State of Hawaii
Department of Health
Adult Mental Health Division

Request for Proposals

RFP # HTH 420-8
Outpatient Treatment, Targeted Case Management, Care Coordination and Clubhouse Services for Waianae Coast

Date Issued
October 12, 2004

Date Due
January 14, 2005

Note: If this RFP was downloaded from the State Procurement Office RFP Website each applicant must provide contact information to the RFP contact person for this RFP to be notified of any changes. For your convenience, an RFP Interest form may be downloaded to your computer, completed and e-mailed or mailed to the RFP contact person. The State shall not be responsible for any missing addenda, attachments or other information regarding the RFP if a proposal is submitted from an incomplete RFP.

October 12, 2004

REQUEST FOR PROPOSALS

OUTPATIENT TREATMENT, TARGETED CASE MANAGEMENT, CARE COORDINATION AND CLUBHOUSE SERVICES FOR WAIANAE COAST
RFP # HTH 420-8

The Department of Health, Adult Mental Health Division is requesting proposals from qualified applicants to provide outpatient treatment, targeted case management, care coordination and clubhouse services for Waianae Coast. The contract term will be from July 1, 2005 through June 30, 2006. Multiple contracts may be awarded under this request for proposals.

Proposals shall be mailed and postmarked by the United State Postal Service on or before January 14, 2005, or hand delivered no later than 4:30 p.m., Hawaii Standard Time (HST), on January 14, 2005, at the drop-off sites designated on the Proposal Mail-in and Delivery Information Sheet. Proposals postmarked or hand delivered after the submittal deadline shall be considered late and rejected. There are no exceptions to this requirement.

The Adult Mental Health Division will conduct an orientation on October 21, 2004 from 10:00 a.m. to 11:30 HST, at North Trotter Basement, 3650 Maunalei Avenue, Honolulu, Hawaii. All prospective applicants are encouraged to attend the orientation.

The deadline for submission of written questions is 4:30 p.m. HST on November 1, 2004. All written questions will receive a written response from the State on or about November 19, 2004.

Inquiries regarding this RFP should be directed to the RFP contact persons Betty Uyema or Lorie Mimura at 1250 Punchbowl Street, Room 256, Honolulu, Hawaii 96813, telephone: (808) 586-4688, fax: (808) 586-4745.

PROPOSAL MAIL-IN AND DELIVERY INFORMATION SHEET

ONE ORIGINAL AND NINE COPIES OF THE PROPOSAL ARE REQUIRED. ADDITIONAL COPIES MAY BE SPECIFIED BY INDIVIDUAL DOH PROGRAMS.

ALL MAIL-INS MUST BE POSTMARKED BY THE USPS BEFORE 12:00 MIDNIGHT, January 14, 2005

All Mail-ins

Department of Health
Administrative Services Office
P.O. Box 3378
Honolulu, HI 96801-3378

DOH RFP Coordinator

Valerie K. Ako
For further info or inquiries
Phone: (808) 586-4556
Fax: (808) 586-4649

ALL HAND DELVERIES WILL BE ACCEPTED AT THE FOLLOWING SITES UNTIL 4:30 P.M., January 14, 2005

Drop-off Sites

For applicants located on **Oahu**:

Department of Health
Administrative Services Office
Room 310, Kinau Hale
1250 Punchbowl Street
Honolulu, HI 96313

For applicants located in **East Hawaii**:

Department of Health
Hawaii District Health Office
State Office Building, Room 105
75 Aupuni Street
Hilo, Hawaii
Attn: DOH Administrative Services Office
Office

For applicants located in **West Hawaii**:

Department of Health
Hawaii District Health Office at Kona
Kealakekua Business Plaza, Room 103
81-980 Halekii Street
Kealakekua, Hawaii
Attn: DOH Administrative Services

For applicants located on **Kauai**:

Department of Health
Kauai District Health Office
Lihue Health Center
3040 Umi Street
Lihue, Kauai
Attn: DOH Administrative Services Office
Office

For applicants located on **Maui**:

Department of Health
Maui District Health Office
State Office Building, 3rd Floor
54 High Street
Wailuku, Maui
Attn: DOH Administrative Services

BE ADVISED: **All mail-ins postmarked USPS after 12:00 midnight, January 14, 2005, will not be accepted for review and will be returned.**

Hand deliveries will not be accepted after 4:30 p.m., January 14, 2005.

Deliveries by private mail services, such as FedEx or UPS, shall be considered hand deliveries, and will not be accepted if received after 4:30 p.m., January 14, 2005.

RFP Table of Contents

Section 1 Administrative Overview

I. Authority 1-1
II. RFP Organization 1-1
III. Contracting Office 1-2
IV. Procurement Timetable 1-2
V. Orientation 1-3
VI. Submission of Questions 1-3
VII. Submission of Proposals 1-3
VIII. Discussions with Applicants 1-6
IX. Opening of Proposals 1-6
X. Additional Materials and Documentation 1-6
XI. RFP Amendments 1-6
XII. Final Revised Proposals 1-7
XIII. Cancellation of Request for Proposals 1-7
XIV. Costs for Proposal Preparation 1-7
XV. Provider Participation in Planning 1-7
XVI. Rejection of Proposals 1-7
XVII. Notice of Award 1-8
XVIII. Protests 1-8
XIX. Availability of Funds 1-11
XX. Monitoring and Evaluation 1-11
XXI. General and Special Conditions of the Contract 1-11
XXII. Cost Principles 1-15

Section 2 - Service Specifications

I. Introduction 2-1
- A. Overview, Purpose or Need 2-1
- B. Description of the Goals of the Service 2-3
- C. Description of the Target Population to be Served 2-4
- D. Geographic Coverage of Service 2-4
- E. Probable Funding Amounts, Source, and Period of Availability. 2-4

II. General Requirements 2-5
- A. Specific Qualifications or Requirements 2-5
- B. Secondary Purchaser Participation 2-15
- C. Multiple or Alternate Proposals 2-15
- D. Single or Multiple Contracts to be Awarded 2-15
- E. Single or Multi-Term Contracts to be Awarded 2-15
- F. RFP Contact Person 2-16

III. Scope of Work 2-16
- A. Service Activities 2-16
- B. Management Requirements 2-25

IV. Facilities 2-37

Section 3 - Proposal Application Instructions

General Instructions for Completing Applications 3-1
I. Program Overview 3-2
II. Experience and Capability 3-2
A. Necessary Skills 3-2
B. Experience 3-2
C. Quality Assurance and Evaluation 3-2
D. Coordination of Services 3-5
E. Facilities 3-5
F. Management Information System 3-5
III. Project Organization and Staffing 3-6
A. Staffing 3-6
B. Project Organization 3-7
IV. Service Delivery 3-7
V. Financial 3-9
A. Pricing Structure 3-9
B. Other Financial Related Materials 3-10
VI. Other 3-10
A. Litigation 3-10

Section 4 – Proposal Evaluation

I. Introduction 4-1
II. Evaluation Process 4-1
III. Evaluation Criteria 4-2
A. Phase 1 – Evaluation of Proposal Requirements 4-2
B. Phase 2 – Evaluation of Proposal Application 4-2
C. Phase 3 – Recommendation for Award 4-8

Section 5 – Attachments

Attachment A. Competitive Proposal Application Checklist

Attachment B. Sample Proposal Table of Contents

Attachment C. Draft Special Conditions

Attachment D. Consumer Rights

Attachment E. Division P&P Regarding Consumer Grievances
Division P&P Regarding Consumer Appeals

Attachment F. QMHP and Supervision

Attachment G. AMHD Level of Care Service Criteria

Attachment H. Comprehensive, Continuous, Integrated Systems of Care Model by Kenneth Minkoff, M.D.

Attachment I. Dual Diagnosis Philosophy and Treatment Guidelines

Attachment J. Treatment Services Definitions

Attachment K. Certifications

Attachment L. Form SPO-H-205A Instructions

Section 1

Administrative Overview

Section 1
Administrative Overview

Applicants are encouraged to read each section of RFP thoroughly. While sections such as the administrative overview may appear similar among RFP's, state purchasing agencies may add additional information as applicable. It is the responsibility of the applicant to understand the requirements of *each* RFP.

I. Authority

This RFP is issued under the provisions of the Hawaii Revised Statutes (HRS), Chapter 103F and its administrative rules. All prospective applicants are charged with presumptive knowledge of all requirements of the cited authorities. Submission of a valid executed proposal by any prospective applicant shall constitute admission of such knowledge on the part of such prospective applicant. Failure to comply with any requirements may result in the rejection of the proposal.

Applicants are advised that the entire RFP, appendices, amendments, memorandum, written responses to questions and answers, and the corresponding proposal shall be a part of the contract with the successful applicant.

II. RFP Organization

This RFP is organized into five sections:

Section 1, Administrative Overview--Provides applicants with an overview of the procurement process.

Section 2, Service Specifications--Provides applicants with a general description of the tasks to be performed, delineates applicant responsibilities, and defines deliverables (as applicable).

Section 3, Proposal Application Instructions--Describes the required format and content for the proposal application.

Section 4, Proposal Evaluation--Describes how proposals will be evaluated by the state purchasing agency.

Section 5, Attachments --Provides applicants with information and forms necessary to complete the application.

III. Contracting Office

The Contracting Office is responsible for overseeing the contract(s) resulting from this RFP, including system operations, fiscal agent operations, and monitoring and assessing provider performance. The Contracting Office is:

Adult Mental Health Division
Department of Health
1250 Punchbowl Street, Room 256
Honolulu, Hawaii 96813
Phone: (808)586-4688 Fax: (808)586-4745

IV. Procurement Timetable

Note that the procurement timetable represents the State's best estimated schedule. Contract start dates may be subject to the issuance of a notice to proceed.

Activity	Scheduled Date
Public notice announcing RFP	10/12/04
Distribution of RFP	10/12/04
RFP orientation session	10/21/04
Closing date for submission of written questions for written responses	11/1/04
State purchasing agency's response to applicants' written questions	11/19/04
Discussions with applicant prior to proposal submittal deadline (optional)	
Proposal submittal deadline	1/14/05
Discussions with applicant after proposal submittal deadline (optional)	
Final revised proposals (optional)	
Proposal evaluation period	Feb/March 2005
Provider selection	March 2005
Notice of statement of findings and decision	4/4/05
Contract start date	7/1/05

V. Orientation

An orientation for applicants in reference to the request for proposals will be held as follows:

Date: **October 21, 2004** **Time:** **10:00– 11:30 a.m.**
Location: **N. Trotter Basement; 3650 Maunalei Ave. Honolulu, HI 96816**

Applicants are encouraged to submit written questions prior to the orientation. Impromptu questions will be permitted at the orientation and spontaneous answers provided at the state purchasing agency's discretion. However, answers provided at the orientation are only intended as general direction and may not represent the state purchasing agency's position. Formal official responses will be provided in writing. To ensure a written response, any oral questions should be submitted in writing following the close of the orientation, but no later than the submittal deadline for written questions indicated in the next paragraph (VI. Submission of Questions).

VI. Submission of Questions

Applicants may submit questions to the RFP Contact Person identified in Section 2 of this RFP. All written questions will receive a written response from the state purchasing agency.
Deadline for submission of written questions:
Date: **November 1, 2004** **Time:** **4:30 P.M. HST**
State agency responses to applicant written questions will be provided by**:**
Date: **November 19, 2004**

Applicants shall submit questions in writing, and/or on diskette in Word 2000 format or lower to the RFP Contact Person. The written questions shall reference the RFP section, page and paragraph number.

Only correspondence coordinated by the RFP Contact Person shall be considered valid. No verbal responses shall be considered as official. All questions regarding the RFP must be directed to the RFP Contact Person.

VII. Submission of Proposals

A. **Forms/Formats -** Forms, with the exception of program specific requirements, may be found on the State Procurement Office website at: www.spo.hawaii.gov, click *Procurement of Health and Human Services* and *For Private Providers.* Refer to the Proposal Application Checklist for the location of program specific forms.

1. **Proposal Application Identification (Form SPO-H-200) -** Provides identification of the proposal.

2. **Proposal Application Checklist –** Provides applicants with information on where to obtain the required forms; information on program specific requirements; which forms are required and the order in which all components should be assembled and submitted to the state purchasing agency.

3. **Table of Contents -** A sample table of contents for proposals is located in Section 5, Attachments. This is a sample and meant as a guide. The table of contents may vary depending on the RFP.

4. **Proposal Application (Form SPO-H-200A) -** Applicant shall submit comprehensive narratives that addresses all of the issues contained in the Proposal Application Instructions, including a cost proposal/budget if required. (Refer to Section 3 of this RFP.**)**

5. **Registration Form (SPO-H-100A) –** If applicant is not registered with the State Procurement Office (business status), this form must be submitted with the application. If applicant is unsure as to their registration status, they may check the State Procurement Office website at: http://www.spo.hawaii.gov, click *Procurement of Health and Human Services*, and *For Private Providers* and *Provider Lists…The List of Registered Private Providers for Use with the Competitive Method of Procurement* or call the State Procurement Office at (808) 587-4706.

6. **Tax Clearance –** A certified copy of a current valid tax clearance certificate issued by the State of Hawaii, Department of Taxation (DOTAX) and the Internal Revenue Service (IRS) will be required either at the time of proposal submittal or upon notice of award at the discretion of the purchasing agency.

   Refer to Section 4, item III.A.1, Administrative Requirements, and the Proposal Application Checklist to see if the tax clearance is required at time of proposal submittal. The tax clearance application may be obtained from the Department of Taxation website at www.hawaii.gov/tax/tax.html.

B. **Program Specific Requirements -** Additional program specific requirements are included in Sections 2 and/or 3, Service Specifications and the Proposal Application Instructions, as applicable. If Federal and/or State certifications are required, they are listed on the Proposal Application Checklist.

C. **Multiple or Alternate Proposals -** Multiple or alternate proposals shall not be accepted unless specifically provided for in Section 2 of this RFP.

In the event alternate proposals are not accepted and an applicant submits alternate proposals, but clearly indicates a primary proposal, it shall be considered for award as though it were the only proposal submitted by the applicant.

D. **Proposal Submittal -** Proposals must be postmarked by USPS or hand delivered by the date and time designated on the Proposal Mail-In and Delivery Information Sheet attached to this RFP. Any proposal post-marked or received after the designated date and time shall be rejected. Note that postmarks must be by United States Postal Service or they will be considered hand-delivered and shall be rejected if late. The number of copies required is located on the Proposal Mail-In and Delivery Information Sheet.

E. **Wages and Labor Law Compliance -** Before a provider enters into a service contract in excess of $25,000, the provider shall certify that it complies with section 103-55, HRS, Wages, hours, and working conditions of employees of contractors performing services. Section 103-55, HRS may be obtained from the Hawaii State Legislature website at http://www.capitol.hawaii.gov/. Or go directly to: http://www.capitol.hawaii.gov/hrscurrent/Vol02_Ch0046-0115/HRS0103/HRS_0103-0055.htm

F. **Confidential Information –** If an applicant believes any portion of a proposal contains information that should be withheld as confidential or proprietary, the applicant shall request in writing nondisclosure of designated proprietary data to be confidential and provide justification to support confidentiality. An explanation to the DIVISION of how substantial competitive harm would occur if the information was released is required. Proprietary or confidential information includes, but is not limited to business/financial information, medical records, and patient information. Such data shall accompany the proposal, be clearly marked as ‘CONFIDENTIAL or ‘PROPRIETARY” and shall be readily separable from the rest of the proposal. The DIVISION will maintain the confidentiality of the information to the extent allowed by law.

All proposals become the property of the State of Hawaii. The successful proposal shall be incorporated into the resulting contract and shall be public record. The State of Hawaii shall have the right to use all ideas, or adaptations to those ideas, contained in any proposal received in response to this RFP. Selection or rejection of the proposal shall not affect this right.

Note that price is not considered confidential and will not be withheld.

VIII. Discussions with Applicants

A. Prior to Submittal Deadline. - Discussions may be conducted with potential applicants to promote understanding of the purchasing agency's requirements.

B. After Proposal Submittal Deadline - Discussions may be conducted with applicants whose proposals are determined to be reasonably susceptible of being selected for award, but proposals may be accepted without discussions, in accordance section 3-143-403, HAR.

From the issue date of this RFP until an applicant is selected and the selection is announced, communications with State staff may be pursuant to Chapter 3-143-401, Hawaii Administrative Rules (HAR).

In order to provide equal treatment to all applicants, questions from applicants shall be submitted in writing and answers to applicants shall be distributed to all known interested parties.

IX. Opening of Proposals

Upon receipt of proposal by a state purchasing agency at a designated location, proposals, modifications to proposals, and withdrawals of proposals shall be date-stamped, and when possible, time-stamped. All documents so received shall be held in a secure place by the state purchasing agency and not examined for evaluation purposes until the submittal deadline.

Procurement files shall be open to public inspection after a contract has been awarded and executed by all parties.

X. Additional Materials and Documentation

Upon request from the state purchasing agency, each applicant shall submit any additional materials and documentation reasonably required by the state purchasing agency in its evaluation of the proposals.

The Adult Mental Health Division ("DIVISION") reserves the right to conduct an on-site visit to verify the appropriateness and adequacy of the applicant's proposal before the award of the contract.

XI. RFP Amendments

The State reserves the right to amend this RFP at any time prior to the closing date for the final revised proposals. Amendments shall be sent to all applicants who requested copies of the RFP. If significant amendments are made to the RFP, the applicants shall be provided additional time to submit their proposals.

XII. Final Revised Proposals

The applicant's final revised proposal, *as applicable* to this RFP, must be postmarked or hand delivered by the date and time specified by the state purchasing agency. Any final revised proposal post-marked or received after the designated date and time shall be rejected. If a final revised proposal is not submitted, the previous submittal shall be construed as their best and final offer/proposal. *The applicant shall submit-**only** the section(s) of the proposal that are amended, along with the Proposal Application Identification Form (SPO-H-200).* After final revised proposals are received, final evaluations will be conducted for an award.

XIII. Cancellation of Request for Proposal

The request for proposal may be canceled and any or all proposals may be rejected in whole or in part, when it is determined to be in the best interests of the State.

XIV. Costs for Proposal Preparation

Any costs incurred by applicants in preparing or submitting a proposal are the applicants' sole responsibility.

XV. Provider Participation in Planning

Provider participation in a state purchasing agency's efforts to plan for or to purchase health and human services prior to the state purchasing agency's release of a request for proposals, including the sharing of information on community needs, best practices, and providers' resources, shall not disqualify providers from submitting proposals if conducted in accordance with sections 3-142-202, 3-142-203 and 3-143-618 of the Hawaii Administrative Rules for Chapter 103F, HRS.

XVI. Rejection of Proposals

The State reserves the right to consider as acceptable only those proposals submitted in accordance with all requirements set forth in this RFP and which demonstrate an understanding of the problems involved and comply with the service specifications. Any proposal offering any other set of terms and conditions contradictory to those included in this RFP may be rejected without further notice.

The DIVISION also reserves the right to waive minor variances in proposals providing such action is in the best interest of the State. Where the DIVISION may waive minor variances, such waiver shall in no way modify the RFP requirements or excuse an applicant from full compliance with the RFP

specifications and other contract requirements if the applicant is awarded the contract.

A proposal may be automatically rejected for any one or more of the following reasons: (Relevant sections of the Hawaii Administrative Rules for Chapter 103F, HRS, are parenthesized)

(1) Rejection for failure to cooperate or deal in good faith. (Section 3-141-201, HAR)
(2) Rejection for inadequate accounting system. (Section 3-141-202, HAR)
(3) Late proposals (Section 3-143-603, HAR)
(4) Inadequate response to request for proposals (Section 3-143-609, HAR)
(5) Proposal not responsive (Section 3-143-610 (1), HAR)
(6) Applicant not responsible (Section 3-143-610 (2), HAR)
(7) Proof of collusion among applicants, in which case all proposals involved in the collusive action shall be rejected and any participant to such collusion shall be barred from future bidding until reinstated as a qualified applicant.
(8) An applicant without a DIVISION approved repayment plan who is in arrears on existing contracts with the State or has defaulted on previous contracts.
(9) An applicant shows any noncompliance with applicable laws.
(10) An applicant's lack of financial stability and viability.
(11) An applicant adds any provisions reserving the right to accept or reject an award, or enters into a contract pursuant to an award, or adds provisions contrary to those in the solicitation.

