

State of Hawaii  
Department of Health  
Adult Mental Health Division

**Request for Proposals**

**RFP No. HTH 420-2-16  
Crisis Services – Statewide  
(excluding the island of Kauai)**

Date Issued  
August 17, 2015

Date Due  
September 16, 2015

*Note: It is the applicant's responsibility to check the public procurement notice website, the request for proposals website, or to contact the RFP point-of-contact identified in the RFP for any addenda issued to this RFP. The State shall not be responsible for any incomplete proposal submitted as a result of missing addenda, attachments or other information regarding the RFP.*

August 17, 2015

**REQUEST FOR PROPOSALS**

**CRISIS SERVICES, STATEWIDE  
(excluding the island of Kauai)**

**RFP No. HTH 420-2-16**

The Department of Health, Adult Mental Health Division (“DIVISION”), is requesting proposals from qualified applicants to provide Crisis Services, statewide, excluding the island of Kauai. The contract term shall be from December 1, 2015 through November 30, 2016. Multiple contracts may be awarded under this request for proposals.

Proposals shall be mailed, postmarked by the United State Postal Service on or before September 16, 2015, and received no later than 10 days from the submittal deadline. Hand delivered proposals shall be received no later than 2:00 p.m., Hawaii Standard Time (“HST”), on September 16, 2015, at the drop-off site 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 DIVISION will conduct an orientation on Tuesday, August 25, 2015, from 10:00 a.m. to 12:00 p.m., HST at Honolulu, Hawaii. All prospective applicants are encouraged to attend the orientation. Teleconferencing capability will be provided for interested out-of-state or neighbor island organizations/agencies. Please call (808) 586-8281 or (808) 586-8282 for more information by Thursday, August 20, 2015.

The deadline for submission of written questions is 2:00 p.m., HST on Friday, August 28, 2015. All written questions shall receive a written response from the State on or about Wednesday, September 2, 2015.

Any inquiries and requests regarding this RFP should be directed to Ms. Enid Kagesa, at 1250 Punchbowl Street, Room 256, Honolulu, Hawaii 96813, telephone: (808) 586-8282, fax: (808) 586-4745, email: [enid.kagesa@doh.hawaii.gov](mailto:enid.kagesa@doh.hawaii.gov).

## PROPOSAL MAIL-IN AND DELIVERY INFORMATION SHEET

**NUMBER OF COPIES TO BE SUBMITTED: 4  
THE 4 COPIES MUST INCLUDE ONE (1) SIGNED ORIGINAL AND  
ONE (1) SINGLE SIDED, UNBOUND COPY.**

ALL MAIL-INS SHALL BE POSTMARKED BY THE UNITED STATES POSTAL SERVICE  
(USPS) NO LATER THAN

**September 16, 2015**

**and received by the state purchasing agency no later than 10 days from the submittal  
deadline.**

**All Mail-ins**

Department of Health  
Adult Mental Health Division  
P.O. Box 3378  
Honolulu, Hawaii 96801-3378

**DOH RFP Contact Person**

Ms. Enid Kagesa  
For further info. or inquiries  
Phone: 586-8282  
Fax: 586-4745

ALL HAND DELIVERIES SHALL BE ACCEPTED AT THE FOLLOWING SITES UNTIL  
**2:00 P.M., Hawaii Standard Time ("HST"), September 16, 2015.** Deliveries by private mail  
services such as FEDEX shall be considered hand deliveries. Hand deliveries shall not be  
accepted if received after **2:00 p.m., September 16, 2015.**

**Drop-off Site**

**Oahu:**

Department of Health  
Adult Mental Health Division  
1250 Punchbowl Street, Room 256  
Honolulu, Hawaii

**BE ADVISED:** All mail-ins postmarked by USPS after **September 16, 2015**, shall be  
rejected.

Deliveries by private mail services such as FEDEX shall be considered  
hand deliveries. Hand deliveries shall not be accepted if received after  
**2:00 p.m., HST, September 16, 2015.**

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# **Section 1**

# **Administrative Overview**

# Section 1

## Administrative Overview

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

### 1.1 Procurement Timetable

**Note that the procurement timetable represents the State's best estimated schedule. If an activity on this schedule is delayed, the rest of the schedule will likely be shifted by the same number of days. Contract start dates may be subject to the issuance of a notice to proceed.**

Activity	Scheduled Date
Public notice announcing Request for Proposals (RFP)	08/17/15
Distribution of RFP	08/17/15
RFP orientation session	08/25/15
Closing date for submission of written questions for written responses	08/28/15
State purchasing agency's response to applicants' written questions	09/02/15
Discussions with applicant prior to proposal submittal deadline (optional)	TBD
Proposal submittal deadline	09/16/15
Discussions with applicant after proposal submittal deadline (optional)	TBD
Final revised proposals (optional)	TBD
Proposal evaluation period	09/18/15 -- 10/15/15
Provider selection	10/16/15
Notice of statement of findings and decision	10/16/15
Contract start date	12/01/15

## 1.2 Website Reference

Item	Website
1 Procurement of Health and Human Services	<a href="http://spo.hawaii.gov/for-vendors/vendor-guide/methods-of-procurement/health-human-services/competitive-purchase-of-services-procurement-method/cost-principles-table-hrs-chapter-103f-2/">http://spo.hawaii.gov/for-vendors/vendor-guide/methods-of-procurement/health-human-services/competitive-purchase-of-services-procurement-method/cost-principles-table-hrs-chapter-103f-2/</a>
2 RFP website	<a href="http://hawaii.gov/spo2/health/rfp103f/">http://hawaii.gov/spo2/health/rfp103f/</a>
3 Hawaii Revised Statutes (HRS) and Hawaii Administrative Rules (HAR) for Purchases of Health and Human Services	<a href="http://spo.hawaii.gov">http://spo.hawaii.gov</a> Click on the "References" tab.
4 General Conditions, AG-103F13	<a href="http://hawaii.gov/forms/internal/department-of-the-attorney-general/ag-103f13-1/view">http://hawaii.gov/forms/internal/department-of-the-attorney-general/ag-103f13-1/view</a>
5 Forms	<a href="http://spo.hawaii.gov">http://spo.hawaii.gov</a> Click on the "Forms" tab.
6 Cost Principles	<a href="http://spo.hawaii.gov">http://spo.hawaii.gov</a> Search: Keywords "Cost Principles"
7 Protest Forms/Procedures	<a href="http://spo.hawaii.gov/for-vendors/vendor-guide/protests-for-health-and-human-services/">http://spo.hawaii.gov/for-vendors/vendor-guide/protests-for-health-and-human-services/</a>
8 Hawaii Compliance Express (HCE)	<a href="http://spo.hawaii.gov/hce/">http://spo.hawaii.gov/hce/</a>
9 Hawaii Revised Statutes	<a href="http://capitol.hawaii.gov/hrscurrent">http://capitol.hawaii.gov/hrscurrent</a>
10 Department of Taxation	<a href="http://tax.hawaii.gov">http://tax.hawaii.gov</a>
11 Department of Labor and Industrial Relations	<a href="http://labor.hawaii.gov">http://labor.hawaii.gov</a>
12 Department of Commerce and Consumer Affairs, Business Registration	<a href="http://cca.hawaii.gov">http://cca.hawaii.gov</a> click "Business Registration"
13 Campaign Spending Commission	<a href="http://ags.hawaii.gov/campaign/">http://ags.hawaii.gov/campaign/</a>
14 Internal Revenue Service	<a href="http://www.irs.gov/">http://www.irs.gov/</a>
<b>(Please note: website addresses may change from time to time. If a State link is not active, try the State of Hawaii website at <a href="http://hawaii.gov">http://hawaii.gov</a>)</b>	

## 1.3 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.

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.

## 1.4 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 provider 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.

## 1.5 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:

Department of Health  
Adult Mental Health Division  
1250 Punchbowl Street, Room 256  
Honolulu, Hawaii 96813  
Telephone: (808) 586-8282  
Facsimile: (808) 586-4745

## 1.6 RFP Point-of-Contact

From the release date of this RFP until the selection of the successful provider(s), any inquiries and requests shall be directed to the sole point-of-contact identified below.

