Behavioral Practitioner with three or more years of clinical experience, or (5) Advanced Practice nurse (certified in a psychiatric mental health specialty, licensed as a registered nurse with a current certification of recognition from the state board of nursing.

b) Contractor agrees that the Outpatient Behavioral Health Manager will be an individual(s) with at least five (5) years of experience in the Behavioral Health field, has familiarity with the pre-authorization process and requirements, has supervisory experience, and extensive skills in working with the public. Contractor agrees that the manager position will be licensed as described in I.7 a) above.

b) Contractor agrees that Clinical Consultant(s) shall be licensed in one of the following categories: (1) a Board Certified Licensed Psychiatrist, (2) a Licensed Clinical Psychologist, or (3) a Licensed Psychopharmacologist.

Internal Quality Control Measures

I.8. Contractor agrees to develop and/or maintain an internal quality control system regarding all "PA" decisions. The Outpatient Behavioral Health Manager shall supervise this system.

I.9. Contractor shall audit each review coordinator on a monthly basis for internal quality control issues. Contractor shall audit a minimum of ten (10) cases per month, per review coordinator.

I.10. Contractor agrees that the Outpatient Behavioral Health Manager and/or a designated and appropriately trained senior review coordinator(s) or consultant(s) will audit each case for the appropriateness of the decision in accordance with Paragraph I.4 and I.5 above.

I.11. If inappropriate decisions are found by Contractor, the Contractor Outpatient Behavioral Health Manager and/or designated personnel shall provide training and education to review coordinators concerning the clinical area of concern.

I.12. Contractor shall complete a monthly report regarding the review coordinator audit. The reports shall be completed and delivered to the OHCA Director of Behavioral Health Services, no later than the tenth day of the following month. The report shall be in a format agreed upon by OHCA and Contractor.

I.13 The Contractor shall develop and implement an ongoing process of assessing, evaluating, and improving inter-rater reliability for the purpose of achieving maximum consistency of reviewer decisions. This report will discuss the outlier reviewer(s), the corrective action plan, and measurable outcomes shall be detailed in each report until the desired level of competency has been achieved and/or employee is no longer employed by the Contractor.

I.14. A report of the inter-rater reliability shall be furnished by Contractor on the same schedule as delineated in I.12.

Prior Authorization Service for All Outpatient Behavioral Health Services

I.15. The Contractor shall collaborate with the OHCA staff members in implementing the prior authorizations internal process. Contractor understands that modifications may be implemented through out the term of the contract due to State, Federal, or Program modifications; and agrees to make such modifications when mandated.

I.16. Contractor agrees to receive by hand delivery, mail, encrypted electronic transmission, or facsimile all prior authorization requests of Medicaid fee-for-service providers who are designated as private or ODMHSAS contracted (and possibly public, if budget is approved). Providers designated as public Contractors will only utilize the prior authorization process conducted by Contractor as mutually agreed upon in writing by the parties.

I.17. Contractor agrees that upon delivery of the prior authorization request it shall determine the recipient's eligibility by accessing the Electronic Data System (EDS) MMIS eligibility file. OHCA agrees to provide on-line access to the EDS eligibility file, and to make the eligibility file accessible to Contractor.

I.18. The parties anticipate that multiple factual scenarios may arise when checking the EDS file regarding recipient eligibility. Below are the agreements of the parties regarding those anticipated factual scenarios:

a) In the case that the EDS file shows eligibility for the recipient to be pending, Contractor agrees to process the prior authorization as stated in I .19 below. Contractor also agrees that in this case, if the requested service(s) are approved and authorized, the provider will receive notification that the "PA" will be binding, upon eligibility determination and/or confirmation. Contractor agrees not to assign a number to a "PA" when the recipient's eligibility status is pending, and agrees that the "PA" will date back to when it was received by Contractor, subject to the eligibility dates contained in the EDS system.

b) In the case Contractor checks the EDS system and it confirms the recipient's eligibility; Contractor agrees to process the "PA" as described below in I.19. Contractor agrees to enter the PA data requested and approved, modified, and/or denied, along with the authorization period requested approved and/or denied into the EDS system.

c) In the case Contractor checks the EDS system and it shows that the recipient is not eligible; Contractor shall process the case and place it in "pending" status until further notification of the patients' eligibility.

I.19. The parties also anticipate that with respect to the completeness of the "PA" request by a provider, some requests will not be complete. Below is the agreement of the parties concerning the duties of the parties should this circumstance arise:

a) In the case the "PA" request is complete, the team member or review coordinator as stated in I.7a) shall complete the "PA" process by using the standards expressed in paragraphs I.3, I.4, I.5, and I.6 above. If clinically denied by a physician consultant, Contractor agrees to generate a denial for the PA by entering the information into the EDS system.

b) In the case the "PA" request is incomplete; the Contractor agrees that the team member or review coordinator shall send the requesting provider an "Important Notice" stating the missing elements. This "Important Notice" shall be faxed/encrypted electronic transmission to the provider. Contractor shall allow the provider ten (10) calendar days from the date of the facsimile/encrypted electronic transmission to respond to the request. If the provider sends in the information requested, then the request will be processed and the PA will begin on the date the original request was received. In the case where the provider fails to respond in ten (10) calendar days, Contractor shall send the provider a "Technical Denial" and require the provider to submit a new "PA" request, which is fully complete. Contractor agrees to generate a denial in the EDS system (this action initiates a denial notice to the recipient as required by OHCA).

I.20. If review coordinator or team member is unable to determine the necessity of the PA request based upon the established criteria, the PA shall be referred to the a clinical consultant (as expressed in paragraph I.7c) for review.

I.21. Contractor agrees to respond to all "PA" requests within the established timelines. Under this section, day of receipt means received by fax, mail, encrypted electronic transmission, or hand delivery before 3:00 p.m., Monday through Friday. After 3:00 p.m., the PA request is dated the next business day. From receipt of the request through the work described in paragraphs I.16 and I.19, Contractor shall respond to the provider according to the following timelines: If the total number of requests for the calendar month is less than 2,500, the response should be completed and the provider notified within one business day. If the total number of requests for the month is between 2,500 and 3,000, the response time will be one and a half business days. If the total number of requests is between 3,000 and 3,500, the response time will be within two business days. If the total number of requests is between 3,500 and 4,000, the response time will be within two and a half business days. If the total number of requests is over 4,000, the response time will be within three business days. These timelines are reported to OHCA each month by the 10th calendar day of the next month as part of the regular monthly report (see section I.25).

a) From receipt of the request through the work described in paragraphs I.16 and I.19b (an incomplete "PA" request), Contractor shall respond to the provider in three business days.

b) From receipt of the request through the work described in paragraphs I.16, I.17 and I.18 (a complete "PA" request reviewed by a Clinical consultant), Contractor shall respond to the provider in three (3) business days.

c) When Contractor receives an Important Notice Response, Pending Eligibility Response, or a Correction Request, Contractor agrees to respond to the provider within three (3) business days. Providers are not penalized for the number of days it takes Contractor to work responses; these are added into their authorizations.

I.22. Contractor agrees that in all cases, once a "PA" has been approved, Contractor shall assign a recipient and provider site-specific authorization number to each "PA" request. Contractor agrees that this recipient and provider site-specific authorization number shall be entered into the EDS via direct on-line entry or by batch entry. Each authorization number will be associated with from/through dates by service and month to indicate the length of service being authorized by Contractor. The work contained in this paragraph shall be completed in the time frames contained in paragraph I.19a, b, or c depending upon whether the associated "PA" request is complete, incomplete, or is reviewed by a medical consultant.

I.23. Extensions or Additional "PA" Requests:

a) In the case a "PA" request is received regarding a recipient for which a current "PA" authorizes services, and the request seeks additional or extended services to begin before the expiration date of the current "PA", Contractor agrees that it shall process requests that are submitted up to fifteen (15) calendar days prior to the end date of the previous authorization. Requests for extensions submitted with more than fifteen (15) calendar days remaining on the previous request will be returned to the provider with an explanation of why the request was not processed.

b) Modification of Current Authorization Request: This applies when a patient is better suited with a different array of services than previously authorized. The start date of the modified authorization will be the date the modification request is received and the end date will remain the same as the current authorization on file.

c) Contractor shall perform updates and limited modifications to previously processed "PA" requests, in cases such as provider mergers or provider change of site-specific numbers.