XVII. Notice of Award

A statement of findings and decision shall be provided to all applicants by mail upon completion of the evaluation of competitive purchase of service proposals.

Any agreement arising out of this solicitation is subject to the approval of the Department of the Attorney General as to form, and to all further approvals, including the approval of the Governor, required by statute, regulation, rule, order or other directive.

No work is to be undertaken by the awardee prior to the contract commencement date. The State of Hawaii is not liable for any costs incurred prior to the official starting date.

Upon receipt and acceptance of the winning proposal, the DIVISION shall initiate the contracting process. The applicant who has been awarded a contract shall be notified in writing that the DIVISION intends to contract with the applicant. This letter shall serve as notification that the applicant should begin to develop its

programs, materials, policies and procedures for the contract. The DIVISION will not reimburse applicants for costs incurred related to services not delivered

If a subcontractor is used, the applicant shall assure the DIVISION that they, as the applicant have the ultimate responsibility that the subcontractors will provide services that meet the criteria of this RFP. The DIVISION must be informed of all subcontractors. The DIVISION reserves the right to approve subcontractors used for the provision of services under this RFP.

All agreements or contracts with subcontractors or providers shall be finalized and fully executed within thirty (30) calendar days of contract award. The DIVISION reserves the right to review any subcontractor or provider contracts or agreements prior to the notification of award of the contract.

Upon award of the contract, the applicant shall submit a plan for implementation of services and shall provide progress/performance reports every two weeks beginning two weeks after the notification of contract award. The format to be used shall be approved by the DIVISION. The purpose of the reports is to ensure that the applicant will be ready to provide services as of the implementation date of the contract and that all required elements are in place. If the applicant is not able to demonstrate readiness to implement the contract, the award shall be withdrawn by the DIVISION and the next qualified applicant shall replace the applicant.

After the award of the contract, prior to implementation, an on-site readiness review will be conducted by a team from the DIVISION and will examine the applicant's staffing, subcontractor and provider contracts, fiscal operations, and other areas specified prior to review.

XVIII. Protests

Any applicant may file a protest against the awarding of the contract. The Notice of Protest form, SPO-H-801, is available on the SPO website (see the Proposal Application Checklist in Section 5 of this RFP. Only the following matters may be protested:

(1) A state purchasing agency's failure to follow procedures established by Chapter 103F of the Hawaii Revised Statutes;

(2) A state purchasing agency's failure to follow any rule established by Chapter 103F of the Hawaii Revised Statutes; and

(3) A state purchasing agency's failure to follow any procedure, requirement, or evaluation criterion in a request for proposals issued by the state purchasing agency.

The Notice of Protest shall be mailed by USPS or hand delivered to the head of the state purchasing agency conducting the protested procurement and the procurement officer who is conducting the procurement (as indicated below) within five working days of the postmark of the Notice of Findings and Decision sent to the protestor. Delivery services other than USPS shall be considered hand deliveries and considered submitted on the date of actual receipt by the state purchasing agency.

Head of State Purchasing Agency	**Procurement Officer**
Name: Chiyome L. Fukino, M.D.	Name: Ann Kinningham
Title: Director of Health	Title: Chief, Administrative Services Office, Adult Mental Health Division
Mailing Address: P.O. Box 3378 Honolulu, Hawaii 96801	Mailing Address: P.O. Box 3378, Honolulu, Hawaii 96801-3378
Business Address: 1250 Punchbowl Street, Honolulu, Hawaii 96813	Business Address: 1250 Punchbowl Street, Honolulu, Hawaii 96813

XIX. Availability of Funds

The award of a contract and any allowed renewal or extension thereof, is subject to allotments made by the Director of Finance, State of Hawaii, pursuant to Chapter 37, HRS, and subject to the availability of State and/or Federal funds.

XX. Monitoring and Evaluation

Any deviation from the contract scope and requirements may result in the penalties described in the temporary withholding of payments pending correction of a deficiency or a non-submission of a report by the provider, in the disallowance of all or part of the cost, or in the suspension of contract services pending correction of a deficiency.

The applicant shall comply with all of the requirements of the RFP and contract and DIVISION shall have no obligation to refer any consumers to the applicant until such time as all of said requirements have been met. The criteria by which the performance of the contract will be monitored and evaluated are:

(1) Performance/Outcome Measures

(2) Output Measures

(3) Quality of Care/Quality of Services

(4) Financial Management

(5) Administrative Requirements

XXI. General and Special Conditions of Contract

The general conditions that will be imposed contractually can be found on **http://www2.hawaii.gov/spoh/Forms_Instructions/contracts/GenCondHHS.PDF** and are contained in the SPO's POS Manual. Special conditions may be also be imposed contractually by the state purchasing agency, as deemed necessary. Terms of the special conditions may include, but not limited to, the requirements as outlined in Section 5, Attachment C.

A. Termination of the Contract

1. This contract may terminate or may be terminated by the DIVISION for any or all of the following reasons:

   a. For any default by the applicant

   b. For necessity or convenience

   c. In the event of the insolvency of or declaration of bankruptcy by the applicant

   d. In the event sufficient appropriated; otherwise unobligated funds no longer exist for the payment of the DIVISION obligations hereunder.

2. Procedure for Termination

   The applicant shall:

   a. Stop work under the contract on the date and to the extent specified in the notice of termination.

   b. Notify the consumers of the termination of the contract and arrange for the orderly transition to the new provider.

   c. Place no further orders or subcontracts for materials, services, or facilities, except as may be necessary for completion of the work under the portion of the contract that is not terminated.

   d. Terminate all orders and subcontracts to the extent that they relate to the performance of work terminated by the notice of termination.

e. Assign to the DIVISION in the matter and to the extent directed by the DIVISION Chief of the right, title, and interest of the applicant under the orders or subcontracts so terminated, in which case the DIVISION shall have the right, in its discretion, to settle or pay any or all claims arising out of the termination of such orders and subcontracts.

f. With the approval of the DIVISION Chief, settle all outstanding liabilities and all claims arising out or such termination of orders or subcontracts, the cost of which would be reimbursable in whole orin part, in accordance with the provisions of the contract.

g. Complete the performance of such part of the work as shall not have been terminated by the notice of the termination.

h. Take such action as may be necessary, or as the DIVISION Chief may direct, for the protection and preservation of any and all property or information related to the contract which is in the possession of the applicant and in which the DIVISON has or may acquire an interest.

i. Within ten (10) working days from the effective date of the termination, deliver to the DIVISION copies of all current data files, program documentation, and other documentation and procedures used in the performance of the contract at no cost to DIVISION. The applicant agrees that the DIVISION or its agent shall have a non-exclusive, royalty-free right to the use of such documentation.

3. Termination Claims

After receipt of a notice of termination, the applicant shall submit to the DIVISION Chief any termination claim in the form and with the certification prescribed the DIVISION Chief. Such claim shall be submitted promptly but in no event later than sixty (60) days from the effective date of termination. Upon failure of the applicant to submit its termination claims within the time allowed, the DIVISION Chief may, subject to any review required by the State procedures in effect as of the date of execution of the contract, determine, on the basis of information available to him/her, the amount, if any, due to the applicant by reason of the termination and shall thereupon cause to be paid to the applicant the amount to be determined.

Upon receipt of notice of termination, the applicant shall have no entitlement to receive any amount of lost revenues or anticipated profits or for expenditures associated with this or any other contract. The applicant shall be paid only the following upon termination:

a. At the contract price(s) for the number of consumers serviced by the applicant at the time of termination; and/or

b. At a price mutually agreed by the applicant and the DIVISION.

In the event of the failure of the applicant and the DIVISION to agree in whole or in part as to the amounts with respect to costs to be paid to the applicant in connection with the total or partial termination of work pursuant to this article, the DIVISION shall determine on the basis of information available the amount, if any, due to the applicant by reason of termination and shall pay to the applicant the amount so determined.

The applicant shall have the right to appeal any such determination made by the DIVISION.

B. Extension of Contract

Options for renewal or extension shall be based on the applicant's satisfactory performance of the contracted services(s) and availability of funds.

Extensions beyond the award period will be time limited in order to accomplish specific short-term goals of the DIVISION. An extension beyond the award period does not imply further extensions once the extension date has ended.

C. Dispute Resolution

Any disputes concerning a question of a fact arising under the contract, which is not disposed of by an agreement shall be decided by the DIVISION Chief or his/her duly authorized representative. The decision shall be in writing and forwarded to the applicant. The decision shall be final and conclusive unless determined by a court of competent jurisdiction to have been fraudulent, capricious, arbitrary, or so grossly erroneous as necessary to imply bad faith. In connection with any dispute proceeding under this clause, the applicant shall be afforded an opportunity to be heard and to offer evidence in support of his/her dispute. Pending final decision of a dispute, the applicant shall proceed diligently

with the performance of the contract in accordance with the disputed decision.

XXII. Cost Principles

In order to promote uniform purchasing practices among state purchasing agencies procuring health and human services under Chapter 103F, HRS, state purchasing agencies will utilize standard cost principles outlined in Form SPO-H-201 which is available on the SPO website (see section 5, the Proposal Application Checklist). Nothing in this section shall be construed to create an exemption from any cost principle arising under federal law.

The DIVISION may also be required to make small or major unanticipated modifications to individual contracts. Reasons for such modifications may include, but are not limited to, requirements imposed by the United States Department of Justice in the implementation of the Settlement Agreement and Stipulations and Orders, recommendations made by the DIVISION's technical assistance consultant, national trends, and needs of the Hawaii State Department of Health.

Section 2

Service Specifications

I. Introduction

A. Overview, purpose or need

The Adult Mental Health Division ("DIVISION") of the Hawaii State Department of Health ("DEPARTMENT") is responsible for coordinating public and private human services into an integrated and responsive delivery system for mental health needs. Provision of direct services to consumers in the public sector is offered through programs offered by the Community Mental Health Centers ("CENTERS") and the Hawaii State Hospital ("HOSPITAL"). In addition, the DIVISION contracts on a purchase of service basis with private providers for mental health services to supplement the efforts of the CENTERS and the HOSPITAL.

For purposes related to this RFP, the basic functions or responsibilities of the DIVISION include:

1. Defining the services to be provided to consumers by the applicant;
2. Developing the rules, policies, regulations, and procedures to be followed under the programs administered by the department;
3. Procuring, negotiating, and contracting with selected applicants;
4. Determining initial and continuing eligibility of consumers;
5. Enrolling and disenrolling consumers;
6. Reviewing and ensuring the adequacy of the applicant's employees and providers;
7. Authorizing and determining necessity of DIVISION funded services
8. Monitoring the quality of services provided by the applicants and subcontractors;
9. Reviewing and analyzing utilization of services and reports provided by the applicants;
10. Handling unresolved consumer grievances and appeals with the applicants;
11. Certifying Medicaid Rehabilitation Option (MRO) providers;
12. Authorizing and paying MRO services and claims;
13. Monitoring and financial status and billing practices of applicants;
14. Identifying and investigating fraud and abuse;
15. Analyzing the effectiveness of the program in meeting its objectives;
16. Conducting research activities;
17. Providing technical assistance to the applicants;
18. Providing consumer eligibility information to the applicants;
19. Payments to the non-MRO contracted applicants; and,
20. Imposing civil or administrative penalties, monetary penalties and/or financial sanctions for violations of specific contract provisions.

Since persons who are severely and persistently mentally ill typically manifest varying levels of need for care and often experience cyclical episodes of recurrence of the illness, a variety of service and housing options must be provided simultaneously to the individual and tailored to meet his/her current needs. Among these required services are those which must address the needs of persons when they are homeless, when they are experiencing a bout of illness or in relapse, and when services sought reflect the assumption that services provided to persons who are severe and persistent mentally ill, are community-based, are well-coordinated, and produce outcomes which are of benefit to both the consumer and society.

A series of planning events, including a needs assessment conducted in 2000, were held with mental health stakeholders (consumers, staff, private providers, advocates, and family members) to determine the range of public mental health services for persons with severe and persistent mental illness. During these meetings, views were expressed on how to improve services and achieve system-wide goals. Most importantly, input had been received for provision of comprehensive, accessible services on each island and in rural locations with a range of housing options, a choice of treatment, and rehabilitation with access to case managers, and other services after regular working hours. Based on these findings, the DIVISION has appropriated funding to provide services to consumers by contracting with purchase of service providers. These services shall reflect national standards of care and best practices and shall be based on a philosophy of recovery-focused and cultural competent treatment, psychosocial rehabilitation and other community supports.

U.S. Department of Justice Stipulation and Order

Since 1991, the State of Hawaii has been under a Settlement Agreement with the United States Department of Justice (DOJ) relative to the treatment and rehabilitation programs and services at the HOSPITAL. Since 1998, the DIVISION has been developing and implementing an array of community-based services. In May 2001, the United States District Court appointed a Special Master to oversee the activities of the HOSPITAL and resulting community services developed by the DIVISION. On January 23, 2003 the Court ordered the implementation of a Plan for Community Adult Mental Health Services that delineates the development and implementation of community services necessary to support the discharge and transfer of patients from the HOSPITAL, and to support the diversion of individuals who would otherwise have to be admitted to the HOSPITAL. The development, implementation, integration, coordination and monitoring of all these programs and

services required by both court ordered plans will require the DIVISION to generate, coordinate and constantly monitor the systematic, uniform and accurate data and information, and the compilation of information into management reports for policy and program and/or services development.

B. Description of the goals of the service

"AMHD is deeply committed to building a system of care which is rooted and grounded in the recovery model. The cornerstone of the recovery process is the centrality of the individual, in their personal definition of meaning and purpose, and the belief that despite the ongoing presence of the illness, people continue to develop."

Hawai'i's adult mental health service delivery system is based on the concept of recovery, that consumers can lead fulfilling lives even in the presence of a severe and persistent mental illness. Services are focused on the need of the individual, not only on symptom relief and stabilization, but on consumer empowerment and the skills needed to lead satisfying, hopeful and contributing lives.

The goals for the services described in this RFP include, but are not limited to:

1. Lessen or eliminate debilitating symptoms of mental illness and minimize or prevent recurrent acute episodes of the illness through creative and progressive treatment interventions and empowerment of the consumer and their family.

2. When there is a co-occurring substance use disorder, both disorders are considered primary and integrated dual diagnosis specific treatment is provided.

3. Ensure the consumer's basic needs and skills for sustaining community living and enhancing quality of life.

4. Realization of recovery, vocational and personal goals.

5. Improve or establish new linkage with a variety of community services and mobilize the involvement of the consumer's support network.

6. Maintain consumer engagement in treatment in a warm, empathic and hope instilling manner.

7. Engage individuals who would not seek or remain involved with mental health services but who would benefit from them.

8. Promote harm reduction, prevention, substance use reduction, abstinence, and recovery for clients by providing substance abuse services

C. Description of the target population to be served

Adults with severe and persistent mental illness.

D. Geographic coverage of service

Waianae Coast on the island of Oahu

E. Probable funding amounts, source, and period of availability

The source of funding is state funds or a combination of state and federal funds. Both profit and non-profit organizations are eligible for state funds. Please note that based on the availability of state funds, the amount allocated to providers who are awarded contracts may change.

The DIVISION considers itself the payor of last resort, and expects providers to obtain third party reimbursement as applicable. The DIVISION gives priority to the uninsured.

Start-up costs up to $2,000.00 will be allowed for the purpose of setting up electronic billing, subject to approval by the DIVISION. Start-up costs should reference the purchase of software that performs the function of creating a Health Insurance Portability and Accountability Act of 1996 ("HIPAA") compliant 837, including optional fields.

The criteria for determining the amount allocated for setting up electronic billing will be based on the applicant demonstrating that they are able to submit 837 compliant claims files including DIVISION optional fields. Where software is being purchased, applicants must submit documentation from the vendor selected which includes the full purchase price of the software and supporting evidence that the software meets required specifications. Direct contact with the vendor selected which includes the full purchase price of the software and supporting evidence that the software meets required specifications. Direct contact with the vendor to confirm the functionality of the product may be necessary prior to allocation of funds. Should an applicant wish to use the funding to support the costs of modifying an existing billing system, the applicant must obtain prior approval of their project plan. This plan must include milestones which demonstrate that the modifications will be completed in time to meet the electronic billing deadline referenced in this RFP. The plan must also identify personnel resources, describe the modifications planned and estimate the number of hours required to complete the

project. Payment would be made upon successful acceptance of an 837 claims file by DIVISION.

The request for start-up costs is optional and not required as part of the proposal application package.

If an applicant materially fails to comply with terms and conditions of the contract, the DIVISION may, as appropriate under the circumstances:

1. Temporarily withhold payments pending correction of a deficiency or a non-submission of a report by a provider.

2. Disallow all or part of the cost.

3. Restrict, suspend or terminate the contract.

In the event that the additional funds become available for similar services, the DEPARTMENT reserves the right to increase funding amounts.

Competition is encouraged among as many applicants as possible.

II. General Requirements

A. Specific qualifications or requirements, including but not limited to licensure or accreditation.

1. The DIVISION will require accreditation by the Rehabilitation Accreditation Commission (CARF), Joint Commission on Accreditation of Healthcare Organizations (JCAHO), International Center for Clubhouse Development (ICCD), Council on Accreditation (COA), or by another DIVISION approved certification/licensing process. Applicants that are currently accredited are required to maintain accreditation. Applicants who are not accredited are required to achieve accreditation within one (1) year from the date of contract award.

2. Applicants shall have an administrative structure in place capable of supporting the activities required by the RFP. Specifically, there shall be clinical, financial, accounting and management information systems, and an organizational structure to support the activities of the applicant.

3. The applicant shall have a written plan for disaster preparedness.

4. The applicant shall cooperate with the DIVISION in approved research, training, and service projects provided that such projects do not substantially interfere with the applicant's service requirements as outlined in this RFP.

5. The applicant shall comply with all specified, applicable existing policies, procedures, directives, and provider manual of the DIVISION and, any applicable policy, procedure, directives, and provider manual developed in the future.

6. Whenever requested, the applicant shall submit a copy of its operating policies and procedures to the DIVISION. The copy is to be provided at the applicant's expense with revisions and updates as appropriate.

7. The applicant shall assign staff to attend provider meetings as scheduled by the DIVISION.

8. The applicant shall notify and obtain the approval of the DIVISION prior to the presentation of any report or statistical or analytical material based on information obtained through this agreement. Formal presentation shall include, but not limited to papers, articles, professional publications, and presentations.

   The applicant shall not advertise, distribute, or provide any material relating to the contract that has not been approved by the DIVISION to any consumer. The applicant shall not change the material without the consent of the DIVISION. All consumer satisfaction surveys and methodology must be reviewed and approved by the DIVISION prior to implementation.

9. Consumer Management Requirements:

   a. Incorporate "best practices/evidence-based practices" in any consumer service.