Ms. Enid Kagesa  
Telephone: (808) 586-8282  
Facsimile: (808) 586-4745  
Email: [enid.kagesa@doh.hawaii.gov](mailto:enid.kagesa@doh.hawaii.gov)

## 1.7 Orientation

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

Date: Tuesday, August 25, 2015 Time: 10:00 a.m. – 12:00 p.m.

Location: Department of Health, Adult Mental Health Division  
1250 Punchbowl Street, Kinau Hale Building  
Second Floor Conference Room, Room 205  
Honolulu, Hawaii 96813

Teleconferencing capability will be provided for interested out-of-state and neighbor island organizations/agencies. Please call (808) 586-8281 or (808) 586-8282 for more information by Thursday, August 20, 2015.

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 subsection 1.8, Submission of Questions.

## 1.8 Submission of Questions

Applicants may submit questions to the RFP point-of-contact identified in Section 1.6. Written questions should be received by the date and time specified in Section 1.1 Procurement Timetable. The purchasing agency will respond to written questions by way of an addendum to the RFP.

Deadline for submission of written questions:

Date: August 28, 2015 Time: 2:00 p.m. HST

State agency responses to applicant written questions will be provided by:

Date: September 2, 2015

## 1.9 Submission of Proposals

- A. Forms/Formats** - Forms, with the exception of program specific requirements, may be found on the State Procurement Office website referred to in subsection 1.2, Website Reference. Refer to the Section 5, Proposal Application Checklist for the location of program specific forms.
- 1. Proposal Application Identification (Form SPO-H-200).** Provides applicant proposal identification.
  - 2. Proposal Application Checklist.** The checklist provides applicants specific program requirements, reference and location of required RFP proposal forms, and the order in which all proposal components should be collated and submitted to the state purchasing agency. The Proposal Application Checklist is located in Section 5, Attachment A.
  - 3. Table of Contents.** A sample table of contents for proposals is located in Section 5, Attachment B. 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 address all proposal requirements specified in Section 3, Proposal Application Instructions, including a cost proposal/budget, if required.
- B. Program Specific Requirements.** Program specific requirements are included in Sections 2 and 3, as applicable. Required Federal and/or State certifications are listed on the Proposal Application Checklist in Section 5.
- C. Multiple or Alternate Proposals.** Multiple or alternate proposals shall not be accepted unless specifically provided for in Section 2. 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. Provider Compliance.** All providers shall comply with all laws governing entities doing business in the State
- **Tax Clearance.** Pursuant to HRS §103-53, as a prerequisite to entering into contracts of \$25,000 or more, providers are required to have a tax clearance certificate from DOTAX and the Internal Revenue Service (“IRS”). Refer to Section 1.2, Website Reference for DOTAX and IRS website address.

- **Labor Law Compliance.** Pursuant to HRS § 103-55, providers shall be in compliance with all applicable laws of the federal and state governments relating to workers' compensation, unemployment compensation, payment of wages, and safety. Refer to Section 1.2, Website Reference for the Department of Labor and Industrial Relations ("DLIR") website address.
- **Business Registration.** Prior to contracting, owners of all forms of business doing business in the state except sole proprietorships, charitable organizations, unincorporated associations and foreign insurance companies shall be registered and in good standing with the Department of Commerce and Consumer Affairs ("DCCA"), Business Registration Division. Foreign insurance companies must register with DCCA, Insurance Division. More information is on the DCCA website. Refer to Section 1.2, Website Reference, for HCE's website address.)

Providers may register with Hawaii Compliance Express (HCE) for online compliance verification from the DOTAX, IRS, DLIR, and DCCA. There is a nominal annual registration fee (currently \$12) for the service. The HCE's online "Certificate of Vendor Compliance" provides the registered provider's current compliance status as of the issuance date, and is accepted for both contracting and final payment purposes. Refer to Section 1.2, Website Reference for HCE's website address.

Providers not utilizing the HCE to demonstrate compliance shall provide paper certificates to the purchasing agency. All applications for applicable clearances are the responsibility of the providers. All certificates must be valid on the date it is received by the purchasing agency. The tax clearance certificate shall have an original green certified copy stamp and shall be valid for six months from the most recent approval stamp date on the certificate. The DLIR certificate is valid for six months from the date of issue. The DCCA certificate of good standing is valid for six months from date of issue.

- E. Wages Law Compliance.** If applicable, by submitting a proposal, the applicant certifies that the applicant is in compliance with HRS §103-55, Wages, hours, and working conditions of employees of contractors performing services. Refer to Section 1.2, Website Reference for statutes and DLIR website address.
- F. Campaign Contributions by State and County Contractors.** HRS §11-355 prohibits campaign contributions from certain State or county government contractors during the term of the contract if the contractors are paid with funds appropriated by a legislative body. Refer to Section 1.2, Website Reference for statutes and Campaign Spending Commission website address.

- G. Confidential Information.** If an applicant believes any portion of a proposal contains information that should be withheld as confidential, the applicant shall request in writing nondisclosure of designated proprietary data to be confidential and provide justification to support confidentiality. Such data shall accompany the proposal, be clearly marked, and shall be readily separable from the proposal to facilitate eventual public inspection of the non-confidential sections of the proposal.

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.*

- H. Proposal Submittal.** All mail-ins shall be postmarked by the United States Postal System (“USPS”) and received by the State purchasing agency no later than the submittal deadline indicated on the attached Proposal Mail-In and Delivery Information Sheet, or as amended. All hand deliveries shall be received by the State purchasing agency by the date and time designated on the Proposal Mail-In and Delivery Information Sheet, or as amended. Proposals shall be rejected when:

1. Postmarked after the designated date; or
2. Postmarked by the designated date but not received within 10 days from the submittal deadline; or
3. If hand delivered, received after the designated date and time.

The number of copies required is located on the Proposal Mail-In and Delivery Information Sheet. Deliveries by private mail services such as FEDEX shall be considered hand deliveries and shall be rejected if received after the submittal deadline. Dated USPS shipping labels are not considered postmarks.

Faxed proposals and/or submission of proposals on diskette/CD or transmission by e-mail, website, or other electronic means is not permitted.

## **1.10 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 HAR §3-143-403.

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

### **1.11 Opening of Proposals**

Upon the state purchasing agency's receipt of a proposal 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.

### **1.12 Additional Materials and Documentation**

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

The 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.

### **1.13 RFP Amendments**

The State reserves the right to amend this RFP at any time prior to the closing date for final revised proposals.

### **1.14 Final Revised Proposals**

If requested, final revised proposals shall be submitted in the manner, and by the date and time specified by the state purchasing agency. If a final revised proposal is not submitted, the previous submittal shall be construed as the applicant's final revised 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.

### **1.15 Cancellation of Request for Proposal**

The RFP 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 interest of the State.

### **1.16 Costs for Proposal Preparation**

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

### **1.17 Provider Participation in Planning**

Provider(s), awarded a contract resulting from this RFP,

are required

are not required

to participate in the purchasing agency's future development of a service delivery plan pursuant to HRS §103F-203.

Provider participation in a state purchasing agency's efforts to plan for or to purchase health and human services prior to the release of a RFP, 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 HAR §§3-142-202 and 3-142-203.

### **1.18 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:

- (1) Rejection for failure to cooperate or deal in good faith. (HAR §3-141-200)

- (2) Rejection for inadequate accounting system. (HAR §3-141-202)
- (3) Late proposals (HAR §3-143-603)
- (4) Inadequate response to request for proposals (HAR §3-143-609)
- (5) Proposal not responsive (HAR §3-143-610(a)(1))
- (6) Applicant not responsible (HAR §3-143-610(a)(2))

### **1.19 Notice of Award**

A statement of findings and decision shall be provided to each responsive and responsible applicant 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 provider(s) awarded a contract 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.

The DIVISION reserves the right to review any applicant's 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 (2) weeks beginning two (2) 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 and provider contracts, fiscal operations, and other areas specified prior to review.

