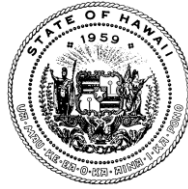


JOSH GREEN, M.D.
GOVERNOR OF HAWAII
KE KIA'ĀINA O KA MOKU'ĀINA 'O HAWAI'I



KENNETH S. FINK, MD, MGA, MPH
DIRECTOR OF HEALTH
KA LUNA HO'OKELE

STATE OF HAWAII
DEPARTMENT OF HEALTH
KA 'OIHANA OLAKINO
ALCOHOL AND DRUG ABUSE DIVISION
KAKUHIHEWA BUILDING
601 Kamokila Boulevard, Room 360
Kapolei, Hawaii 96707
PH: (808) 692-7506
FAX: (808) 692-7521

In reply, please refer to:
File: DOH/ADAD

Provider Meeting
September 1, 2023 at 9:00 am
Department of Health
Alcohol and Drug Abuse Division

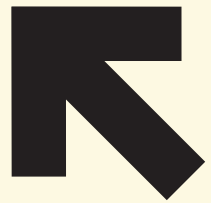
AGENDA:

1. **Division Announcements**
 - *Treatment and Recovery Branch*
 - ❖ *New TRB Provider Contact Information*
 - *QAIO*
 - ❖ *OHI Proclamation*
 - *Planning*
 - ❖ *Milliman Rate Study Kick-Off*
 - *Fiscal*
 - ❖ *Reminders*
2. **Provider Announcements**
 - *AUW*
 - ❖ *Hawaii CARES Updates*
 - *UH Thompson School*
 - ❖ *Hawaii SUPD Update*
3. **Other**

Next Meeting: Friday, October 6, 2023



Administrator Update



9-1-23 Provider Meeting



Items

New staff

3

Recent RFI/RFP Notices

4

ADAD Rate Study Update

6





3

New staff

Helen San

ADAD eMIS Project Specialist

Chayla Nakamoto

Program Specialist – SPF-PFS



4

Recent RFI/RFP Notices

- **Resiliency Center, Islands of Maui County**
- **Behavioral Health Crisis Center**
- **FY 2024 CCP Immediate Services Program for Maui County**
- **Thank you also for your recent input into several of our most recent RFIs, much appreciated!**



ADAD Rate Study Update

Introduced the Milliman team members:

- **Jeremy Cunningham**
- **John Belanger**
- **Jason Howard**
- **Justin Birrell**

Presentation slides attached.

Email me if you have further questions.





Thank you

John Valera

john.valera@doh.hawaii.gov

Hawai'i ADAD Rate Study Project Kick Off

Alcohol & Drug Abuse Division



SEPTEMBER 1, 2023



Agenda

1

Project Overview

2

Stakeholder Engagement

3

Overview of Independent Rate Model Approach

4

Next Steps

Project Overview

Two core components



Rate Study: Evaluate current reimbursement rates for ADAD services, develop a rate development methodology, and construct a set of rates to aid ADAD in upcoming provider procurements



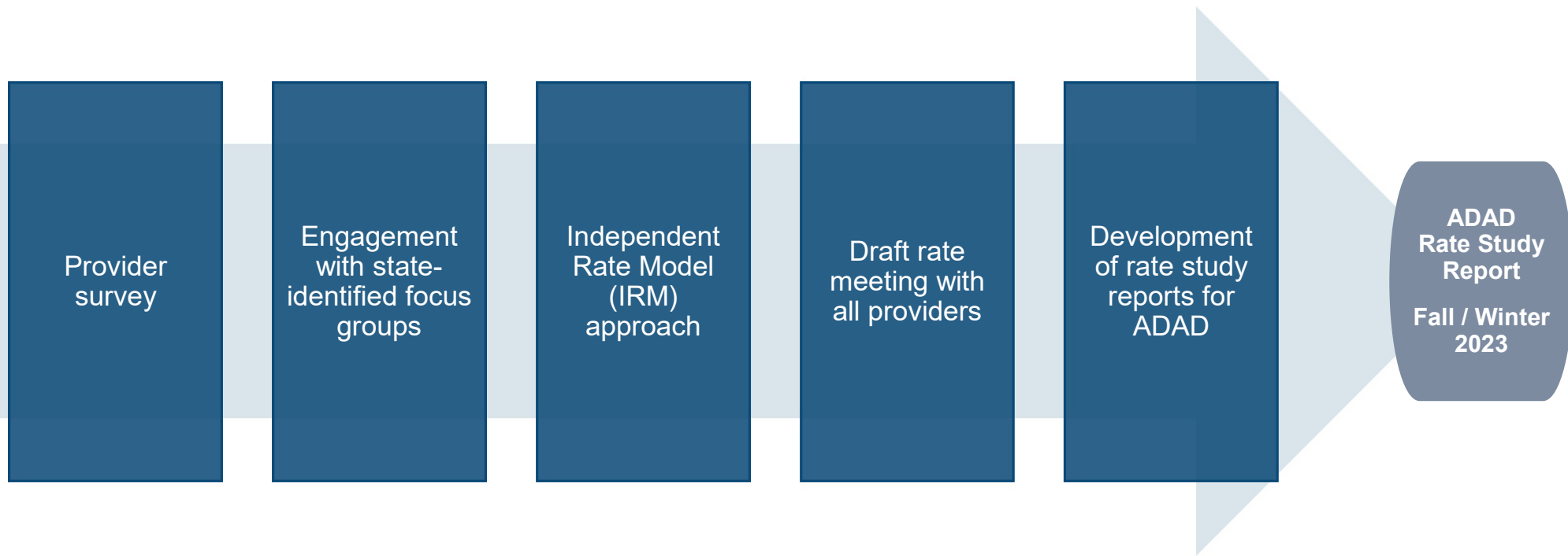
Billing Activities: Crosswalk billing codes to the existing service array and provide hands-on, technical support to operationalize any changes in the agencies' billing and coding systems resulting from the Rate Study

Project Overview

Purpose of project

- Develop and publish Medicaid behavioral health comparison rates that reflect reasonable and necessary costs associated with the delivery of behavioral health services, consistent with the access and quality of care provisions specified in U.S.C. §1396a(a)(30)(A).
- Provide an examination and understanding of the provider resources involved in delivering individual covered BH services.
- Provide transparent payment rate benchmarks for use by all stakeholders, including during negotiations between payors and providers
- Support ADAD's ability to:
 - Make informed decisions when proposing changes to covered benefits.
 - Improve transparency in analysis and communication between ADAD and other stakeholders, such as the program's authorizing environment (i.e., State Legislature and Department of Budget and Finance), providers, insurers, and advisory work groups
 - Evaluate variation in provider payments by comparing actual payment rates to comparison benchmark rates.

Rate Study Approach



Stakeholder Engagement Plan

Stakeholder Engagement Plan

Phase 1: Kickoff and Focus Group Engagement

Approx. Timing: Sep 2023

- Release communication announcing initiative to all providers
- Conduct kick-off webinar
- Engage focus group members

Phase 2: Conduct Focus Groups and Conduct Survey

Approx. Timing: Sep – Nov 2023

- Obtain feedback on key payment rate assumptions
 - Provider survey
 - Four focus groups
 - Outpatient
 - Medication assisted treatment
 - Residential
 - Recovery Homes
- Engage individual providers as needed

Phase 3: Obtain All Provider Feedback

Approx. Timing: Nov 2023 – Dec 2023

- Release draft rates and assumptions to all providers for feedback
- Incorporate feedback as appropriate and update documentation of assumptions and results
- Finalize report

Stakeholders are invited to provide feedback at any point in the project via HawaiiBH@Milliman.com

Focus Group Role

- Consists of 5-8 individuals with provider level programmatic and financial technical expertise
- Represents a wide variety of provider experience, including geographic, populations served and practice size
- Provides subject matter expertise regarding service delivery and related costs for BH services, for example:
 - Staffing patterns and supervisor span of control
 - Non-face-to-face time required for service delivery
 - Transportation needs
 - Workforce considerations such as wage levels and turnover
- Informs the development of rate models and related assumptions
- Advises ADAD and the Milliman project team of the current state and local landscape with respect to service requirements