      "Best practices/evidence practices" is defined as a body of contemporaneous empirical research findings that produce the most efficacious outcomes for person with severe and persistent mental illness, has literature to support the practices, is supported by national consensus, has a system for implementing and maintaining program integrity and conformance to professional standards. The DIVISION has developed fidelity scales based on best practices/evidence – based practices for some services. Applicants will be

required to incorporate these into their service delivery and cooperate with educational and monitoring activities.

b. Documented evidence of consumer input into all aspects of treatment planning inclusive of service related decisions.

c. Consumers shall be served in the "least restrictive" environment as determined by the consumer's level of care assessment, as established in section 334-104, Hawaii Revised Statutes and in any appropriate federal guidelines.

d. Consumers shall be made aware of and have access to community resources appropriate to their level of care and treatment needs.

e. Consumers shall receive services in a manner compatible with their cultural health beliefs, practices and preferred language.

f. In accordance with Chapter 11-175, Hawaii Administrative Rules, and any appropriate federal guidelines, the applicant shall respect and uphold consumer rights. The applicant shall recognize the rights of authority of the consumer in the delivery of services, in deciding on appropriate treatment and services and in providing input into the decisions of all aspects of service. The rights of the consumer are listed in Section 5, Attachment D.

g. The applicant shall have a mechanism for receiving, documenting and responding to consumer grievances, including an appeals process. The mechanism must be consistent with the DIVISION's Policies and Procedures on Consumer Grievances and Consumer Appeals which are found in Section 5, Attachment E.

h. The applicant shall provide a written record of sentinel events, incidents, grievances, and appeals and efforts to address the situation and improve services on-site to the DIVISION's Quality Management program.

i. The applicant shall comply with any applicable Federal and State laws such as title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 C.F.R. part 80, the Age Discrimination Act 1975 as implemented by regulations at 45 C.F.R. part 91, the Rehabilitation Act of

1973, and titles II and III of the Americans with Disabilities Act.

j. The applicant shall describe how they protect confidential information. The applicant shall not use or disclose patient health information (PHI) in any manner that is not in full compliance with HIPAA regulations or with the laws of the State of Hawaii. The applicant shall maintain safeguards, as necessary, to ensure that PHI is not used or disclosed except as provided by the Agreement or by law. The applicant shall not use or further disclose PHI for any purpose other than the specific purposes stated in this contract or as provided by law and shall immediately report to DIVISION any use of disclosure of PHI that is not provided in this contract by law.

k. The applicant shall maintain confidential records on each consumer pursuant to section 334-5, Hawaii Revised Statutes, 42 U.S.C. sections 290dd-3 and 290ee.3 and the implementing federal regulations, 42 C.F.R. Part 2, if applicable, and any other applicable confidentiality statute or rule. Such records shall be made available to the DIVISION upon request.

l. Written consumer consent shall be obtained for individuals and services funded by the DIVISION including:

1) Consent for evaluation and treatment;

2) Consent to release information by the DIVISION funded service providers as needed for continuity of care, including after care services;

3) Consent to enter registration and treatment information in the confidential Statewide DIVISION information system; and

4) Other consent documents as needed.

Consumer consent is not required for oversight activities of the DIVISION and its agents, and in the case of Medicaid Rehabilitation Services, the Centers for Medicare and Medicaid Services (CMS) Office of the Inspector General (OIG), the Med-QUEST Division (MQD) and their agents.

10. If a subcontractor is used, the applicant shall ensure the DIVISION that they, as the applicant have the ultimate responsibility that subcontractor(s) will provide behavioral health services that meet the criteria of this RFP. Subcontractors must be responsive and responsible to meet the expectations of the applicant and the DIVISION.

11. Financial Requirements

    a. The State may require providers to submit an audit as necessary. If the applicant expends $500,000 or more in a year of federal funds from any source, it shall have a single audit conducted for that year in accordance with the Single Audit Act and Amendments of 1999, Public Law 104-156.

    b. The applicant shall comply with the COST PRINCIPLES developed for Chapter 103F, HRS and set forth in the document SOP-H-201. This form (SPO-H-201) is available on the SPO website (see the Competitive POS Application Checklist located in the Attachments Section of this RFP).

    c. Eligibility and enrollment is determined through the assessment process by DIVISION assessors. Eligible consumers are:

        1) At least 18 years old.

        2) Live in Hawaii

        3) Have severe and persistent mental illness, be in a state of crisis (short-term services), be victims of natural disasters and terrorism, or court ordered for treatment by the DIVISION.

    d. Notification of Changes in Consumer Status.

        As part of education conducted by the DIVISION, consumer shall be notified that they are to provide the applicant and DIVISION with any information affecting their status. The DIVISION shall describe the information that is to be provided and explain the procedures to be followed through the DIVISION staff and in its printed material. The applicant shall also explain the information and the procedures to be followed by the consumers during the orientation process.

It is expected that not all consumers will remember to or be able to provide the DIVISION with the information on changes to their status. Therefore, it is important for the applicant, which will have more contact with the consumers, to forward such information to the DIVISION on a timely basis and inform the consumer of his/her responsibility to report changes directly to the DIVISION.

The applicant shall notify each case manager and the DIVISION for changes in consumer status by calling or faxing the information to the DIVISION, Utilization Management within five (5) calendar days of discovery.

e. Changes in Consumer Status include:

1) Death of the consumer

2) Change in address, including homelessness

3) Change in name

4) Change in phone number

5) Institutionalization (imprisonment or long term care)

6) Short term inpatient psychiatric treatment

7) Third Party Liability (TPL) coverage, especially employer-sponsored, Medicare or Medicaid

f. Disenrollment from DIVISION

Consumers will be disenrolled if no longer living in Hawaii, refuse services that are not court ordered, or are incarcerated.

g. Third Party Liability (TPL) means any individual, entity or Program that is or may be liable for all or part of the expenditures for furnished services. The DEPARTMENT must take all reasonable measures to identify legally liable third parties and treat verified TPLs as a resource of the consumer.

The applicant shall establish systems for eligibility determination, billing, and collecting from all eligible sources to maximize third party reimbursements and other sources of funding before using funds awarded by the DIVISION. The applicant shall bill the DIVISION only after exhausting the third party denial process, when the service is not a covered benefit or when the consumer is uninsured. The applicant shall maintain documentation of denials and of limits of benefit coverage and make these records available to the DIVISION upon request. The DIVISION is the payor of last resort and the applicant shall consider payment from third party sources as payment in full. An annual review and reconciliation of amounts collected from third party payors by the applicant will be conducted and, if needed, adjustments will be made within 90 days either crediting the DIVISION or providing payment to the applicant upon the receipt of a claim.

The Applicant shall:

1) Provide a list of service expenses, in the format requested by the DIVISION, for recovery purposes

2) Recover service expenses incurred by consumers from all other TPL resources

3) Inform the DIVISION of TPL information uncovered during the course of normal business operations

4) The applicant shall describe all eligible sources of revenue from third parties and plans to pursue additional sources of revenues.

h. Fraud and Abuse/Neglect

Through its compliance program, the applicant shall identify employees, subcontractors or providers who may be committing fraud and/or abuse. The applicant activities may include, but are not limited to, monitoring the billings of its employees, subcontractors or providers to ensure consumers receive services for which the applicant and the State are billed; monitoring the time cards of employees that provide services to consumers under cost payment arrangements; investigating all reports of suspected fraud and over-billings (upcoding, unbundling, billing for

services furnished by others, billing for services not performed, and other over-billing practices), reviewing for over- or under-utilization, verifying with consumers the delivery of services and claims, and reviewing and trending consumer complaints regarding employees, subcontractors and providers.

The applicant shall promptly report in writing to the DIVISION instances in which suspected fraud has occurred within thirty (30) days of discovery. The applicant shall provide any evidence it has on the billing practices (unusual billing patterns, services not rendered as billed, and same services billed differently and/or separately). If the billing has not been done appropriately and the applicant does not believe the inappropriate billing meets the definition of fraud (i.e., no intention to defraud), the applicant shall notify the DIVISION in writing of its findings, adjustments made to billings, and education and training provided to prevent future occurrences.

Any suspected case of physical, emotional or financial abuse or neglect of a consumer who is a dependent adult must be reported by the applicant to Adult Protective Services, or of a child to Child Protective Services, and the DIVISION immediately upon discovery.

i. All reimbursements for services shall be subject to review by the DIVISION or its agent(s) for medical necessity and appropriateness, respectively. The DIVISION or its agents shall be provided access to medical records and documentation relevant to such a review and the applicant agrees to provide access to all requested medical records/documents. It is the responsibility of the applicant to ensure that its subcontractors and providers also provide DIVISION and its agents and in the case of MRO services, the CMS, the OIG, the MQD and their agents, access to requested medical records/documents. Reimbursements for services deemed not medically necessary or not following billing guidelines by DIVISION or its agent shall be denied. Reimbursements received by applicants for consumers with third party coverage (including consumers with Medicaid and/or Medicare) will be considered full payment (see Section 2.II.11.g.). Any DIVISION overpayments for services shall be recouped by the DIVISION from the applicant.

The DIVISION has final determination in what is considered a necessary, reimbursable service.

j. Medicaid

The MQD under the Department of Human Services (DHS) administers medical assistance to qualified, indigent, uninsured and underinsured. Aged, blind, and disabled recipients receive medical, dental, and behavioral health services under Medicaid Fee-for-Service from contracted providers. A large group of Medicaid eligible recipients receive medical and behavioral health services from contracted Medicaid Managed Care Health Plans under the QUEST and QUEST-Net programs. A small population of Medicaid Fee-for-Service, QUEST, and QUEST-Net recipients are enrolled in a behavioral health care-out program for severely mentally ill adults. This behavioral health carve-out program is contracted by MQD. Some of the services provided to the individuals in the carve-out program are similar or identical to services provided by the DIVISION and consumers enrolled in this program shall receive services through them except for those services not included as a benefit of that program. Section 2.II.A.11.m. describes the MRO and how applicants providing certain services will participate.

k. The applicant shall submit claims for non-health care services using the DIVISION Standard Claims Form. Claims for fee-for-service health care services shall be submitted electronically in the HIPAA compliant 837 format unless a waiver permitting use of the CMS 1500 is granted from the DIVISION's Fiscal Unit. Claims shall be submitted for payment within 60 days of the provision of services. Any invoices or requests for payment received after the 60 days will be paid upon availability of funds. Claims for dates of service over one (1) year prior to submission of the original claim shall be denied for untimeliness.

l. If the applicant is required to provide encounter data, the HIPAA compliant 837 format shall be utilized to submit that data electronically.

m. The applicant shall make an application as a provider under the MRO within one (1) month of contract award for certification by the DIVISION, and receive certification

within six (6) months of contract award for MRO services. Providers must maintain certification, and shall have a ninety (90) day period to take corrective action. The DIVISION shall, on behalf of the DHS, certify providers to deliver services under the MRO.

1) MRO services are:

   a) Assertive Community Treatment (ACT)

   b) Intensive Case Management (ICM)

   c) Psychosocial Rehabilitation Services (PSR)

   d) Intensive Outpatient Hospital Services (Partial Hospitalization)

   e) Therapeutic Living Supports Provided in a Mental Health and/or Substance Abuse Residential Setting (non-IMD) (Specialized Residential Services).

   f) Licensed Crisis Residential Services (LCRS)

   g) Crisis Mobile Outreach (CMO)

   h) Crisis Support Management (CSM)

   i) Respite Beds

   j) Interim Housing

2) The DIVISION shall be responsible for:

   a) Certification of Adult Medicaid Rehabilitation Option applicants and providers;

   b) Utilization Management

   c) Receipt and adjudication of claims;

   d) Development and maintenance of a provider manual;

   e) Monitoring appropriateness and quality of services and claims;

f) Paying providers for services; and

g) Returning federal share that is disallowed.

3) The DHS shall:

a) Set rates;

b) Pay federal match to the DIVISION; and

c) Conduct reviews of claims, encounters and other documentation.

Applicants for services listed as MRO services shall follow the Medicaid Rehabilitation Options requirements for staffing and supervision found in Section 5. Attachment F.

B. Secondary purchaser participation
(Refer to §3-143-608, HAR)

After-the-fact secondary purchases will be allowed.
There are no planned secondary purchases.

C. Multiple or alternate proposals
(Refer to §3-143-605, HAR)

☐ Allowed ☒ Not Allowed

D. Single or multiple contracts to be awarded
(Refer to §3-143-206, HAR)

☒ Single ☐ Multiple ☐ Single & Multiple

The DIVISION plans to award a single contract.

E. Multi-term contracts to be awarded
(Refer to §3-149-302, HAR)

☐ Single term ($\leq$ 2 yrs) ☒ Multi-term (> 2 yrs.)

Initial term of contract:	1 year
Length of each extension:	1 year
Number of possible extensions:	3
Maximum length of contract:	4 years

The initial period shall commence on the contract start date or Notice to Proceed, whichever is later.

Conditions for extension: Option for renewal or extension shall be based on the provider's satisfactory performance of the contracted service(s) and availability of funds.

F. RFP Contact Person

The individuals listed below are the sole points of contact from the date of release of this RFP until the selection of the successful provider or providers. Written questions should be submitted to the RFP contact persons and received on or before the day and time specified in Section I, Item IV (Procurement Timetable) of this RFP. The contact persons are Betty Uyema or Lorie Mimura. They can be reached at (808) 586-4688.

III. Scope of Work

The scope of work encompasses the following tasks and responsibilities:

A. Service Activities
(Minimum and/or mandatory tasks and responsibilities)

The provider shall provide culturally appropriate outpatient treatment, targeted case management (TCM), care coordination and clubhouse services to severely and persistently mentally ill adults who live on the Waianae Coast on the island of Oahu. Services shall be provided by a community-based mental health provider. Program staff shall provide services in a warm, welcoming setting and manner, and respect, understand and provide services according to the cultural background and preferences of the individual. Consumers' families and significant others shall be involved in an integral manner to develop their treatment and rehabilitation services.

In the event of a proposal submitted jointly by more than one organization, one organization shall be designated as the primary applicant and shall have responsibility for not less than forty percent (40%) of the work to be performed. All other participants shall be designated as subcontractors. The primary applicant shall sign the contract with the DEPARTMENT. If a subcontractor is used, the applicant shall ensure the DIVISION that they,

as the applicant have the ultimate responsibility that subcontractor(s) will provide behavioral health services that meet the criteria of this RFP. Subcontractors must be responsive and responsible to meet the expectations of the prime applicant and the DIVISION.

The program shall:

1. Provide standardized mental health assessments to consumers and potential consumers referred to the DIVISION for the purpose of eligibility determination, case management assignment, and/or hospital admission. Referrals are taken only from the DIVISION Access Line. Assessments include: risk assessment, bio-psychosocial assessment, alcohol and substance use and abuse assessments, multi-axial diagnoses and level of care determination. Protocols and standards set by the DIVISION for eligibility determination shall be followed.

2. Provide and complete an intake assessment for each consumer referred for outpatient treatment and/or TCM services. The assessment shall be completed through face-to-face contacts with the consumer and significant others involved in each consumer's treatment. The assessment shall be comprehensive and shall include, but not be limited to, each consumer's strengths, preferences, abilities, needs, and other current and historical data regarding the consumer's family, social support, medical status including psychiatric illness, substance abuse, legal, employment, education, abuse and neglect issues, and activities of daily living. Assessments are used to develop appropriate individualized treatment plans. “Assessment entails more than information gathering. It is the start of building a trusting, helping, healing relationship, the forging of an alliance upon which to build a plan that is responsive to the consumer’s and family’s needs.” (Yawn 2004 National Council News).

3. Provide each consumer with a single, individualized, coordinated, master treatment plan referred to as an Individual Service Plan (ISP) that complies with the DIVISION standards for treatment planning. There must be documented evidence of each consumer’s input into all aspects of their treatment planning, inclusive of service-related decisions.

    a. Through the ISP, at a minimum the case manager and psychiatrist are part of a team which includes others as appropriate, that works together with the consumer to set goals toward recovery. The plan helps each member of the team know what the other person is doing to help the consumer. The plan describes psycho-therapy, medication,

clinical services, substance abuse treatment (if applicable), general health services, dental services, and living-support services. The plan also addresses crisis and shall include the preferences of the consumer and detail the steps to be taken if a crisis occurs. Each consumer's ISP shall guide service delivery even if the consumer changes providers.

b. The treatment team shall include, at a minimum, the consumer, the psychiatrist, and the case manager. The psychiatrist shall be in charge of the treatment team and has ultimate authority for all clinical decisions. The case manager shall be responsible for coordinating the development of and monitoring the implementation of the ISP.

4. Have a policy that emphasizes a welcoming, empathic and integrated approach to working with individuals with co-occurring substance and mental illness.

5. Provide outpatient treatment services that:

a. Are provided to the consumer in outpatient clinic and community settings in combination with intensive case management, TCM or care coordination. Intensive case management and/or TCM may also be provided by staff of other organizations.

b. Ensure that consumers with severe and persistent mental illness and substance abuse are provided with treatment that combines interventions directed simultaneously to both conditions and utilize behavioral (motivational) approaches to substance abuse treatment

c. Provide psycho-education to consumers either individually or in-group settings. These psycho-education services assist consumers in understanding and coping with their illness, following prescribed treatment protocols, and remaining medically compliant.

6. Provide treatment services which include but are not limited to:

a. Somatic Treatment - Services provided by a licensed psychiatrist or Advanced Practice Registered Nurse (APRN) in behavioral health with prescriptive authority, to evaluate, prescribe, and monitor medications for the treatment of psychiatric disorders. Includes medication review and administration services provided by a

Registered Nurse (RN) under the supervision/order of a physician. Includes visits for the purpose of prescribing medication, as well as for medication refills or dosage regulation. Medication services does not include methadone maintenance or methadone detoxification.

b. Individual Therapy- Therapeutic interaction by a licensed psychiatrist, licensed clinical psychologist, licensed clinical social worker or APRN in behavioral health to address the consumer's therapeutic goals by providing emotional support, developing insight, producing cognitive/behavioral change improving decision-making and/or reducing stress. May include education about management of a behavioral health and or substance use disorder, including relapse prevention and recovery strategies.

c. Group Therapy- Therapeutic interaction by a licensed psychiatrist, licensed clinical psychologist, licensed clinical social worker or APRN in behavioral health to address the consumer's therapeutic goals in a group of unrelated persons by providing emotional support developing insight, producing cognitive/behavioral change, improving decision-making and/or reducing stress. May include education about management of a behavioral health and or substance use disorder, including relapse prevention and recovery strategies

d. Family Therapy- Therapeutic interaction by a licensed psychiatrist, licensed clinical psychologist, licensed clinical social worker, or APRN in behavioral health with family members or significant others, with or without the presence of the consumer to address the consumer's therapeutic goals, by providing emotional support, developing insight, producing cognitive/behavioral change, improving decision making and/or reducing stress. May include education about management of behavioral health and or substance use disorder, including relapse prevention and recovery strategies. May be provided to multiple families.

7. Provide TCM services which are based on a therapeutic supportive relationship with the consumer. The relationship between consumer and staff shall be structured to develop increasing independence and autonomy of the consumer. TCM services shall include, but not be limited to, the following:

a. When the consumer agrees to case management services, ensure that the consumer meets the criteria for TCM services as defined in the "Level of Care Service Criteria," which is provided in Section 5, Attachment G. TCM shall be provided according to Hawaii Administrative Rules, Title 17, Department of Human Services, Subtitle 12, Chapter 1738, Subchapter 3 which can be found at http://www.hawaii.gov/dhs/1738.PDF.

b. Provide assistance with obtaining general assistance, entitlements, housing and residential services.

c. Provide consumers with access to a psychiatrist for direct care and consultative services.

d. Provide the consumer with information and training to access and utilize transportation services.

e. Ensure that consumers with severe and persistent mental Illness and substance abuse/addiction co-morbidity are provided with treatment that combines interventions directed simultaneously to both conditions and utilize behavioral (motivational) approaches to substance abuse treatment.

f. Provide or link consumers to skill-building and educational services including, but not limited to, on-site skill-building necessary to maintain consumers in the community, including problem solving, decision-making, food shopping and preparation, menu planning, budgeting, accessing transportation, personal hygiene, laundry, home care and cleaning.

g. Provide collateral face-to-face contact services to the consumer's family members and significant others including, but not limited to, the following services: coordination, mobilization, or evaluation of the implementation of services specified in the consumer's ISP. Services include:

1) Education to increase understanding of and ability to cope with the illness of the seriously ill family member;

2) Education on co-occurring substance use disorders;

3) Group support to increase the ability of family members to assist one another in the coping process and

4) Consumer advocacy.

h. Provide support and implementation of necessary treatment and restorative interventions. Advocate on behalf of each consumer and coordinate services with collateral contacts with relevant members of each consumer's treatment team, inclusive of each consumer's family or other person's responsible for treatment, i.e., courts, probation officer, homeless programs, crisis services. These services shall be ongoing activities on behalf of the consumer and may be accomplished in face-to-face or telephone contacts.

i. Maintain a maximum consumer caseload per targeted case manager of no more than forty (40) consumers to one (1) case manager.

8. Provide care coordination which is the least intensive level of case management services and is a recovery maintenance and health management service. The consumer should be receiving at least one other service arranged for or provided by the DIVISION. Case management services are not routinely needed or provided due to the consumer's ability to access needed services or due to stable and natural supports that serve as case managers for the consumer in the community. Care coordination is normally provided by any professional (psychiatrist, social worker, psychologist, RN, APRN, case manager) member of the clinic staff who has a face-to-face contact with the consumer at least once every three (3) months. This service assures that the consumer continues to have an ISP, is accessing needed services, and is maintaining current level of functioning in the community while receiving clinic or other service(s) arranged for or provided by the DIVISION.