## 1.20 Protests

Pursuant to HRS §103F-501 and HAR Chapter 148, an applicant aggrieved by an award of a contract may file a protest. The Notice of Protest form, SPO-H-801, and related forms are available on the SPO website. Refer to Section 1.2, Website Reference for website address. 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 postmarked by USPS or hand delivered to 1) the head of the state purchasing agency conducting the protested procurement and 2) the procurement officer who is conducting the procurement (as indicated below) within five (5) 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.

<b>Head of State Purchasing Agency</b>	<b>Procurement Officer</b>
Name: Virginia Pressler, M.D.	Name: Amy Yamaguchi
Title: Director of Health	Title: Administrative Officer, Adult Mental Health Division
Mailing Address: P.O. Box 3378, Honolulu, Hawaii 96801-3378	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

## 1.21 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 HRS Chapter 37, and subject to the availability of State and/or Federal funds.

## 1.22 General and Special Conditions of Contract

The general conditions that will be imposed contractually are on the SPO website. Special conditions may also be imposed contractually by the state purchasing

agency, as deemed necessary. Terms of the special conditions may include, but are not limited to, the requirements as outlined in Section 5, Attachment C.

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, recommendations made by the DIVISION's technical assistance consultant, national trends, and needs of the Hawaii State Department of Health.

### **1.23 Cost Principles**

To promote uniform purchasing practices among state purchasing agencies procuring health and human services under HRS Chapter 103F, state purchasing agencies will utilize standard cost principles outlined on the SPO website. Refer to Section 1.2 Website Reference for website address. Nothing in this section shall be construed to create an exemption from any cost principle arising under federal law.

# **Section 2**

# **Service Specifications**

## 2.1 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 provider;
2. Developing the policies, regulations, and procedures to be followed under the programs administered by the DEPARTMENT;
3. Procuring, negotiating, and contracting with selected providers;
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 provider and subcontractors;
9. Reviewing and analyzing utilization of services and reports provided by the provider;
10. Handling unresolved consumer grievances and appeals with the providers;
11. Certifying Medicaid Rehabilitation Option (“MRO”) providers;
12. Authorizing and paying MRO services and claims;
13. Monitoring the financial status and billing practices of providers;
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 providers;
18. Providing consumer eligibility information to the providers; and
19. Payments to the non-Medicaid Rehabilitation Option (“MRO”) contracted providers.

### B. Planning activities conducted in preparation for this RFP

The DIVISION published a Request for Information on September 17, 2014, seeking the public’s input on the design of this service for statewide services, the

availability of potential service providers, staffing capabilities for services and culturally specific service capabilities.

**C. Description of the goals of the service**

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 goal for the Crisis Services program described in this RFP is to provide community-based interventions for individuals experiencing an episode of emotional, behavioral or psychological crisis. This is achieved through rapid response to emergent needs, assisting individuals in resolving crises in the least restrictive setting, prevention of more intensive interventions, and through assisting frequent users of crisis services in developing plans to promote their own wellness. The service components included in this program include Crisis Mobile Outreach, Crisis Support Management, Licensed Crisis Residential Service, Certified Peer Specialist support, Mental Health Emergency Worker (Hawaii and Maui counties only), and a Crisis Management Fund.

**D. Description of the target population to be served**

Adults, 18 years and older, who are experiencing an emotional, behavioral or psychological crisis.

**E. Geographic coverage of service**

Statewide, excluding the island of Kauai.

Organizations may apply for one (1) or more counties. Providers who wish to apply to provide the service array in more than one (1) county must demonstrate the ability to successfully manage and monitor services, both clinically and administratively, across distances and geographic boundaries. A multi-county provider shall need to have, or have developed prior to implementation, standardized policies and procedures across counties in order to ensure consistent application of the scopes of service.

**F. 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 funds, the amount allocated to providers who are awarded contracts may change.

The DIVISION considers itself the payer of last resort, and expects applicants to seek and obtain third party reimbursement as applicable. The DIVISION gives priority to the uninsured. (See section on Financial Requirements, Third Party Liability.)

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

1. Temporarily withhold new referrals 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 additional funds become available for similar services, the DEPARTMENT reserves the right to increase funding amounts, drawing from other possible funding sources, such as state or federal grants.

From time to time, the DIVISION may seek outside funding opportunities to transform its existing public mental health services into an improved system of care. Providers of this service may be asked to participate in these opportunities, with funding sources to include, but not be limited to, federal, state, county, and private foundations.

Competition is encouraged among as many applicants as possible.

For new providers to the DIVISION, 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 shall 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.

## **2.2 Contract Monitoring and Evaluation**

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

## **2.3 General Requirements**

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

1. The DIVISION shall require accreditation by the Commission on Accreditation of Rehabilitation Facilities (“CARF”), The Joint Commission (“TJC”), Council on Accreditation (“COA”), or by another DIVISION-approved accreditation body. Providers that are currently accredited are required to maintain accreditation throughout the contract period. Providers who are not accredited at the time of contract award, are required to achieve accreditation within two (2) years from the date of contract award and in the interim, shall meet accreditation standards. Once a Provider receives accreditation for a service, should they decide to cancel their existing accreditation, they do not qualify to receive two (2) years to achieve accreditation from another accreditation body.
2. Providers 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 provider.
3. The provider shall have within six (6) months of the contract start date, a written plan for emergency preparedness and disasters that has been accepted by their accreditation body or by the DIVISION.

4. The provider shall cooperate with the DIVISION in approved research, training, and service projects provided that such projects do not substantially interfere with the provider's service requirements as outlined in this RFP.
5. The provider shall comply with all specified, applicable DIVISION policies, procedures, directives, and the provider manual of the DIVISION.
6. The provider shall have, or develop within six (6) months of the contract start date, policies, procedures, and other documentation or tracking systems that demonstrate the services and requirements of this RFP. Whenever requested, the provider shall submit a copy of its operating policies and procedures to the DIVISION. The copy shall be provided at the provider's expense with revisions and updates as appropriate.
7. The provider shall assign staff to attend provider meetings and trainings as scheduled by the DIVISION.
8. The provider shall notify and obtain the approval of the DIVISION prior to formal presentation of any report or statistical or analytical material based on information obtained through this contract. Formal presentations shall include, but not be limited to, published papers, articles, professional publications, and conference presentations. Any written material distributed in relation to this contract must carry the following disclosure: "Funding for this program was made possible, in part, by the State of Hawaii, Department of Health, Adult Mental Health Division. The views expressed do not necessarily reflect the official policies of the Department of Health, nor does mention of trade names, commercial practices, or organizations imply endorsement by the State of Hawaii."
9. Consumer Management Requirement
  - a. Incorporate "best practices/evidence-based practices" in any consumer service.

Best practices/evidence-based practices" are defined as a body of contemporaneous empirical research findings that produce the most efficacious outcomes for person with severe and persistent mental illness, have literature to support the practices, are supported by national consensus, and have 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. Providers will be required to incorporate these best

practices into their service delivery and cooperate with educational and monitoring activities.

- b. Documented evidence of consumer input into all aspects of recovery planning inclusive of service related decisions.
- c. Consumers shall be served with respect 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, to the extent it is practical, in a manner compatible with their cultural health beliefs, practices, and preferred language.
- f. The provider shall comply, as a covered entity according to the provisions of chapter 321C, Hawaii Revised Statutes, regarding language access; and with federal law regarding language access, Title VI of the Civil Rights Act of 1964, 42 USC section 2000d et seq., and 45 CFR part 80. These laws require the PROVIDER to, among other things, link clients and their families with interpreter services if, on account of national origin, clients and their families do not speak English as their primary language and identify themselves as having a limited ability to read, write, speak, or understand the English language.
- g. In accordance with chapter 11-175, Hawaii Administrative Rules, and any appropriate federal guidelines, the provider shall respect and uphold consumer rights. The provider 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.
- h. The provider shall provide the DIVISION’s Quality Management program with a written record of sentinel events, incidents, grievances, and appeals and efforts to address the situation and improve services on-site.
- i. The provider 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 CRR part 80, the Age Discrimination Act of 1975 as implemented by regulations at 45

CFR. part 91, the Rehabilitation Act of 1973, and titles II and III of the Americans with Disabilities Act (“ADA”).