Focus Group Member Responsibilities

- Attend virtual focus group meeting(s)
- Provide feedback on a particular service from the perspective of their organization and the broader service delivery system in the state
- Work across their respective organizations between focus group meetings to obtain feedback on specific payment rate assumptions

Overview of Independent Rate Model Approach

Independent Rate Model

Overview



Ground-up approach

- Rates are built from the ground up
- Based on sum of independently determined rate inputs and components
- Inputs are based on expected resources required to provide the service



Commonly applied method for rate determination for residential, community-based services

- Many states employ independent rate model approach
- One of accepted methods based on CMS guidance for HCBS services



Leverages data and information from many sources

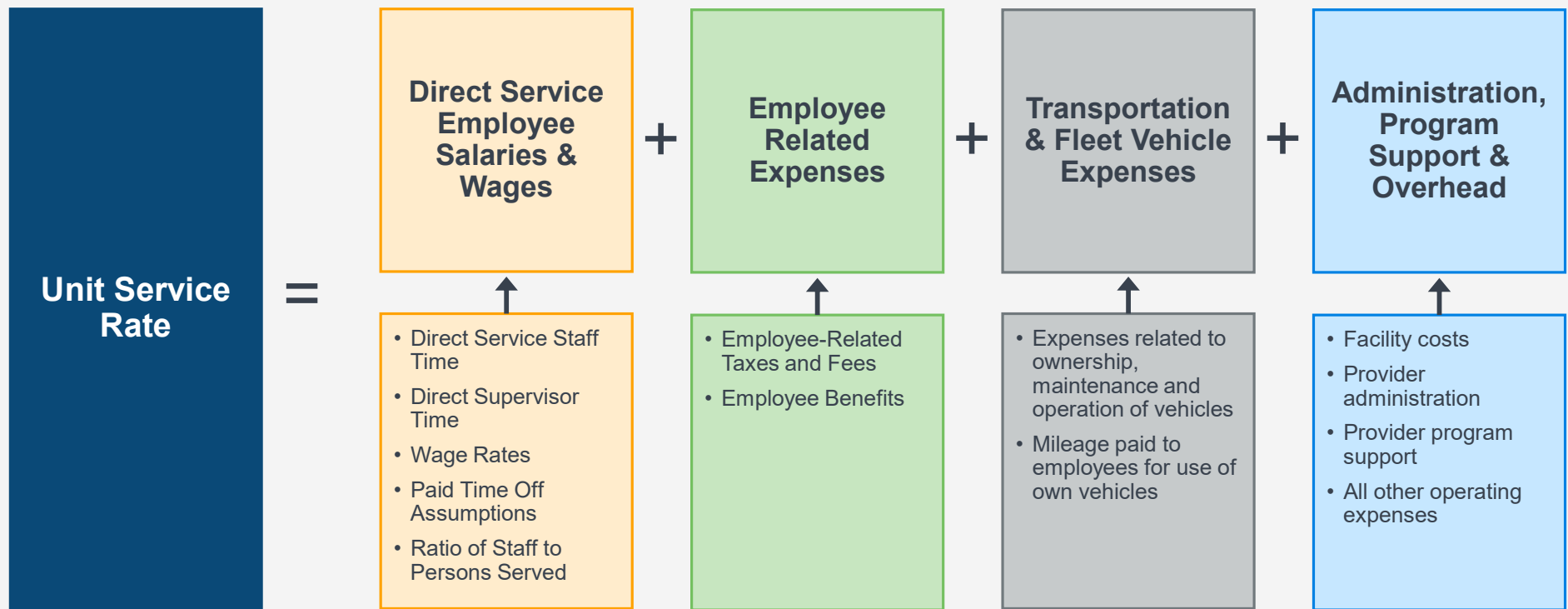
- Publicly available data, such as Bureau of Labor Statistics data
- Data collected from providers directly
- State and stakeholder feedback and guidance
- State procedure code descriptions and regulations

Benefits

- Provides transparency as to the reasonable costs required to provide the service
- Facilitates streamlined process to update rates in future periods
- Facilitates comparison of actual costs of providing services
- Can be adopted to support future rate updating or modification efforts
- Developed independently from actual costs incurred

Independent Rate Model

Rate Build Up Components



Independent Rate Model Framework

Major Components and Elements

COMPONENT	ELEMENTS	SUB-ELEMENTS	CLARIFYING NOTES
Clinical Staff and Supervisor Salaries and Wages	Service-related Time	Direct time	<ul style="list-style-type: none"> Corresponding time unit or staffing requirement assumptions where not defined. Adjusted for staffing ratios for some services (i.e., more than one person served concurrently, e.g., in group counseling sessions).
		Indirect time	<ul style="list-style-type: none"> Service-necessary planning, note taking and preparation time
		Transportation time	<ul style="list-style-type: none"> Travel time related to providing service
		PTO/training/ conference time	<ul style="list-style-type: none"> Paid vacation, holiday, sick, training and conference time. Also considers additional training time attributable to employee turnover
		Supervisor time	<ul style="list-style-type: none"> Accounted for using a span of control variable
	Wage Rates	Can vary for overtime and weekend shift differentials	<ul style="list-style-type: none"> Wage rates vary depending on types of direct service employees, which have been assigned to provider groups
	Stipends	Payments for on-call capacity	<ul style="list-style-type: none"> Used for selected services
Employee Related Expenses	Payroll-related Taxes and Fees	Federal Insurance Contributions Act (FICA), Federal Unemployment Tax Act (FUTA), State Unemployment Insurance (SUI), Workers Compensation	<ul style="list-style-type: none"> Applicable to all employees, and varies by wage level assumption
	Employee Benefits	Health, dental, vision, life and disability insurance, and retirement benefits	<ul style="list-style-type: none"> Amounts may vary by provider group
Transportation – Fleet Vehicle Expense	Vehicle Operating Expenses	Includes all ownership and maintenance-related expenses	<ul style="list-style-type: none"> Varies by service. Some services assume employee-owned vehicle at federal rate. Other services assume fleet vehicle expenses or vans.
Administration, Program Support, Overhead	All other business-related costs	Includes program operating expenses, including management, accounting, legal, information technology, etc.	<ul style="list-style-type: none"> Excludes expenses related to managed care administration

Independent Rate Model Framework

Use of Provider Groupings



Provider groups represent multiple provider types or clinical staff positions that have similar characteristics (e.g., educational degrees, professional credentials, and expected wage rates).



Use of provider groups balances the need for the rates to reflect appropriate variation in labor costs by type of clinical staff and supervisors, and at the same time reasonably limit the number of rates needed for each service.



Use of provider groups allows states to consider and incorporate national and state wage datasets (e.g., Bureau of Labor Statistics and provider survey data).



Preliminary ADAD Provider Groups

- Less than Bachelors
- Bachelors
- Masters
- Doctoral
- Registered Nurse

Independent Rate Model Framework

Assumptions are applied at the provider group level for several elements/sub-elements

COMPONENT	ELEMENTS	SUB-ELEMENTS	CLARIFYING NOTES
Clinical Staff and Supervisor Salaries and Wages	Service-related Time	Direct Time	<ul style="list-style-type: none"> Corresponding time unit or staffing requirement assumptions where not defined. Adjusted for staffing ratios for some services (i.e., more than one person served concurrently, e.g., in group counseling sessions).
		Indirect Time	<ul style="list-style-type: none"> Service-necessary planning, note taking and preparation time
		Transportation Time	<ul style="list-style-type: none"> Travel time related to providing service
		PTO/Training/ Conference Time	<ul style="list-style-type: none"> Paid vacation, holiday, sick, training and conference time. Also considers additional training time attributable to employee turnover
		Supervisor Time	<ul style="list-style-type: none"> Accounted for using a span of control variable
	Wage Rates	Can Vary for Overtime and Weekend Shift Differentials	<ul style="list-style-type: none"> Wage rates vary depending on types of direct service employees, which have been assigned to provider groups
	Stipends	Payments for On-call Capacity	<ul style="list-style-type: none"> Used for selected services
Employee Related Expenses	Payroll-related Taxes and Fees	Federal Insurance Contributions Act (FICA), Federal Unemployment Tax Act (FUTA), State Unemployment Insurance (SUI), Workers Compensation	<ul style="list-style-type: none"> Applicable to all employees, and varies by wage level assumption
	Employee Benefits	Health, Dental, Vision, Life and Disability Insurance, and Retirement Benefits	<ul style="list-style-type: none"> Amounts may vary by provider group
Transportation – Fleet Vehicle Expense	Vehicle Operating Expenses	Includes all Ownership and Maintenance-Related Expenses	<ul style="list-style-type: none"> Varies by service. Some services assume employee-owned vehicle at federal rate. Other services assume fleet vehicle expenses or vans.
Administration, Program Support, Overhead	All other business-related costs	Includes program operating expenses, including management, accounting, legal, information technology, etc.	<ul style="list-style-type: none"> Excludes expenses related to managed care administration

Independent Rate Model Framework

Employee Related Expenses



Employer entity's portion of payroll taxes, employee medical and other insurance benefits



Employer portion of retirement expenses incurred on behalf of clinical staff and supervisors



All other taxable fringe benefits consistent with IRS Publication 15-B rules, such as club memberships

A significant portion of Employee Related Expenses is driven by the cost of health insurance and retirement benefits.