The applicant shall ensure that the consumer meets the criteria for Care Coordination Services as defined in the "Level of Care Criteria," which is provided in Section 5, Attachment G.

9. The outpatient clinic services shall at a minimum follow the State business hours which are Monday to Friday, 7:45AM-4:30PM, excluding holidays

10. Provide a Clubhouse program which is a voluntary program whose participants are called members not patients or clients. Members' strengths and needs are emphasized rather than their mental illness,

symptoms or psychiatric history. The program relies on the talents, skills and abilities of all its members in order to function. The program, under the direct supervision of a mental health professional, maintains adequate staff support to enable a safe, structured environment in which consumers can meet and provide mutual support. Program activities promote socialization, recovery, self-advocacy, development of natural supports, maintenance of community living skills and development of meaningful vocational opportunities.

a. Hours of operation shall be a minimum of five (5) days per week with recreation and social programs on evenings and weekends.

b. Staffing

1) The member to staff ratio shall be no greater than 20 members: 1 staff.

2) Services shall be provided by individuals who have been trained and certified at a Clubhouse training site.

3) Staff have generalist roles. All staff share employment, housing, evening and weekend and unit responsibilities.

4) Staff, under the direct supervision of a mental health professional as defined in Section 2, III.B.1.d., lead structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports and maintenance of community living skills.

5) Staff engage in employer outreach to develop transitional and supported employment opportunities for members.

6) Staff emphasize and build support and activities upon members' individual strengths, talents and abilities.

c. Membership

1) Membership is open to anyone with a history of mental illness, unless that person poses a significant

and current threat to the general safety of the clubhouse community.

2) Consumers with co-occurring disorders of severe and persistent mental illness (SPMI) and substance abuse or SPMI and developmental disabilities shall not be excluded due to a dual diagnosis.

3) Consumers who have a legal or forensic status shall not be excluded based solely on this status.

4) Membership is voluntary and without time limits.

5) Outreach shall be conducted when a member misses more than two (2) scheduled days.

6) Members, at their choice, are involved in the writing of all records reflecting their participation in the clubhouse. All such records are to be signed by both members and staff.

7) Attendance of each consumer participating shall be documented on a daily basis.

d. Relationships

1) All Clubhouse meetings are open to both members and staff. There are no formal member only meetings or formal staff only meetings where program decisions and member issues are discussed.

2) Consumers participating in the service at any given time shall be given the opportunity to participate in and make decisions about the activities that are conducted or services offered within the program, the scheduling of those activities and services, and other operational issues.

e. Space

1) The service shall operate at an established site approved by the DIVISION for services. Adequate space, equipment, furnishings, supplies and other resources must be provided in order that services can be provided effectively. The facility must be

clean and in good repair. If a facility vehicle is used to transport consumers, it must be maintained according to safety and legal standards.

2.) The service may operate in the same building as other services, however, there must be a distinct separation between these services in staffing, program description and physical space.

3) All program space is member and staff accessible. There are no staff only or member only spaces.

f. Vocational

1) All work in the program is designed to help members regain self worth, purpose and confidence; it is not intended to be job specific training.

2) The program is organized into one (1) or more work units, each of which has sufficient staff, members and meaningful work to sustain a full and engaging work-ordered day.

3) The work-ordered day engages members and staff together, side-by-side, in the running of the clubhouse.

4) Transitional Employment, as outlined in the International Center for Clubhouse Development (ICCD) International Standards for Clubhouse Programs, is offered to all consumers.

5) Consumers shall be assisted in securing, sustaining and upgrading independent employment.

6) Supported education is offered to all consumers to provide or link resources to help them attain their educational/vocational goals.

g. Governance and Administration

1) The Clubhouse shall be certified and maintain certification, or if not certified, shall be actively seeking certification of the ICCD and shall adopt the ICCD's International Standards for Clubhouse Programs. Programs not certified shall achieve

certification within one (1) year of execution of the contract.

2) This service may operate as a free standing program or within a larger clinical or community human service provider agency.

3) The governing board of a freestanding service shall be composed of 75% consumers and shall represent the cultural diversity of the population of the community being served. For programs that are a part of a larger organizational structure that is not consumer led and operated, the service shall have an advisory body with the same composition as a freestanding program. The Board or advisory committee must have the ability to develop programmatic descriptions and guidelines (consistent with state and federal regulations, accreditation requirements and sponsoring agency operating policies), review and comment on the program's budgets, review activity offerings and participate in dispute resolution activities for the program.

11. Provide services in a manner consistent with the Comprehensive, Continuous, Integrated System of Care, in areas which apply to this service, as provided in Section 5, Attachment H and the Dual Diagnosis Philosophy and Treatment Guidelines as provided in Section 5. Attachment I.

12. Provide treatment services in a manner consistent with the definitions provided in Section 5, Attachment J.

B. Management Requirements
(Minimum and/or mandatory requirements)

1. Personnel

The PROVIDER's personnel requirements for staff providing outpatient treatment, TCM and Clubhouse services shall include, but are not limited to, the following:

a. The outpatient treatment services and TCM program shall be under the clinical supervision of a Qualified Mental Health Professional (QMHP). A QMHP shall be defined as a licensed psychiatrist, a licensed clinical psychologist, a

licensed clinical social worker, or a licensed APRN in behavioral health. A QMHP shall be licensed to practice in the State of Hawaii.

b. The outpatient treatment services shall be provided by the following:

1) Psychiatrists shall be board certified or board eligible, licensed to practice in the State of Hawaii and have a minimum of one (1) year of experience working with seriously mentally ill adults. If the psychiatrist is not on site during clinic hours, he/she shall be available by phone. A psychiatrist shall also be available twenty-four (24) hours per day, seven (7) days per week for psychiatric crisis and emergencies.

2) RN's shall be licensed to practice in the State of Hawaii and have a minimum of three (3) years of experience in psychiatric and mental health nursing.

3) Individual, group and family therapy shall be provided by independent licensed practioners who are licensed in the State of Hawaii. (Psychiatrist, Clinical Psychologist, Clinical Social Workers, APRN in Behavioral Health or other licensed behavioral health professional designated by the DIVISION).

4) Substance abuse treatment (substance abuse assessments, individual and group therapy) for those with co-occurring disorders may be provided by an individual who is a Hawaii State certified substance abuse counselor pursuant to 321-193(10), Hawaii Revised Statutes.

c. Case management services shall be provided by case managers who have at least one (1) year of experience in the delivery of case management services. Case managers, at a minimum shall have graduated from an accredited four (4) year college or university with a bachelor's degree which included a minimum, of 12 semester credit hours in courses such as counseling, criminal justice, human services, psychology, social work, social welfare, sociology or other behavioral sciences. The education background must also demonstrate the ability to write clear and

comprehensive reports and other documents, read and interpret complex written material, and solve complex problems logically and systematically. The case manager must have a valid Hawaii driver's license to provide community outreach services.

d. The Clubhouse Program shall be under the supervision of a Mental Health Professional. A Mental Health Professional must meet one of the following minimum requirements:

1) Licensed Social Worker (LSW)

2) Master of Science in Nursing (MSN)

3) APRN in a non-behavioral health field

4) Licensed Marriage and Family Therapist

5) Master's degree from accredited school in behavioral health field

a) Counseling

b) Human Development

c) Psychology

d) Psychosocial Rehabilitation

e) Criminal Justice

6) Master's degree in health related field with two (2) years experience in mental health

7) Licensed RN with a Bachelors in Nursing and five (5) years experience in behavioral health.

e. Clubhouse services shall be provided by individuals who have been trained and certified at a Clubhouse training site.

f. The organization must have a consistently applied, documented method for measuring staff competencies which include:

1) Staff proficiency in treating individuals with a co-occurring substance use disorder using a DIVISION tool or a tool approved by the DIVISION.

2) Staff competency in providing warm, empathic approaches in dealing with consumers using a DIVISION tool or a tool approved by the DIVISION.

3) Staff competencies related to the requirements of the job and the needs of the persons served.

g. The applicant shall submit position descriptions as a part of their response to the RFP for direct care and supervisory staff responsible for the delivery of services as indicated in Section 3.III.A. Position descriptions shall include the minimum qualifications, including experience for staff assigned to the service.

h. The applicant shall have an organization-wide and program-specific organization chart. The program specific chart shall show the position of each staff and the line of responsibility and supervision (clinical and administrative).

i. The applicant shall ensure and document that staff receive appropriate and regular clinical and administrative supervision.

j. The applicant shall ensure and document that its personnel receive appropriate education and training in techniques and modalities relevant to their service activity for the treatment and rehabilitation of individuals with mental illness, following the organization's policy and procedures.

k. The applicant shall ensure that all of its personnel attend trainings sponsored or required by the DIVISION, as appropriate to the service(s) they are providing. Training shall include compliance and fraud and abuse.

2. Administrative

a. Services shall be authorized by the DIVISION's utilization management process either by prior authorization or registration. Designated case managers are responsible for initiating these requests. However, it is the program's responsibility to ensure that registration or authorizations

have been secured prior to the initiation or continuation of services in order that reimbursement can be approved by the DIVISION.

b. The applicant shall accept all referrals deemed appropriate by the DIVISION's utilization management process. If the applicant is unable to meet the needs of the referral, the applicant shall work conjointly to find an alternate approach that will adequately meet the needs of the referred case.

c. There will be a single point of accountability for each consumer entering the system that will be responsible for the continuity of communication, care, and follow up regardless of service, setting, or provider. In most cases, the single point of accountability will be the DIVISION designated case manager.

d. All consumers shall be registered for services and have a record open within the DIVISION'S information system. When requested by the DIVISION, the applicant shall obtain and provide the information necessary to register, open and monitor services received. Applicants shall also report all required information when cases are closed or consumers transferred to another level of care within one (1) working day of such action. All recipients shall be registered with the DIVISION and authorized for services as appropriate.

e. The applicant shall cooperate with the coordination and the transition of services for newly enrolled consumers with the consumer's current DIVISION provider, Medicaid fee-for-service provider, Community Care Services (CCS), and/or a QUEST health plan, since many of the eligible consumers already have an established behavioral health care provider.

Individuals who are receiving services from the Child and Adolescent Mental Health Division (CAMHD), and will no longer be eligible for services (age 21) with CAMHD, will also need to be transitioned to the DIVISION, if determined to meet DIVISION eligibility criteria, or back to their QUEST health plan or Medicaid fee-for-service if they are determined to no longer meet DIVISION criteria for continued enrollment.

If the consumer is to be enrolled in the DIVISION from a QUEST health plan, CAMHD, Fee-for-Service Program, or CCS, the disenrolling program and the applicant shall equally assist the consumer in the transition process.

f. All providers shall submit a rate schedule which outlines charges made to consumers for service(s) rendered.

DIVISION consumers shall not be charged finance charges, co-payments for services or no-show fees. Consumers must be informed that they cannot be terminated by the applicant for non-payment of co-payments, finance charges, no-show fees, non-covered services or for receipt of services from unauthorized applicant employees or providers.

3. Quality assurance and evaluation specifications

a. The purpose of quality management is to monitor, evaluate, and improve the results of the applicant's services in an ongoing manner. Quality care includes, but is not limited to:

1) Provision of services in a timely manner with reasonable waiting times;

2) Provision of services in a manner which is sensitive to the cultural differences of consumers;

3) Provision of services in a manner which is accessible for consumers;

4) Opportunities for consumers to participate in decisions regarding their care;

5) A emphasis on recovery;

6) Appropriate use of services in the provision of care;

7) Appropriate use of best practices and evidence-based practices;

8) Appropriate documentation, in accordance with defined standards;

9) Improved clinical outcomes and enhanced quality of life;

10) Consumer satisfaction;

11) User friendly grievance procedures which resolve issues in a timely manner; and

12) Upholds consumer rights.

b. The applicant's quality management program must include at a minimum the content indicated in Section 3, II.

c. The applicant shall participate in the DIVISION's continuing quality management program and activities as directed by the DIVISION. The applicant shall ensure that a staff member be available to participate in system-wide quality management meetings as scheduled by the DIVISION.

d. The Quality Management reporting requirements provide

1) Information on the activities and actions of the applicant's Quality Management and related programs and

2) Performance measures.

The objectives of the performance measures are:

1) To standardize how the applicant specifies, calculates and reports information; and

2) To trend an applicant's performance over time and to identify areas with opportunities for improvement.

e. Required Quality Management Activities Reports

The applicant shall provide the following reports and information:

1) Annual consumer satisfaction survey report.

2) Written notification of any Quality Management Program (if written Program required) modifications.

3) Senior personnel changes within thirty (30) calendar days of change.

4) Annual Quality Management Program evaluation if written Quality Management Program required.

5) Written request for approval of any delegation of quality management activities to subcontractors and providers.

6) Written notification of lawsuits, license suspensions, revocation to provide Medicaid or Medicare services, or other actions brought against the applicant, employees, subcontractors or providers as soon as possible, but no later than five (5) working days after the applicant is made aware of the event.

7) Notice to Utilization Management of consumer admission and discharge from services or change in level of care in writing within one (1) working day of such action.

8) Written notification of suspected fraud within thirty (30) calendar days of discovery, and of consumer abuse and neglect immediately upon discovery.

9) Report of the Quality Management activities conducted quarterly. At a minimum these reports shall include the following:

a) Number of cases selected for quality of care reviews and medical record documentation. Minimum data for each case selected for review shall include (a) sample of records reviewed; (b) findings; (c) actions taken, if applicable; and (d) progress toward meeting performance goals established by agency Quality Management Committee.

b) Aggregated report of any suspected consumer, employee, subcontractor, or

provider fraud and the status of any investigations.

c) Participation with monitoring activities designated by the DIVISION.

d) Direct care staff and provider to consumer ratios.

e) Direct care staff and provider turnover rates.

f) A report on consumer grievances and appeals. Minimum data for each case shall include: (a) date of grievance or appeal; (b) date of service; (c) type of service; (d) consumer name, age, diagnosis; and (e) date of resolution.

g) Sentinel events.

4. Output and performance/outcome measurements.

The applicant shall be required to meet ongoing informational needs of the DIVISION over the course of the contract period through the production of informational responses in both paper and computer format. The specific content of these requests cannot be readily specified in advance as the DIVISION is required to provide a variety of ad hoc reports to funding sources including the legislature and other branches of State government, as well as to national tracking and research groups, the Federal government, advocacy organizations, accreditation bodies, professional groups, stakeholder groups, and others. Regular requests for information to the applicant shall occur in the following areas, including consumer demographics, consumer needs, clinical and service information including encounter data, staffing and capacity patterns, risk management areas, consumer outcomes, regulatory compliance, organizational processes, resource utilization, and billing and insurance areas. The DIVISION will work with the applicant over the contract period to streamline requests for information when those requests are regular and ongoing.

5. Experience

Experience providing service to the target population is mandatory.

6. Coordination of Services

Refer to the Service Activities, Section 2, III.A.

7. Reporting requirements for program and fiscal data

a. Reports shall be submitted in the format and by the due dates prescribed by the DIVISION.

b. The required content and format of all reports shall be subject to ongoing review and modification by the DIVISION as needed.

c. At the discretion of the DIVISION, providers may be required to submit reports in an approved electronic format, replacing some written reports.

8. Contract Compliance

The State performs periodic reviews, including validation studies, in order to ensure contract compliance. The State is authorized to impose financial penalties if the data is not provided timely and accurately.

The DIVISION reserves the right to request additional data, information and reports from the applicant, as needed, to comply with external requirements and for its own management purposes.

1) Timeliness of Data Submitted

All information, data, medical records, and reports shall be provided to the DIVISION by the specified written deadlines. The applicant shall be assessed a penalty of $200.00 per day until the required information, data, medical records, and reports are received by the DIVISION. If the applicant will not be able to comply with the request, the applicant may ask for an extension in writing with an explanation to justify the extension. The DIVISION reserves the right to determine if an extension is acceptable and set a new date for submission.

The applicant, may in turn, sanction its subcontractors and providers if the required information, data, medical records, and reports are not provided to the applicant within the timeframe established by the applicant.

2) Accuracy and Completeness

The information, data, medical records, and reports provided to the DIVISION shall be reasonably accurate and complete. Data and reports shall be mathematically correct and present accurate information. The applicant shall be notified within thirty (30) calendar days from the receipt date of the initial submission of any information, data, medical records, and reports that do not appear to be accurate and complete. The applicant shall be given thirty (30) calendar days to correct the errors or provide documentation to support the accuracy of the initial submission. If at the end of the thirty (30) calendar days the new submission continues to not be accurate or complete, a penalty will be assessed.

9. Pricing structure or pricing methodology to be used.

The pricing structure is based on fixed unit of service rate. If a state purchasing agency is utilizing a fixed rate pricing structure for the RFP, the applicant is requested to furnish a reasonable estimate of the maximum number of service units it can provide for which there is sufficient operating capacity (adequate, planned and budgeted space, equipment and staff).

10. Units of Service and Unit Rate

Fee Schedule

Licensed Clinical Psychologist

Procedure Code	Description	Fee
90801	Psychiatric Diagnostic Interview Examination	$101.30
90804	Individual Psychotherapy (20-30 minutes)	44.75
90806	Individual Psychotherapy (45-50 minutes)	75.00
90846	Family Psychotherapy w/o patient	69.67
90847	Family Psychotherapy w patient	81.17
90849	Multiple Family Group Psychotherapy	23.82
90853	Group Psychotherapy	21.41
96100	Psychological testing * per hour	59.00

Licensed Clinical Social Worker

Procedure code	Description	Fee
90801	Psychiatric Diagnostic Interview Examination	$75.97
90804	Individual Psychotherapy (20-30 minutes)	33.56
90806	Individual Psychotherapy (45-50 minutes)	56.25

90846	Family Psychotherapy w/o patient	52.25
90847	Family Psychotherapy w patient	60.87
90849	Multiple Family Group Psychotherapy	17.86
90853	Group Psychotherapy	16.05

Licensed Psychiatrist

Procedure code	Description	Fee
90801	Psychiatric Diagnostic Interview Examination	$104.43
90804	Individual Psychotherapy (20-30 minutes)	46.62
90805	Individual Psychotherapy with E/M (20-30 minutes)	49.84
90806	Individual Psychotherapy (45-50 minutes)	75.00
90807	Individual Psychotherapy with E/M (45-50 minutes)	78.00
90846	Family Psychotherapy w/o patient	71.55
90847	Family Psychotherapy w patient	82.73
90849	Multiple Family Group Psychotherapy	25.38
90853	Group Psychotherapy	27.20
90862	Medication Management	38.28
99362	Joint Treatment Planning	88.00

Licensed Advance Practice Registered Nurse in Behavioral Health

Procedure code	Description	Fee
90801	Psychiatric Diagnostic Interview Examination	$ 78.32
90804	Individual Psychotherapy (20-30 minutes)	34.96
90805	Individual Psychotherapy with E/M (20-30 minutes)	37.38
90806	Individual Psychotherapy (45-50 minutes)	56.25
90807	Individual Psychotherapy with E/M (45-50 minutes)	58.50
90846	Family Psychotherapy w/o patient	53.66
90847	Family Psychotherapy w patient	62.04
90849	Multiple Family Group Psychotherapy	19.03
90853	Group Psychotherapy	20.40
90862	Medication Management	28.71

Certified Substance Abuse Counselor **

Procedure code	Description	Fee
90801	Assessment/Diagnostic	$42.00
90804	Individual Therapy (20-30 minutes)	20.00
90806	Individual Therapy (45-60 minutes)	40.00
90853	Group Therapy (60 minutes)	20.00

Clinic Services

Procedure Code	Description	Fee
90782	Therapeutic Injection	$3.68

Targeted Case Management

Procedure Code	Description	Fee
T1017-HE	Case Assessment (one per year) per 15 minutes	$9.75
T1017-US	Case Planning (one per year) per 15 minutes	9.75
T1017-U6	Monitoring and Follow-Up per 15 minutes	9.75

Care Coordination

Procedure Code	Description		Fee
T1016	Follow-up	Per 15 minutes	$9.75

Clubhouse

Procedure Code	Description	Fee
H0036	Social Skills Per 15 minutes	$3.00
H0036-52	Social Recreation per 15 minutes	3.00
H2001-52	Pre-vocational Rehabilitation per 15 minutes	3.00

*Psychological testing requires prior authorization.