Appeals Process

I.24. a) It is hereby agreed and understood by the Parties that OHCA does not provide an appeals process for providers for denials issued by the Contractor.

b) Contractor shall provide recipients written instructions regarding the appeals process afforded to recipients through OHCA, pursuant to O.A.C. 317:2-1-2 and 42 CFR 431.211. Contractor shall develop an effective referral program to assist recipients in acquiring appeals information, and shall refer them to the address and or telephone number listed below:

The Oklahoma Health Care Authority's address is:
Docket Clerk
P.O. Box 18497
Oklahoma City, OK 73154-0497
(405) 522-7431
A copy of the OHCA LD-1 Form can be found on www.ohca.org.

Prior Authorization Request Reporting

I.25. Contractor agrees to provide two sets of reports to OHCA regarding the activities described herein:

a) Contractor agrees to submit a monthly report to OHCA detailing the activities in Attachment I of this contract. Contractor agrees to provide the report by the tenth (10th) calendar day of the next month for the duration of the contract. The monthly report shall contain:

1. Number of all "PA" requests made during the calendar month,

2. Number of all "PA" requests approved, modified, and denied (not including reconsiderations),
3. Average response time of all "PA" decisions (not including reconsiderations),
4. The number of reconsiderations of all cases,
5. A detailed list of all reconsideration cases, the final decision, and provider information,
6. Average response time for reconsideration cases,
7. All cases categorized by level of care, and
8. Provider report including the number of units of each type of service requested and authorized and/or denied by level of care.

b) The parties agree to discuss and resolve any problems or concerns relating to "PA" services.

c) Contractor agrees to collect and record specified data elements (elements to be determined by OHCA) as requested.

d) Contractor agrees to send table/data extract (format to be determined) with specified data fields to OHCA on a monthly basis.

e) The issuance of any prior authorization shall not require OHCA to pay for behavioral health services rendered. OHCA shall retain authority to determine whether any service is a covered benefit under the Medicaid Plan.

f) Contractor agrees to provide data runs for OHCA upon request and in mutually agreed timeframes. These data runs have been utilized in the past for determining problematic prior-authorization request patterns by providers, level of care changes, reviewer decision patterns, etc. In addition, the data requested may include analysis of authorizations over time for various recipient sub-groups.

g) Contractor agrees to provide established behavioral health data reports as agreed upon by both parties. The reports will be submitted quarterly; October 10th, January 10th, March 10th, and July 10th unless otherwise specified. The different reports can be modified or changed at anytime throughout the year to better meet OHCA's needs for behavioral health information. OHCA may request revisions to the format if additional data is required.

Psychologists Prior Authorization

I.26. OHCA reimburses psychologists to provide certain mental health therapies to Medicaid recipients who are less than twenty-one years of age. Prior authorization is required if the child is to receive more than a standard amount of defined treatment.

I.27. Contractor agrees to evaluate the requests for prior authorization of psychological services. The guidelines to be followed will be developed collaboratively between the OHCA Behavioral Health staff and the Contractor.

I.28. Contractor agrees to authorize services for Psychological Services pursuant to O.A.C. 317:30-5-275 through 317:30-5-279, and adhere to the process and timeframes as described in I.15 through I.23 of this contract.

I.29. Contractor will provide education to psychologists regarding the prior authorization of services via telephone, meetings, mailings, and other written information as necessary.

Informational Meetings and Notifications

I.30. Contractor shall offer a monthly meeting with providers to educate providers about the prior authorization process. The purpose of this requirement is to allow providers direct access to personnel and provide an educational dialogue. These meetings shall be posted within the provider manual and on the Contractor's website, and per reviewer communications with providers. The Contractor will conduct annual Provider Manual Trainings in OKC, Tulsa, and Lawton.

I.31. Contractor agrees to develop and distribute monthly provider newsletters to educate providers about the "PA" process as needed.

Case Management Prior Authorization for Clients under Age 21

I.32. Purpose: OHCA reimburses agencies contracted to provide case management services for Medicaid recipients who are less than twenty-one years of age pursuant to O.A.C. 317:30-5-595 through 317:30-5-599. Prior authorization is required for all children's case management services.

I.33. Contractor agrees to evaluate the requests for prior authorization of case management services following the guidelines in the Outpatient Behavioral Health Rehabilitative Services Manual. Contractor will prior authorize case management services with licensed master's level clinicians.

I.35. Contractor shall provide education to agency staff regarding the prior authorization process on an ongoing basis and shall monitor staff as appropriate.

I.36. Contractor shall maintain a database of case management providers, the geographical location of coverage, and will update the database periodically to maintain a current provider directory.

I.37. Contractor shall facilitate coordination of care with the agencies providing case management services, and the inpatient hospital facilities to which or from which a child is admitted or discharged. When a child is admitted to inpatient (acute or RTC) psychiatric treatment, it is the treating hospital's responsibility to make the case management referral. The goal of case management services is to maintain the child at the least restrictive level of care.

I.38. Contractor shall facilitate referrals for case management services when a child is denied hospitalization. Case management service will be offered to the child's guardian at the time of the denial. When the guardian accepts the referral, the Contractor shall inform the guardian of the different case management agencies in the family's catchment area. Contractor shall fax the referral to the case management agency on the same day the guardian selects an agency.

I.39. Contractor agrees to prior authorize the initial 48 units of case management authorized for clients referred directly from inpatient or from hospitalization denials.

I.40. Contractor will provide data runs monthly with the number of PA requests and extensions requested and approved, denied and/or modified in the same general format specified in in I.25.

ATTACHMENT J

INPATIENT, TFC, AND MEDICAL PRIOR AUTHORIZATION OF BEHAVORIAL HEALTH SERVICES

J.1 Purpose: The parties agree that the purpose of this portion of the contract is to utilize the services of Contractor to prior authorize children's psychiatric inpatient (Acute and RTC) and Therapeutic Foster Care. This function is important as one facet of utilization control and quality improvement in the area of behavioral health services.

J.2. Contractor agrees to conduct all activities of prior authorization including: 1) the receipt of the call/request from the provider; 2) the review of the medical/psychological conditions asserted for the care; and, 3) notification to the recipient and/or provider of Contractor's decision. Contractor agrees to conduct prior authorization processes in the following areas: 1) children's psychiatric inpatient (Acute and RTC), and 2) therapeutic foster care. Children's inpatient psychiatric authorizations will be referred to as "inpatient authorizations" for the remainder of this section.

J.3. Contractor shall provide services determining the appropriateness of behavioral health-care services for Medicaid recipients, otherwise known as "inpatient authorization," in keeping with sound professional practice and this Contract, and OHCA shall pay for such services as provided by this Contract. This inpatient authorization service shall serve as the determination of whether a particular patient's care may be eligible for Medicaid payment.

J.4. Contractor agrees that all inpatient review coordinator staff shall carry an active license as a: (1) Licensed Professional Counselor with three or more years of clinical experience, (2) Licensed Marital & Family Therapist with three or more years of clinical experience, (3) Licensed Social Worker with a clinical specialty with three or more years of clinical experience, (4) Licensed Behavioral Health Practitioner with three or more years of clinical experience, or (5) Registered Nurse with at least three years of clinical experience. All staff identified in (1) through (5) above must have a minimum of two years experience in inpatient psychiatric services for children.

J.5. Contractor shall directly provide the services described in Paragraphs j) through l) of Section J.5 below. Contractor shall assure such services comply with the latest publication of the procedural manual entitled *"Inpatient Authorization Procedures Manual for Children's Psychiatric Services"* and as revised by agreement between the parties periodically.

In inpatient authorization, Contractor shall:

a) Cause a licensed mental health professional (MHP) as defined in J.4. above, to conduct a telephone evaluation of any Oklahoma Medicaid-eligible child younger than twenty-one (21) years of age, who is presented for in-patient acute psychiatric care or inpatient Residential Treatment to determine whether such care is medically necessary, and if such care is found medically necessary, shall issue a prior authorization (Acute is paid under a DRG rate, therefore, the PA is only for the physician's services), and shall include a statement of the number of days permitted for the care, for the hospital, and for the physician's services;

b) Cause a MHP to conduct a telephone evaluation of any Oklahoma Medicaid-eligible child younger than twenty-one (21) years of age who is presented for therapeutic foster care (also known as Residential Behavioral Management in a foster care setting) to determine whether such treatment is medically necessary; and if such treatment is found medically necessary, shall issue a prior authorization which shall include a statement of the number of days permitted for the treatment.