- j. The provider is required to comply with all Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and the State of Hawaii’s Health Care Privacy Harmonization Act, Hawaii Revised Statutes, chapter 323B, in written policies and procedure requirements. The provider shall describe how they protect confidential information. The provider 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 provider shall maintain safeguards, as necessary, to ensure that PHI is not used or disclosed except as provided by the contract or by law. The provider shall not use or further disclose PHI for any purpose other than the specific purposes stated in DIVISION contracts or as provided by law and shall immediately report to DIVISION any use or disclosure of PHI that is not provided in this contract or by law. The provider shall keep the DIVISION informed of the name, address, and telephone number of their Privacy Officer and their Security Officer.
- k. Confidentiality. The DIVISION and the provider agree to keep confidential and to take reasonable precautions to prevent the unauthorized disclosure of any and all medical records and information required to be prepared or maintained by the PROVIDER, its employees, contractors or the DIVISION under this Contract pursuant to chapter 323B, Hawaii Revised Statutes.
- l. Written consumer consent shall be obtained for individuals and services funded by the DIVISION including:
  - 1) Consent to release information by DIVISION-funded service providers as needed for continuity of care, or for transition to another service provider, including after care services;
  - 2) Consent for claims to be submitted, on behalf of the consumer, for reimbursement or third party billing;
  - 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 Option Services (“MRO”), the Centers for Medicare and Medicaid Services (“CMS”) Office of Inspector General (“OIG”), the Med-QUEST Division (“MQD”) and their agents.

10. Prior written approval must be obtained from the DIVISION if the provider elects to utilize subcontractors. If a subcontractor is used, the provider shall ensure the DIVISION that they, as the provider, have the ultimate responsibility that subcontractor(s) will provide behavioral health services that meet the criteria of this RFP. Subcontractors shall be responsive and responsible to meet the expectations of the provider and the DIVISION.
11. When organization vehicles are used for activities outlined in this RFP, the vehicles shall be maintained according to safety and legal standards.
12. Financial Requirements
  - a. The State may require providers to submit an audit as necessary. If the provider expends \$750,000 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 provider shall comply with the cost principles developed for Chapter 103F, HRS and set forth by the State Procurement Office. The cost principles are available on the SPO website (see page 1-2, Website Reference).
  - 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.
    - 4) Homeless consumers registered through ACCESS by Homeless Outreach providers shall be given provisional eligibility into the DIVISION until a formal eligibility assessment is completed.

d. **Notification of Change of Consumer Status.**

As part of education conducted by the DIVISION, consumers shall be notified that they are to provide the provider, through their case manager, with any information affecting their status. The case manager and/or consumers should report changes to their case manager and/or provider. The provider shall complete the DIVISION UM Admission/Discharge/Update form and send it to the DIVISION's Utilization Management ("UM"). 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 provider 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 information on changes to their status. Therefore, it is important for the provider to obtain and forward such information to the DIVISION on a timely basis and inform the consumer of his/her responsibility to report changes to their case manager.

The provider shall notify each case manager and the DIVISION of changes in consumer status by faxing the information to UM 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, Medicaid, or Quest

f. **Consumers shall be disenrolled from DIVISION, if they meet any of the following criteria:**

- 1) Are no longer living in Hawaii
- 2) Refuse all services that are not court ordered
- 3) Anticipated to be incarcerated for more than one (1) year
- 4) No longer meet the criteria for DIVISION funded services either because of a change in diagnosis, functional impairment or legal status.

- g. 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 provider 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 provider 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 provider 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 provider 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 provider will be conducted and, if needed, adjustments will be made within ninety (90) days either crediting the DIVISION or providing payment to the provider upon the receipt of the claim. The provider shall obtain all third party insurance information from each consumer served and forward that information to the DIVISION.

The provider 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 provider shall identify employees or providers who may be committing fraud and/or abuse. The provider activities may include, but are not limited to, monitoring the billings of its employees and providers to ensure consumers received services for which the provider and the State

are billed; monitoring the time cards of employees who 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 provider shall promptly report in writing to the DIVISION instances in which suspected fraud has occurred within thirty (30) days of discovery. The provider shall provide any evidence it has on the suspicious 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 provider does not believe the inappropriate billing meets the definition of fraud (i.e., no intention to defraud), the provider 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 provider to Adult Protective Services, or of a child to Child Welfare Services, and to 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 provider agrees to provide access to all requested medical records/documents. It is the responsibility of the provider to ensure that its subcontractors and providers also provide DIVISION and its agents access to requested medical records/documents. Reimbursements for services deemed not medically necessary or not following billing guidelines by the DIVISION or its agent shall be denied. Reimbursements received by providers for consumers with third party coverage (including consumers with Medicaid and/or Medicare) will be considered full payment (see Section 2.3A11.g.). Any DIVISION overpayments for services shall be recouped by the DIVISION from the provider.

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 individuals. Aged, blind, and disabled recipients receive medical, dental, and behavioral health services under QUEST Expanded Access from contracted providers.

k. The provider shall submit HIPAA compliant (clean) claims to the DIVISION once a month. Claims shall be submitted for payment within three hundred sixty-five (365) calendar days of the date of service. Claims for payment received after three hundred sixty-five (365) calendar days of the date of service shall be denied for exceeding the filing deadline. For claims that have been denied by the DIVISION, the provider shall have thirty (30) days from the date of denial, to resubmit a claim for payment. Claims resubmitted after thirty (30) days of the date of denial shall be denied for exceeding the filing deadline.

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

m. When submitting Claims and/or Encounter Data, the provider shall: (a) use the most current coding methodologies on all forms; (b) abide by all applicable coding rules and associated guidelines as allowed by Federal/State law, including without limitation, inclusive code sets; and (c) agree that regardless of any provision or term in the contract, in the event a code is formally retired or replaced, the provider shall discontinue use of such code and begin use of the new or replacement code following the effective date published by the American Medical Association. Should a provider submit claims using retired or replaced codes, the provider understands and agrees that the DIVISION may deny such claims until appropriately coded and resubmitted.

n. All claims must include the diagnostic code that supports the medical necessity of the service being billed. For example, the ICD-9 Code V71.09 (No diagnosis on Axis I) and the ICD-10 code Z03.09 (Encounter for observation for other suspected diseases and conditions ruled out) would be denied.

o. 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.

13. The provider shall have current, valid licenses and certificates, as applicable, in accordance with federal, state and county regulations, and all applicable Hawaii Administrative Rules, and provide copies to the DIVISION, as requested.

Residential programs, in accordance with Title 11, Chapter 98 HRS, shall have a Special Treatment Facility license prior to submitting an application to the DIVISION, and the license shall remain current throughout the contract period.

14. **Insurance Policies.** In addition to the provisions of the General Conditions No. 1.4, the provider, at its sole cost and expense, shall procure and maintain policies of professional liability insurance and other insurance necessary to insure the provider and its employees against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance of the contract. Subcontractors and contractors shall also be bound by this requirement and it is the responsibility of the provider to ensure compliance with this requirement.

The provider shall obtain, maintain, and keep in force throughout the period of this Contract the following types of insurance:

General Liability insurance issued by an insurance company in the amount of at least ONE MILLION AND NO/100 DOLLARS (\$1,000,000.00) for bodily injury and property damage liability arising out of each occurrence and not less than THREE MILLION AND NO/100 DOLLARS (\$3,000,000.00) in the aggregate annually.

Automobile Insurance issued by an insurance company in an amount of at least ONE MILLION AND NO/100 DOLLARS (\$1,000,000.00) per accident/occurrence.

Professional Liability insurance issued by an insurance company in the amount of at least ONE MILLION AND NO/100 DOLLARS (\$1,000,000.00) for liability arising out of each occurrence and not less than THREE MILLION AND NO/100 DOLLARS (\$3,000,000.00) in the aggregate annually

All policies shall be made by occurrence and not on a claims-made basis.

The insurance shall be obtained from a company authorized by law to issue such insurance in the State of Hawaii (or meet Section 431:8-301,

Hawaii Revised Statutes, if utilizing an insurance company not licensed by the State of Hawaii).

For general liability, automobile liability, and professional liability insurance, the insurance coverage shall be primary and shall cover the insured for all work to be performed under the contract, including changes, and all work performed incidental thereto or directly or indirectly connected therewith. The provider shall maintain in effect this liability insurance until the State has certified that the provider's work under the contract has been completed satisfactorily.