**Services are not covered if the consumer is in a facility or program where dual diagnosis services is inclusive in the facility's contract. Services are also not covered if the consumer is treated by another provider for a similar type service (i.e. depression and substance abuse/dependency where the provider have diagnosed and is actively treating both conditions).

IV. Facilities

See Section 2, III.A.10.e.

Section 3

Proposal Application Instructions

Section 3
Proposal Application Instructions

General instructions for completing applications:

- *Proposal Applications shall be submitted to the state purchasing agency using the prescribed format outlined in this section.*
- *The numerical outline for the application, the titles/subtitles, and the applicant organization and RFP identification information on the top right hand corner of each page should be retained. The instructions for each section however may be omitted.*
- *Page numbering of the Proposal Application should be consecutive, beginning with page one and continuing through for each section.* ***See sample table of Contents***
- *Proposals may be submitted in a three ring binder (Optional).*
- *Tabbing of sections (Recommended).*
- *Applicants must also include a Table of Contents with the Proposal Application. A sample format is reflected in Section 5, Attachment B of this RFP.*
- *A written response is required for* ***each*** *item unless indicated otherwise. Failure to answer any of the items will impact upon an applicant's score.*
- *Applicants are* ***strongly*** *encouraged to review evaluation criteria in Section 4, Proposal Evaluation when completing the proposal.*
- *This form (SPO-H-200A) is available on the SPO website (for the website address see the Proposal Application Checklist in Section 5, Attachments). However, the form will not include items specific to each RFP. If using the website form, the applicant must include all items listed in this section.*

The Proposal Application comprises the following sections:

- *Proposal Application Identification Form*
- *Table of Contents*
- *Program Overview*
- *Experience and Capability*
- *Project Organization and Staffing*
- *Service Delivery*
- *Financial*
- *Other*

I. Program Overview

Applicant shall give a brief overview to orient evaluators as to the program/services being offered.

II. Experience and Capability

A. Necessary Skills

The applicant shall demonstrate that it has the necessary skills, abilities, and knowledge relating to the delivery of the proposed services.

B. Experience

The applicant shall provide a description of projects/contracts, including references, pertinent to the proposed services. The applicant shall include points of contact, addresses, e-mail addresses, and phone numbers. The State reserves the right to contact references to verify experience.

C. Quality Assurance and Evaluation

The applicant shall describe its own plans for quality assurance and evaluation for the proposed services, including methodology.

Quality assurance shall include, but not be limited to, the following elements:

1. A written Quality Management Program description and outlined structure which includes the Quality Committee reporting structure, including Governing Board Involvement, voting composition, and a written process for goal and priority setting following standardized methodology and data collection, which is updated and signed annually.

2. The Quality Management Program must address consumer complaints, grievances, appeals, sentinel events and consumer satisfaction.

3. The Quality Management Program must have a system or policy that outlines how items are collected, tracked, reviewed, and analyzed (and reported to the DIVISION as appropriate).

4. The Quality Management Program Work Plan is established annually and selects goals and activities that are based on the annual program evaluation and are relevant to the DIVISION consumer and problem area under review, with designated timelines for the project and indicates department/persons responsible for carrying out the project(s) on the Work Plan.

5. Provision for the periodic measurement, reporting, and analysis of well-defined output, outcome measures and performance indicators of the delivery system, and an indication of how the applicant will use the results of these measurements for improvement of its delivery system.

6. A process of regular and systematic treatment record review, using established review criteria. A report summarizing findings is required. Additionally, the applicant shall develop a written plan of corrective action as indicated.

7. Provision of satisfaction surveys of consumers.

8. Assurance that a staff member be available to represent utilization and quality management issues at meetings scheduled by the DIVISION.

9. Provision of a utilization management system, including but not limited to the following: a) system and method of reviewing utilization; b) method of tracking authorization approvals; c) method of reviewing invoices against authorizations; d) consumer appeals process; e) annual evaluation of the applicant's utilization management plan; and, g) identification of the person in the organization who is primarily responsible for the implementation of the utilization management plan.

10. A policy and procedure for consumer complaints, grievances and appeals which includes documentation of actions taken, and demonstration of system improvement.

11. Assurance that the applicant has established and will maintain and regularly update the following QM policies and procedures:

    a. Consumer complaints, grievances and appeals

    b. Consumer Safety

    c. Consumer Satisfaction

    d. Disaster preparedness

    e. Emergency Evacuation

    f. Evidence Based Practice Guidelines

    g. LOCUS/Level of Care Placement

    h. Compliance

i. Consumer Rights and Orientation

j. Confidentiality/HIPAA

k. Treatment Records

l. Individualized Service Plans

m. Transition of consumers to other programs

n. Treatment Team

o. Use of Restraints

p. Restricting Consumer Rights

q. Credentialing Staff

12. A training plan and staff handbook/personnel manual for staff who are responsible for delivery of services. Training shall include but not be limited to: Substance Abuse, Forensics, Sentinel Events, Risk Management, Compliance, HIPAA Compliance, Consumer Rights, Treatment Planning, and Access and Treatment for Non-English Speaking Consumers.

13. A consumer handbook/brochure(s) that outline services available to the consumer, hours of operations, contact information (phone numbers, and instructions on emergency services), is written at a 6th grade reading level, provides an overview and the applicant's approach to care, and clearly outlines any major program rules that could lead to discharge from services offered by the organization.

14. A description of the steps that the applicant will take to comply with all of the DIVISION'S reporting requirements as specified in Section 2. III. B. 2., 4., and 7. The applicant shall also indicate how it will use the information in the report to improve its services.

15. Where there is an intention to subcontract, the applicant must demonstrate that services provided by the subcontractor are consistent with all applicable requirements specified in Section 2 including, but not limited to, compliance with reporting requirements. The applicant must describe the monitoring if will perform to ensure subcontractors are compliant with the DIVISION requirements.

16. For applicants whose annual contract or estimated reimbursements will be less than $100,000.00 or whose staff number five (5) or less, a modified

Quality Management and Utilization Management Plan are acceptable with prior approval from the DIVISION. A modified quality and utilization management system shall include the following:

a. A method for tracking authorizations.

b. A method for assuring that consumers are informed of their rights, including the right to file a complaint, grievance, or appeal a service delivery decision.

c. A method of documenting goals and service activity as they relate to the Individual Service Plan developed by the DIVISION designated case manager and consumer.

d. Consumer involvement in service planning.

e. Statement that the applicant will participate in the use of outcome instruments at the discretion of the DIVISION.

f. Identification of fiscal and program contact person.

17. For services described in this RFP, a statement that the applicant shall participate with the DIVISION'S quality and utilization management process including, but not limited to, case reviews, specific data gathering and reporting, peer review, concurrent review, site visitation, special studies, monitoring, credentialing, and training.

D. Coordination of Services

The applicant shall demonstrate the capability or plan to coordinate services with other agencies and resources in the community, if required in the RFP.

Demonstration or plan of the applicant's coordination efforts shall include, but not be limited to, the following:

1. A history of the applicant's cooperative efforts with other providers of mental health services.

2. Memorandum of agreements with other agencies (if required in the RFP).

3. Applicant's current efforts to coordinate with the DIVISION, CENTERS, HOSPITAL, and other POS providers, and where there is no current coordination, the applicant's plans to do so.

E. Facilities

The applicant shall provide a description of its facilities and demonstrate its adequacy in relation to the proposed services. If facilities are not presently

available, describe plans to secure facilities. Also describe how the facilities meet ADA requirements, as applicable, and special equipment that may be required for the services.

F. Management Information System (MIS) Requirements

The applicant shall submit a description of its current management information system (MIS) and plans for the future. The description shall include, but not be limited to, the following:

1. A statement about whether the applicant is a covered entity as defined by HIPAA. A statement that the applicant will comply with all HIPAA privacy, security and transactional code set requirements.

2. An explanation of how the applicant currently manages information in order to submit required information and data in the format prescribed by the DIVISION. Required data elements captured in the provider system and reported to the DIVISION may include, but are not limited to: consumer's last name, first name, middle name, any aliases, social security number, DIVISION-generated unique ID number, DIVISION-generated authorization number(s), Medicaid ID#, medicare ID#, other third party insurer #'s, address, telephone number, admission date, discharge date, service data using DIVISION approved procedure codes, date of birth, and gender, primary language spoken.

3. The DIVISION may add data reporting requirements or specify required formats for downloading data or submitting claims in the future. Applicants are encouraged to describe their flexibility in meeting changing data requirements.

4. For any Fixed Unit of Service Rate contracts, a statement that the applicant shall submit claims electronically in the 837 format.

5. Where infrastructure is lacking to meet MIS requirement, applicants shall propose solutions and include the proportion of cost related to this contract in their response to the RFP.

III. Project Organization and Staffing

A. Staffing

1. Proposed Staffing

The applicant shall describe the proposed staffing pattern, client/staff ratio and proposed caseload capacity appropriate for the viability of the services. The applicant shall give the number and title of the positions needed to provide the specific service activities. Positions descriptions

shall also be submitted. Refer to the personnel requirements in the Service Specifications, as applicable.

2. Staff Qualifications

The applicant shall describe in this section of its proposal how it will ensure its compliance with the personnel requirements, which includes, but not limited to, licensure, educational degrees, and experience for staff assigned to the program. Refer to Section 2.III.B.1. for personnel requirements of staff delivering specific service activities.

B. Project Organization

1. Supervision and Training

The applicant shall describe its ability to supervise, train and provide administrative direction relative to the delivery of the proposed services.

2. Organization Chart

The applicant shall reflect the position of each staff and line of responsibility/supervision. (Include position title, name and full time equivalency) Both the "Organization-wide" and "Program" organization charts shall be attached to the Proposal Application.

IV. Service Delivery

A. Scope of Work

Applicant shall include a detailed discussion of the applicant's approach to applicable service activities and management requirements from Section 2,III. - Scope of Work, including (if indicated) a work plan of all service activities and tasks to be completed, related work assignments/responsibilities and timelines/schedules.

The applicant's description of its service delivery system shall include, but not be limited to, the following:

1. A detailed description of each service including hours of operation and qualifications of staff providing the service. Service descriptions also address the services provided to the consumers who may have a co-occurring substance abuse disorder. Services subcontracted out must be included in this description.

    a. Eligibility assessments

b. Assessment and treatment planning

c. Somatic, individual, group and family therapies

d. Targeted case management

e. Care Coordination

f. Clubhouse

2. A clear description of the services for consumers from point of entry to discharge, aftercare and follow-up. The description must be consistent with the scope of work found in Section 2.III.A. and with the personnel requirements in Section 2.III.B.1. Services proposed to be subcontracted out must be included in this description.

3. A clear description of the target population to be served.

4. A reasonable estimate of the number of consumers it could serve and, where applicable, an indication of its total capacity (e.g. total beds available), and the number of units it will provide.

5. A description of the methods the applicant will use to determine when treatment goals are accomplished and when to terminate services

6. A description of the accessibility of services for the target population, and a description of impediments to services and efforts to overcome barriers.

7. A statement that the applicant shall not refuse a referral, and that it shall not have an exclusionary policy that is inconsistent with the DIVISION'S guidelines.

8. An indication of the "best practices/evidence-based practices" the applicant incorporates and a citation of the literature to support its "best practices/evidence-based practices". A description of the system it uses to implement and maintain its "best practice/evidence-based practices" program integrity.

9. Where applicable, demonstration that the applicant is capable of providing twenty-four (24) hour coverage for services.

10. For services with twenty-four (24) hour, seven (7) days a week coverage, description of how the applicant's on-call system works, i.e., methodology relative to applicant's answering service. Specifically describe how consumers access applicant's service and staff availability.

11. Where the service is a housing, residential or day treatment / intensive outpatient hospital service, a weekly schedule that can be individualized to consumers and consistent with the requirements of the scope of services described in Section 2.III.A.

12. A description by the applicant of the involvement of the consumer in the decisions regarding the services the consumer receives.

13. A statement by the applicant that it is ready, able, and willing to provide services throughout the time of the contract period.

14. A statement by the applicant that it has read and understands the Request for Proposal and will comply with the DIVISION requirements.

B. General Requirements

The applicant shall describe in this section of its proposal how it will comply with the general requirements specified in Section 2.II.

C. Administrative Requirements

The applicant shall describe in this section of its proposal how it will comply with the administrative requirements specified in Section 2.III.B.2.

V. Financial

A. Pricing Structure

Applicant shall submit a cost proposal utilizing the pricing structure designated by the state purchasing agency. The cost proposal shall be attached to the Proposal Application.

The DIVISION is permitting the use of a fixed unit of service rate pricing structure for the RFP, the applicant is requested to furnish a reasonable estimate of the maximum number of service units it can provide for which there is sufficient operating capacity (adequate, planned and budgeted space, equipment and staff). All budget forms, instructions and samples are located on the SPO website (see the Proposal Application Checklist in Section 5 for website address). The following budget forms shall be submitted with the Proposal Application:

- SPO-H-205 – Budget
- SPO-H-205A – Organization-Wide Budget by Source of Funds (special instructions are located in Section 5)
- SPO-H-206A – Budget Justification – Personnel: Salaries & Wages

- SPO-H-206B – Budget Justification – Personnel: Payroll Taxes, Assessments & Fringe Benefits
- SPO-H-206C – Budget Justification – Travel-Inter-Island
- SPO-H-206D – Budget Justification – Travel-Out of State
- SPO-H-206E – Budget Justification – Contractual Services - Administrative
- SPO-H-206F – Budget Justification – Contractual Services - Subcontracts
- SPO-H-206H – Budget Justification – Program Activities
- SPO-H-206I – Budget Justification – Equipment Purchases
- SPO-H-206J – Budget Justification – Motor Vehicle

B. Other Financial Related Materials

1. Accounting System

   In order to determine the adequacy of the applicant's accounting system as described under the administrative rules, the following documents are requested as part of the Proposal Application (may be attached):

   a. The applicant shall submit a cost allocation plan showing how costs are allocated across different funding sources.

   b. Also, the applicant shall submit a copy of its most recent audited or compiled financial statements.

2. The applicant shall describe all eligible sources of revenue from third parties and plans to pursue additional sources of revenue and how the applicant will prevent billing more than one payer and submit overpayments to the DIVISION. The applicant may not bill other payers for services already paid for by the DIVISION or bill the DIVISION for services eligible for payment by another payer.

3. The applicant shall describe its billing/claims process and how it ensures accurate and timely submission of billing/claims based on written documentation which supports the bill/claim, and how it processes adjustments, reconciles payment, and posts payment.

VI. Other

A. Litigation

The applicant shall disclose any pending litigation to which they are a party, including the disclosure of any outstanding judgment. If applicable, please explain.

Section 4

Proposal Evaluation

Section 4
Proposal Evaluation

I. Introduction

The evaluation of proposals received in response to the RFP will be conducted comprehensively, fairly and impartially. Structural, quantitative scoring techniques will be utilized to maximize the objectivity of the evaluation.

II. Evaluation Process

The procurement officer or an evaluation committee of designated reviewers selected by the head of the state purchasing agency or procurement officer shall review and evaluate proposals. When an evaluation committee is utilized, the committee will be comprised of individuals with experience in, knowledge of, and program responsibility for program service and financing.

The evaluation will be conducted in three phases as follows:

- Phase 1 - Evaluation of Proposal Requirements
- Phase 2 - Evaluation of Proposal Application
- Phase 3 - Recommendation for Award

Evaluation Categories and Thresholds

Evaluation Categories		**Possible Points**
Administrative Requirements		
Proposal Application		**100 Points**
Program Overview	0 points	
Experience and Capability	20 points	
Project Organization and Staffing	15 points	
Service Delivery	55 points	
Financial	10 Points	
TOTAL POSSIBLE POINTS		**100 Points**

III. Evaluation Criteria

A. Phase 1 - Evaluation of Proposal Requirements

1. Administrative Requirements

2. Proposal Application Requirements

- Proposal Application Identification Form (Form SPO-H-200)
- Table of Contents
- Program Overview
- Experience and Capability
- Project Organization and Staffing
- Service Delivery
- Financial (All required forms and documents)
- Program Specific Requirements (as applicable)

B. Phase 2 - Evaluation of Proposal Application (100 Points)

Program Overview: No points are assigned to Program Overview. The intent is to give the applicant an opportunity orient evaluators as to the service(s) being offered.

1. Experience and Capability ***Total 20 Points***

Up to 10 points may be deducted from agencies who in the past demonstrated unsatisfactory performance.

The State will evaluate the applicant's experience and capability relevant to the proposal contract, which shall include:

a. Necessary Skills (5 points)

1) Demonstrated skills, abilities, and knowledge relating to the delivery of the proposed services.

2) Demonstrate the ability to respond to consumer complaints, appeals and grievances including those brought to the attention of the DIVISION.

b. Experience (2 points)

1) Possesses the skills, abilities, knowledge of, and experience relating to the delivery of the proposed

services including, but not limited, to previous and current contract performance with the DIVISION and other agencies.

c. Quality Assurance and Evaluation (4 points)

Sufficiency of quality assurance and evaluation plans for the proposed services, including methodology.

1) The applicant has sufficiently described its quality improvement program which shall include the following:

   a) Provision of a utilization management system.

   b) Provision of a quality management program.

   c) A policy and procedure for consumer complaints, grievances and appeals, documentation of actions taken, and demonstration of system improvement.

2) A training plan and staff handbook/personnel manual for staff who are responsible for the delivery of services. The plan includes the required trainings listed in Section 3.II.C.12.

3) When there is an intention to subcontract, the applicant must demonstrate that the services meet all applicable requirements specified in Section 2, including but not limited to, compliance with reporting requirements. The applicant must adequately describe the monitoring it will perform to ensure subcontractor(s) are compliant with DIVISION requirements.

d. Coordination of Services (2 points)

Demonstrated capability to coordinate services with other Agencies and resources in the community.

e. Facilities (2 points)

Adequacy of facilities relative to the proposed services.

f. Management Information Systems (MIS) (5 points)

1) Demonstrate that their management information system (MIS) shall include, but not be limited to, the following:

2) Relative to HIPAA requirements:

   a) The applicant states whether they are a covered entity.

   b) The applicant states they will comply with all HIPAA privacy, security, and transactional code set requirements. (No points if statement is absent or applicant cannot comply.)

3) Relative to current MIS:

   a) Applicant is able to collect all required information.

   b) Applicant currently able to collect some required information with a plan to upgrade the MIS to collect all information by the time the contract begins.

   c) If applicant is not currently able to collect all required information and unable to do so in the future or no description of implementation plan to collect information, no points shall be applied to applicants that provide this response.

4) Relative to the applicant's infrastructure:

   a) A clear statement that their MIS system is fully functional.

   b) Inclusion of an implementation plan to create a fully functional MIS system by initiation of a contract.

5) In regards to flexibility, a statement that describes flexibility in adding data elements or reporting requirements is addressed in their information system.

6) Relative to claims: (applies to contracts based on Fixed Unit of Service Rate)

a) The applicant is currently able to produce either paper or electronic 837 file.

b) The applicant will be able to produce and electronic 837 file by the time that a contract is initiated.

c) The applicant is unable to produce an electronic 837 file but can produce CMS 1500 claims.

d) The applicant is unable to produce either an 837 or CMS 1500 now or in the future. (No points to a provider who will not be able to produce a compliant claim).

2. Project Organization and Staffing Total 15 Points

The State will evaluate the applicant's overall staffing approach to the service that shall include:

a. Staffing (10 points)

1) Proposed Staffing: That the proposed staffing pattern, client/staff ratio, and proposed caseload capacity is reasonable to insure viability of the services and complies with applicable DIVISION requirements.

2) Staff Qualifications: Minimum qualifications (including experience) for staff assigned to the program, comply with applicable DIVISION requirements.

b. Project Organization (5 points)

1) Supervision and Training: Demonstrated ability to supervise, train and provide administrative direction to staff relative to the delivery of the proposed services, comply with applicable DIVISION requirements.

2) Organization charts: Approach and rationale for the structure, functions, and staffing of the proposed organization for the overall service activity and tasks.

3) Applicable submission of evidence that the applicant is licensed if licensure is required; and for all applicants, accreditation of the service(s) the applicant is applying for if it is an accreditable service.

3. Service Delivery ***Total 55 Points***

Evaluation criteria for this section will assess the applicant's approach to the service activities and management requirements outlined in the Proposal Application.