Contractor will submit a quarterly data analysis report on October 10th, January 10th, April 10th, and July 10th, of each calendar year.

c) Cause a MHP to conduct a telephone evaluation of any Oklahoma Medicaid-eligible child presented for medical detoxification to determine whether such care is medically necessary, and if such care is found medically necessary, shall issue a prior authorization for such care which shall include a statement of the number of days permitted for the care;

d) Cause a MHP to provide care management to beneficiaries through evaluation; where an individual reviewer will follow the patient through their hospital stay and any re-admission. The review, performed by telephone, would consist of detailing the pertinent clinical information of any person identified in Paragraphs a) through c) of this section for which a certificate of need has been issued, and for whom a behavioral health-care provider requests an extension of such treatment, to determine whether such an extension is medically necessary. If such an extension is found medically necessary Contractor shall issue a prior authorization for such extension, which shall include a statement of the number of days permitted for the extension of treatment. Contractor shall request additional information from provider, if necessary, to make a determination regarding medical necessity criteria and/or appropriateness of care. OHCA will develop and train Contractor on the care coordination protocols.

e) Cause a MHP to make a physician consultant referral on any request they feel does not meet medical necessity criteria. The physician consultant shall review the denial made by the MHP reviewer and make a final determination on the case; and either issue a prior authorization for such care which shall include a statement of the number of days permitted for the care, or a modification which shall include a statement of the modified number of days permitted for care, or a determination of denial.

f) The parties anticipate that on a number of authorization requests, the review coordinator will not be able to determine the medical necessity of the request based upon the information provided. In that case, Contractor agrees the review coordinator shall refer the request to a clinical consultant.

g) In cases where a child is in acute care for over 15 days, standard residential treatment for over 3 months, or in specialized residential treatment for over 6 months, Contractor shall provide review of additional information, should the stay appear clinically unwarranted. These reviews will assess the appropriateness of the extension request of care provided within the treating facility. The Contractor inpatient authorization manager or an identified Contractor inpatient review coordinator may perform this review. Contractor agrees to refer the request to a clinical consultant when necessary.

h) It is hereby agreed and understood by the Parties that OHCA does not provide an appeals process for providers for denials issued by the Contractor.

i) Contractor shall provide recipients verbal and written instructions regarding the appeals process pursuant to O.A.C. 317:2-1-2 afforded to recipients through OHCA and shall refer them to the address and or telephone number listed below:

The Oklahoma Health Care Authority's address is:
Docket Clerk
P.O. Box 18497
Oklahoma City, OK 73154-0497
(405) 522-7431

A copy of the OHCA LD-1 Form can be found on www.ohca.org.

j) Assist OHCA with the process of determining the need for particular clients to be placed in out-of-state Acute and RTC placements (both custody and non-custody children): 1) Contractor will work with the current treatment providers to collect the information needed to determine if the client needs an out-of-state placement; and, 2) Once the needed information has been collected, Contractor will staff the client's case with an OHCA representative who will approve payment for the out-of-state placement. Contractor will provide Care Coordination for children placed out of state. This will include reviewing and assessing provider's discharge plan, as well as communication with parent/guardian or DHS/OJA caseworker on the discharge plan/status of these children. Contractor will work with provider and/or guardian to ensure appropriate referrals to a lower level of care. Contractor will submit a monthly census and case status report to OHCA by the 14th calendar day of each month.

k) Maintain and update as needed the "*Inpatient Authorization Procedures Manual for Children's Psychiatric Services*".

l) Contractor shall offer a minimum of four (4) trainings sessions via: (face-to-face or teleconference) sessions with providers to provide education regarding the inpatient authorization process.. The will assist providers in gaining direct access to Contractor personnel regarding inquiries. These meetings shall be posted for providers on the Contractor's website, and providers will also be notified by phone or fax regarding these meetings.

m) Contractor agrees to provide data reports for OHCA upon request and in mutually agreed upon timeframes. These data reports have been utilized in the past for determining problematic prior-authorization request patterns by providers, level of care changes, problematic reviewer decisions, etc. In addition, the data requested may include analysis of authorizations over time for various recipient subgroups.

n) Contractor shall send the initial review for admission, resulting in prior authorization for children in DHS custody, to a DHS supervisor in each of the 77 counties in Oklahoma. Initial reviews for admission resulting in prior authorization for children in OJA custody will be sent to OJA district supervisors and administrators for juvenile justice institutions. OHCA will provide a direcotry to the Contractor for the above mentioned agencies.

Inpatient Authorization Request Reporting

J.6. Contractor agrees to provide two sets of reports to OHCA regarding the activities described herein:

a) Contractor agrees to submit a monthly report to OHCA detailing the activity in Attachment J of this contract. Contractor agrees to provide the report by the fourteenth (14th) calendar day of each month for the duration of this contract. The monthly report shall contain:

1. Number of all "PA" requests made during the calendar month,
2. Number of all "PA" requests approved, modified, or denied (not including reconsiderations),
3. The number of reconsiderations of all cases,
4. Listing of reconsideration cases and the final decision with specific provider information provided whenever requested by OHCA,
5. All cases categorized by level of care,

6. Provider report: # of units of each type of service requested and authorized and/or denied by level of care.

b) Contractor agrees to collect and record specified data elements (elements to be determined by OHCA).

c) Contractor agrees to sending table/data extract (format to be determined by OHCA) with specified data fields on a monthly basis.

d) Reports will be submitted to the OHCA by the agreed upon timetables and in the agreed upon format, throughout the contract period. OHCA may request revisions to the format if additional data is required.

Internal Quality Control Measures

J.7. Contractor agrees to an internal quality control system regarding all "PA" decisions. The Inpatient Behavioral Health Manager shall supervise this system.

J.8. Each month during the term of this contract, Contractor shall review 10 cases from each review coordinator for internal quality control.

J.9. Contractor agrees that the Inpatient Behavioral Health Manager, and/or a designated and appropriately trained review coordinator, or consultant will review each case for the appropriateness of the decision in accordance with J.5 above.

J.10. If inappropriate decisions are found by Contractor, the Contractor Inpatient Behavioral Health Manager, and/or designated review coordinator, or consultant shall educate the review coordinator concerning the clinical area of concern.

J.11. Contractor shall complete reports regarding the sample and reviews. The reports shall be completed and received by the OHCA Director of Behavioral Health Services no later than the 10th of the following month. The report shall be in a format agreed upon by the OHCA and Contractor.

J.12. The Contractor shall develop and implement an ongoing process of assessing, evaluating and improving inter-rater reliability for the purpose of achieving maximum consistency of reviewer decisions.

J.13. A report of the inter-rater reliability shall be completed and received by the OHCA. Following the reporting schedule in J.11 above, the report shall be in a format agreed upon by the OHCA and Contractor.

J.14. Limitations: The issuance of any prior authorization shall not require OHCA to pay for behavioral health services rendered. OHCA shall retain sole authority to determine whether any service is a covered benefit under the Medicaid Program.

J.15. ADMINISTRATION

As to administrative services, Contractor shall:

a) Provide for the generation of a prior authorization ("PA"), by entering "PA" information into the data base, resolve problems which may arise with providers related to the "PA" decisions;

b) Create and maintain a database of "PA" decisions and other agreed upon data elements related to the inpatient authorization functions; and,

c) In each case Contractor agrees to utilize all OHCA regulations regarding prior authorizations, all regulations regarding eligible providers, and all regulations regarding the services noted within this ITB. OHCA agrees to submit an active provider file to Contractor at an agreed-upon frequency for reconciliation by Contractor. Contractor will ensure their staff verifies recipient and provider eligibility.

J.16 Contractor shall provide administrative services necessary to:

a) Assist in the review, development, and implementation of amendments to the State Medicaid Plan relating to provision of behavioral healthcare services;

b) Assist in the review, develop, and implementation of rules and procedures for the administration of any activities provided under this Contract; and,

c) Contractor agrees to provide update letters to providers, whenever necessary, to educate providers about the "PA" process. Contractor shall be responsible for distribution of the letters to providers.

ATTACHMENT K
INSPECTIONS OF CARE OF THERAPEUTIC FOSTER CARE PROGRAMS

K.1. Purpose: The parties agree that the purpose of this portion of the activities in the contract is to determine whether behavioral management services provided in foster home settings by Therapeutic Foster Care (TFC) agencies under the Medicaid Program involve: 1) active, individualized, and appropriate treatment; 2) promote maximum physical, mental, and psychosocial functioning; and, 3) whether the environment is safe and therapeutically appropriate.

K.2. Contractor agrees to provide Inspections of Care to all programs in which Medicaid patients under the age of 21 are served. Addendum III to this Contract contains a listing of all such programs. These on-site Inspections of Care will be conducted by a designated inpatient review coordinator(s). The reviews will include chart reviews for documentation of appropriate and required treatment services, assessments, treatment planning, and discharge planning. Contractor will report to OHCA and DHS the findings of these Reviews. The forms, instruments and reporting formats to be used in these reviews will be approved by OHCA, and shall be reviewed and updated as needed with agreement of both parties.