Independent Rate Model Framework

Example of Employee Related Expense Buildup Using Bureau of Labor Statistics Wages and Other Publicly Available Data

Provider Group	A Trended Wage (50 th Percentile)	B Annual Employee Salary $A \times 2080$	C FICA, FUTA, SUI	D Workers Comp	E Health Insurance	F Retirement	G ERE per Employee $SUM (C - F)$	H ERE Percentage G/B	I Annual Salary and ERE $B \times (1+H)$
Less than Bachelors	\$ 18.78	\$ 39,072	\$ 5,831	\$ 551	\$ 9,755	\$ 1,575	\$ 17,712	45.3%	\$ 56,784
Bachelors	25.45	52,928	7,751	746	9,755	2,133	20,385	38.5%	73,313
Masters	40.67	84,601	10,407	1,193	9,755	3,409	24,765	29.3%	109,366
Registered Nurse	64.48	134,126	14,196	1,891	9,755	5,405	31,248	23.3%	165,374
Doctoral	132.46	275,525	17,863	3,885	9,755	11,104	42,607	15.5%	318,131

Notes:

1. The list does not represent the complete list of provider groups to use in the comparison rates.
2. Wages reflect the sum product of the BLS wages weights by provider group.
3. FICA taxes include social security taxes and Medicare taxes. FUTA tax is the federal unemployment tax. <https://www.irs.gov/taxtopics>. The annual employee salary considered for FICA is capped at the 160,200 taxable limit.
4. Worker's compensation is estimated to be approximately 1.4% of total wages. <https://www.bls.gov/web/ecec/ececqrtn.pdf>.
5. Insurance estimated using hourly rate for private industry health care and social assistance industry group, and is inclusive of health, life, vision, dental, and disability insurance benefits. <https://www.bls.gov/web/ecec/ececqrtn.pdf>.
6. Retirement Benefits assume a 4% employer match to a retirement account. <https://www.bls.gov/web/ecec/ececqrtn.pdf>

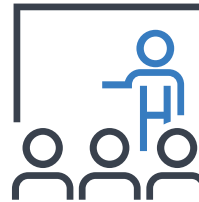
Independent Rate Model Framework

Paid Time Off, Training and Overtime/Holiday Adjustments



Paid Time Off Adjustment Factor

- Accounts for additional time that must be covered over the course of a year by other clinical staff, thereby representing additional clinical staff time per unit.
- Reflects paid vacation, holiday, and sick time.
- Annual training and/or conference time expected to be incurred by clinical staff and supervisors.



Training for New Hires

PTO adjustment factor is an estimated increase for one-time training/onboarding and considers the frequency of this type of training time attributable to employee turnover.



Overtime/Holiday Adjustment Factor

For certain services, such as licensed residential services that are staffed using a 24/7 staffing model, there is an expectation that the “typical” staffing model should include some incremental payment for overtime and holiday pay.

Independent Rate Model Framework

Example of Paid Time Off, Training and Productive Time Assumptions

Provider Group	A Annual productive time $2,080 - H$	B Paid Holidays and PTO per year	C On-going training/ conference time hours per year	D Total $B + C$	E Training hours/ inefficient time for each new hire	F Turnover percentage	G New hire training hours per year $E * F$	H Hours of replacement for non-productive time $D + G$	I PTO/training/ conference time adjustment factor $2,080 / (2,080 - H) - 1$
Less than Bachelors	1,824	192	24	216	80	50%	40	256	14.0%
Bachelors	1,824	192	24	216	80	50%	40	256	14.0%
Masters	1,804	232	24	256	40	50%	20	276	15.3%
Registered Nurse	1,804	232	24	256	40	50%	20	276	15.3%
Doctoral	1,804	232	24	256	40	50%	20	276	15.3%

Notes:

- The list does not represent the complete list of provider groups to use in the comparison rates.

Example Rate Buildup *(for illustration purpose only)*

ASAM 3.5: clinically managed high-intensity residential services

Ref.	Description	Resident Assistant	RA Third Shift/Weekend	Case Manager	UR Specialist	Registered Nurse	Therapists (LMHC/LCDP)	On-Call Physician	Program Manager	Total	Notes
A	First shift workers	2.00		0.50	0.33	0.75	3.00	0.10	0.50		
B	Second shift workers	2.00		-	-	-	-	-	-		
C	Third shift workers		1.00	-	-	-	-	-	-		
D	Weekend first shift workers		2.00	-	-	-	3.00	-	-		
E	Weekend second shift workers		2.00	-	-	-	-	-	-		
F	Weekend third shift workers		1.00	-	-	-	-	-	-		
G	Total weekly hours	160.00	120.00	20.00	13.33	30.00	168.00	4.00	20.00		$G = [(A+B+C) \cdot 5] + [(D+E+F) \cdot 2] \cdot 8$
H	Number of Clients Served									16	The assumed number of clients in the home
I	PTO/training/conference time adjustment factor	11.1%	11.1%	16.1%	16.1%	16.3%	16.7%	18.2%	16.7%		Based on separate PTO build
J	Adjusted total hours of time per week	177.78	133.33	23.21	15.48	34.90	196.09	4.73	23.34		$J = G \cdot (1+I)$
K	Hourly wage	\$ 16.23	\$ 19.23	\$ 18.74	\$ 23.67	\$ 39.59	\$ 25.26	\$ 100.93	\$ 32.67		Based on separate wage build
L	Total wages expense per week	\$ 2,884	\$ 2,563	\$ 435	\$ 366	\$ 1,382	\$ 4,953	\$ 477	\$ 763		$L = J \cdot K$
M	Holidays worked	10	10	10	10	10	10	10	10		10 holidays per year
N	Percent of non-holiday hours paid at time and a half	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%		Based on assumptions
O	Percent of total hours paid at time and a half	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%		$O = (365.25 \cdot N + M) / 365.25$
P	Direct care wage adjusted for overtime and holidays per week	\$ 3,097.06	\$ 2,752.27	\$ 467.06	\$ 393.31	\$ 1,483.39	\$ 5,318.47	\$ 512.26	\$ 818.95	\$ 14,842.76	$P = L \cdot (1-O) + L \cdot O \cdot 1.5$
Q	Employee related expense (ERE) percentage	39.4%	35.8%	36.3%	32.1%	25.7%	31.1%	17.4%	27.7%		Based on separate ERE build
R	Total ERE expense per week	\$ 1,220.53	\$ 984.76	\$ 169.49	\$ 126.23	\$ 380.98	\$ 1,653.51	\$ 89.03	\$ 226.85	\$ 4,851.38	$R = P \cdot Q$
S	Transportation fleet costs per week									\$ 196.08	Based on van build-up estimates
T	Administration / program support / overhead									20.0%	Portion of total rate
U	Administration expenses per week									\$4,972.56	$U = (P+R+S) \cdot T / (1-T)$
V	Medication costs									\$ 0.00	No medication expenses
W	Caseload efficiency									95.0%	
X	Units per week									7.00	
Y	Rate per diem									\$233.67	$Y = [(P+R+S+U)/W] + V/H/X$

Ref.	Summary of Rate by Component									Total	Notes
Z	Direct Service Employee Salaries & Wages									\$ 139.50	
AA	Indirect Service Employee Salaries & Wages									\$ 0.00	
AB	Employee Related Expenses									\$ 45.60	
AC	Transportation & Fleet Vehicle Expenses									\$ 1.84	
AD	Administration, Program Support & Overhead									\$ 46.73	
AE	Total Rate									\$233.67	

Data Sources Informing the ADAD BH Rate Buildup

- Bureau of Labor Statistics (BLS)
 - Wage amounts specific to Hawai'i, by occupational code
 - Workers' compensation
 - Retirement
 - Health, dental, vision and life insurance rates
- Internal Revenue Service
 - Standard mileage rates
 - FICA percentages and limits and FUTA tax information
- Published policies and guidance by the State of Hawai'i
- Subject matter expert focus group feedback

Note: A provider survey will inform any adjustments needed to publicly available data sources.