Evaluation criteria may include, but not be limited to, the following:

a. A detailed description of each service including hours of operation and qualifications of staff providing the service. Service descriptions also address the services provided tot he consumers who may have a co-occurring substance abuse disorder. Services subcontracted out must be included in this description.

1) Eligibility assessments **(5 points)**

2) Assessment and treatment planning **(2 points)**

3) Somatic, individual, group and family therapies **(9 points)**

4) Targeted case management **(9 points)**

5) Care Coordination **(3 points)**

6) Clubhouse **(6 points)**

b. A detailed description of how a consumer is served from point of entry to discharge, aftercare and follow up which includes how the program determines when treatment goals are accomplished and when to move consumers throughout the various services in the program. **(10 points)**

c. The description of the services shows how the program incorporates "best practices/evidence-based practices", has literature to support his, and has a system for implementing and maintaining best practice program integrity. **(2 points)**

d. The applicant has demonstrated twenty-four (24) hour per day coverage for services where required. **(2 points)**

e. The description by the applicant demonstrates consumer involvement in decisions regarding the services the consumer receives. **(2 points)**

f. A statement by the applicant that is has read the Request for Proposal and will comply with DIVISION requirements. **(5 points)**

4. ***Financial*** ***Total 10 Points***

a. Pricing structure based on fixed unit of service rate

1) Applicants proposal budget is reasonable, given program resources and operational capacity.

2) A cost allocation plan clearly describing the allocation of funds across different funding sources.

3) The submission of a copy of the most recent audit report or compiled financial statement.

4) Adequacy of accounting system.

5) An indication of the third party reimbursements the applicant is eligible to receive and of the plans the applicant has made or is making to obtain as many third party reimbursements as possible without collecting payment from more than one payer.

b. Eligible Sources of revenue

Description of all eligible sources of revenue from third parties and plans to pursue additional sources or revenue.

C. Phase 3 - Recommendation for Award

Section 5
Attachments

Attachment A

Competitive POS Application Checklist

Proposal Application Checklist

Applicant: _____ RFP No.: HTH 420-1

The applicant's proposal must contain the following components in the order shown below. This checklist must be signed, dated and returned to the state purchasing agency as part of the Proposal Application. *SPO-H forms are located on the web at http://www.spo.hawaii.gov Click *Procurement of Health and Human Services* and *For Private Providers.**

Item	Reference in RFP	Format/Instructions Provided	Required by Purchasing Agency	Completed by Applicant
General:				
Proposal Application Identification Form (SPO-H-200)	Section 1, RFP	SPO Website*	**X**	
Proposal Application Checklist	Section 1, RFP	Attachment A	**X**	
Table of Contents	Section 5, RFP	Section 5, RFP	**X**	
Proposal Application (SPO-H-200A)	Section 3, RFP	SPO Website*	**X**	
Registration Form (SPO-H-100A)	Section 1, RFP	SPO Website*	**(Required if not Registered)**	
Tax Clearance Certificate (Form A-6)	Section 1, RFP	Dept. of Taxation Website (Link on SPO website)*		
Cost Proposal (Budget)				
SPO-H-205	Section 3, RFP	SPO Website*		
SPO-H-205A	Section 3, RFP	SPO Website* Special Instructions is applicable, Section 5		
SPO-H-205B	Section 3, RFP,	SPO Website* Special Instructions, Section 5		
SPO-H-206A	Section 3, RFP	SPO Website*		
SPO-H-206B	Section 3, RFP	SPO Website*		
SPO-H-206C	Section 3, RFP	SPO Website*		
SPO-H-206D	Section 3, RFP	SPO Website*		
SPO-H-206E	Section 3, RFP	SPO Website*		
SPO-H-206F	Section 3, RFP	SPO Website*		
SPO-H-206G	Section 3, RFP	SPO Website*		
SPO-H-206H	Section 3, RFP	SPO Website*		
SPO-H-206I	Section 3, RFP	SPO Website*		
SPO-H-206J	Section 3, RFP	SPO Website*		
Certifications:				
Federal Certifications		Section 5, RFP		
Debarment & Suspension		Section 5, RFP		
Drug Free Workplace		Section 5, RFP		
Lobbying		Section 5, RFP		
Program Fraud Civil Remedies Act		Section 5, RFP		
Environmental Tobacco Smoke		Section 5, RFP		
Program Specific Requirements:				

_____ Authorized Signature

_____ Date

Attachment B

Sample Table of Contents for the POS Proposal Application

Proposal Application
Table of Contents

I. Program Overview **1**

II. Experience and Capability **1**
- **A.** Necessary Skills 2
- **B.** Experience 4
- **C.** Quality Assurance and Evaluation 5
- **D.** Coordination of Services 6
- **E.** Facilities 6

III. Project Organization and Staffing **7**
- **A.** Staffing **7**
  1. Proposed Staffing 7
  2. Staff Qualifications 9
- **B.** Project Organization 10
  1. Supervision and Training 10
  2. Organization Chart (Program & Organization-wide)
     (See Attachments for Organization Charts)

IV. Service Delivery **12**

V. Financial **20**
See Attachments for Cost Proposal

VI. Litigation **20**

VII. Attachments
- **A.** Cost Proposal
  - SPO-H-205 Proposal Budget
  - SPO-H-206A Budget Justification - Personnel: Salaries & Wages
  - SPO-H-206B Budget Justification - Personnel: Payroll Taxes and Assessments, and Fringe Benefits
  - SPO-H-206C Budget Justification - Travel: Interisland
  - SPO-H-206E Budget Justification - Contractual Services – Administrative
- **B.** Other Financial Related Materials
  - Financial Audit for fiscal year ended June 30, 1994
- **C.** Organization Chart
  - Program
  - Organization-wide
- **D.** Performance and Output Measurement Tables
  - Table A
  - Table B
  - Table C

Program Specific Requirements

Attachment C

Draft Special Conditions

SPECIAL CONDITIONS

1. Time of Performance. The PROVIDER shall provide the services required under this Agreement from _____, to and including _____, unless this Agreement is extended or sooner terminated as hereinafter provided.

2. Option to Extend Agreement. Unless terminated, this Agreement may be extended by the STATE for specified periods of time not to exceed three (3) years or for not more than three (3) additional twelve (12) month periods, without resolicitation, upon mutual agreement and the execution of a supplemental agreement. This Agreement may be extended provided that the Agreement price shall remain the same or is adjusted per the Agreement Price Adjustment provision stated herein. The STATE may terminate the extended agreement at any time in accordance with General Conditions no. 4.

3. Agreement Price Adjustment. The Agreement price may be adjusted prior to the beginning of each extension period and shall be subject to the availability of state funds.

4. Audit Requirement. The PROVIDER shall conduct a financial and compliance audit in accordance with the guidelines identified in Exhibit _____ attached hereto and made a part hereof. Failure to comply with the provisions of this paragraph may result in the withholding of payments to the PROVIDER.

5. The PROVIDER shall have bylaws or policies that describe the manner in which business is conducted and policies that relate to nepotism and management of potential conflicts of interest.

Attachment D

Consumer Rights

ADULT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	**Number: 60.X00X.NEW**
AMHD Administration	Effective Date: XX/XX/XX History: New
SUBJECT: Consumer Rights	Page: 1 of 7
REFERENCE:	Recommended: _____ Title: Medical Director, AMHD APPROVED: _____ Title: Chief, AMHD

PURPOSE

To ensure that specified rights of each consumer are protected.

POLICY

Each provider shall have a statement designed to protect consumer's rights and comply with requirements of the Americans with Disabilities Act. The statement shall be:

a. Consistent with Federal and State laws and regulations;

b. Posted in strategic and conspicuous areas to maximize consumer, family and staff awareness;

c. Signed and dated by the consumer prior to treatment; and

d. Maintained in the treatment records of consumers.

PROCEDURE

A. The statement given to consumers must include at the minimum the following language:

1. You have rights no matter what your situation is. Adult Mental Health Division (AMHD) and all its providers will uphold these rights. You have these rights regardless of your:

    - Age
    - Race
    - Sex
    - Religion
    - Culture
    - Amount of education
    - Lifestyle
    - Sexual orientation
    - National origin
    - Ability to communicate
    - Language spoken
    - Source of payment for services
    - Physical or mental disability

2. You have the right to be treated with respect and dignity, and to have your right to privacy respected.

3. You have the right to know about the AMHD, the services you can receive, who will provide the services, and their training and experience.

4. You have the right to have as much information about your treatment and service choices as you need so you can give an informed consent or refuse treatment. This information must be told to you in a way you can understand. Except in cases of emergency services, this information shall include a description of the treatment, medical risks involved, any alternate course of treatment or no treatment and the risks involved in each.

5. You have a right to information about your medications; what they are, how to take them, and possible side effects.

6. You have a right to be informed of continuing care following discharge from the hospital or outpatient services.

7. You have a right to look at and get an explanation of any bills for non-covered services, regardless of who pays.

8. You have a right to receive emergency services when you, as a prudent layperson, acting reasonably, would believe that an emergency medical condition existed. Payment for emergency services will not be denied in cases when you go for emergency services.

9. You have a right to receive emergency services when traveling outside the State of Hawaii when something unusual prevents you from getting care from an AMHD provider.

10. You have a right to usually have the same provider when you get services.

11. You have a right to an honest discussion with your providers of the options for your treatment, regardless of cost and benefit coverage.

12. You have a right to be advised if a provider wants to include you in experimental care or treatment. You have the right to refuse to be included in such research projects.

13. You have a right to complete an advance directive, living will, psychiatric advance directive, medical durable powers of attorney or other directive to your providers.

14. You have a right to have any person who has legal responsibility make decisions for you regarding your mental health care. Any person with legal responsibility to make health care decisions for you will have the same rights as you would.

15. You have the right to know all your rights and responsibilities.

16. You have the right to get help from AMHD in understanding your services.

17. You are free to use your rights. Your services will not be changed and you will not be treated differently if you use your rights.

18. You have the right to receive information and services in a timely way.

19. You have the right to be a part of all choices about your treatment. You have the right to have a copy of your written Individual Service Plan.

20. You have the right to disagree with your treatment or to ask for changes in your Individual Service Plan.

21. You have the right to ask for a different provider or case manager. If you want a different provider or case manager, we will work with you to find another one in the AMHD network.

22. You have the right to refuse treatment to the extent allowed by the law. You are responsible for your actions if you refuse treatment or if you do not follow your providers' advice.

23. You have the right to get services in a way that respects your culture and what you believe in.

24. You have the right to an interpreter, if needed, to help you speak to AMHD or your providers. You have the right to have an interpreter in the room when your provider sees you.

25. You have the right to ask us to send you mail and call you at the address or telephone number of your choice, in order to protect your privacy. If we cannot honor your request, we will let you know why.

26. You have a right to a second opinion when deciding on treatment.

27. You have the right to expect that your information will be kept private according to the Privacy law.

28. You have the right to complain about your services and to expect that no one will try to get back at you. If you complain, your services will not stop unless you want them to.

29. You have the right to be free from being restrained or secluded unless a doctor or psychologist approves, and then only to protect you or others from harm. Seclusion and restraints can never be used to punish you or keep you quiet. They can never be used to make you do something you don't want to do. They can never be used to get back at you for something you have done.

If you have any questions or concerns about these rights, you can speak to the Rights Advisor at your Community Mental Health Center or call the AMHD Consumer Advisor at (808) 586-4688.

B. Each consumer must be provided an orientation to the program at a level educationally appropriate for the consumer, communicated in either the consumer's native language or sign language, as is appropriate for the individual. Documentation of the orientation must be kept in the consumer's treatment record and signed and dated by the consumer. If a consumer who received the orientation refuses to sign the form acknowledging that he/she received information regarding his/her rights, the staff shall document on the form that the consumer refuses to sign and the date that the information was provided to the consumer. At a minimum such orientation must include:

1. An explanation of the:

   a) Rights and responsibilities of the consumer,

   b) Grievance and appeal procedures

   c) Ways in which input is given regarding:

      - the quality of care
      - achievement of outcomes
      - satisfaction of the consumer

2. An explanation of the organization's:

   a) Services and activities

   b) Expectations

   c) Hours of operation

   d) Access to after-hour services

   e) Code of ethics

   f) Confidentiality policy

g) Requirements for follow-up for the mandated consumer served, regardless of his or her discharge outcome

3. An explanation of any and all financial obligations, fees, and financial arrangements for services provided by the organization

4. Familiarization with the premises, including emergency exits and/or shelters, fire suppression equipment, and first aid kits

5. The program's policies regarding:

   a) the use of seclusion or restraint

   b) Smoking

   c) Illicit or licit drugs brought into the program

   d) Weapons brought into the program

6. Identification of the person responsible for case management

7. A copy of the program rules to the consumer, that identifies the following:

   a) Any restrictions the program may place on the consumer

   b) Events, behaviors, or attitudes that may lead to the loss of rights or privileges for the consumer

   c) Means by which the consumer may regain rights or privileges that have been restricted

8. Education regarding advance directives, when legally applicable

9. Identification of the purpose and process of the assessment

10. A description of how the Individualized Service Plan (ISP) or other plan will be developed and the consumer's participation

11. Information regarding transition criteria and procedures

12. When applicable, an explanation of the organization's services and activities include:

    a) Expectations for consistent court appearances

    b) Identification of therapeutic interventions, including:

    - Sanctions
    - Interventions
    - Incentives
    - Administrative discharge criteria

Date of Review:___/___/___; ___/___/___; ___/___/___; ___/___/__

Initials: [_____] [_____] [_____] [_____]

Attachment E

Division P&P Regarding Consumer Grievances

Division P&P Regarding Consumer Appeals

ADULT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	**Number: 60.X00X.NEW**
AMHD Administration	Effective Date: XX/XX/XX History: New
SUBJECT: Consumer Grievances	Page: 1 of 6
REFERENCE: Consumer Appeals, Consumer Rights, Consumer Handbook	Recommended: _____ Title: Medical Director, AMHD APPROVED: _____ Title: Chief, AMHD

PURPOSE

To outline the internal process and procedure for reviewing and resolving consumer grievances or any expressions of dissatisfaction.

POLICY

The grievance process is administered by Adult Mental Health Division's (AMHD) Office of Consumer Affairs.

A description of AMHD's grievance process is included in the Consumer Handbook, which is distributed to all consumers within ten (10) days of entry into the AMHD service system. There is no punitive or retaliatory action taken against a consumer, consumer advocate or provider, acting on behalf of the consumer, for filing a grievance.

DEFINITIONS

- Action – The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, unreasonable delays in services, or grievances not acted upon within prescribed timeframes.

- Appeal – A request for review of an action made by AMHD, as "action" is defined. Consumer Appeals are discussed in a separate policy and procedure.

- Consumer – Anyone who is receiving services or potentially could be eligible to receive services.

- Grievance – An expression of dissatisfaction from a consumer or provider, or any authorized representative on behalf of the consumer about any matter other than an action, as "action" is defined.

- Grievance Review – A review process for grievance resolutions. A consumer may request a "grievance review" by AMHD if they do not agree with a provider's resolution of a grievance.

- Inquiry – A contact from a consumer, or on behalf of the consumer, that questions any aspect of AMHD's or a provider's operations, activities, or behavior, or to request change to another provider, and does not express dissatisfaction.

PROCEDURE

1. Inquiry

   A. Consumers should call their Case Manager for any Inquiry or question regarding any aspect of AMHD or a provider's operations, activities, or behavior, or request to change to another provider.

   B. If during the contact, the consumer expresses dissatisfaction of any kind, the Inquiry becomes an expression of dissatisfaction and becomes a Grievance or Appeal (see Grievance and Appeal process below).

2. Grievance

   A. Consumers may file a grievance if they express any dissatisfaction in regards to the following:

- AMHD or provider's operations
- AMHD or provider's activities
- AMHD or provider's failure to respect the consumer's rights
- AMHD or provider's behavior
- Provider or AMHD employee is rude
- Provider quality of care
- AMHD or provider's privacy practices – copies of these grievances are also forwarded to AMHD's Privacy Officer.

B. A consumer, provider or a consumer's authorized representative, acting on behalf of the consumer, may file a grievance orally or in writing.

(1) For oral filing of grievance, the consumer may call the Office of Consumer Affairs and a Consumer Specialist will assist the consumer in writing the grievance by completing an AMHD Consumer Grievance Form (see Attachment A), however, any AMHD staff may assist the consumer and may complete the Grievance Form. The Consumer will be given an option to receive a copy of the written grievance. The form is forwarded to the individual responsible for tracking grievances within the Office of Consumer Affairs who is defined as the Grievance Coordinator.

(2) If a provider or an authorized representative on behalf of the consumer files the grievance orally, the consumer must give written authorization.

(3) The Grievance Coordinator directs the grievance to the appropriate individual within AMHD for investigation and resolution of the grievance. That individual forwards the written results of their investigation and resolution to the Grievance Coordinator for data entry and tracking.

(4) All written grievances should be submitted to:

Adult Mental Health Division
Office of Consumer Affairs
Grievance Coordinator
P.O. Box 3378
Honolulu, Hawaii 96801-3378

(5) Within five (5) working days of the receipt date, the grievant will be informed by letter that the grievance has been received.

(6) Each grievance will be thoroughly investigated by gathering facts from all relevant parties and using the applicable statutory, regulatory, and contractual provisions, as well as AMHD's policies and procedures.

(7) AMHD will render a resolution of the grievance within thirty (30) calendar days of the receipt date. If the thirtieth (30th) day falls on a Saturday, Sunday, or State holiday, a resolution will be rendered the next working day. A letter of resolution will be mailed to the grievant and copies are sent to all parties whose interest has been affected by the decision. If the grievant has requested not to be identified, consumer identifying information will be left off other parties' letters.

(8) The effective date of the decision will be the date of personal delivery, or if mailed, the postmarked date of the mailing.

C. The resolution letter includes and describes the following details:

- Nature of the grievance
- Issues involved
- Actions AMHD has taken or intends to take
- Reasons supporting AMHD's decision or action, including references to applicable statutes, rules, and procedures.
- A statement that AMHD's resolution of the grievance is final, unless the consumer requests an appeal by contacting the Office of Consumer Affairs.

D. AMHD may grant an extension of the resolution deadline of up to fourteen (14) calendar days if the consumer requests an extension or if additional information is needed. In this case, a letter will be sent to the grievant. The content of the notification will include the following details:

- Nature of the grievance
- Reason for the extension of the decision and how the extension is in the consumer's interest

3. Appeals

A. Consumers may file an appeal for the following actions or decisions made by AMHD:

- Prior authorization for a service is denied or limited
- The reduction, suspension, or termination of a previously authorized service
- The denial, in a whole or in part, of payment for a service
- The denial of eligibility
- Failure to provide services in a timely manner
- Unreasonable delays in services, or appeals not acted upon within prescribed timeframes
- Not satisfied with resolution of grievance

B. The appeal process is discussed in a separate policy and procedure.

4. Other Requirements

A. The AMHD Grievance Coordinator shall compile an aggregate quarterly grievance report and submit such report to the Quality Council in the required format no later than forty-five (45) days from the end of each quarter.

The Aggregate Grievance Report shall at a minimum include the following elements:

(1) Number of grievances sorted by date, nature of the grievance, county, and provider of services, if applicable;

2) Status of Resolution and if resolved, result including feedback, and

3) Turn-around times.

B. An Aggregate Annual Grievances Report shall be prepared and presented to the Quality Council within sixty (60) days of the last quarter of the calendar year. The report shall contain an aggregate data report, analysis by county, and recommendations for improvement of clinical and service areas.

C. Privacy of the grievance records is maintained at all times, including the transmittal of medical records.

D. All grievances and related documentation are maintained in a secure, designated area and retained for a period of seven (7) years following the final decision, or closure of grievance.

E. All grievances that concern provider organization actions and are proven quality of care or non-compliance with AMHD contracts or policies and procedures will be collated by Performance Management and used in certification and contract activities.

ATTACHMENTS

Consumer Grievance Form

Date of Review:___/___/___; ___/___/___; ___/___/___; ___/___/__

Initials: [_____] [_____] [_____] [_____]

Attachment A

Consumer Grievance Form

Date Received: _____

Taken by: _____

Consumer Name: _____

AMHD ID#: _____

Mailing Address: _____

Island: _____

Telephone #: _____

Name of Grievant: _____

Relationship to Consumer: _____

Mailing Address: _____

Telephone Number: _____

Note: If a representative is filing an oral grievance on behalf of an adult consumer, please obtain a written authorization from the consumer through the Authorization To Disclose Protected Information form.