Prior to or upon execution of the contract, the provider shall obtain a certificate of insurance verifying the existence of the necessary insurance coverage in the amounts stated above. The parties agree that the certificate of insurance shall be attached and be made a part of the contract.

Each insurance policy required by the contract shall contain the following clause:

It is agreed that any insurance maintained by the State of Hawaii will apply in excess of, and not contribute with, insurance provided by this policy.

The general liability and automobile liability insurance policies required by this contract shall contain the following clause:

The State of Hawaii and its officers and employees are additional insured with respect to operations performed for the State of Hawaii.

The certificate of insurance shall indicate these provisions are included in the policy.

The provider shall immediately provide written notice to the contracting department or agency should any of the insurance policies evidenced on its certificate of insurance forms be cancelled, limited in scope, or not renewed upon expiration.

If the scheduled expiration date of the insurance policy is earlier than the expiration date of the time of performance under the contract, the provider, upon renewal of the policy, shall promptly cause to be provided to the State an updated certificate of insurance.

The provider should check with its insurance company to ensure its ability to comply with these requirements. If the provider is unable to provide a

Certificate of Insurance that addresses the requirements of the State, two (2) months before contract implementation, the contract award may be canceled due to the provider's inability to meet the requirements of the State.

The provider is required to submit copies of its Certificates of Insurance to the DEPARTMENT's Administrative Services Office and to the DIVISION.

**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

Criteria for multiple awards:

The State needs the flexibility to award funding to more than one (1) applicant. In the event that more than one (1) applicant's proposal for a service meets the minimum requirements in Section III, Scope of Work, the proposal will be reviewed in accordance with the following additional criteria in determining the funding allocations:

1. Interest of the State to have a variety of providers in order to provide choices for consumers.
2. Interest of the State to have geographic accessibility.
3. Readiness to initiate or resume services.
4. Ability to maximize third party reimbursement.
5. Proposed budget in relation to the proposed total number of service recipients.
6. If funded in the past by the DIVISION, ability of applicant to fully utilize funding.
7. Previous DIVISION contract compliance status (e.g. timely submittal of reports and corrective action plans).
8. Accreditation status.
9. Applicants' past fiscal performance based on the DIVISION's fiscal monitoring.

10. Applicants' past program performance based on the DIVISION's program monitoring.
11. Applicants' previous internal utilization management ability based on demonstrated past performance.
12. Applicants' past program performance, based on other state agencies' program and/or contract monitoring.

Not all applicants who submit a proposal application may be awarded a contract.

**E. Single or multi-term contracts to be awarded**  
(Refer to §3-149-302, HAR)

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

Contract terms:

Initial term of contract:	<u>1 year</u>
Length of each extension:	<u>1 year</u>
Number of possible extensions:	5 years or 60 months
Maximum length of contract:	<u>6 years or 72 months</u>
The initial period shall commence on the contract start date or Notice to Proceed.	
Conditions for extension: Contract extensions shall be requested in writing, and must be executed prior to contract expiration.	

**2.4 Scope of Work**

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

The Crisis Services Program is designed to provide face to face, short term intensive mental health services in a variety of community settings. Services are available twenty-four (24) hours per day, three hundred sixty-five (365) days per year, and are initiated during a mental health crisis with the intent of helping the individual to cope with immediate stressors, identify and use available resources and individual strengths, and to assist the individual in returning to their baseline level of functioning. The Crisis Services program includes six (6) distinct components: Crisis Mobile Outreach ("CMO"); Crisis Support Management ("CSM"); Licensed Crisis Residential Service ("LCRS"), including capacity for 23:59 services; Certified Peer Specialist support; Mental Health Emergency Worker (Hawaii and Maui counties only); and Crisis Management Fund.

All primary service components and additional services must be provided, with the exception that in remote and rural areas or in areas where the need for licensed crisis beds is not sufficient enough to financially support the service, an applicant may propose a reasonable and adequate alternative to the LCRS component.

In each county that it proposes to serve, the provider shall designate a Qualified Mental Health Professional (“QMHP”) to lead the CMO team(s). The CMO QMHP shall provide clinical oversight and accountability of the entire crisis services program in that county, in order to ensure seamless entry and coordination of care. In most cases, the QMHP must be located in the same county where the services are being provided. Exceptions may be granted on a case by case basis for rural areas or in areas where demand for services is insufficient to cover the costs.

At each level of service (CMO, CSM, LCRS) provide screening and assessment of a scope necessary to gather essential demographics and adequately plan for the individual’s immediate and short term needs and support. For CMO, the assessment is to be comprehensive enough to ensure thorough assessment of immediate risks, needs, strengths, and supports and includes an immediate safety plan, and at the same time remains sensitive to the level and nature of the crisis and the individual’s immediate ability to contribute to a comprehensive assessment. For each subsequent level of service requested (CSM, LCRS), the assessment should build off of the CMO assessment and include additional necessary demographic information, additional psychiatric, medical, family and developmental history, and develop interventions and goals appropriate to that service.

1. All staff assigned by the provider to the Crisis Services Program described in this RFP must be trained and be able to demonstrate competency in the following areas to include, but not be limited to:
  - a. Screening, assessment, including suicide risk assessment and intervention, and treatment planning;
  - b. De-escalation and safe, non-violent intervention with individuals with challenging behaviors;
  - c. Provision of Recovery-based services;
  - d. Integrated Dual-Diagnosis Treatment;
  - e. Commonly used psychotropic medications and recognition of side effects;
  - f. Provision of services in a culturally sensitive and empathetic manner;
  - g. The effects of trauma on emotional and psychological development; and
  - h. The principles and application of Trauma Informed Care.

2. The provider shall have a policy that emphasizes a welcoming, emphatic and integrated approach to working with individuals with co-occurring substance and mental illness.

**Service Specific requirements:**

3. CMO:

The CMO component is the central point of access for the Crisis Services program and will receive requests for outreach only from the DIVISION'S Crisis Line (formerly known as the Access Line) Program.

The CMO component, through the QMHP, provides clinical oversight, accountability, and referral to all other components of the crisis services program.

The CMO service shall:

- a. Provide a face to face intervention at the scene of the crisis within forty-five (45) minutes of dispatch by the DIVISION'S Crisis Line. CMO services must be available twenty-four (24) hours per day, three hundred sixty five (365) days per year and at a level of availability sufficient to respond to multiple requests at the same time.
- b. The CMO will provide an initial screening and assessment to determine the nature of the crisis, evaluate immediate need for service, apply clinically appropriate interventions, determine ongoing needs, and ensure linkage with additional resources, including other components of the Crisis Services program as necessary. The CMO assessment will include, at a minimum:
  - 1) Sources of stress,
  - 2) Brief mental health history,
  - 3) Current symptoms,
  - 4) Co-occurring disorders,
  - 5) Immediate medical needs,
  - 6) Medications and allergies,
  - 7) Strengths and vulnerabilities,
  - 8) Support network,
  - 9) Third party insurance coverage,
  - 10) Cultural considerations,
  - 11) Current level of functioning, and
  - 12) Plan for immediate needs.

- c. When referring individuals to additional Crisis Service components (CSM, LCRS, Certified Peer Specialist), provide the CMO screening and assessment results in order to ensure seamless entry and coordination of care.
- d. When referring individuals to additional Crisis Services components (CSM, LCRS, Certified Peer Specialist) ensure that the referral is requested through the DIVISION'S Crisis Line and additional service components are authorized prior to initiating those services.
- e. Utilize Certified Peer Specialist support to assist consumers stabilizing from crisis. Certified Peer Specialists may be requested following the initial response by CMO when on-going support is clinically indicated to provide therapeutic support and assist the consumer recover from their crisis, and when the services of a Peer Specialist can assist the person in crisis navigate through the system, complete benefit applications, attend appointments, and complete other tasks necessary to ensure linkage with ongoing services following a crisis.
- f. Consult with CMO QMHP as necessary, and for all LCRS admission decisions, in order to ensure that interventions, treatment and disposition decisions are clinically sound and appropriate.
- g. The CMO will maintain disposition responsibility for all cases referred to LCRS for 23:59 Observation. The CMO is responsible to maintain periodic contact with LCRS staff during periods of observation, consult with the LCRS staff on the clinical issues and need(s) for observation, assist LCRS staff with disposition of the case, and to ensure that the case is resolved prior to authorized time (23 hours and 59 minutes from moment of arrival at LCRS) expiring.
- h. Utilize Crisis Management Funds to acquire emergency medication(s), emergency shelter and/or food or sustenance for individuals in crisis, as needed and clinically indicated.
- i. Work closely with local law enforcement personnel to provide support and intervention for individuals with mental illness eligible for Pre-booking Jail Diversion programs.
- j. Provide or arrange for transportation when necessary to further facilitate crisis stabilization.