Next Steps

- Review feedback from initial kick-off meeting
- Establish focus groups
- Conduct provider survey
 - Training
 - Release
 - Dedicated email for Q&A
- Develop initial assumptions for focus group discussion and review

Email HawaiiBH@Milliman.com if you have any feedback or questions during this important project.

Limitations

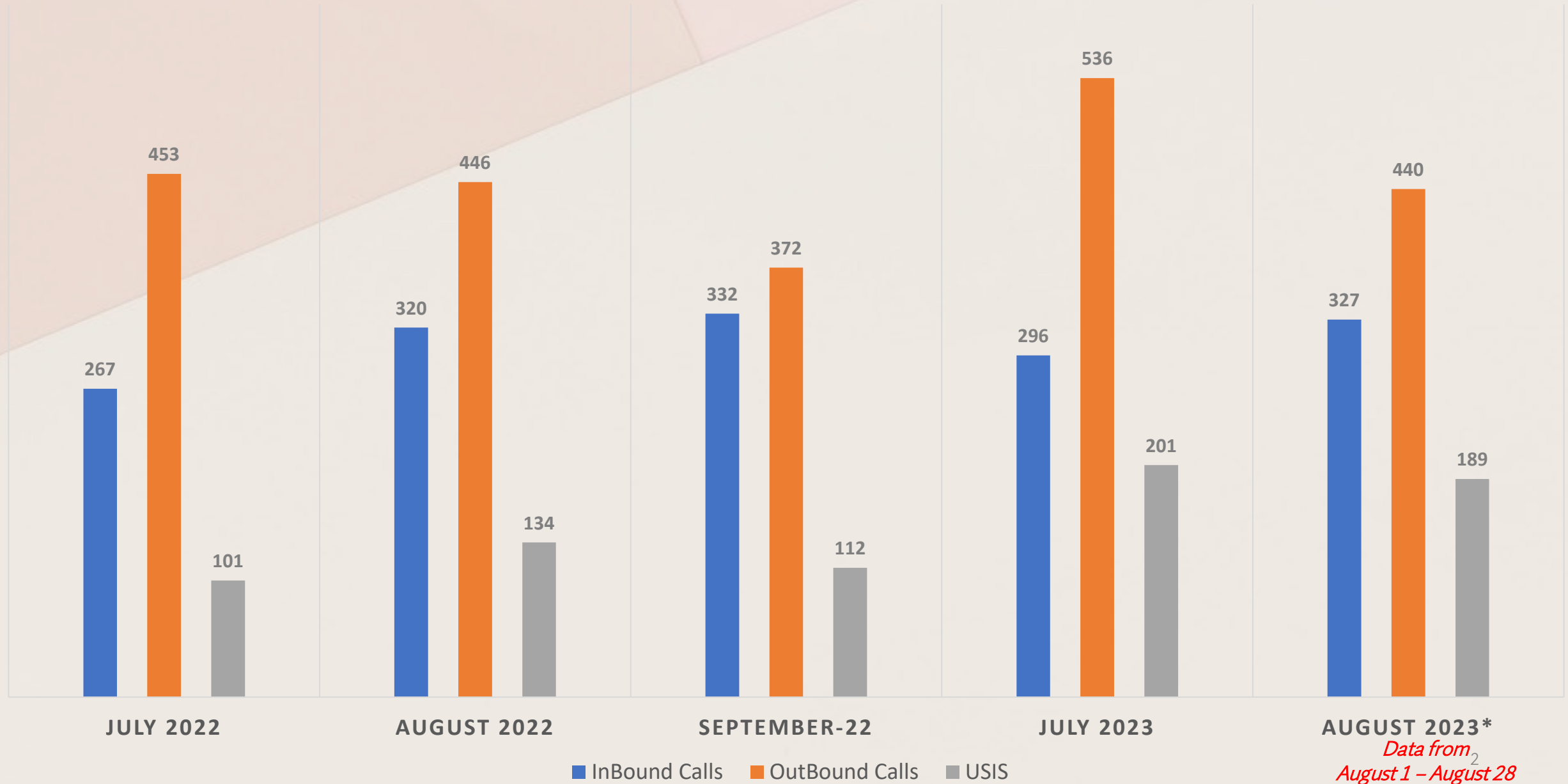
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Hawaii Cares Update