K.3. Contractor agrees that should new programs be created during the term of this Contract to serve Medicaid patients under age 21, Contractor shall be responsible for providing the same reviews as reflected below. OHCA agrees to notify Contractor in writing as soon as reasonably possible of any new programs being added under the terms of this Contract. Contractor agrees to perform ad hoc reviews at the request of OHCA.

K.4. For each review, Contractor agrees to use a team of two healthcare professionals as identified in a) or b) below

a) A Registered Nurse with at least three years of clinical experience, two of which must be in psychiatric services to children.

b) A Psychiatrist, Licensed Psychologist, Licensed Marriage and Family Therapist, Licensed Social Worker (with clinical specialty), Licensed Behavioral Practitioner or a Licensed Professional Counselor with at least three years of clinical experience.

The Contractor will identify one member of the team, of healthcare professionals delineated above, to serve as the coordinator of the "Inspection of Care "(IOC) process. Contractor will ensure there is maximum standardization and consistency regarding Contractor's behavioral health services contracted under this agreement.

K.5. Contractor agrees to utilize the coordinator(s) to provide on-site visits to all of the programs listed in Addendum III, and review a minimum of 1 and a maximum of 10 Medicaid records for patients admitted within the past 12 months. Contractor agrees to go onsite to each program once during the term of this Contract to conduct reviews as identified in K.2 and K.3, except as provided in K.12.

K.6. Contractor agrees to conduct on site reviews that include each of the following components:

a) Conduct an initial annual conference with the providers to review the IOC process for the current contract year.
b) Chart reviews for documentation of appropriate and individualized assessments, treatment planning, treatment services, family involvement (in care and therapy), and discharge planning;
c) Review of accreditation status by Commission on Accreditation for Rehabilitative Facilities (CARF) or Council on Accreditation (COA);

d) Crisis intervention services relative to any psychiatric admission from TFC;
e) Evaluate the treatment and services provided for children who have mental retardation, developmental disabilities or medical conditions;
f) Evaluate for adherence to any additional policy requirements for Medicaid compensation for services provided; and,
g) Conduct an exit interview with the provider to go over the results; and complete a letter for both parties to sign and keep a copy on unfound records.

K.7. Reports, Appeals and Penalties

a) Contractor will report to the OHCA regarding findings. This initial report will go to the Provider via Certified Mail within 15 days of the review according to the agreed upon guidelines.
b) If the Provider chooses to file an Appeal of this Initial Decision/Report, they shall have ten (10) days from the date they receive the Initial Decision/Report to respond.
c) Upon Contractors receipt of a provider appeal, the Contractor shall submit a Final Decision/Report to the Provider, via Certified Mail, within twenty-one (21) calendar days of the receipt of the appeal.
d) Based upon the findings from the process listed above or issues identified in other information received, an ad hoc review may be convened by mutual agreement between Contractor and OHCA (see ad hoc standards below in K.11) and scheduled within 90 days.

K.8. Final Report:
a) For a review with no problems/discrepancies found, Contractor will deliver the Final Decision/Report to OHCA within thirty (30) calendar days of the exit of the review.
b) For a review with problems identified, Contractor will deliver the Final Decision/Report to OHCA within thirty (30) calendar days of the exit review dependent upon whether the Provider chooses to Appeal the Initial Decision/Report.

K.9. The form, instruments, and reporting formats to be used in the review described in K.6 and K.7 shall be developed by Contractor and approved by the OHCA. The forms and instruments will be reviewed and updated as needed with agreement of both parties.

K.10. The scheduled site reviews will begin no later than July 30th, and will be conducted through June 30th, of each calendar year. If requested by OHCA, an ad hoc review may begin as early as July 1st.

K.11. The Contractor agrees to provide one on-site review per year for each TFC program listed in Addendum III. The Contractor also agrees to provide a maximum of three ad hoc reviews of facilities identified at the request of OHCA. The OHCA will request an ad hoc review when there is reason to believe a significant problem exists with the services being performed. In the case of an ad hoc review, the Contractor will perform a partial or full review as described in K.6 dependent upon the complaint and/or issues relevant, and may use the evaluation instruments described in K.6 through K.9. A minimum of 5 and a maximum of 10 records will be reviewed. At OHCA's discretion, representative(s) or OHCA, OKDHS, OCCY and/or other parties with fiscal or legislatively mandated interest may accompany the Contractor team on the ad hoc review. Contractor agrees to send the coordinator as identified in K.4 a) and b) above. Unless otherwise instructed by OHCA, the Contractor will attend to any difficult areas of policy and practice relevant to the specific concerns. It is agreed by Contractor that when an ad hoc review is requested by the OHCA, Contractor shall conduct the review within fourteen (14) calendar days of the request and subject to the availability of OHCA staff.

K.12. In the case Contractor has reviewed a program described in Addendum III in a prior year contract with OHCA, or in the case a corrective action plan is implemented with the provider during the term of this contract, in addition to reviewing for items in K.6, Contractor agrees to review the program with specific focus on the

corrective action plan guidelines agreed upon between OHCA and the facility. In this case, Contractor shall include any finding on this matter in the full report.

K.13. Contractor agrees that 24-hour prior notice of its on-site review shall be provided to each program to allow time to collect charts at the designated location. Contractor agrees to notify the OHCA Behavioral Health Unit immediately in any instance in which a program refused Contractor access to Medicaid patient records.

K.14. Contractor agrees to provide all finalized reports to OHCA concerning each program reviewed following the guidelines listed under K.8 above. The report shall contain the name of the program, the name of the team member(s), and all observations made by the team member(s) during the review. Additionally, in instances where a site or program reviewed by Contractor where the program, environment, treatment, or practices are placing the child at risk of physical or emotional injury, the Contractor will contact the OHCA Behavioral Health Unit by phone within twenty-four (24) hours of the review, and will follow up with either a meeting with OHCA staff or a summary report to the OHCA within four (4) calendar days of the review.

K.15. Contractor agrees to provide TFC provider training and TFC provider newsletter/letter updates whenever there is a change in the TFC prior authorization or IOC review processes.

ATTACHMENT L

(This schedule is optional. Responding or not responding to this schedule will not affect any bidder's evaluation or chance of being awarded the bid.

MEDICAID PROVIDER PUBLICATION

L.1. Provider Update Newsletter

The purpose of the Medicaid newsletter, *Provider Update*, is to provide a vehicle of communication from OHCA to the Medicaid providers and their staff. Content will include information relative to qualitative reviews conducted jointly with OHCA and Contractor for the Medicaid population. It will also provide limited clinical/technical information to physicians, nurse practitioners, and other primary care providers to assist them in helping OHCA meet its goals for the Oklahoma's Medicaid population.

Articles will highlight timely medical information (e.g., survey results, psychiatric reviews, QARI reviews, focused study results, etc.) and topics related to disease-oriented information pertinent to Oklahoma's Medicaid population, as well as information to assist providers as they navigate the managed care system. The newsletter will also provide operational information that is relevant to the administration of Oklahoma's Medicaid program.

L.2 Scope of Responsibilities

Contractor will work jointly with OHCA in the development, publication, and distribution of a quarterly, four (4)-color newsletter, up to 8.5 x 11" size paper, on a stock comparable to 100 lb. Productolith gloss book, twelve (12) pages in length, of which four (4) will be a separate insert containing MMIS-related information, in a quantity up to 20,000 printed pieces. To achieve the stated objectives for the *Provider Update* newsletter, Contractor will be responsible for the coordination, implementation and/or procurement of: writing, editing, design, layout, and printing of publication and cover, and mailing house services. OHCA will provide timely direction related to article content, including a written description sufficient to define the desired intent of the article. OHCA will contribute articles as appropriate, will identify appropriate OHCA contacts, and will provide final approval. EDS/OHCA will be responsible for the writing and editing of the four (4) page MMIS-related insert of the publication, and Contractor will be responsible for the layout of the insert. Contractor will be responsible for providing postage and mailing.

OHCA will provide Contractor with the updated database of newsletter recipients at least four (4) weeks prior to release date of each issue.

L.3 Schedule and dates for each calendar year this contract is effected:

The first issue of the quarterly newsletter will be completed for draft review by July 25th and released by September 5th. The second newsletter will be produced for draft review by October 25th, and released by December 4th. The third newsletter will be produced for draft review by January 29th, and released by March 5th. The fourth newsletter will be produced for draft review by April 24th, and released by June 4th. OHCA will complete the review of each draft and submit revisions to Contractor within fourteen (14) calendar days of the draft review deliverable date. In the event that OHCA exceeds the fourteen (14) calendar day schedule, a revision to the release date may be considered and authorized in writing by a designated staff member of OHCA.