**4. CSM:**

CSM is designed to help ensure that individuals who have received a crisis intervention continue to receive support and assistance while they are linked or referred to other support services. For individuals who are enrolled with a health plan, CSM will assist with referral and linkage with their health plan for follow up support. CSM services must include a consulting psychiatrist to provide medication assessment, prescription and medication management for individuals receiving CSM services and who are otherwise not connected with or receiving services from a psychiatrist.

CSM will receive authorization from the DIVISION'S Crisis Line program when a referral is requested by CMO as part of the final disposition of a crisis intervention.

CSM accepts all referrals made by CMO and authorized by the DIVISION'S Crisis Line program and provides a face to face contact at the first possible opportunity, but in any event not longer than twenty-four (24) hours after the referral is received.

The CSM service shall:

- a. CSM will utilize the CMO screening and assessment as a basis for completing a comprehensive assessment, based upon observation and collaboration with the individual in crisis, with the CMO and through a review of collateral information when available, which identifies both immediate and short-term needs for crisis stabilization and on-going support.
- b. CSM will assist individuals with third-party or other payors with referral and linkage to their health plan for follow-up care.
- c. Ensure that a referral for an assessment to determine eligibility for continuing services is arranged through the DIVISION'S Eligibility Line, whenever clinically appropriate and when the person in crisis is not already receiving behavioral health services through an insurance plan.
- d. Provide community-based interventions designed to assist the individual stabilize from their crisis event. Community-based interventions may include, but are not limited to, supportive counseling, linkage with medical/psychiatric care, assistance with benefit applications, referrals for shelter or housing, development or revision of a Wellness Recovery Action Plan ("WRAP"), crisis planning, or other similar activities designed to assist in stabilizing

and/or preventing crisis. CSM support must be available twenty-four (24) hours per day for follow up with assigned cases.

- e. Utilize Certified Peer Specialist support to assist consumers stabilizing from crisis. Certified Peer Specialists may be requested following the initial contact by CSM when on-going Certified Peer Specialist support is clinically indicated to assist the consumer recover from their crisis or when the Peer Specialist can be engaged to provide therapeutic support, assistance with benefit applications, attending appointments, development or revision of a WRAP, crisis planning, or other similar activities designed to assist in stabilizing from a crisis and getting linked to ongoing support services.
- f. Ensure a medication assessment, prescriptive services and medication management are provided to individuals receiving crisis services who are not already under the care of a psychiatrist.
- g. Provide or arrange for transportation when necessary to further facilitate crisis stabilization.

5. **LCRS:**

The LCRS is designed to provide shelter and support for individuals recovering from crisis. Individuals referred to LCRS include those individuals who have received an outreach by CMO and who would continue to be at high risk without the benefit of 24-hour support services, and those who would be at risk for further, serious de-compensation without the benefit of twenty-four (24) hour support. Although nursing services are on-site twenty-four (24) hours per day, the primary focus of those services is the individual's psychiatric or behavioral health needs. Individuals who have been assessed as requiring an ICF/SNF level of care, or whose medical conditions are beyond the scope of the program, would not be eligible for admission.

The LCRS program shall:

- a. Receive admission referrals only from CMO, following a crisis intervention.
- b. Ensure that an authorization for admission is received from the DIVISION'S Crisis Line program prior to admission.
- c. Provide screening and assessment as a basis for completing a comprehensive assessment and treatment plan, based upon observation and collaboration with the individual in crisis, with the

CMO and through a review of collateral information when available. The treatment plan shall be designed to identify the nature of the crisis, provide continued intervention and support, and assist the consumer in developing skills to manage their recovery. Assessment shall include a physical health assessment and referral(s) for health care for physical health issues which require urgent follow-up.

- d. Collaborate with other health care providers, including assigned primary care physicians, psychiatrists, or other behavioral health caregivers to ensure clinically appropriate, well-coordinated care.
- e. Provide a medication assessment, prescription and medication management for any individuals admitted to the LCRS and who are not otherwise connected with a psychiatrist.
- f. Provide physician to physician contact with primary care providers or psychiatrists when necessary to ensure clinically appropriate treatment and discharge planning.
- g. Provide a safe, structured milieu program adequately staffed and monitored based on the acuity and safety needs of the consumers, and which provides opportunity for individuals to recover from their crisis and learn skills necessary to promote their recovery and well-being. All consumers should be given the opportunity to work with a Certified Peer Specialist to develop or modify an existing WRAP or other forms of recovery planning.
- h. Recognize that individuals in crisis may demonstrate difficult or challenging behavior related to their psychiatric illness or crisis situation. The LCRS program must maintain a safe and therapeutic milieu at all times and must have the capacity to adjust staffing during periods when the acuity of the milieu requires staffing beyond the minimum requirements.
- i. Individuals may not be summarily discharged from the program solely because their behavior poses a challenge for the milieu, without having documented attempts at engagement and de-escalation.
- j. In the event an individual is sent or transferred from the LCRS to a hospital, emergency department, or other setting for evaluation or treatment of acute psychiatric or medical condition(s), the LCRS shall keep the person on the LCRS census until confirmation is received that the person has been admitted for further evaluation and/or treatment. Upon receiving evaluation or treatment, the

person will be promptly re-admitted to their bed at the LCRS unless a period of more than twenty-four (24) hours has elapsed from the time they were transferred or sent to another setting.

- k. Ensure that ancillary treatment providers are involved in treatment, discharge and follow-up care planning.

6. 23:59 Observation in LCRS

The primary distinction of 23:59 observation is the continual presence of supportive staff, including nursing care, to ensure close observation and support in a safe and structured environment when additional time is needed by CMO for clinical assessment, and when the assessment can be resolved in less than twenty-four (24) hours.

23:59 observation may be an appropriate crisis services intervention when an individual has presented in crisis and does not meet criteria for hospital or LCRS admission, yet presents in a condition whereby CMO is concerned that being left alone or un-monitored may result in further de-compensation or increased risk of harm, or when the cause of the crisis remains unclear and effective recovery planning cannot occur without further observation.

- a. Services available to someone placed at the LCRS site for 23:59 observation may include, but are not necessarily limited to:
  - 1) Assessment of need;
  - 2) Supportive counseling;
  - 3) Nursing care;
  - 4) Medication monitoring;
  - 5) Social detoxification when that process can be accomplished within the designated timeframe and within the scope of services for the LCRS;
  - 6) Close observation and therapeutic support during acute crisis stabilization;
  - 7) Psychiatric assessment and initiation or re-start and monitoring of medications when clinically appropriate; or
  - 8) For facilitating follow-up contact and/or linkage with case management, treatment teams, clinics, or primary care physician.
- b. 23:59 Observation is not a substitute for detox and should not be used solely for detox purposes.
- c. CMO is the only authorized referral source for this level of service. CMO retains responsibility to ensure a clinically appropriate

disposition is arrived at prior to the end of the authorized period.