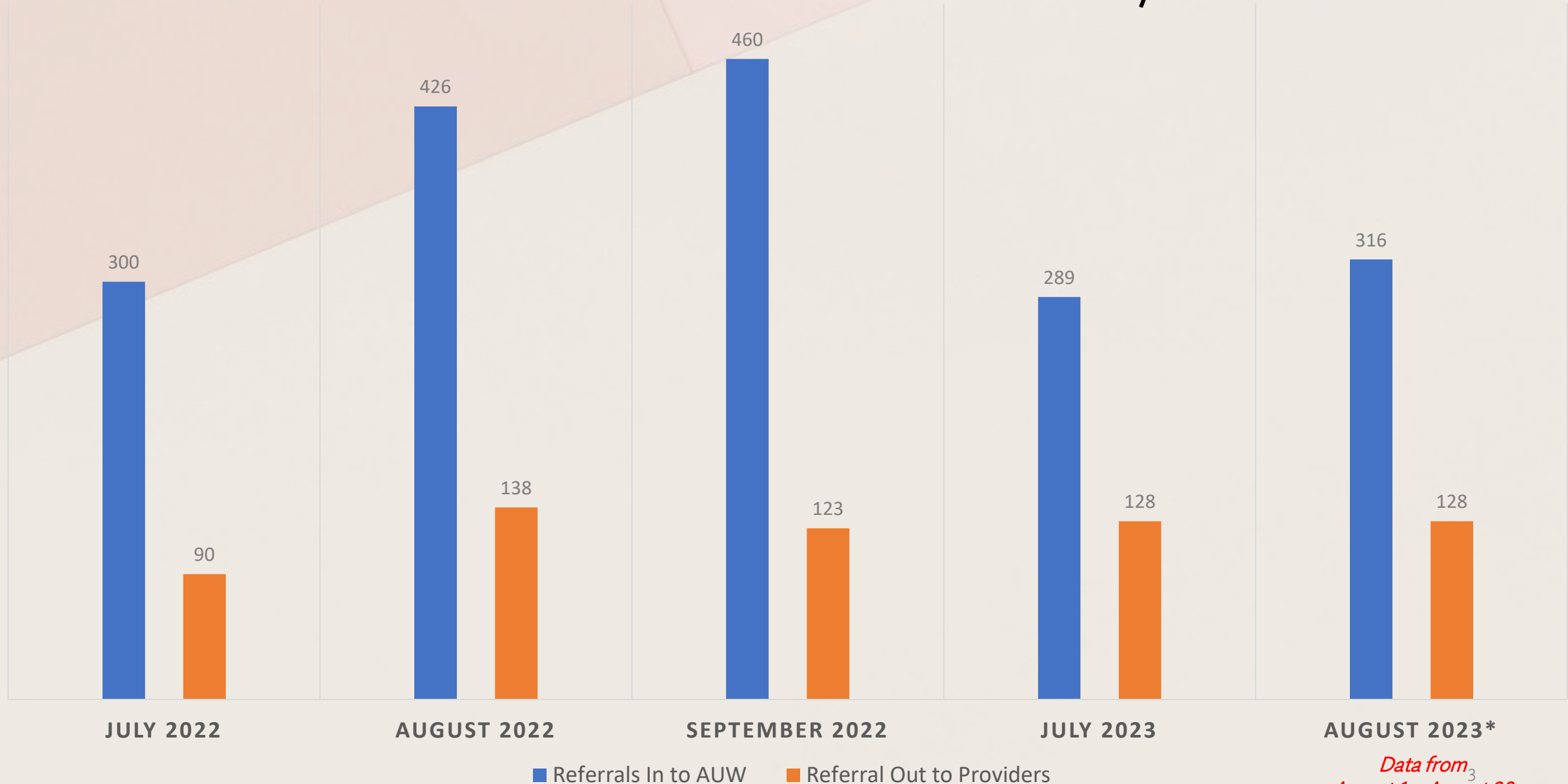
ALOHA UNITED WAY - HAWAII CARES

SUD SEASONAL DATA 2022/2023



ALOHA UNITED WAY - HAWAII CARES

SUD SEASONAL REFERRAL DATA 2022/2023



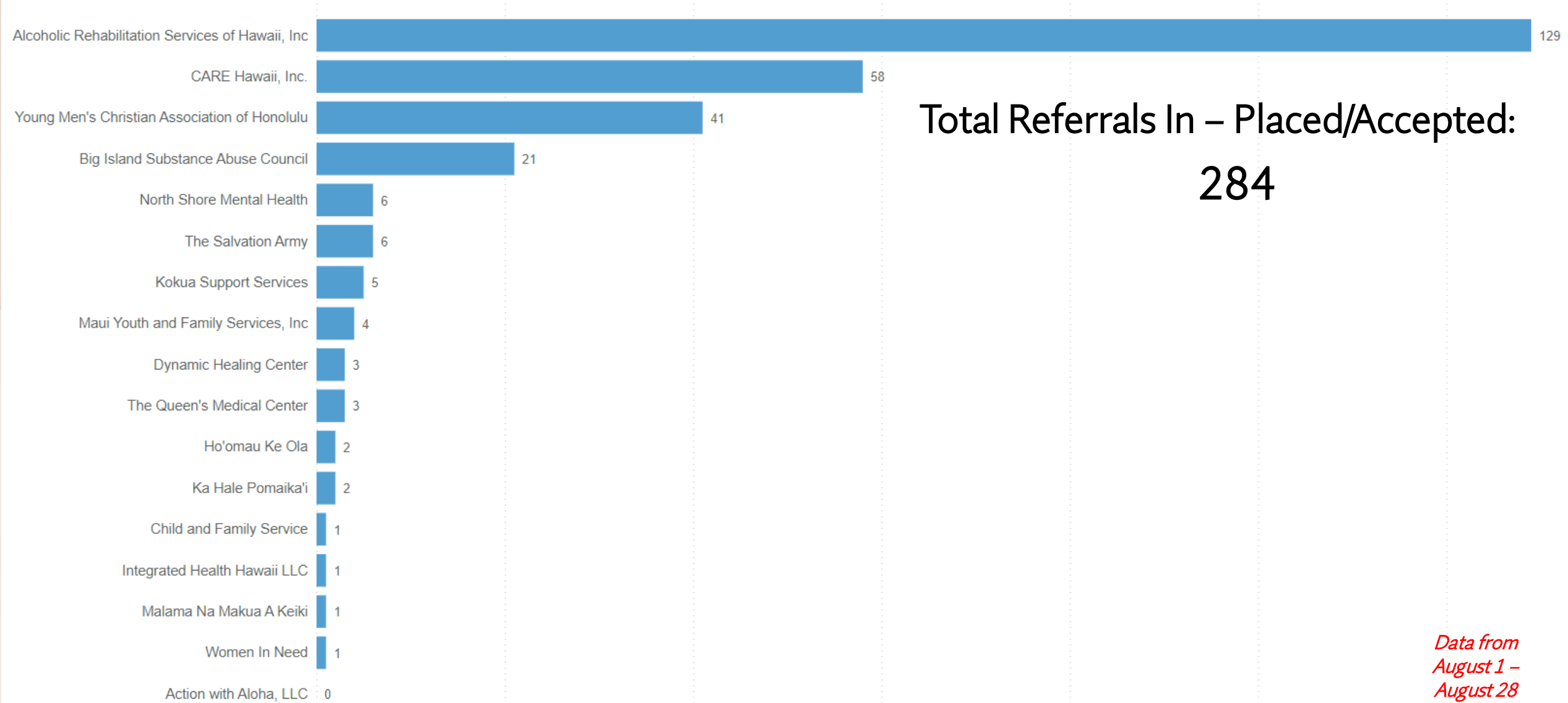
*Data from₃
August 1 – August 28*

ALOHA UNITED WAY - HAWAII CARES

SUD Referrals In to AUW (August 2023)

< Back to report

REFERRALS IN - PLACED/ACCEPTED



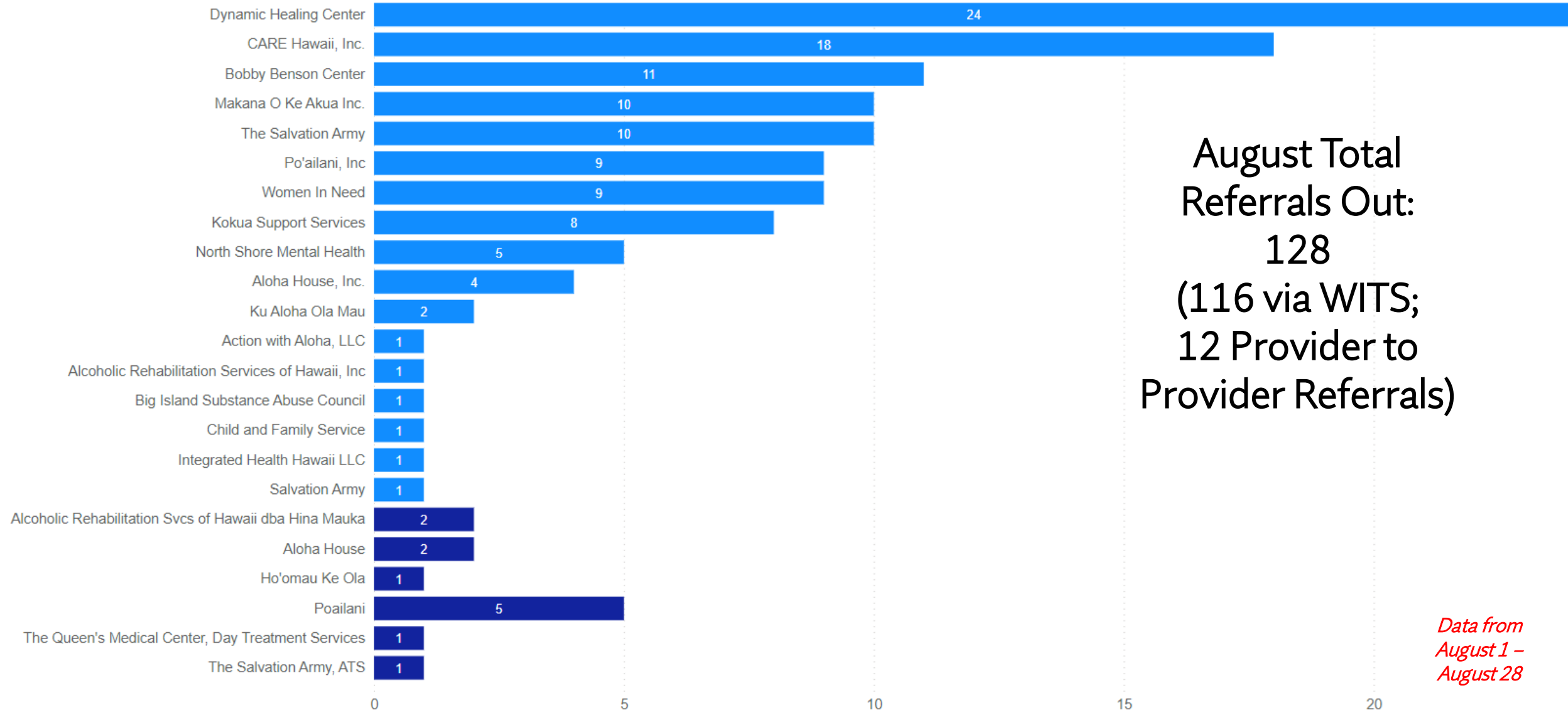
*Data from
August 1 –
August 28*

ALOHA UNITED WAY - HAWAII CARES

SUD Referrals Out to Providers (August 2023)