L.4 <u>Annual Quality Report</u>

Contractor will work collaboratively with OHCA to produce an Annual Quality Report. This report will coincide with the release of the OHCA State Fiscal Year (SFY) Annual Report, but will focus on quality outcomes achieved by the *SoonerCare* program. The format and content will be jointly determined by Contractor and OHCA, with the final report being submitted to OHCA by October 31st of each year.

Contractor will work collaboratively with OHCA to produce a draft report for the Annual Quality Report. This report will coincide with the release of the OHCA Annual Report, but will focus on quality outcomes achieved by the SoonerCare program. The format and content will be jointly determined by Contractor and OHCA with the final detailed outline of the report being submitted to OHCA by June 30th.

L.6 In the event this portion of the Bid is awarded to an outside vendor, the Bidder receiving the total award portion of this ITB shall be required to work collaboratively with OHCA and the Medicaid Provider Publication vendor and shall be required to provide all information on a timeline to be determined at a future date.

Addendum I
Community Mental Health Centers Listing
Referenced in Attachment G

Name of Organization

Associated Centers for Therapy, Inc (ACT), 7010 S. Yale, Ste.215, Tulsa, OK 74136

Bill Willis Community Mental Health Center, 1400 Hensley Drive, Tahlequah, OK 74465

Carl Albert Community Mental Health Center, 1101 E. Monroe, McAlester, OK 74502

Central Okla Community Mental Health Center, 909 E. Alameda, Norman, OK 73071

Creoks Comm Mental Health Center, 209 W. Broadway, Extension, Okemah, OK 74859

Edwin Fair Comm Mental Health Center, Inc, 1500 N. 6th, Ponca City, OK 74601

Family and Children's Services, Inc., 3150 E. Skelly Drive, Ste 120, Tulsa, OK 74105

Grand Lake Mental Health Center, 2000 W. Blue Starr Road, Claremore, OK 74017

Green Country Behavioral Health Services, Inc.,619 N. Main, Muskogee, OK 74401

HOPE Community Services, 105 SE 45th, OKC, OK 73129

Jim Taliaferro Comm Mental Health Center, 602 SW 38th Street, Lawton, OK 73505

Mental Health Serv of Southern Okla, 301 West 4th, Ada, OK 74820

NorthCare Mental Health Center, 6300 N. Classen Blvd, OKC, OK 73109

Northwest Center for Behavioral Health, 702 N. Grand, Enid, OK 73701

Red Rock Behavioral Health Services, 4400 N. Lincoln Blvd., OKC, OK 73105

Addendum II - A

Inspection of Care Review Facilities

Referenced in Attachment H
Regular In-state and Border Placements

Name of Organization	Program	Location of Site
Crewson Youth Center	RTC	4012 East 35th Street, Tulsa, OK 74135
Glenoaks	Acute	301 Division Street, Greenville, TX 75402
Heartland (Psyc. Solutions)	Acute & RTC.	1500 W. Ashland, Nevada, MO 64772
Hillcrest Riverside, Inc., dba Children's Medical Center	Acute & RTC	744 W. 9th, Ste. H210, Tulsa , OK 74127
Integris Willowview Integris Bass BH	Acute & RTC Acute & RTC	2601 Spencer Road, Spencer, OK 73084 2216 S. Van Buren, Enid, OK 73702
Laureate	Acute	6655 S. Yale, Tulsa, OK 74136
Moccasin Bend	RTC	62410 East 105th Road, Miami, OK 74354
Oklahoma Youth Center	Acute & RTC	320 12th Street, Norman, OK 73071
Parkside	Acute & RTC	1220 S. Trenton, Tulsa, OK 74120
Rolling Hills Hospital	Acute	1000 Rolling Hills Lane, Ada, OK 74820
Shadow Mountain (Psyc. Solutions)	Acute & RTC RTC	6262 S. Sheridan, Tulsa, OK 74133 425 E. 22nd Street, Owasso, OK 74055
Southwestern BH	Acute & RTC	5602 SW 82nd Street, Lawton, OK 73505
St. Anthony Hospital St. Anthony Accents St. Anthony JSOP (St. Michaels – Positive Outcomes)	Acute & RTC RTC RTC	1000 N. Lee, Oklahoma City, OK 73101 1000 N. Lee, Oklahoma City, OK 73101 2129 SW 59th Street, OKC, OK 73119
Vista Health of Ft. Smith	Acute	10301 Mayo Rd., Barling, AK 72923
Willowcrest Hospital	Acute & RTC	130 A. SW, Miami, OK 74354

Addendum II - B

Inspection of Care Review Facilities

Referenced in Attachment H
Out-of-State Facilities

Name of Organization	Program	Location of Site
Alabama Clinical Schools	RTC	1221 Alton Drive, Birmingham, AL 35210
Benchmark	RTC	592 W. 1350 S., Woods Cross, UT 84087
Camelot Schools	RTC	1502 N. NW Hwy, Palatine, IL 60067
Cedar Crest Hospital	RTC	3500 IH-35, Belton, TX 76513
Cedar Springs (PSI)	Acute & RTC	2135 Southgate Rd, Colorado Springs, C 80906
Cinnamon Hills Youth Crisis	RTC	770 E. St. George Blvd., St. George, UT 84770
Dessert Springs	RTC	330 S FM 1788, Midland, TX 79706
Gulf Coast Treatment Center	RTC	1015 Marwalt Drive, Ft. Walton, FL 32547
La Amistad Behavioral Health	RTC	1650 Park Ave. N., Maitland, FL 32751
National Deaf Academy	RTC	19560 US Hwy 441, Mt Dora, FL 32757
The Oaks Treatment Center	RTC	1407 W. Stassney Lane, Austin, TX 78745
San Marcos Treatment Center	RTC	120 Bert Brown Rd, San Marcos, TX 78666
Tampa Bay Academy	RTC	12012 Boyette Rd., Riverview, FL 33569
Texas Neuro Rehab Center	RTC	1106 W. Dittmar Rd., Austin, TX 78745

Addendum II - C

Inspection of Care Review Facilities

Referenced in Attachment H
Facilities Serving 18-21 Year Olds

Name of Organization	Program	Location of Site
Brookhaven	Acute	210 S. Garnett, Tulsa, OK 74128
Deaconess	Acute	5501 N. Portland, OKC, OK 73112
Griffin Memorial Hospital	Acute	900 E. Main, Norman, OK 73069
Hillcrest Health Center	Acute	744 W. 9th Street, Tulsa, OK 74127
Jim Taliaferro	Acute	602 SW 38th Street, Lawton, OK 73505
Laureate	Acute	6655 S. Yale, Tulsa, OK 74136
Mercy Memorial Health Center	Acute	1011 14th Ave NW, Ardmore, OK 73401
Miami Baptist	Acute	200 2nd Ave SW, Miami, OK 74354
Midwest City Hospital	Acute	2825 Parklawn Drive, Midwest City, OK 73110
Norman Regional Med Center	Acute	901 N. Porter, Norman, OK 73070
Northwest Center for Behavioral Health	Acute	Hwy 270 East, Fort Supply, OK 73841
OU Medical Center	Acute	1200 Everett Drive, Oklahoma City 73104
Parkside	Acute	1620 E. 13th Street, Tulsa, OK 74120
Pavillion	Acute	Muskogee
Rolling Hills	Acute	1000 Rolling Hills Lane, Ada, OK 74820
St Anthony's	Acute	1000 N. Lee, OKC, OK 73101
St John's	Acute	1923 S. Utica Ave, Tulsa, OK 74104
Via Christi	Acute	1900 N. 14th, Ponca City, OK 74601
Waggoner Comm Hospital	Acute	1200 W. Cherokee, Waggoner, OK 74467

Addendum III
Therapeutic Foster Care Agencies
(Referenced in Attachment K)

Name of Organization	
Bair Foundation	1601 Greenbriar Place, OKC, OK 73159
Brown Schools	6262 S. Sheridan, Tulsa, OK 74133
Children's Medical Center	744 W. 9th, Tulsa, OK 74127
Choices for Life Foster Care	4101 Perimeter Center Drive, Ste 350, OKC, OK 73112
Cimmaron Valley	1005 9th Street, Woodward, OK 73802
Eagle Ridge Institute	601 NE 63rd, OKC , OK 73105
Families First	101 E. Gray Bldg. C, Norman, OK 73069
Human Skills and Resources	1710 E. 51st Street, Tulsa, OK 74105
SAFY	1209 Sovereign Row, OKC, OK 73108
Southwest Foster Care	4801 N. Classes, Ste 135, OKC, OK 73118
Sunbeam Family Services	616 NW 21st, OKC, OK 73106
Wesleyan Youth Inc.	4500 N. Classen, Ste 200, OKC, OK 73118
Western Plains Youth and Family	1111 2nd Street, Woodward, OK 73801
Youth and Family Services, Enid	2925 N. Midway, Enid, OK 73701
Youth & Fam Services, Bartlesville	2200 SE Washington Blvd., Bartlesville, OK 74006

Date: February 15, 2006

Attention:

Please note the revised bid sheet attached to this amendment. The new bid sheet includes an additional column for the last (5) year option.