- d. An individual placed at the LCRS for 23:59 observation may only receive this service for a maximum of twenty-three (23) hours and fifty-nine (59) minutes. Time of service begins when the individual arrives at the LCRS site. CMO is responsible to ensure a proper and valid authorization has been received from the DIVISION's Crisis Line.
- e. Although this is an observation and stabilization service of less than twenty-four (24) hours, the individual receiving this service at the LCRS site will count towards the maximum number of individuals that may occupy the site by OHCA license.
- f. Payment for this service may not occur more than one (1) time in any twenty-four (24) hour period of time for the same individual.
- g. No more than one (1) individual per LCRS site may be receiving this service at any given time.
- h. If an individual receiving this service continues to decompensate, resulting in a critical level of risk of harm, the individual may be considered for full admission to the LCRS or, transfer to an emergency room for further assessment and/or hospitalization.
- i. LCRS is responsible to provide observation and support, shall document their observations, and shall make recommendations to CMO on clinically appropriate disposition needs.
- j. Individuals referred for 23:59 Observation do not require full admission to the LCRS but should have documentation in place which outlines, at a minimum, basic, required demographic information, the need for the referral, the nature of the crisis, what the LCRS is observing for, ongoing observations which include periodic assessment of mental status, and recommendations for disposition.

**7. Certified Peer Specialist Support:**

The Certified Peer Specialist is assigned to provide continuing intervention and support to individuals who have received an intervention from CMO and/or have been assigned to CSM services. Certified Peer Specialists provide a unique perspective based on their shared experiences and utilize their skills to assist individuals better understand their illness, plan for their recovery and in navigating their way through the service

delivery system. A Certified Peer Specialist may not be dispatched as an unaccompanied first-responder to an individual in crisis.

- a. Authorization for Certified Peer Specialist support will be requested by either CMO or CSM from the DIVISION'S Crisis Line program. An authorization must be requested and be in place before services are provided.
- b. Certified Peer Specialists may assist individuals recovering from a crisis episode in a number of ways which might include, but are not necessarily limited to:
  - 1) Providing supportive counseling,
  - 2) Assisting in the development or modification of a WRAP,
  - 3) Assisting with benefit applications,
  - 4) Assisting with scheduling and attending psychiatric, medical, benefit application or other necessary appointments, or
  - 5) Providing brief 1:1 support for individuals recovering from crisis at home or in an emergency shelter setting.

**8. Mental Health Emergency Worker (Hawaii and Maui counties only):**

**Mental Health Emergency Worker (Hawaii and Maui counties only)**  
 Hawaii Revised Statute (HRS) 334-5 specifies that the Director of the Department of Health designates certain, qualified individuals as Mental Health Emergency Workers ("MHEW") in order to provide consultative guidance to law enforcement personnel under specific circumstances outlined in the statute. The responsibility for the designation of and oversight of the MHEW functions flows to the DIVISION through the Director of Health. The DIVISION now seeks to determine the feasibility of requiring this function to be operationalized through the Scope of Services of the Crisis Services Program. In addition to requirements regarding professional experience, the MHEW is required to meet the qualifications of a QMHP. The role and function of the MHEW includes, but may not necessarily be limited to:

- a. Ensuring that qualified personnel are available 24-hours per day, 365 days per year to provide immediate emergency examination and hospitalization ("MH-1") consultation for law enforcement personnel.
- b. Providing on scene, face to face consultation when necessary to determine if MH-1 criteria are met.

- c. Working with law enforcement agencies to draft procedures for initiating MH-1 consultation and appropriate follow-up.
- d. Collaborating with law enforcement agencies on training needs, and provision of training, as necessary, to law enforcement agencies/personnel on relevant topics pertaining to mental illness, MH-1 criteria, and working with persons with mental illness.
- e. Collaborating with law enforcement and local MH-1 receiving facilities to provide other crisis services supports, when clinically indicated, for persons who do not meet admission criteria.
- f. Documenting of each consultation, including demographic information, nature of the person's presenting condition, assessment, intervention, linkages and disposition; and
- g. Providing reports, in a format and frequency determined by the DIVISION, on activities provided as a result of designated status.

Interested applicants for Hawaii and Maui counties are asked to include with their proposal, a detailed description of the structure they would develop and implement to provide the service as outlined above, including a detailed description of the steps necessary to establish and/or maintain collaborative relationships with the necessary parties, a plan to ensure immediate availability of services 24 hours per day, 365 days per year, and a plan to incorporate this role into the broader crisis services program. Along with the detailed description outlined above, interested applicants shall submit a budget that details the costs associated with this portion of the crisis services program and which is based on a cost-reimbursement methodology.

9. Crisis Management Fund:

The Crisis Management Fund is designed to provide a resource for CMO to provide emergency shelter, medication, and food for individuals experiencing a crisis.

Funds will be assigned by county.

- a. CMO shall provide accounting and management oversight for the Crisis Management Fund.
- b. Crisis Management Funds will be used to:
  - 1) Provide emergency shelter for up to three (3) days for individuals who do not meet the level of an LCRS, but is in

- “crisis” and who would otherwise be at substantial risk for harm if left un-sheltered.
- 2) Provide up to a fourteen (14) day supply of psychotropic medications for individuals in crisis as a result of being without medication.
  - 3) Provide nourishment for individuals in crisis. Nourishment may take the form of providing one to two (1-2) days of light meals or an equivalent amount of groceries.
  - 4) Purchases shall be approved by the QMHP. All purchases shall be made by the CMO or another member of the crisis services program staff. Cash funds shall not be given to individuals to make their own purchases under any circumstances.
  - 5) These funds are to be used as a last resort when an individual’s own or other resources are unavailable or inaccessible. The provider will be required to keep records, documenting their inquiries into an individual’s resources.

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

**1. Personnel**

The provider shall ensure that all direct staff meet all personnel requirements for each service. The provider shall maintain verification that staff meets personnel requirements in current and complete personnel files. Personnel files shall include any communication from the DIVISION concerning the individual staff.

The provider’s personnel requirements for staff providing Crisis Services include, but are not limited to, the following:

- a. A board certified or -eligible psychiatrist(s) shall be available to the Crisis Services teams twenty-four (24) hours per day, seven (7) days per week for telephone consultation, on-site evaluation when necessary, physician to physician contact for individuals entering the Crisis Services program and who are already connected to a primary care physician (“PCP”) or treating psychiatrist, and prescription and medication management services for individuals entering the Crisis Services program and not already connected with a treating psychiatrist.

**Service specific personnel requirements:**

**b. CMO:**

- 1) A QMHP shall be assigned to the CMO team in each county, and will provide clinical supervision and oversight for the entire Crisis Services program in that county. The QMHP shall provide on-site intervention and support when clinically necessary and ensure on-call QMHP availability for consultation twenty-four (24) hours per day, seven (7) days per week. The QMHP shall ensure that clinical supervision is provided to Crisis Services program staff according to DIVISION requirements and that Crisis Services program staff receive consultation and training. The definition and role of the QMHP is defined in Section 5, Attachment D.
- 2) Mental Health Workers shall staff the CMO component at a sufficient level to ensure that the needs of the community are met in a consistent and timely manner. The Provider must ensure an adequate number of CMO staff are available to manage simultaneous multiple responses within required response times. The definition and role of the MHW is defined in Section 5, Attachment E.

**c. CSM:**

Mental Health Workers shall staff the CSM component at a sufficient level to ensure that the needs of the consumers are met in a consistent and timely manner. CSM services must be available twenty-four (24) hours per day, seven (7) days per week for follow up with assigned consumers.

**d. LCRS:**

- 1) Mental Health Workers shall staff the program at a minimum ratio of one (1) staff for every eight (8) residents, twenty-four (24) hours per day, seven (7) days per week. Program staff is expected to be awake, diligent and available to provide consumer care and support on all shifts.

Staffing above the minimum requirement may be necessary from time to time due to the acuity of the milieu and needs of residents. The program must have the capacity to adjust

staffing patterns whenever necessary in order to maintain a safe and therapeutic milieu.