< Back to report

REFERRALS OUT



August Total
Referrals Out:
128
(116 via WITS;
12 Provider to
Provider Referrals)

*Data from
August 1 –
August 28*



Aloha United Way/ADAD Best Practices for Reducing Rejection of Referrals



The Hawai'i CARES and all BH COC Providers shall use BHA-approved screening and assessment tools. Prior to billing for services, APPLICANT shall ensure that BH COC clients have all “Bundle” components completed and submitted to Hawai'i CARES within 3 business days. Components of the “Bundle” for SUD service array include the following screening and assessment tools:

- Complete BHA-network client consent. <https://health.hawaii.gov/substance-abuse/prevention-treatment/>
- Complete BHA-designated Universal Standardized Intake and Screening form (“USIS”) <https://health.hawaii.gov/substance-abuse/files/2022/02/CARES-USIS.Revised-02.16.2022.pdf>
- Complete BHA-designated assessment for adults and adolescents in the BHA-designated EMIS.
- Complete ASAM tool documented in the BHA-designated EMIS.
- Complete and current BHA-designated Health and Wellness Plan documented in the BHA-designated EMIS.
- Individual provider intake, assessment or eligibility documentation SHALL not impede, delay or otherwise interfere with the Hawai'i CARES intake or admission process.



Aloha United Way/ADAD Best Practices for Reducing Rejection of Referrals



For more information, please review the documents below:

RFP 440-21-1 Attachment D-8 Clinical Documentation Requirements
(BH SUD COC SERVICE ARRAY CLINICAL DOCUMENTATION REQUIREMENTS)

- <https://acrobat.adobe.com/link/review?uri=urn:aaid:scds:US:df52c412-143f-33d6-8fdd-e310a9cecb14>

RFP 440-21-1 Attachment D-4 Hawaii CARES
THE BEHAVIORAL HEALTH CONTINUUM OF CARE COORDINATED ENTRY SYSTEM HAWAII COORDINATED ACCESS
RESOURCE ENTRY SYSTEM (HAWAII CARES)

- <https://acrobat.adobe.com/link/review?uri=urn:aaid:scds:US:c58cdf06-8bb4-348e-9836-b1cb7b39afd4>

THE BEHAVIORAL HEALTH CONTINUUM OF CARE COORDINATED ENTRY SYSTEM

HAWAI'I COORDINATED ACCESS RESOURCE ENTRY SYSTEM (HAWAI'I CARES)

A. Goal and Purpose.

The Hawai'i CARES is a statewide, 24/7 coordinated entry system that provides access to the Hawaii Behavioral Health Continuum of Care (BH COC) network of service arrays including but not limited to substance use disorder (SUD) prevention, treatment and recovery support services, mental health support services, behavioral health crisis intervention, child and adolescent mental health services, and services for individuals with intellectual and developmental disabilities. SUD interventions and levels of care are modeled after the American Society of Addiction Medicine (ASAM) criteria for SUD services.

This synchronized system of care unites an assortment of independent programs and treatment modalities in a coordinated and responsive system of care that provides clinically appropriate behavioral health and substance abuse treatment and recovery support services statewide. Services are accessible on demand to those who need it, when they need it, and where they need it. Thus, reducing all barriers to treatment and recovery support services in the BH COC. Improving accessibility and quality of care and minimizing or eliminating shortfalls in services availability are primary goals for the Hawai'i CARES.

B. Roles and Responsibilities.

1. The Hawai'i CARES is the entry-point and coordinating center for behavioral health services focusing on real-time data of utilization of all levels of care to maintain and facilitate an around the clock call and referral center for client flow through the BH COC. As the managing entity for service request and authorization, Hawai'i CARES monitors the effectiveness of the screening and referral process, authorizes client services utilization, and reviews all referrals for services and requests for extension of services. This continuous review of quality improvement (QI) is intended to ensure that the most costly and scarce services offered in the BH COC are utilized efficiently. BHA-contracted treatment and recovery support service providers ("Providers") must accept clients referred by the Hawai'i CARES. Upon receipt of a Notice of Award from the STATE, the APPLICANT becomes part of the BH COC as a BH COC Provider and shall be responsible for responding and interacting with other BH COC Providers the Hawai'i CARES.
2. Responsibilities and authority of the Hawai'i CARES managing entity include but are not limited to the following:

- a. Serve as gateway that assures universal intake and screening of clients in order to create a client record in the BHA-designated EMIS;
- b. Serve as an authorizing agent;
- c. Serve as the system quality assurance agent that monitors effectiveness of screening and referral procedures.
- d. Administratively close and reject any authorizations not compliant with the Hawai'i CARES BH SUD COC service array in coordination with ADAD.

The Hawai'i CARES authorizing agent utilizes QI tools and processes to assure that the most clinically effective services are delivered in the most cost-effective way.

C. Procedures.

1. The Hawai'i CARES shall provide and authorize the following SUD services for BH COC clients: screening, intake, assessment, care coordination, and referral and placement determination resulting in linkages to appropriate service modalities and resources.
2. Payor of Last Resort. BHA will support BH SUD COC Service Array Services for those clients that are not covered by Medicaid/Medicare or other payment source. Insurance denials for administrative or clinical reasons shall not be supported by the STATE. Services that are denied because they are not covered benefits or are unable to be paid under Medicaid/Medicare, or other payment source can be submitted to determine eligibility under BHA. Submission of denial letters and/or other documentation shall not guarantee approval/payment of claims.
3. The Hawai'i CARES and all BH COC Providers shall use BHA-approved screening and assessment tools. Prior to billing for services, APPLICANT shall ensure that BH COC clients have all "Bundle" components completed and submitted to Hawai'i CARES within 3 business days. Components of the "Bundle" for SUD service array include the the following screening and assessment tools:
 - a. A completed BHA-network client consent. Refer to the ADAD website: <https://health.hawaii.gov/substance-abuse/prevention-treatment/> for the most current version of the BHA-network Client Consent form.
 - b. A completed BHA-designated Universal Standardized Intake and Screening form ("USIS"). Refer to the ADAD website: <https://health.hawaii.gov/substance-abuse/prevention-treatment/> for the most current version of the BHA-designated USIS.
 - c. A completed BHA-designated assessment for adults and adolescents in the BHA-designated EMIS.

- d. A completed ASAM tool documented in the BHA-designated EMIS.
 - e. A completed and current BHA-designated Health and Wellness Plan documented in the BHA-designated EMIS.
 - f. Individual provider intake, assessment or eligibility documentation SHALL not impede, delay or otherwise interfere with the Hawai'i CARES intake or admission process.
4. The latest edition of the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC) shall be used for client SUD placement determination. See Section 5, Attachment E-1 Description of BH SUD COC Service Array.
 5. The BHA-designated EMIS shall be used for clinical documentation, billing and data review and analysis.
 6. A BHA client may enter the Hawai'i CARES via two paths: 1) from an outside referral to the Hawai'i CARES; or 2) from a Provider. The outside referral path may include self-referral or referral from an independent source (ie. homeless shelter; emergency room). Clients who are referred directly to a Provider must be admitted to the BH COC through the Hawai'i CARES . Under no circumstances shall a client enter treatment with a Provider, without Hawai'i CARES referral or authorization.
 7. The Hawai'i CARES shall make referrals to each Provider through each program's Hawai'i CARES Referral Contact or Clinical Supervisor via telephone, email or the BHA-designated EMIS. A Provider shall perform BH COC services according to RFP guidelines and timelines once the Hawai'i CARES has referred a client or authorized services for a client.
 8. The Hawai'i CARES shall review and approve all components of "the Bundle" in support of referrals to other treatment and recovery support services.
 9. The Hawai'i CARES shall maintain a daily inventory of all available treatment modality services all Providers. Providers shall update the Hawai'i CARES system with a daily inventory of all available treatment modality services open for referral and shall coordinate system availability with Hawai'i CARES as directed by Hawai'i CARES and/or ADAD.

D. BH COC Priority Populations.

The Hawai'i CARES and all BHA-funded treatment programs shall meet the requirements listed below and in Section 5, Attachment D-1 General Requirements.