The deadline for submitting questions for the QIO bid are officially closed as February 15, 2006.

The Oklahoma Health Care Authority's response to questions received regarding the Quality Improvement Invitation to Bid are as follow:

1. Reference ITB, Attachment B - Outpatient Hospital Observation Services Retrospective Reviews Fee-For-Service Program: B5, page 23. "After 500 cases are selected contractor shall analyze these cases with first level of review being completed within 45 calendar days from receipt of the tape."

If the first level review is to be done within 45 calendar days and the facilities are allowed the traditional 30 days to submit charts, allowing 15 days to select the sample would preclude the Contractor from completing the review.

Is there any consideration to matching the time frames documented in Attachment A?

At this time, there is no consideration to matching the time frames documented in Attachment A. The OHCA would expect that sampling time would be minimal following the receipt of the tape. Because record review would likely be initiated as soon as records are received and the amount of time to complete each review would be reduced as compared to those required in Attachment A, the number of days necessary to complete all reviews is anticipated to be lower.

2. Reference ITB, Section 9.2 Bid Submission Format, Chapter 1: Functional Requirements, 1.3 Client Satisfaction Surveys, page 16: "If you have submitted such data to the National Database, please submit a copy of the final report. If not, please submit a sample report."

Data is electronically uploaded to the National CAHPS Benchmarking Database (NCBD) with verification of acceptance posted on the NCBD website, therefore no report is available.

Would a final report summarizing survey results be acceptable?

The documentation requested is a final report or a sample report summarizing survey results. If an organization has submitted data to the National Database, that information would be expected to be included in the final report submitted for review.

3. Reference ITB, Attachment D – Quality of Care Review of Medicaid Managed Care Programs (SoonerCare), D1, page 28. "Should OHCA choose to exercise this option, Contractor agrees to provider encounter data claims validation services; and such services shall be incorporated under Schedule D."

Can we receive a copy of Schedule D?

The last sentence of paragraph D.1. Purpose (page 28) should read:

> Should OHCA choose to exercise this option, Contractor agrees to provide encounter data claims validation services; and such services shall be incorporated under Attachment D.

Will the scope of the encounter data claims validation encompass only claims identified through the QAPI projects specified in Attachment E or will it encompass a sample selection from OHCA's entire encounter data claims database?

If OHCA decides to exercise this option, encounter data claims validation services would be completed through a sample selection from OHCA's entire encounter data claims database.

4. Reference ITB, Attachment D – Quality of Care Review of Medicaid Managed Care Programs (SoonerCare), page 28:

All references to QISMC have been deleted from the CMS Website. CMS has a QAPI Module Operational Guide available that is specific only to projects, but there does not appear to be a mechanism available through CMS for evaluation of an organizational infrastructure.

Since QISMC Standards for Domains 2 through 4 have been removed, is it acceptable to continue to use them?

Attachment D, Section D.2 states:

> QISMC Domains and Standards to be reviewed will be jointly determined by Contractor and OHCA based upon CMS guidelines, deemed elements, and prior QARI reviews.

As of the date of this ITB, the relevant guidelines for SFY 2007 have not been determined. It is possible that the OHCA and its Contractor for SFY 2007 will jointly determine that the previously used QISMC guidelines are no longer useful for an evaluation of an organization infrastructure. If that determination is made, then the QISMC guidelines would be replaced with relevant guidelines for completion of the review. Attachment D serves as the placeholder for the completion of the evaluation.

5. Reference ITB, Attachment E – Quality Assessment and Performance Improvement (QAPI) Projects, E6, page 29: "A draft of each report shall be produced and submitted

to OHCA by March 15th . . ." Previously stated in E 2, E4, and E5, the draft reports for each of the projects are due on April 1st.

What draft reports are due by March 15th?

Attachment E, Section E.6. should read:

> Contractor agrees to produce a report documenting the status of each QAPI in a format agreeable with OHCA. A draft of each report shall be produced and submitted to OHCA by April 1st. OHCA shall have thirty (30) calendar days to review the document and return to Contractor with changes limited to formatting only. The final report for each study shall be submitted to OHCA by May 15th.

What date will the contractor receive the recipient and encounter data necessary for project implementation?

Those dates will be determined during the development phase of each project as the data will be specific to each project.

6. Reference ITB Section 9 Bid Submission Content and Requirements, 9.0 Responses, B. Page Limitations, pg 14: "Responses to this bid shall have a maximum of 100 pages, including all text, diagrams, attachments, and additional information."

Several requirements in the ITB call for attachments of several documents such as QAPI project samples (page 16), client satisfaction survey report (page 16), review worksheets and quality screens (page 16), letters to providers for utilization and quality issues (page 16), forms, instruments, and reports used for inspection of care (page 16), sample letters, notices, forms, and reports for prior authorization of behavioral health services (page 17), samples of quarterly Medicaid provider newsletters (page 17), SME resume (page 17, if desired), five professional references on company letterhead, including signed authorizations from each reference (page 19). Some of these documents are as long as 20 pages.
Can requested reports and documents such as those described above be included as attachments and be exempt from the 100 page limitation?

The following attachments will be exempt from the 100 page limitation requirement. Bidder must appropriately identify all attachments to the bid and include all attachments behind the required bid response.

1.2 (pg. 16) final report for a quality improvement study required in 1.2.

1.3 (pg. 16) Sample report or final report of CAHPS and ECHO submitted to the National Database.

1.4 (pg. 16) Sample forms, instruments and reports for section 1.4.

1.5 (pg. 16) Sample letters, notices, forms and reports requested in 1.5.

1.7 (pg. 17) Samples of previous quarterly Medicaid Provider Newsletters requested in 1.7.

Can the table of contents, executive summary, and tabs also be exempt from the 100 page limitation?

The table of contents and tabs are exempt from the 100 page limitation. The executive summary is included in the 100 page limitation.

7. Reference ITB Section 9 Bid Submission Content and Requirements, 9.0 Responses, B. Page Limitations, pg 14: "The type size shall not be smaller than 10 point and top, bottom, left and right margins shall be at least one inch, excluding headers and footers."

Can imbedded graphics also be excluded the type size requirement?

Yes, imbedded graphics may be excluded from the type size requirements.

8. Reference ITB Attachments H and K Inspections of Care for Inpatient and TFC H.8.b) and H.8.c) page 36 and K.7.b) and K.7.c) page 51:

Will providers continue to have an appeal process through the contractor for Inspections of Care for inpatient and TFC providers?

We are currently in the process of amending our rules to eliminate reconsideration and provider appeals, effective as of July 1, 2006. Therefore, the bidder should assume that there will be no reconsideration process and no provider appeals. In the event that the rule change does not take place, we will amend the contract to reflect that change and we understand that the bidder may want additional reimbursement.

9. Reference ITB Section 9 Bid Submission Content and Requirements, 9.1 Submission of Bids, A, pg 14: "Bidders shall be required to deliver the following number of bids to the DCS Central Purchasing, as indicated on the ITB instruction form:

- **One (1) clearly identified original bid and six (6) copies of the completed bid.**
- **One (1) electronic file of the proposal in Microsoft Word."**

In order to comply with the requirement to submit the proposal in Microsoft Word, will the Solicitation Request, bid sheet, and the Vendor/Payee Form be provided in Word format?

No. The solicitation request, bid sheet and vendor/payee form will be exempt from the electronic bid submission format.

Will these documents be exempt from the 100 page limitation?

Yes.

2# Questionnaire

1. **Will the clarifications presented to the DCS by all bidders be made available to everyone?**

Yes – they will be posted to the DCS website as an amendment.

2. **Can you verify the expected contract volumes in the QIO Bid Sheet for Attachment A, Attachment B, Attachment E- Will there be 2 emergency room projects, Attachment H and Attachment I.**

Expected contract volumes are as stated in Attachment A, Attachment B and Attachment E .
Will there be 2 emergency room projects? Answer: no – there is 1 project.
Unable to respond to the question related to Attachment H and I as unable to determine question; if bidder is seeking additional information regarding contract utilization, please see the bidders' library listed in the ITB.

3# Questionnaire

1. **Could you please share with us your methodology for scoring the technical and pricing components of RFP 8070000006?**

All responses will be evaluated as stated in section 1.7 of the ITB.