Type of Contact: □ Letter
□ Telephone
□ In Person
Consumer Request Copy of Grievance? Yes □ No □

Grievance Regarding:

□ Provider

Full Name: _____

□ AMHD

Date(s) Problem began: _____

Description of Grievance: _____
_____
_____
_____
_____
_____
_____
_____
_____

□ Reviewed written grievance with consumer verbally on: _____

For Grievance Coordinator Use Only: File#: _____
Sent copy of grievance to consumer on: ___/___/___
Sent acknowledgement letter on: ___/___/___
Sent to _____on: ____/_____/_____ New 12/03/03 hj

ADULT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	**Number: 60.903 REV**
AMHD Administration	Effective Date: XX/XX/XX History: 5/03
SUBJECT: Consumer Appeals	Page: 1 of 9
REFERENCE: Consumer Grievances, Denial Letter, Consumer Handbook HRS 91	Recommended: _____ Title: Medical Director, AMHD APPROVED: _____ Title: Chief, AMHD

PURPOSE

To outline the process by which a consumer may appeal an action or decision made by Adult Mental Health Division (AMHD).

POLICY

The consumer appeals process is administered by the Office of Consumer Affairs.

A description of AMHD's appeals process is included in the Consumer Handbook, which is distributed to all consumers within ten (10) days of entry into the AMHD service system. There is no punitive or retaliatory action taken against a consumer, consumer advocate or provider, acting on behalf of the consumer, for filing an appeal.

DEFINITIONS

- Action – The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, unreasonable delays in services, or appeals not acted upon within prescribed timeframes.

- Appeal – A request for review of an action may by AMHD, as "action" is defined.

- Consumer – Anyone who is receiving services or potentially could be eligible to receive services.

- Grievance – An expression of dissatisfaction from a consumer or provider, or any authorized representative on behalf of the consumer about any matter other than an action, as "action" is defined.

- Grievance Review - A review process for grievance resolutions. A consumer may request a "grievance review" by AMHD if they do not agree with a provider's resolution of a grievance.

- Inquiry – A contact from a consumer, or on behalf of the consumer, that questions any aspect of AMHD's or a provider's operations, activities, or behavior, or to request change to another provider, and does not express dissatisfaction.

PROCEDURE

1. Inquiry

   A. Consumers should call their Case Manager for any Inquiry or question regarding any aspect of AMHD or a provider's operations, activities, or behavior, or request to change to another provider.

   B. If during the contact, the consumer expresses dissatisfaction of any kind, the Inquiry becomes an expression of dissatisfaction and becomes a Grievance (see Grievance and Appeal process below).

2. Grievance

   A. Consumers may file a grievance if they express any dissatisfaction in regards to the following:

      - AMHD or provider's operations
      - AMHD or provider's activities
      - AMHD or provider failure to respect the consumer's rights
      - AMHD or provider's behavior
      - Provider or AMHD employee is rude
      - Provider quality of care

- AMHD or provider's privacy practices – copies of these grievances are also forwarded to AMHD's Privacy Officer.

B. The grievance process is administered by the Office of Consumer Affairs as delineated in the Consumer Grievances Policy and Procedures.

3. Appeals

A. Consumers may file an appeal for the following actions or decisions made by AMHD:

- Prior authorization for a service is denied or limited
- The reduction, suspension, or termination of a previously authorized service
- The denial, in a whole or in part, of payment for a service
- The denial of eligibility
- Failure to provide services in a timely manner
- Unreasonable delays in services, or appeals not acted upon within prescribed timeframes
- Not satisfied with resolution of grievance

B. Assessment and Utilization Management shall notify consumers about their appeal rights and processes at the time of denial of eligibility or service request. Consumers shall have access to consumer advocacy and AMHD shall assure that any consumer who requests an advocate for this process shall be linked to this assistance.

C. A consumer, provider or a consumer's authorized representative, acting on behalf of the consumer with the consumer's written consent or if documentation is available to demonstrate the consumer is incapacitated, may file an appeal orally or in writing.

D. For oral filing of appeal, the consumer (or consumer's representative with the written consent of the consumer or if documentation is available to demonstrate the consumer is incapacitated), may call the Office of Consumer Affairs and must also submit a follow-up written appeal.

E. The designated case manager, or the designated crisis support manager, may appeal on behalf of the consumer without written consent if documentation is available to demonstrate the consumer is incapacitated. The case manager or crisis support manager shall provide specified clinical information to support the appeal request.

F. An AMHD Consumer Appeal Form (see Attachment A) may also be completed on behalf of the consumer or consumer's representative. In this case, the completed Consumer Appeal Form will be sent to the consumer or the consumer's authorized representative if a written authorization has been received for review and signature.

G. The consumer or the consumer's authorized representative must submit the follow-up written appeal or return the signed Consumer Appeal Form to the Office of Consumer Affairs which is designated as the Consumer Appeals Coordinator within one (1) week from the receipt date of the oral appeal. If the follow-up written appeal or the signed Consumer Appeal form is not received within the allotted timeframe, a follow-up call will be made to the consumer or the consumer's representative. If the consumer requests an extension for the filing deadline of the written appeal, AMHD will grant another one (1) week to submit the written appeal.

H. If a written follow-up is not received, the appeal will be closed after thirty (30) calendar days without further action or investigation. The consumer will receive written notification of this.

I. If a provider files a written appeal on behalf of a consumer, it will be initially designated as a Provider Complaint unless accompanied by the consumer's written consent. If the written appeal is filed with the consumer's written consent, AMHD will contact the provider to determine if consent was given. If the written consent is received, AMHD will transfer the Provider Complaint to a Consumer Appeal.

J. All written appeals should be submitted to:

Adult Mental Health Division
Office of Consumer Affairs
Consumer Appeal
P.O. Box 3378
Honolulu, Hawaii 96801-3378

4. First Level Appeal

   A. The appeal must be filed within thirty (30) days from the date of the initial action or decision made by AMHD. Exceptions to this deadline may be granted if details regarding extenuating circumstances are provided. At no time will an appeal be considered that is 180 days from the date of the initial action or decision made by AMHD.

   B. Within five (5) working days of receipt of the written appeal, the consumer, provider, or the consumer's authorized representative will be informed by letter that the appeal has been received.

   C. The consumer or authorized representative of the consumer may request to examine the consumer's case file, including medical records and any other documents considered during or before the appeal process by contacting the Consumer Appeals Coordinator in accordance with federal and state privacy regulations.

   D. All appeals will be thoroughly investigated by gathering facts from all relevant parties and using the applicable statutory, regulatory, and contractual provisions, as well as AMHD's policies and procedures.

   E. For appeals regarding reduction, suspension, or termination of a previously authorized service such care will be continued until resolution of the appeal.

   F. The AMHD Medical Director shall review the denial and shall make a determination (overturning or ratifying the denial). The AMHD Medical Director has the option of obtaining a second physician opinion prior to rendering a decision about the appeal.

   G. AMHD will render a resolution of the appeal within thirty (30) calendar days of the receipt date except in the case of an expedited appeal. If the thirtieth (30th) day falls on a Saturday, Sunday, or State holiday, a resolution will be rendered by the next working day. A letter of resolution will be mailed to the provider and copies are sent to all parties whose interest has been affected by the decision. The effective date of the decision will be the date of personal delivery, or if mailed, the postmarked date of the mailing.

H. The resolution letter includes and describes the following details:

- Nature of the appeal
- Issues involved
- Actions AMHD has taken or intends to take
- Reasons supporting AMHD's decision or action, including references to applicable statutes, rules, and procedures
- Process for a second level appeal if appeal denied.

I. AMHD may grant an extension of the resolution deadline of up to fourteen (14) calendar days if the consumer requests the extension or if additional information is needed. In this case, a letter will be sent to the consumer. The content of the notification will include the following details:

- Nature of the appeal
- Reason for the extension of the decision and how the extension is in the best interest of the consumer

5. Expedited Appeals

A. Any AMHD consumer (or provider acting on behalf of the consumer with the consumer's written authorization) may request an expedited appeal.

B. An expedited appeal may be authorized if the standard review time frame of AMHD's appeal process may:

- Seriously jeopardize the life or health of the consumer
- Seriously jeopardize the consumer's ability to access services with limited availability with a resulting loss of function

C. All expedited appeals will be thoroughly investigated by gathering facts from all relevant parties and using the applicable statutory, regulatory and contractual provisions, as well as AMHD's policies and procedures.

D. The AMHD Medical Director will review all expedited appeals.

E. A decision will be rendered within forty-eight (48) working hours of receipt of the request for an expedited appeal.

F. The decision will be phoned by the Consumer Appeals Coordinator to the consumer and provider.

G. The resolution letter includes and describes the following details:

- Nature of the appeal
- Issues involved
- Actions AMHD has taken or intends to take
- Reasons supporting AMHD's decision or action, including references to applicable statutes, rules, and procedures
- Process for a second level appeal if appeal denied

6. Second Level Appeal

A. The consumer or appealing party may proceed with a written second level appeal within thirty (30) calendar days from the date of the first level appeal determination letter.

B. The second level appeal letter along with any additional clinical information shall be sent to the AMHD Chief who shall obtain all relevant documentation from the AMHD UM Coordinator and the AMHD Medical Director. The second level appeal will be thoroughly investigated by gathering facts from all relevant parties and using the applicable statutory, regulatory, and contractual provisions, as well as AMHD's policies and procedures.

C. For appeals regarding reduction, suspension, or termination of a previously authorized service such care will be continued until resolution of the appeal by the AMHD Chief.

D. Expedited appeals which result in an expedited second level appeal shall be reviewed and a decision rendered within forty-eight (48) working hours of receipt of the request for an expedited second level appeal if the request has been designated as such. The decision shall be phoned by the Consumer Appeals Coordinator to the consumer and provider.

E. Within five (5) working days of receipt of the written non-expedited second level appeal, the consumer, provider, or the consumer's authorized representative will be informed by letter that the appeal has been received.

F. AMHD will render a resolution of the appeal for non-expedited appeals within thirty (30) calendar days of the receipt date except in the case of expedited appeal. If the thirtieth (30th) day falls on a Saturday, Sunday, or State holiday, a resolution will be rendered by the next working day. A letter of resolution will be mailed to the consumer and copies are sent to all parties whose interest has been affected by the decision. The effective date of the decision will be the date of personal delivery, or if mailed, the postmarked date of the mailing.

G. The resolution letter includes and describes the following details:

- Nature of the appeal
- Issues involved
- Actions AMHD has taken or intends to take
- Reasons supporting AMHD's decision or action, including references to applicable statutes, rules, and procedures
- Statement concerning any other avenues of appeal, if any, available to the appellant.

H. Consumers or their legal representatives who wish to appeal further must follow the Department of Health administrative appeals process, HR91f, or pursue through the legal system.

7. Other Requirements

A. The AMHD Consumer Appeals Coordinator shall compile a quarterly aggregate appeal report and submit such report to the Quality Council in the required format no later than forty-five (45) days from the end of each quarter.

The aggregate Appeals Report shall include at a minimum include the following elements:

(1) Number of appeals sorted by date, nature of the appeal, county level of appeal, and provider of services, if applicable,

(2) Number of decisions upheld,

(3) Number of decisions overturned, and

(4) Turn-around times.

B. An aggregate Annual Appeals Report shall be prepared and presented to the Quality Council within sixty (60) days of the last quarter of the calendar year. The report shall contain an aggregate data report, analysis, and recommendations for improvement of clinical and service areas.

C. Privacy of the appeal records is maintained at all times, including the transmittal of medical records.

D. All appeals and related documentation are maintained in a secure, designated area and retained for a period of seven (7) years following the final decision, or closure of appeal.

E. All appeals that concern provider organization actions and are proven quality of care or non-compliance with AMHD contracts or policies and procedures will be collated by Performance Management and used in certification and contract activities.

ATTACHMENTS

Consumer Appeal Form

Date of Review:___/___/___; ___/___/___; ___/___/___; ___/___/__

Initials: [_____] [_____] [_____] [_____]

Attachment A

Consumer Appeal Form

Print Name of Consumer: _____

AMHD ID#: _____

Mailing Address: _____

Island: _____

Phone Number: _____

Signature of Consumer: _____ Date Signed: _____

Note to Consumer: By signing this form, you as a consumer are authorizing your provider or any representative (if there's any) to file this appeal on your behalf.

** Please fill out this section if a provider or a representative is filing the appeal on behalf of the consumer**

Print Name of Representative: _____

Relationship to Consumer: _____

Phone Number: _____

Mailing Address: _____

Signature of Representative: _____ Date Signed: _____

Description of Service: _____

Date(s) of Service: _____

Describe on the space below what you disagree with and why. Also include copies of any papers that have to do with the appeal.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

(Write on back of this form if you need more space. Or write your appeal on a separate sheet and attach to this form)

<u>You must sign this form and send it back to us within one (1) week.</u> Please sent it to: Adult Mental Health Division, Attn. Consumer Appeals Coordinator, P.O. Box 3378, Honolulu, Hawaii 96801-3378. Or if you need help, call us at (808)586-4691 (Oahu)

Attachment F

QMHP AND SUPERVISION

Qualified Mental Health Professional (QMHP)

A Qualified Mental Health Professional (QMHP) is defined as a Licensed Psychiatrist, Licensed Clinical Psychologist (Ph.D. or Psy.D.), Licensed Clinical Social Worker (LCSW), or Licensed Advanced Practice Registered Nurse (APRN) in behavioral health currently licensed in the State of Hawaii.

The QMHP must oversee the development of each consumer's treatment plan to ensure it meets the requirements stated in the Community Plan and sign the treatment plan.

The QMHP shall serve as a consultant to the treatment team.

The QMHP shall serve as the LOCUS expert.

The QMHP shall provide oversight and training.

The QMHP must review and sign each authorization request for clinical services prior to submittal to ensure that the services requested are medically necessary.

The QMHP must provide clinical consultation and training to team leaders and/or direct care providers as needed.

For Specialized Residential Treatment Programs, the QMHP will provide day-to-day program planning, implementation, and monitoring.

Mental Health Professionals (MHP)

Except for ACT, the team leader is not required to be a QMHP. Non-QMHP team leaders must be clinically supervised by a QMHP.

Non-QMHP team leaders are defined as Mental Health Professionals (MHP) and must meet the following minimum requirements:

- Licensed Social Worker (LSW); or
- Licensed Marriage and Family Therapist; or
- Master of Science in Nursing (MSN); or
- APRN in a non-behavioral health field; or
- Master's degree from accredited school in behavioral health field
    a) Counseling, or
    b) Human Development, or
    c) Marriage, or
    d) Psychology, or
    e) Psychosocial Rehabilitation, or
    f) Criminal Justice.
- Master's degree in health related field with two (2) years experience in behavioral health; or

- Licensed Registered Nurse with a Bachelors in Nursing and five (5) years experience in behavioral health

The MHP may supervise para-professional staff if the MHP is clinically supervised by a QMHP.

The MHP may function as the AMHD Utilization Management Liaison.

Supervision:

Clinical supervision of all staff is ongoing and sufficient to ensure quality services and improve staff clinical skills and is according to community standards, scope of license as applicable, and agency policies and procedures. Treatment team meetings are consumer focused whereas clinical supervision is staff focused. Therefore treatment team meetings do not meet clinical supervision requirements.

One-on-one clinical supervision of MHP team leaders and direct care providers, if there is no MHP team leader, must be performed by the QMHP at a minimum of once per month. If a MHP is the team leader, the MHP must provide one-on-one monthly clinical supervision of non-MHP and non-QMHP staff.

The supervision must be documented in writing, legible, signed and dated by the QMHP or MHP as directed by the provider agency's policies and procedures.

The AMHD funded provider agencies must have policies and procedures to select and monitor the MHP team leaders if non-QMHP team leaders are used.

The QMHP and non-QMHP staff do not have to work in the same physical setting but must have routine meetings as defined in the provider agency's policies and procedures.

Attachment G

AMHD Level of Care Service Criteria

TARGETED CASE MANAGEMENT
Effective Date 09/03/02

Targeted case management services assists individuals to gain access to necessary services to reduce psychiatric and addiction symptoms and to develop optimal community living skills. Services include, but are not limited to, maintenance of a supportive relationship to assist with problem solving and development of necessary skills to sustain recovery, regular contact for the purpose of assessing or reassessing needs for planning or monitoring services, contact with collaterals (family and agency) to mobilize services and provide support and education. Advocacy on behalf of the individual, coordination of services specified in the plan, such as medication management and rehabilitation services, and some limited crisis intervention.

The goals of targeted case management are reflective of the goals of Intensive Case Management: 1) realization of recover and vocation/personal goals, 2) Lessen/eliminate debilitating symptoms of mental illness and to minimize or prevent recurrent acute episodes of the illness through rehabilitation and progressive treatment interventions, 3) Ensure that consumers have the basic needs and skills for sustaining community living and enhancing the qualify of life, 4) Improve/establish new linkages with a variety of community services and mobilize the involvement of the consumer's support network, 5) Maintain consumer engagement in treatment, 6) Promote harm reduction, substance use reduction, abstinence, and recovery for SPMI consumers with co-occurring substance abuse/addiction by providing substance abuse services.

Targeted case management services are authorized to include all clinic based treatment services. Units of authorization include targeted case management, psychiatric evaluations, medication review with psychotherapy, intramuscular therapy, individual therapy, group therapy, somatic treatment, family therapy (with consumer), family therapy (without consumer), pharmacological management, and clinical visit by nurses.

Targeted case management services are provided, as a minimum, of one time per month; however, other clinic services may be provided more often.

Level Of Care	LOCUS Level 2
Population Focus	Adults who are registered and eligible for Adult Mental Health Division services who meet the following criteria
Initial Authorization	Unit-15 minutes (100 units); 365 days
Re-Authorization	Unit-15 minutes (100 units); 365 days
Admission Criteria	Meets all of the following: 1. Consumer is capable of living in the community either in supportive or independent settings, and does not require intensive supervision or very frequent contact in order to access needed services 2. Low risk of harm to self and others 3. Moderate or less functional impairment as evidenced by at least one of the following: a. Troubled significant relationships but impulsive or abusive behaviors are under control b. Appearance and hygiene are below usual standards on a frequent basis

	c. Serious disturbances in vegetative activities but not serious threat to health d. Neglect or avoidance on some occasions of ability to fulfill social or vocational responsibilities and obligations e. Deficits in interpersonal relationships but able to engage in socially constructive activities f. Recent stabilization has been achieved through structured and/or protected setting 4. Either there is no co-morbidity or, if a medical or substance abuse problem exists, the problem may not adversely affect, or be adversely affected, by the presenting disorder to the extent that it may require medical monitoring 5. Consumer's environment may be moderately stressful with limited or few supports but more intensive intervention is not necessary in order for consumer to access needed services and supports 6. Treatment and recovery history supports this level of case management as evidenced by one of the following: a. Most symptoms are controlled but intensive or repeated interventions were required b. Recovery has been managed for moderate periods of time with limited support or structure 7. Consumer has shown positive engagement in treatment and has some recognition/responsibility for illness and recovery
Continued Stay Criteria	**Meets all of the following:** 1. Continues to meet initial criteria 2. In order to maintain current community stability, requires this level of service at least 1 time per month, face-to-face contact with case manager 3. There is documented evidence that consumer is showing stabilization/improvements in the areas of functional status, increased environmental supports, and engagement to reasonably conclude that continued services at this level will further stabilize/increase consumer's functioning
Discharge Criteria	**Meets one of the following:** 1. Service no longer needed due to all of the following a. Functional stability has been maintained in the current community setting in the past 12 months b. In order to maintain current community stability, requires less than 1 time per month face-to-face contact with a similar service 2. Consumer is in inpatient facility with expectation of stay to exceed 90 days 3. Consumer is in specialized treatment service that

	incorporates case management services **4. Consumer refuses case management services at this level**
Service Exclusions	**No other case management service would be appropriate while consumer is receiving this service.**
Clinical Exclusion	**Consumers who require inpatient services or who are in specialized treatment services as a result of discharge from inpatient. Consumers who can maintain functioning with less intensive case management interventions or who show increased risk factors for harm or hospitalization would not be appropriate.**

CARE COORDINATION
Effective Date 09/03/02

Care Coordination is the least intensive level of case management services and is a recovery maintenance and health management service. The consumer is receiving at least one other service arranged for or provided by the Division. Case management services are not routinely needed or provided due to consumer's ability to access needed services or due to stable and natural supports that serve as case managers for the consumer in the community.