1. Priority Populations.
 - a. Pregnant Women.
 - 1) If a treatment program does not have the capacity to immediately admit a pregnant woman to treatment, or if placement in the program is not appropriate, the program must refer the woman to Hawai'i CARES in order to coordinate BH SUD COC services at an appropriate and available service provider in the BH COC network.
 - 2) While Hawai'i CARES is linking the client to other services, the program must:
 - a) Provide interim services within 48 hours;
 - b. Person Who Injects Drugs (PWID):
 - 1) If a treatment program does not have the capacity to immediately admit a PWID client into treatment, or if the placement in the program is not appropriate, the program must refer the client to Hawai'i CARES in order to coordinate BH SUD COC services at an appropriate and available service provider in the BH COC network.
 - 2) While Hawai'i CARES is linking the client to other services, the program must:
 - a) Provide interim services within 48 hours.
 - c. All BH COC clients in interim services shall be admitted to treatment within 120 days of the initial request.
 - d. All STATE-funded substance abuse treatment programs shall inform the Hawai'i CARES of all request for services that it receives from a pregnant woman or PWID, and of the status of the client who made the request.
 - e. All treatment programs serving a population that includes people who inject drugs shall have a policy that prioritizes preference for admission to treatment for pregnant women and persons who inject drugs in the following order:
 - 1) Pregnant injecting drug users;
 - 2) Pregnant substance abusers;

- 3) Persons who inject drugs; and
 - 4) All others.
2. No Reject Policy. APPLICANTS must accept clients referred by the Hawai'i CARES. APPLICANTS must demonstrate a commitment to accept all clients that are referred in accordance with the processes described in this RFP (this is referred to as a No Reject Policy). In the situation where a treatment program is unable or not equipped to accept a referral, the proposed rejection of the referral (other than those due to full capacity) must be accompanied by a written Notification of Rejection of Services (Refer to **Section 5, Attachment D-2**) to the Hawai'i CARES from the treatment program's Clinical Director explaining why the individual was rejected for services and submitted within 3 business days upon receipt of referral. The STATE reserves the right to take contractual action due to a treatment program's inability to provide services in accordance with the terms and conditions of the contract.



Department of Health
Behavioral Health Administration

Authorization to Jointly Disclose Protected Health Information (PHI)
Hawaii Coordinated Access Resource Entry System (CARES) for Substance Use Disorder (SUD) and Mental Health (MH) Services
Hawaii CARES Continuum of Care Consent Form (Required for SUD and MH Services)

Individual Whose Protected Health Information is Being Disclosed	
First Name: _____	Last Name: _____
Address: _____ Birth Date: _____	
FROM: State of Hawaii, Department of Health, Behavioral Health Administration 601 Kamokila Boulevard, Room 360, Kapolei, HI 96707	TO: All Parties Identified within the Hawaii CARES Continuum of Care
FROM: All Parties Identified within the Hawaii CARES Continuum of Care	TO: State of Hawaii, Department of Health, Behavioral Health Administration 601 Kamokila Boulevard, Room 360, Kapolei, HI 96707
<input type="checkbox"/> I authorize disclosure of my Protected Health Information to any agencies within the Hawaii CARES Continuum of Care for the purpose of care coordination, treatment, and service provision, as listed on the Alcohol and Drug Abuse Division (ADAD) website (http://health.hawaii.gov/substance-abuse/) and Adult Mental Health Division (AMHD) website (http://health.hawaii.gov/amhd/).	
<p>I authorize that the following Protected Health Information be disclosed: Any and all information relevant to substance use and mental health pre-treatment, pre-recovery, treatment, recovery, care coordination, health and wellness plans, interim care, continuing care, assessments and support services. This includes but is not limited to:</p> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> All health information (e.g., diagnosis, test results, treatment); OR </div> <div style="width: 50%;"> <input type="checkbox"/> Images and/or Films <input type="checkbox"/> Reports <input type="checkbox"/> Billing <input type="checkbox"/> Dental </div> <div style="width: 50%;"> <input type="checkbox"/> HIV/AIDS Test Result </div> <div style="width: 50%;"> <input type="checkbox"/> Drug and Alcohol Treatment (e.g., diagnosis, test results, treatment, billing, attendance) </div> <div style="width: 50%;"> <input type="checkbox"/> Mental Health (e.g., diagnosis, test results, treatment, billing) </div> <div style="width: 50%;"> <input type="checkbox"/> Other: _____ </div> </div> <div style="display: flex; justify-content: flex-end; margin-top: -20px;"> <div style="width: 45%;">Initial here _____</div> <div style="width: 45%;">Initial here _____</div> <div style="width: 45%;">Initial here _____</div> <div style="width: 45%;">Initial here _____</div> </div>	
<p>The Protected Health Information is being disclosed for the following purpose: To help identify the client's needs and strengths, assist in developing treatment recommendations, assist in screening of eligibility for services and to provide care coordination of substance use and mental health services.</p>	
<p>This authorization will be in force and effect until: One Year after Termination of Services. At that time, this authorization to disclose this protected health information expires.</p>	
<p>I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Department of Health. I understand that a revocation is not effective to the extent that the Department has relied on the disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.</p> <p>I understand that certain information disclosed pursuant to this authorization may be disclosed by the recipient (e.g., HIPAA or mandated reporting). However, I understand that any information related to education (FERPA 34, CFR Part 99), alcohol or drug treatment services (42 CFR Part 2) may not be disclosed or re-disclosed without my authorization.</p> <p>The Entity or Person(s) receiving this information will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested disclosure.</p> <p>I understand the information provided may be used in a de-identified form for research and, audit and system evaluation purposes.</p> <p>The disclosure requested under this authorization will result in direct or indirect remuneration to the Department from a Third Party. I understand that I may be denied services if I refuse to consent to disclosure for purposes of treatment, payment, healthcare operations or eligibility for benefits, as permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.</p> <p>(Check this box ONLY if the disclosing party will receive compensation or other benefit when using or disclosing this Protected Health Information). <input checked="" type="checkbox"/></p>	
Individual or Personal Representative Signature: _____	Date: _____
Print Name of Individual or Personal Representative: _____	Description of Personal Representative's Authority _____

ID: _____

Hawaii CARES Continuum of Care
Consent Form, Page 1 of 1
Rev. 08/05/2020

Fax Information to:
Attention:

INTAKE FORM**CONFIDENTIAL**

Date: _____

Name: _____
(First, Middle Initial, Last)

Current Address: _____

City/Island: _____ / _____ Zip Code: _____ Phone No.: _____

Presenting Problem(s): _____

Other Reference No. (A#, Adolescent Judiciary #, etc.): _____ Citizenship: _____

Date of Birth: _____ Birth Place: _____

Biological Gender: _____ Gender Identity: _____

Race: _____ Ethnicity: _____

Initial Contact: _____

Source of Referral: _____

Do you consent for (AGENCY NAME: _____) to contact the Source of Referral? ☐ Yes ☐ No

Referral Contact Name: _____ Phone No: _____

Personal Contact Name: _____ Phone No: _____

Emergency Contact Name: _____ Phone No: _____

(By entering contact information, you are consenting that we contact this person in case of emergency)

Health Insurance: _____ Membership #: _____

Employment Status: _____ Veteran: ☐ Yes ☐ No

Current living arrangements (check one of the following):

☐ Houseless ☐ Living in other's homes ☐ Living in my home ☐ Jail / Incarcerated

Marital status (check one): ☐ Never Married ☐ Divorced ☐ Now Married

☐ Widowed ☐ Separated ☐ Living together

of children living with you: _____ Ages: _____ Pregnant: ☐ Yes ☐ No

Describe Current Legal Status: _____

Page 1 of 2

Client Name: _____

Date: _____

CONFIDENTIAL

1. Have you been in a controlled environment in the past 30 days? ☐ Yes ☐ No
- ☐ Jail ☐ Alcohol/drug treatment ☐ Medical treatment ☐ Psychiatric treatment
- ☐ Other: _____
2. Do you need transportation assistance? ☐ Yes ☐ No
3. Do you consume tobacco products? ☐ Yes ☐ No
4. In the last 30 days have you misused alcohol or other drugs? ☐ Yes ☐ No
5. Are you an Injection Drug User? ☐ Yes ☐ No
6. Have you ever felt you should cut down on your drinking or drug use? ☐ Yes ☐ No
7. Have people annoyed you by criticizing your drinking or drug use? ☐ Yes ☐ No
8. Have you ever felt bad or guilty about your drinking or drug use? ☐ Yes ☐ No
9. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)? ☐ Yes ☐ No
10. Current medical problems: ☐ Yes ☐ No PCP Doctor's Name: _____
11. List medications currently using (over the counter and prescribed): _____
12. Do you have any current medical or psychiatric concerns? ☐ Yes ☐ No
- _____
13. Do you have any chronic health conditions? ☐ Yes ☐ No
- _____
14. Do you have any mental health conditions? ☐ Yes ☐ No
- _____
15. Do you have a history of causing physical harm to others? ☐ Yes ☐ No
- If yes, current risk action: _____
16. Do you have a history of causing physical harm to yourself? ☐ Yes ☐ No
- If yes, current risk action: _____
17. What services are you interested in? ☐ Counseling ☐ Sober Living ☐ Outpatient
- ☐ Residential ☐ Other _____