2. **May the bidder use OHCA as a reference if we currently conduct business with the Authority** Yes.

3. **The sentence on page 20, Attachment A, in the last paragraph begins, "*The OHCA Medical Director and Contractor shall collaborate to establish any additional.*" Can you please complete this sentence?**

The sentence should read as follows:
The OHCA Medical Director and Contractor shall collaborate to establish any additional exclusions.

4. **Page 29, E.6 states that drafts are due March 15th and final report is due May 1st. Sections E.2, E.4 and E.5, have draft due dates of April 1st and final report due dates of May 15th. Section E.10. also has similar discrepancies. Can you clarify?**

Attachment E, Section E.6. should read:

Contractor agrees to produce a report documenting the status of each QAPI in a format agreeable with OHCA. A draft of each report shall be produced and submitted to OHCA by April 1st. OHCA shall have thirty (30) calendar days to review the document and return to Contractor with changes limited to formatting only. The final report for each study shall be submitted to OHCA by May 15th.

QIO BID SHEET - OKLAHOMA HEALTH CARE AUTHORITY

This form is required in the bid submission format

	Expected Contract Volume per year	PROPOSED PRICE for date of award -6/30/06	PROPOSED PRICE for 7/1/06-6/30/07	PROPOSED PRICE for 7/1/07-6/30/08	PROPOSED PRICE for 7/1/08-6/30/09	PROPOSED PRICE for 7/1/09-6/30/10	PROPOSED PRICE for 7/1/10-6/30/11
Attachment A: 'Retrospective Review/FFS Inpatient							
Price per review completed	12,000						
Attachment B: Retrospective Review/FFS Outpatient							
Price per review completed	500						
Attachment C: Quality Interventions & Education							
Price per educ./intervention with a CAP & monitoring	40						
Price per educ /intervention without a CAP	100						
Total Price for Schedule C							
Attachment D: Quality of Care Reviews (Managed Care Prog.)							
Fixed price for services in Attachment D	1						
Attachment E: Quality Assessment & Performance Improve							
EPSDT Project	1						
Diabetes Project	1						
Emergency Room Project	1						
Peri-natal Project	1						
Behavioral Health Project	1						
Emergency Room Project	1						
QAPI Status Report	1						
Total Price for Schedule E							
Attachment F: Client Satisfaction Survey							
Price per CAPHS Survey Completed	825						
Price per ECHO Survey Completed	1,200						
Total Price for Schedule F							

Attachment G: Retrospective Review/Outpatient CMHC	15 Facilities						
Price per review							
Attachment H: Inspection of Care in Psychiatric Fac.	15 Facilities						
Price per review completed							
Attachment I: Outpatient Auth. Of Behavioral Health Svc.	55,000						
Price per authorization / extension							
Attachment J: Inpatient Authorization of Behavior Health Sv	30,200						
Price per authorization / extension							
Attachment K: Review Audits Therapeutic Foster Care Prg.	19 Facilities						
Price per review completed							
TOTAL PROPOSED PRICE		$ -					
		7/1/06-6/30/07	**7/1/07-6/30/08**	**7/1/08-6/30/09**	**7/1/09-6/30/10**	**7/1/10-6/30/11**	**7/1/10-6/30/11**
Attachment L: Medicaid Provider Publication (OPTIONAL)							
Quarterly Reports							
Price per report completed and accepted by OHCA	4						

Helping People Lead Healthier Lives

March 6, 2006

Irene Bowman, Contracts and Procurement Officer
Department of Central Services
2401 N. Lincoln Blvd. Suite 116
Oklahoma City, OK 73105

Dear Ms. Bowman:

APS Healthcare Midwest (APS) is in receipt of your request for clarification on our pricing proposal for Invitation to Bid (ITB) 8070000074 dated March 2, 2006. We appreciate this opportunity to respond due to the amendment of the expected number of reviews for your four highest volume categories.

APS uses a rigorous pricing methodology to arrive at all our final pricing submissions and subsequent budgets for our state programs. Our heavy emphasis on quality improvement and provider education, and our considerable investments in customized Health Information Technology (HIT) to automate data collection, analysis and reporting, often accounts for 40% or more of our costs. Although these activities and technology investments are vital to the success of the program they are not directly related to a specific per unit review category.

Any time a state agency requests that we price out our services on a per unit cost, we apply a pricing methodology that distributes these indirect costs across the various unit categories based on the nature and volume of each category. Therefore, changes in any review category, particularly a category or categories that make up a large percentage of total reviews, will have a dramatic impact on the allocation of these costs. We have applied our methodology for redistributing these costs across the review categories and new quantity estimates provided in the clarification letter of March 2.

We believe we can deliver a high quality, cost-effective review service to Oklahoma at the price quotes contained in the attached tables. I can make myself available to discuss these quotes, should you or your colleagues desire, at your convenience.

Sincerely,

David [illegible]
President, APS Public Programs

8403 Colesville Road ♦ Suite 1600 ♦ Silver Spring, MD 20910 ♦ Tel 800.305.3720 ♦ Fax 301.563.7337

March 2, 2006

Mr. Jim L. Williams
President and Chief Executive Officer
Oklahoma Foundation for Medical Quality, Inc.
14000 Quail Springs Parkway, Suite 400
Oklahoma City, Okla. 73134-2600

Dear Mr. Williams:

The purpose of this letter is to request that you provide clarification to your bid submitted in response to Invitation to Bid (ITB) 8070000074 Contract to conduct medical retrospective hospital reviews etc. For purposes of this request, clarification is defined to be such information that elaborates, explains or amplifies what is already presented in your ITB response.

With this in mind, please provide the following clarifications only:

1. The intention of OHCA on Attachment I, Outpatient Behavioral Health, Substance Abuse and Psychologist Services, was to have the bidder quote a per unit price for authorizations and provide a separate per unit price for extensions. However, the bid sheet did not clearly request separate quotes for authorizations and a quote for extensions, and the estimated volume was combined. Please provide a quote for authorizations and a separate quote for extensions below.

JW/03/03/06 Ratify the price(s) as previously submitted.
Initial/Date

JW 03/03/06 The prices below are separate quotes for (a) price per authorization and (b) per extension.
Initial/Date

Price per review	7/1/06-6/30/07	7/1/07-6/30/08	7/1/08-6/30/09	7/1/09-6/30/10	7/1/10-6/30/11
New PA Request Annual Estimate of: 17,600	[redacted]	[redacted]	[redacted]	[redacted]	$41.74
Request for PA Extension: Annual Estimate of: 37,400	$28.92	[redacted]	$30.09	[redacted]	[redacted]
Annual Total	$1,760,527	$1,795,738	$1,831,652	$1,868,285	$1,905,651

The intention of OHCA on Attachment J, Inpatient, Therapeutic Foster Care, and Medical Prior Authorization of Behavioral Health Services, was to have the bidder quote a per unit price for authorizations and a per unit price for extensions. However, the bid sheet did not specify that separate quotes were needed for authorizations and extensions, and the estimated volume was combined. Please provide a quote for authorizations and a separate quote for extensions below.

JW 03/03/06 Ratify the price previously submitted.

Initial/Date 03/03/06 The prices below are separate quotes for (a) price per authorization and (b) per extension.

Price per review	7/1/06-6/30/07	7/1/07-6/30/08	7/1/08-6/30/09	7/1/09-6/30/10	7/1/10-6/30/11
New PA Request Annual Estimate of: 12,986	$49.04	$50.04	$51.05	[illegible]	$53.05
Request for PA Extension: Annual Estimate of: 17,516	[illegible]	$50.04	$51.05	$52.09	$53.15
Annual Total *	$1,520,220	$1,550,624	$1,581,637	$1,613,269	$1,645,535

This form should not be modified in any manner. All of the numbers are estimates and will be utilized in determining an overall estimated annual cost analysis. Responses may be faxed to the listed buyer at 405-522-1077, no later than March 6, 2006, 3:00 p.m. Please mail your original to DCS-Central Purchasing 2401 N. Lincoln Blvd. Suite 116, Oklahoma City, Okla. 73105

Authorized Signature

03/03/06
Date

Irene Bowman
Contracts and Procurement Officer
Dept of Central Services

Notes*
Attachment J - Annual volume count provided on this clarification is 302 records higher than established in the ITB. Unit price is the same as quoted in ITB bid sheet and is the same for a new or extension PA. The increase in total cost stated on this clarification response for attachment J is created by the additional 302 reviews times the same unit price indicated on the original ITB bid sheet.