Care coordination services are authorized to include all clinic based treatment services. Units of authorization include case management, psychiatric evaluations, medication review with psychotherapy, intramuscular therapy, individual therapy, group therapy, somatic treatment, family therapy (with consumer), family therapy (without consumer), pharmacological management, and clinical visit by nurses.

Care coordination is normally provided by any professional member of the clinic staff. This service assures that the consumer continues to have an individual Master Treatment Plan, is accessing needed services, and is maintaining current level of functioning in the community while receiving clinic or other service(s) arranged for or provided by the Division.

Face-to-face consumer contact by the designated care coordinator occurs at least once every three months.

Level Of Care	LOCUS Level 1
Population Focus	Adults who are registered and eligible for Adult Mental Health Division services who meet the following criteria
Initial Authorization	Unit-15 minutes; 35 units; 365 days
Re-Authorization	Unit-15 minutes; 35 units; 365 days
Admission Criteria	Meets all of the following criteria: 1. Consumer is capable of living in the community either in supportive or independent settings, and does not require frequent contact in order to access needed services 2. Low risk of harm to self and others 3. Mild or less functional impairment as evidenced by at least one of the following: a. Meaningful/satisfying relationship are maintained although there may be some mild conflict and hostility in relationships b. Minor disruptions in self care or usual activities c. Minor difficulties in social role functioning and meeting social/vocational responsibilities d. Significant improvements have followed a period of deterioration 4. Either there is no co-morbidity or, if a medical or substance abuse problem exists, the problem does not adversely affect, or be adversely affected, by the presenting disorder 5. There are sufficient supports in the environment to address

	routine needs **6. There has been significant response to treatment and recovery management for moderate periods of time**
Continued Stay Criteria	**Meets all of the following:** **1. Continues to meet initial criteria** **2. In order to maintain current community stability, requires this level of service at least 1 time every 3 months by designated care coordinator** **3. There is documented evidence that consumer is showing stabilization/improvements in the areas of functional status, environmental supports, and engagement to reasonably conclude that continued services at this level will continue stabilization or will increase consumer's functioning**
Discharge Criteria	**Meets one of the following:** **1. Service no longer needed due to all of the following** **a. Functional stability has been maintained in the current community setting in the past 24 months** **b. In order to maintain current community stability, requires less than 1 time every 3 months face-to-face contact with a similar service** **2. Consumer is in inpatient facility with expectation of stay to exceed 90 days** **3. Consumer is in specialized treatment service that incorporates case management services** **4. Consumer refuses case management services at this level**
Service Exclusions	**No other case management service would be appropriate while consumer is receiving this service.**
Clinical Exclusion	**Consumers who require inpatient services or who are in specialized treatment services as a result of discharge from inpatient. Consumers who show increased risk factors for harm or hospitalization would not be appropriate.**

Attachment H

Dual Diagnosis Philosophy and Treatment Guidelines

Comprehensive, Continuous, Integrated System of Care Model

By Kenneth Minkoff, M.D.

The eight research-derived and consensus-derived principles that guide the implementation of the CCISC are as follows:

1. *Dual diagnosis is an expectation, not an exception:* Epidemiologic data defining the high prevalence of comorbidity, along with clinical outcome data associating individuals with co-occurring psychiatric and substance disorders ("ICOPSD") with poor outcomes and high costs in multiple systems, imply that the whole system, at every level, must be designed to use all of its resources in accordance with this expectation. This implies the need for an integrated system planning process, in which each funding stream, each program, all clinical practices, and all clinician competencies are designed proactively to address the individuals with co-occurring disorders who present in each component of the system already.

2. *All ICOPSD are not the same; the national consensus four quadrant model for categorizing co-occurring disorders (NASMHPD, 1998) can be used as a guide for service planning on the system level.* In this model, ICOPSD can be divided according to high and low severity for each disorder, into high-high (Quadrant IV), low MH – high SA (Quadrant III), high MH – low SA (Quadrant II), and low-low (Quadrant I). High MH individuals usually have SPMI and require continuing integrated care in the MH system. High SA individuals are appropriate for receiving episodes of addiction treatment in the SA system, with varying degrees of integration of mental health capability.

3. *Empathic, hopeful, integrated treatment relationships are one of the most important contributors to treatment success in any setting; provision of continuous integrated treatment relationships is an evidence based best practice for individuals with the most severe combinations of psychiatric and substance difficulties.* The system needs to prioritize a) the development of clear guidelines for how clinicians in any service setting can provide integrated treatment in the context of an appropriate scope of practice, and b) access to continuous integrated treatment of appropriate

intensity and capability for individuals with the most complex difficulties.

4. *Case management and care must be balanced with empathic detachment, expectation, contracting, consequences, and contingent learning for each client, and in each service setting.* Each individual client may require a different balance (based on level of functioning, available supports, external contingencies, etc.); and in a comprehensive service system, different programs are designed to provide this balance in different ways. Individuals who require high degrees of support or supervision can utilize contingency based learning strategies involving a variety of community based reinforcers to make incremental progress within the context of continuing treatment.

5. *When psychiatric and substance disorders coexist, both disorders should be considered primary, and integrated dual (or multiple) primary diagnosis-specific treatment is recommended.* The system needs to develop a variety of administrative, financial, and clinical structures to reinforce this clinical principle, and to develop specific practice guidelines emphasizing how to integrate diagnosis-specific best practice treatments for multiple disorders for clinically appropriate clients within each service setting

6. *Both mental illness and addiction can be treated within the philosophical framework of a "disease and recovery model" (Minkoff, 1989) with parallel phases of recovery (acute stabilization, motivational enhancement, active treatment, relapse prevention, and rehabilitation/recovery), in which interventions are not only diagnosis-specific, but also specific to phase of recovery and stage of change.* Literature in both the addiction field and the mental health field has emphasized the concept of stages of change or stages of treatment, and demonstrated the value of stagewise treatment (Drake et al, 2001.)

7. *There is no single correct intervention for ICOPSD; for each individual interventions must be individualized according to quadrant, diagnoses, level of functioning, external constraints or supports, phase of recovery/stage of change, and (in a managed care system) multidimensional assessment of level of care requirements.* This principle forms the basis for developing clinical practice guidelines for assessment and treatment matching. It also forms the basis for designing the template of the CCISC, in which

each program is a dual diagnosis program, but all programs are not the same. Each program in the system is assigned a "job": to work with a particular cohort of ICOPSD, providing continuity or episode interventions, at a particular level of care. Consequently, all programs become mobilized to develop cohort specific dual diagnosis services, thereby mobilizing treatment resources throughout the entire system.

8. *Clinical outcomes for ICOPSD must also be individualized, based on similar parameters for individualizing treatment interventions.* Abstinence and full mental illness recovery are usually long term goals, but short term clinical outcomes must be individualized, and may include reduction in symptoms or use of substances, increases in level of functioning, increases in disease management skills, movement through stages of change, reduction in "harm" (internal or external), reduction in service utilization, or movement to a lower level of care. Systems need to develop clinical practice parameters for treatment planning and outcome tracking that legitimize this variety of outcome measures to reinforce incremental treatment progress and promote the experience of treatment success.

Attachment I

Comprehensive, Continuous, Integrated System of Care Model by Kenneth Minkoff, M.D.

DUAL DIAGNOSIS
PHILOSOPHY AND TREATMENT GUIDELINES

GUIDING PRINCIPLES:

- We agree that psychiatric and substance disorders tend to be persistent and recurrent, and that co-occurrence of these disorders occurs with sufficient frequency in both systems that a continuous and integrated approach to assessment and treatment is required.
- We agree that individuals with co-occurring serious and persistent mental illness and substance disorders should be regarded as having two (or more) co-occurring primary disorders, each of which requires specific assessment and diagnosis, and appropriately intensive treatment. The presence of co-occurring disorders makes each disorder more difficult to treat.
- We agree that the recommended treatment approach for individuals with co-occurring serious and persistent mental illness and substance disorders is an integrated dual primary treatment in which:
    - Each individual has a primary treatment relationship with a clinician, or team of clinicians.
    - Each individual receives specific, and appropriately intensive, primary treatment for each disorder that takes into account the complications resulting from the co-occurring disorder.
    - Each individual receives integrated and coordinated treatment for both disorders in a single setting.
- We agree that because the underlying goal of working together is to improve consumer outcomes, any successful program must be consumer-centered. A consumer-centered system is one in which dual diagnosis consumers and their families are actively involved, not only in treatment decisions, but also in program design, administration and evaluation. The role of consumers in advancing care for people with serious and persistent mental illness should be the cornerstone in program planning.

TREATMENT PHILOSOPHY:

- Serious, persistent psychiatric disorders and substance disorders are both examples of primary psychiatric or behavioral illness that can utilize a disease and recovery model for conceptualizing assessment, treatment, and rehabilitation.
- The program must incorporate the recovery model. Recovery is defined as an ongoing personal process of empowerment by which an individual overcomes the negative impact of a psychiatric disability (and other co-occurring disabilities), regains hope, self-esteem, self-worth, pride, dignity and meaning by acquiring increasing ability to maintain stabilization or remission of the disorder, and maximizing functioning with appropriate supports despite the possible ongoing constraints of the disorder.
- Every individual, regardless of the severity and disability associated with each disorder, is entitled to experience the promise and hope of dual recovery, and considered to have the potential to achieve dual recovery.

- Bringing optimism to the treatment process creates consumer motivation. Treatment success derives from the implementation of an empathic, hopeful, continuous treatment relationship, which takes place over time and often in multiple treatment episodes.

PSYCHOPHARMACOLOGY GUIDELINES:

- Initial psychopharmacologic evaluation in mental health should not require consumers to be abstinent.
- Initial psychopharmacologic evaluation in substance disorder treatment should occur as early in treatment as possible, and incorporate capacity to maintain existing non-addictive psychotropic medication during detoxification and early recovery.
- Psychopharmacology with individuals with co-occurring disorders is not an absolute science. It is best performed in the context of an ongoing, empathic clinical relationship. Treatment should emphasize a continuous re-evaluation of diagnosis and medication, and artful utilization of medication strategies to promote outcome of both disorders.

The applicant must have expertise in Best Practices and Evidenced Based Practices in the area of treatment for individuals with serious and persistent mental illness and a co-occurring substance use disorder defined in the literature by a variety of authors, including but not limited to, Robert E. Drake, Ken Minkoff, JO Prochaska. The applicant shall also provide a listing of verifiable experience with projects or contracts for the most recent five years that are pertinent to the proposed services.

Attachment J

Treatment Services Definitions

Diagnostic/Functional Assessment. Intensive clinical and functional evaluation which results in a treatment plan that documents and identifies needed services and supports, goals and objectives related to the provision of these services and supports, and methods for achieving the objectives. Required components include: (1) evidence that an interdisciplinary team process was conducted; (2) evidence of consumer participation including families and/or guardians where required; (3) assessment of a person's psychological, neuropsychological, psychiatric, psychosocial, and physical health (including nutrition) associated with a person's mental health, as well as conducting a risk and developmental assessment; and (4) periodic review of the treatment plan which shall occur no less frequently than every ninety (90) days. This service also includes the assessment of the need for psychiatric hospitalization for persons being referred to psychiatric inpatient services to assure less restrictive alternatives are considered and evaluated when appropriate.

Biopsychosocial Rehabilitative Programs. A set of therapeutic and rehabilitative social skill building services which promotes resiliency and recovery and which allows children with serious emotional or behavioral disturbance and adults with serious mental illness to gain the necessary social, independent living, work-related, and communication skills necessary to allow them to remain in or return to communities of their choice and access naturally occurring community supports. Services include, but are not limited to: individual or group skill building activities that focus on the development of problem-solving techniques, independent living skills, social skills, medication management, and recreational activities that improve self-esteem.

Crisis Management. This service provides mobile assessment for children or adults in an active state of crisis twenty-four (24) hours per day, seven (7) days per week and can occur in a variety of settings including the consumer's home, local emergency departments, etc. It does not include transportation time to and from clinic/hospital and community settings. Immediate response is provided to conduct a thorough assessment of risk, mental status, and medical stability, explore service options in the community, and assure immediate crisis resolution and de-escalation as applicable. The presenting crisis situation is one where it is medically necessary to deliver the services in the consumer's home or natural environment setting as the consumer does not have the resources to present at the clinic for crisis services.

Licensed Crisis Residential Services. This service offers short-term, acute interventions to individuals experiencing crisis. This is a structured residential alternative or diversion from psychiatric inpatient hospitalization. Licensed Crisis Residential Services are for individuals who are experiencing a period of acute stress that significantly impairs the capacity to cope with normal life circumstances. The program provides psychiatric services that address the psychiatric, psychological, and behavioral health needs of the individuals. Specific services are: psychiatric medical assessment, crisis stabilization and intervention, medication management and monitoring, individual, group and/or family counseling, daily living skills training, and linkage to other services, as needed.

Counseling and Psychotherapy Services. Individual, group or family face-to-face services include symptom/behavior management, development, restoration, or enhancement of adaptive behaviors and skills, enhancement or maintenance of daily living skills. These skills include those necessary to access community resources and support systems, interpersonal skills, and restoration or enhancement of the family unit and/or support of the family.

Medication/Somatic Treatment. Medical interventions include: physical examinations; prescription, supervision or administration of psychoactive medications; monitoring of diagnostic studies; and medical interventions needed for effective mental health treatment provided as either an individual or group intervention. Activities include promoting compliance, evaluating the clinical effectiveness of the medication, monitoring and treating the side effects of medication and any adverse reactions, and providing education and direction for symptom and medication self-management. Group treatment is always therapeutic, educational, and interactive with a strong emphasis on group member selection, peer interaction, and support as specified in the treatment plan.

Assertive Community Treatment (ACT). ACT is an intensive case management community service for adults discharged from the state or community hospitals after multiple or extended stays. Intensive, integrated rehabilitative, crisis, treatment, and community support services provided by an interdisciplinary staff team is available twenty-four (24) hours per day, seven (7) days per week. Services offered by the ACT team must be documented in a treatment plan and must include (in addition to those provided by other systems): some medication prescription, administration, and monitoring medication and self medication; crisis assessment and intervention; symptom assessment, management, and individual supportive therapy; substance abuse and co-occurring disorders treatment; psychosocial rehabilitation and skill development; personal, social, and interpersonal skill training; consultation, education, and support for individuals, families, and their support systems; representative payee and money management; and general client support services.

Intensive Case Management. This is an intensive community rehabilitation service for adults at-risk of hospitalization, or for crisis residential or high acuity substance abuse services. Treatment and restorative interventions assist individuals to gain access to necessary services to reduce psychiatric and addiction symptoms and to develop optimal community living skills. Services can be provided by a team or an individual case manager and documented in a treatment plan. Services provided by the intensive case management team or individual include: assistance and support for the individuals in crisis situations; service coordination; consultation, education, and support for individuals, families, and their support systems; individual restorative interventions for the development of interpersonal, community coping, and independent living skills; development of symptom monitoring and management skills; medication prescription, administration, and monitoring medication and self medication; representative payee and money management; and treatment for substance abuse or other co-occurring disorders.

Screening. Determination of an individual's need and eligibility for psychiatric services, as well as registration for psychiatric evaluation and treatment.

Targeted Case Management. The least intensive model of case management and it is generally used in conjunction with at least one additional community mental health service. Interventions employed to assist eligible individuals in gaining access to needed medical services, including psychiatric, social, educational, vocational, and other services. Services include, but are not limited to, maintenance of a supportive relationship to assist with problem solving and development of necessary skills to sustain recovery; regular contact for the purpose of assessing or reassessing needs for planning or monitoring services; contact with collaterals (family and agency) to mobilize services and provide support and education; advocacy on behalf of the individual; coordination of services specified in the plan, such as medication management and rehabilitation activities; and some limited crisis intervention.

Treatment Planning. Development of a comprehensive, individualized document specifying treatment modalities and interventions to be provided for the consumer that is approved by a licensed psychiatrist, licensed psychologist, or licensed advanced psychiatric practice nurse. The plan is derived from the assessment and includes:

1. DSM – IV, five axes diagnoses;
2. Signs and symptoms expressed in measurable terms;
3. Specification of needs or problems which are barriers to consumer's enhancement of independent psychosocial functioning;
4. Integration of consumer's preferences, expectations, strengths, and expressed goals;
5. Clearly stated measurable, output performance, and outcome measurements;
6. Intervention and treatment methods which specifically address identified needs or problems;
7. Identification of staff, community supports, other professionals responsible for treatment or interventions;
8. Medications prescribed;
9. A prognosis expressed in expected length of stay in current level of care.

Licensed psychiatrists shall approve treatment plans for consumers who have prescribed medications. Licensed psychologists and licensed advanced practice psychiatric nurses may approve treatment plans for consumers who have not been prescribed medications. There should be some cooperation between all three on all treatment plans in case some consumers have unidentified needs.

Supported Housing Program. This program provides housing for persons who are able to live in the community with appropriate supports. This type of housing is directed to those individuals who desire, and are capable of, living independently with flexible tailored services in accordance with their needs. Services are provided, with prior authorization from the Adult Mental Health Division ("DIVISION"), to targeted consumers and include, but are not limited to, assisting consumers in search of housing,

developing and sustaining working relationships with local landlords and property managers, working collaboratively with DIVISION-designated case managers regarding consumer/tenant status, and assisting consumers/tenants in meeting tenancy requirements under the Supported Housing Program.

Pharmaceuticals. As defined in Chapter 10 of the Medicaid Provider's Manual, "pharmacy services as allowed by the Medicaid program pays for medically necessary and non-experimental drugs and pharmacy services with certain limitations." The dispensement and drug formulary shall be in accordance with the guidelines as specified in Chapter 19 of the Medicaid Provider Manual Pharmacy Services (Date issued: November 15, 2001; Date revised: November 5, 2001).

Medical Supplies. As defined in Chapter 10 of the Medicaid Provider Manual, "durable medical equipment, prosthetic and orthotic devices and medical supplies (DMEPOS) include medically necessary equipment/appliances/items provided either through purchase or rental and prescribed by a physician for the maximum reduction of medical disability and for the restoration or maximum improvement in the patient's functional level."

Ancillary Services. Not considered as a main part of a patient's treatment milieu. Services are regarded as supportive services which may include durable medical equipment and medical supplies, as defined in Chapter 10 of the Medicaid Provider Manual.

Attachment K

Certifications

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub- grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about--
   (1) The dangers of drug abuse in the workplace;
   (2) The grantee's policy of maintaining a drug-free workplace;
   (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
   (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   (1) Abide by the terms of the statement; and
   (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical an mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
APPLICANT ORGANIZATION	DATE SUBMITTED

Attachment L

Form SPO-H-205A
Instructions

Instructions for Completing
FORM SPO-H-205A ORGANIZATION - WIDE BUDGET BY SOURCE OF FUNDS

Applicant/Provider:	Enter the Applicant's legal name.
RFP#:	Enter the Request For Proposal (RFP) identifying number of this service activity.
For all columns (a) thru (d)	Report your total organization-wide budget for this fiscal year by **source of funds**. Your organization's budget should reflect the total budget of the "organization" legally named. Report each source of fund in separate columns, by budget line item. For the first column on the first page of this form, use the column heading, "Organization Total". For the remaining columns you may use column headings such as: Federal, State, Funds Raised, Program Income, etc. If additional columns are needed, use additional copies of this form.
Columns (b), (c) & (d)	Identify sources of funding in space provided for column titles.
TOTAL (A+B+C+D)	Sum the subtotals for Budget Categories A, B, C and D, for columns (a) through (d).
SOURCE OF FUNDING: **(a)** **(b)** **(c)** **(d)**	Identify all sources of funding to be used by your organization.
TOTAL REVENUE	Enter the sum of all revenue sources cited above.
Budget Prepared by:	Type or print the name of the person who prepared the budget request and their telephone number. If there are any questions or comments, this person will be contacted for further information and clarification. Provide signature of Applicant's authorized representative, and date of approval.

Special Instructions by the State Purchasing Agency:

Provide a budget by source of funds for this specific service activity.