Client Name: _____

Date: _____

BH SUD COC SERVICE ARRAY CLINICAL DOCUMENTATION REQUIREMENTS

For all services provided on the continuum of care during a client treatment episode, the APPLICANT shall maintain a clinical record that substantiates the clinical necessity, frequency, duration and intensity of the service provided. Acceptable substantiating documentation includes, but is not limited to, clinical summaries, encounter notes and wellness plans. The STATE reserves the right to conduct audits of all services to ensure adequacy of substantiating documentation. Should inadequacies be found, the STATE reserves the right to impose corrective actions that may include but are not limited to reversal of payment or contract termination.

The APPLICANT shall submit through the electronic format specified by the STATE the following information as part of each client's health record:

- A. Screening Report.** An BHA-designated Screening Report shall be documented in the BHA-designated EMIS utilizing an BHA-designated screening tool.

Screening shall occur for co-occurring disorders (substance use and mental health disorders) and for tobacco use. If a client screens positive for tobacco use, then the program shall note this on the Health and Wellness Plan and document tobacco cessation activities for the client with the client's agreement. Documentation shall be on the BHA-designated EMIS Health and Wellness Plan, Plan Reviews and Encounter notes.

- B. Clinical Assessment Report.** The BHA-designated biopsychosocial Clinical Assessment Report in the BHA-designated EMIS shall be completed and include a clinical summary, relevant data, an analysis of this data used to support the diagnosis/diagnoses, recommended client treatment placement determination, and any additional health and wellness recommendations. A clinical assessment report is required for each episode of care.

A clinical assessment report shall be completed at the following intervals:

1. At the time of admission;
2. At subsequent 6-month intervals within the current episode of care; and
3. At 6-months post discharge from the episode of care.

A diagnosis/diagnoses shall be documented on the Clinical Assessment Report. Diagnosis/Diagnoses shall be from the most current United States (CM-Clinical Modification) version of the International Classification of Diseases (ICD) of the World Health Organization (WHO) for 1) a substance use disorder (per ICD, a mental and behavioral disorder due to psychoactive substance use alone; or 2) in combination with a mental disorder (per ICD, a mental, behavioral or neurodevelopmental disorder not due to psychoactive substance abuse).

In the Clinical Assessment Report, in the narrative section, shall be included severity ratings for all six ASAM dimensions according to the most current version of the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC) with clinical justification for each severity rating. These ratings should coincide with development of the Health and Wellness Plan.

In the ASAM section of the BHA-designated EMIS, severity ratings for all six ASAM dimensions shall be accompanied by clinical justification to support each one. An ASAM patient placement recommendation for each dimension shall also be made, and an overall patient placement based on all dimension patient placement recommendations shall follow. Administrative recommendations with comments for alternative placement shall be included when the client cannot be placed at the clinically recommended patient placement level.

Sufficient staff time shall be allocated for follow-up to ensure at least three (3) attempts to contact clients using at least two (2) different methods (e.g., mail out, telephone, face-to-face) are made, and to assure that unless the client has died or left no forwarding address they will be contacted. A six-month post-discharge assessment shall be conducted for all clients regardless of the reason for discharge.

The assignment of a new BHA-designated biopsychosocial assessment may occur at any point during the contract period. Allowances and time will be made to ensure adequate training and implementation. Official notification will be made by ADAD prior to this taking effect.

- C. Placement Determination/Referral.** A Placement Determination/Referral must be documented in the BHA-designated EMIS prior to billing and prior to documenting all client-related and BHA-reimbursable services. This shall be documented utilizing the ASAM Profile in the BHA-designated EMIS. This placement determination should be congruent with the clinical assessment report, in the narrative section as well as with all pertinent dimensions listed in the Health and Wellness Plan.
- D. Health and Wellness Plans.** Health and Wellness Plans shall be linked to the client's clinical assessment report and identify the holistic areas targeted for intervention and linked to all ASAM dimensions. Service recommendations should promote positive changes for the areas targeted for intervention. Plans should include a behavioral prescription which indicates the type, duration and frequency of each intervention activity (where applicable) as well as the type of professional or individual that provides substance abuse, behavioral health, health and social services as well as skills training, support and mentoring. The Health and Wellness Plan shall be documented in the BHA-designated EMIS prior to billing client-related BHA-reimbursable services.

Updated Health and Wellness Plans shall be linked to the initial or previous Health and Wellness Plan and should provide a summary of progress in identified services and interventions for each ASAM Dimension. Updates for different modalities (e.g. residential, day treatment, etc.) should be completed based on requirements as described in Section 5, Attachment E-1. Updated Health and Wellness Plans shall be completed

when a client transitions from one modality of service to another (e.g. OP to IOP, or a treatment modality to a recovery support modality) or when clinically indicated. Health and Wellness Plan Updates **MUST** be documented in the BHA-designated EMIS prior to billing and documenting all client-related and BHA-reimbursable services.

- E. Encounter Notes.** Encounter notes shall be completed for each encounter. Encounter notes shall provide a description of the services and/or activities provided and use a standard clinical format (e.g. D.AP., SOAP), which correlate with the area(s) of intervention in the Health and Wellness Plan and clinical assessment report. Each encounter note provides the client response to the intervention as well as recommendation(s) for the next related activity. Each encounter note will also serve as the basis for each Health and Wellness Plan Review and be linked to each relevant ASAM dimension. Encounter notes are required for all client and client-related activities (whether directly billable to a specific code or non-billable) and shall be documented on the BHA-designated EMIS.
- F. Addiction Care Coordination.** Addiction care coordination **MUST** be documented as an ongoing service throughout the entire episode of care. Addiction Care Coordination shall be documented on encounter notes and on the Health and Wellness Plan, Updated Health Wellness Plans and related services.
- G. Miscellaneous.** The APPLICANT shall document in the BHA-designated EMIS as an encounter note that the following were reviewed and completed with the client:
 1. Client Signed Statement of Consumer's Rights and Responsibilities
 2. Informed Consent to Treatment
 3. Consent(s) to Release Information/Authorization(s)
 4. Written Notice Prohibiting Re-disclosure
 5. TB Screening/Test Results (where applicable)
 6. ADAD HIPAA Notice of Privacy Practices
 7. Agency's HIPAA Notice of Privacy Practices
 8. Communicable Disease Risk Assessment
 9. Tobacco Screening

The STATE reserves the right to request refunds or withhold payment for any service that is not satisfactorily documented in the BHA-designated EMIS. For all services provided during an episode of care, the APPLICANT shall maintain a clinical record that substantiates the clinical necessity, frequency, duration and intensity of the service provided. Acceptable substantiating documentation includes, but is not limited to, clinical summaries, encounter notes and wellness plans. The STATE reserves the right to conduct audits of all services to ensure adequacy of substantiating documentation. **Should inadequacies be found, the STATE reserves the right to impose corrective actions that may include, but are not limited to, reversal of payment or contract termination.**

The above described reports, notes and other client data are used as the basis for adjudicating all invoices submitted by the provider. It is the responsibility of the provider to maintain an BHA-designated EMIS that conforms to the expectations described above. **In order to bill for**

Treatment services (OP, IOP, Day Treatment, Residential, Clean & Sober, TLP, Continuum Care) APPLICANTS must complete and document all applicable/appropriate Pre-treatment services to include Clinical Assessment Report, Placement/Referral and Health and Wellness Planning.