- 2) Nursing services are required to be on-site 24-hours per day, 7 days per week. The registered nurse shall have successfully completed an accredited nursing program and are licensed to practice as a Registered Nurse in the state of Hawai'i; and have a minimum of four (4) years nursing experience, with at least one (1) of those years in a psychiatric or behavioral health setting.
- e. The provider shall have a program description that addresses all required provisions in this section. The provider shall include the following:
- 1) The staffing pattern and how staff is deployed to ensure that the proposed staff to consumer ratios is maintained including how unplanned staff absences are accommodated.
  - 2) Clinical and administrative supervision. The provider shall ensure and document that staff receive appropriate and regular clinical and administrative supervision.
- f. The provider shall ensure that the appropriate personnel attend trainings sponsored or required by the DIVISION, as appropriate to the service(s) they are providing. Training shall include compliance with DIVISION requirements for fraud and abuse prevention.
- g. Attend DIVISION provider meetings as scheduled by the DIVISION.
- h. As part of their response to the RFP, the applicant shall submit position descriptions of direct care and supervisory staff responsible for the delivery of services as indicated in Section 3.3.A. Position descriptions shall include the minimum qualifications, including experience for staff assigned to the service.
- i. The applicant shall submit an organization-wide and program specific organization chart as part of their response to the RFP for direct care and supervisory staff. The program-specific chart shall show the position of each staff and the line of responsibility including clinical and administrative supervision.

**2. Administrative**

- a. Services shall be authorized by the DIVISION's utilization management process, in accordance with the DIVISION's processes as outlined in current DIVISION policies and procedures and directives from the DIVISION Chief. It is the responsibility of each provider to understand and follow these policies, procedures, and directives in order that reimbursement can be approved by the DIVISION. Authorization of services is not a guarantee of payment.
- b. The provider shall accept all referrals deemed appropriate by the DIVISION's utilization management process. If the provider is unable to meet the needs of the referral, the provider shall indicate on the Provider Decision Form, the reason for the denial and recommend as alternative appropriate option.
- 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 provider shall obtain and provide the information necessary to register, open, confirm DIVISION eligibility status, all third party insurance coverage, and monitor services received.
- e. The provider 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, and/or a QUEST Expanded Access 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 Expanded Access health plan, CAMHD, or Fee-for-Service Program, the disenrolling program and the provider 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.
- g. DIVISION consumers shall not be charged finance charges, co-payments for services, or no-show fees. Consumers shall be informed that they cannot be terminated by the provider for non-payment of co-payments, finance charges, no-show fees, and non-covered services or for receipt of services from unauthorized provider employees or providers. Housing providers shall establish a clear and consistently applied schedule of fees required from consumers, which outline the cost of rent, security deposit and any other fees for incidental needs such as toiletries and personal use items which the consumer will be responsible for. This fee schedule shall clearly outline the process for refunding of the consumer's security deposit when the consumer moves out of the home.
- h. The provider shall negotiate and develop written agreements, as deemed appropriate, which shall be approved by the DIVISION, with the following parties, which may include, but not be limited to, hospital facilities, CENTERS and other DIVISION purchase of service providers.
- i. The provider shall collaborate with the DIVISION to facilitate outcome evaluation. This collaboration shall involve cooperation in the administration of a consumer satisfaction survey.

### **3. Quality assurance and evaluation specifications**

- a. The purpose of quality management is to monitor, evaluate, and improve the results of the provider'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) An 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) Monitoring and improving clinical outcomes and enhancing quality of life;
  - 10) Consumer satisfaction;
  - 11) User friendly grievance procedures which resolve issues in a timely manner; and
  - 12) Upholding consumer rights.
- b. The provider's quality management program shall include at a minimum the content indicated in Section 3.2C.
- c. The provider shall participate in the DIVISION's continuing quality management program and activities as directed by the DIVISION. The provider 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 provider's Quality Management and related programs; and
  - 2) Performance measures.

The objectives of the performance measures are:

- 1) To standardize how the provider specifies, calculates and reports information; and
- 2) To trend a provider's performance over time and to identify areas with opportunities for improvement.

**e. Required Quality Management Activities Reports**

The provider 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, including professional staff/consultants, 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, and revocation to provide Medicaid or Medicare services, or other actions brought against the provider, 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 discharge via Authorization Request form. The housing provider shall also notify the appropriate parties identified in the treatment plan in the event of an elopement or removal of the home via telephone call within twenty-four (24) hours;
- 8) Written notification of suspected fraud within thirty (30) calendar days of discovery, and of consumer abuse and neglect immediately upon discovery; and
- 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
    - (1) sample of records reviewed;
    - (2) findings;

- (3) actions taken, if applicable; and
  - (4) 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: (1) date of grievance or appeal; (2) date of service; (3) type of service; (4) consumer name, age, diagnosis; and (5) date of resolution.
  - g) Sentinel events.

**4. Output and performance/outcome measurements.**

The provider 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. Requests for information to the provider can 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, as applicable. The DIVISION will work with the provider over the contract period to streamline requests for information when those requests are regular and ongoing.

**5. Experience**

The organization providing these services shall need to demonstrate the expertise and experience in crisis services to DIVISION consumers. Providers with verifiable expertise and experience in serving this target population will be given preference in the evaluation process. Providers are strongly encouraged to identify all previous experience providing similar services and/or the target population. Details of the provider's performance in providing these services, past contracts, performance outcomes, and references should be included in their proposal.

**6. Coordination of Services**

Providers are required to demonstrate the coordination of services with other involved agencies or partners including each consumer's case managers/DIVISION personnel and contracted service providers, primary care physicians, justice personnel and agencies, MedQuest, community service providers and organizations. Refer to the Service Activities, Section 2.3A for coordination of care and activities.

**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.

**C. Facilities**

The provider shall provide a description of its facilities and demonstrate its adequacy in relation to the proposed services. If facilities are not presently available, the applicant shall describe plans to secure facilities and the general prospective geographical locations which they will be exploring. The applicant shall also describe how the facilities meet ADA requirements, as applicable; comply with HIPAA requirements for maintaining the privacy and confidentiality of PHI; and describe any provisions for special equipment that may be required for the service.

All facility changes where direct services are provided, require a minimum advance 60 day notification to the DIVISION for approval. Site changes without

DIVISION approval may result in non-payment for services not authorized in the appropriate time frame.

The provider shall comply with the DIVISION's Housing Quality Standards, provided in Section 5, Attachment "F."

## 2.5 COMPENSATION AND METHOD OF PAYMENT

### A. Pricing structure or pricing methodology to be used.

- 1) The CMO, CSM, LCRS, and CPSS services shall be on a structure based on a 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, staff, etc.).

The Room and Board rate is a fixed daily rate which shall be paid to the provider for each contracted LCRS bed. The Room and Board fixed rate shall be paid to the Provider whether a bed is occupied or vacant and is designed to assist in ensuring minimum service capacity.

- 2) The Mental Health Emergency Worker (Hawaii and Maui counties only) services shall be on a Cost Reimbursement pricing structure.

The cost reimbursement pricing structure reflects a purchase arrangement in which the purchasing agency pays the provider for budgeted agreed-upon costs that are actually incurred in delivering the services specified in the contract, up to a stated maximum obligation.

### B. Units of Service and Unit Rate.

<u>Billing Code</u>	<u>Service</u>	<u>Rate</u>
H2011	Crisis Mobile Outreach	\$27.50 per fifteen (15) minutes, per consumer
H2015	Crisis Support Management	\$20.25 per fifteen (15) minutes, per consumer
H0038	Certified Peer Specialist	\$13.75 per fifteen minutes, per consumer
H0018	LCRS, Treatment Rate	\$211.80 per day, per consumer

S9976	LCRS, Room and Board	\$88.20 per day, per consumer (Oahu) \$130.00 per day, per consumer (Neighbor Islands)
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**CRISIS MANAGEMENT FUND ALLOCATION BY COUNTY**

City and County of Honolulu	\$45,000 per year
Hawaii County	\$30,000 per year
Maui County	\$25,000 per year

**C. Method of compensation and payment.**

1) CMO, CSM, LCRS, and CPSS services:

Providers shall be compensated in accordance with the Rates described above, upon monthly submission of claims identifying the service performed for DIVISION consumers.

2) Mental Health Emergency Worker:

- a) Payments shall be made in monthly installments upon the monthly submission by the provider of expenditure reports for the services provided in accordance with the contract and in accordance with the costs identified in the budget. The State shall withhold not more than five percent (5%) of the total budget amount until final settlement of the contract.
- b) The expenditure reports shall be reviewed by the state and shall be subject to the state's preliminary determination of appropriateness and allowability of the reported expenditures. The state's preliminary determination of appropriateness and allowability of the reported expenditures shall be subject to later verification and subsequent audit.