QIO BID SHEET - OKLAHOMA HEALTH CARE AUTHORITY

This form is required in the bid submission format

	Expected Contract Volume per year	Proposed Price for date of award - 6/30/06	Proposed Price for 7/1/06 - 6/30/07	Proposed price for 7/1/07 - 6/30/08	Proposed price for 7/1/08 - 6/30/09	Proposed price for 7/1/09 - 6/30/10	Proposed price for 7/1/10 - 6/30/11
Attachment A : Retrospective Review / FFS Inpatient							
Price per review completed	12000		$ 48.78	$ 48.78	$ 49.26	$ 52.35	$ 53.97
Attachment B : Retrospective Review / FFS Outpatient							
Price per review completed	500		$ 35.31	$ 35.31	$ 36.40	$ 37.52	$ 38.68
Attachment C: Quality Intervention & Education							
Price per educ/intervention with a CAP & Monitoring	40		$ 4,746.49	$ 4,746.49	$ 4,893.29	$ 5,044.63	$ 5,2[illegible]65
Price per educ/intervention without a CAP	100		$ 129.78	$ 129.78	$ 133.80	$ 137.93	$ 142.20
Total Price for Schedule C			$ 202,837.74	$ 202,837.74	$ 209,111.07	$ 215,578.42	$ 222,245.79
Attachment D - Quality of Care Reviews (Managed Care Prog.)							
Fixed price for services in Attachment D	1		$ 6,051.56	$ 6,051.56	$ 6,238.72	$ 6,431.67	$ 6,630.58
Attachment E - Quality Assessment & Performance Improve.							
EPSDT Project	1		$ 9,462.05	$ 9,462.05	$ 9,754.69	$ 10,056.39	$ 10,367.41
Diabetes Project	1		$ 7,624.10	$ 7,624.10	$ 7,859.90	$ 8,102.99	$ 8,353.60
Emergency Room Project	1		$ 6,015.90	$ 6,015.90	$ 6,201.96	$ 6,393.77	$ 6,591.52
Peri-Natal Project	1		$ 6,795.90	$ 6,795.90	$ 7,006.08	$ 7,222.76	$ 7,446.15
Behavioral Health Project	1		$ 5,786.16	$ 5,786.16	$ 5,965.11	$ 6,149.60	$ 6,339.79
Emergency Room Project	1	delete	$ 6,015.90	$ 6,015.90	$ 6,201.96	$ 6,393.77	$ 6,591.52
QAPI Status Report	1		$ 137,217.46	$ 137,217.46	$ 141,461.30	$ 145,836.39	$ 150,346.80
Total Price for Schedule E			$ 178,917.47	$ 178,917.47	$ 184,451.00	$ 190,155.67	$ 196,[illegible]
Attachment F: Client Satisfaction Survey							
Price per CAPHS Survey Completed	825		$ 37.84	$ 37.84	$ 39.01	$ 40.21	$ 41.46
Price per ECHO Survey Completed	1200		$ 37.84	$ 37.84	$ 39.01	$ 40.21	$ 41.46
Total Price for Schedule F			$ 76,615.98	$ 76,615.98	$ 78,985.55	$ 81,428.40	$ 83,946.80

QIO Bid Sheet - Oklahoma Health Care Authority -Page 2

This form is required in the bid submission format

	Expected Contract Volume per year	Proposed Price for date of award - 6/30/06	Proposed Price for 7/1/06 - 6/30/07	Proposed price for 7/1/07 - 6/30/08	Proposed price for 7/1/08 - 6/30/09	Proposed price for 7/1/09 - 6/30/10	Proposed price for 7/1/10 - 6/30/11
Attachment G: Retrospective Review / Outpatient CMHC	15						
Price per review	facilities		$ 4,643.99	$ 4,643.99	$ 4,787.61	$ 4,935.68	$ 5,088.33
Attachment H: Inspection of Care in Psychiatric Fac.	15						
Price per review completed	facilities		$ 5,177.01	$ 5,177.01	$ 5,337.12	$ 5,502.19	$ 5,672.36
Attachment I: Outpatient Auth. Of Behavioral Health Svc.	55000						
Price Per Authorization			$ 29.09	$ 29.09	$ 29.99	$ 30.92	$ [illegible].88
Price per Extension			$ 7.27	$ 7.27	$ 7.50	$ 7.73	$ 7.97
Attachment J: Inpatient Authorization of Behavior Health Svces	30200						
Price per Authorization			$ 43.71	$ 43.71	$ 45.07	$ 46.46	$ 47.90
Price per Extension			$ 38.03	$ 38.03	$ 39.21	$ 40.42	$ 41.67
Attachment K: Review Audits Therapeutic Foster Care Prg.	19		$ 4,643.99	$ 4,643.99	$ 4,787.61	$ 4,935.68	$ 5,088.33
Price per review completed	facilities						
Total Proposed Price		125,000	$ 4,417,465.02	$ 4,417,465.02	$ 4,541,716.88	$ 4,701,029.69	$ 4,846,422.36

		7/1/06-6/30/07	07/1/07-06/30/08	7/1/08-6/30/09	7/1/09-6/30/10	7/1/10-6/30/11	7/1/10-6/30/11
Attachment L: Medicaid Provider Publication (Optional)							
Price per Report Completed and accepted by OHCA	4	$ 15,051.28	$ 15,051.28	$ 15,516.79	$ 15,996.69	$ 16,491.43	$0
Total Proposed Annual Price		$ 60,205.13	$ 60,205.13	$ 62,067.14	$ 63,986.74	$ 65,965.72	$0

3/6/06

QIO Bid Sheet - Oklahoma Health Care Authority -Page 2

This form is required in the bid submission format

	Expected Contract Volume per year	Proposed Price for date of award - 6/30/06	Proposed Price for 7/1/06 - 6/30/07	Proposed price for 7/1/07 - 6/30/08	Proposed price for 7/1/08 - 6/30/09	Proposed price for 7/1/09 - 6/30/10	Proposed price for 7/1/10 - 6/30/11
Attachment I: Outpatient Auth. Of Behavioral Health Svc.							
Price Per Authorization	17600		$ 34.35	$ 34.35	$ 35.38	$ 36.44	$ 37.54
Price per Extension	37400		$ 16.50	$ 16.50	$ 17.00	$ 17.50	$ 18.03
Annual Total			$ 1,221,660.00	$ 1,221,660.00	$ 1,258,309.80	$ 1,296,059.09	$ 1,334,940.87
Attachment J: Inpatient Authorization of Behavior Health Svces							
Price per Authorization	12986		$ 49.35	$ 49.35	$ 50.83	$ 52.36	$ 53.93
Price per Extension	17516		$ 43.25	$ 43.25	$ 44.55	$ 45.88	$ 47.26
Annual Total			**$ 1,398,426.10**	**$ 1,398,426.10**	**$ 1,440,378.88**	**$ 1,483,590.25**	**$ 1,528,097.96**

		7/1/06-6/30/07	07/1/07-06/30/08	7/1/08-6/30/09	7/1/09-6/30/10	7/1/10-6/30/11	7/1/10-6/30/11
Attachment L: Medicaid Provider Publication (Optional)							
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Total Proposed Annual Price		$ 60,205.13	$ 60,205.13	$ 62,067.14	$ 63,986.74	$ 65,965.72	$0

March 2, 2006

Mr. David Hunsaker
President APS Public Programs
Innovative Resource Group, LLC d/b/a
APS Healthcare Midwest
8403 Colesville Road, Suite 1600
Silver Spring, ~~MO~~ MD 20910

Dear Mr. Hunsaker:

The purpose of this letter is to request that you provide clarification to your bid submitted in response to Invitation to Bid (ITB) 8070000074 Contract to conduct medical retrospective hospital reviews etc. For purposes of this request, clarification is defined to be such information that elaborates, explains or amplifies what is already presented in your ITB response.

With this in mind, please provide the following clarifications only:

1. The intention of OHCA on Attachment I, Outpatient Behavioral Health, Substance Abuse and Psychologist Services, was to have the bidder quote a per unit price for authorizations and provide a separate per unit price for extensions. However, the bid sheet did not clearly request separate quotes for authorizations and a quote for extensions, and the estimated volume was combined. Please provide a quote for authorizations and a separate quote for extensions below.

_____Ratify the price(s) as previously submitted.
Initial/Date

OK 3/6/06 The prices below are separate quotes for (a) price per authorization and (b) per extension.
Initial/Date

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				$1,296,059.09	

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_____Ratify the price previously submitted.

Initial/Date

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Initial/Date

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Annual Total	$1,398,426.10	$1,398,426.10	$1,440,378.88	$1,483,590.25	$1,528,097.96

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Authorized Signature

3/6/2006
Date

Irene Bowman
Contracts and Procurement Officer
Dept of Central Services