

State of Hawaii  
Department of Health  
Adult Mental Health Division

**Request for Proposals**

**RFP No. HTH 420-5-16**  
**Representative Payee Services**  
**Statewide**

Date Issued  
September 16, 2015

Date Due  
October 19, 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.*

September 16, 2015

**REQUEST FOR PROPOSALS**

**REPRESENTATIVE PAYEE SERVICES  
STATEWIDE**

**RFP No. HTH 420-5-16**

The Department of Health, Adult Mental Health Division (“DIVISION”), is requesting proposals from qualified applicants to provide Representative Payee Services, statewide. The contract term shall be from April 1, 2016 through March 31, 2017. Multiple contracts may be awarded under this request for proposals.

Proposals shall be mailed, postmarked by the United State Postal Service on or before October 19, 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 October 19, 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 Thursday, September 24, 2015, from 9:00 a.m. to 11:00 a.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 Tuesday, September 22, 2015.

The deadline for submission of written questions is 2:00 p.m., HST on Tuesday, September 29, 2015. All written questions shall receive a written response from the State on or about Friday, October 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/APPLICATIONS TO BE SUBMITTED: 5**

**THE 5 COPIES/APPLICATIONS MUST INCLUDE ONE (1) SIGNED ORIGINAL (BOUND), THREE (3) BOUND COPIES, AND ONE (1) UNBOUND, SINGLE SIDED COPY.**

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

**October 19, 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”), October 19, 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., October 19, 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 **October 19, 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, October 19, 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)	09/16/15
Distribution of RFP	09/16/15
RFP orientation session	09/24/15
Closing date for submission of written questions for written responses	09/29/15
State purchasing agency's response to applicants' written questions	10/02/15
Discussions with applicant prior to proposal submittal deadline (optional)	TBD
Proposal submittal deadline	10/19/15
Discussions with applicant after proposal submittal deadline (optional)	TBD
Final revised proposals (optional)	TBD
Proposal evaluation period	10/20/15 – 11/05/15
Provider selection	11/10/15
Notice of statement of findings and decision	11/10/15
Contract start date	04/01/16

## 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/1hce/">http://spo.hawaii.gov/1hce/</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: Thursday, September 24, 2015 Time: 9:00 – 11:00 a.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 Tuesday, September 22, 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: September 29, 2015 Time: 2:00 p.m. HST

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

Date: October 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 July 8, 2015, 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**

Many consumers receive some type of financial support. The ability to manage these funds appropriately can vary with some consumers being unable to manage or direct the management of their own funds, to those who are independent in these money management tasks. The purpose of representative payee services is to help to ensure that benefit payments are used for basic needs, which provide the consumer with a more stable environment.

A Representative Payee Program is intended to provide money management for registered consumers of the DIVISION. The representative payee shall be directly responsible for the payment of rent, utilities and transportation, disbursement of funds for food and clothing for the consumer, and the provision of a daily or weekly amount of money for each consumer's personal use from their entitlements. Preference will be provided to applicants who propose to locate a representative payee, physically, on the island/county where the service will be provided.

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

1. Provide money management services for registered consumers of the DIVISION.
2. Develop a budget in collaboration with consumers and their DIVISION-assigned case manager.
3. Establish a separate bank account for representative payee services for consumers to ensure an efficient and flexible financial system to implement this money management service.
4. Ensure the timely and appropriate payment of rent, utilities, transportation, food, clothes and other essential daily living needs of consumers.
5. Provide a daily or weekly amount of money for each consumer's personal use.
6. Provide ongoing money management and budgeting training and assessments of consumers' ability to manage their resources independently.
7. For consumers who begin to demonstrate the ability to become financially self-sufficient, provide opportunities for increased independence and work towards achieving complete independence from representative payee services.
8. Establish effective linkages with the United States Social Security Administration, state operated and purchase of service case management providers, and other pertinent continuity community agencies.
9. Maintain oversight of consumers' finances to ensure appropriate disbursement and receipt of funds and mitigate any detrimental reduction

to these funds.

The representative payee agency shall collaborate with the DIVISION'S Utilization Management process and community designated case manager to effectively service their consumers.

For consumers who begin to demonstrate the ability to be responsible with money and become self-sufficient, involvement with the representative payee program shall decrease.

The program shall have effective linkages with the United States Social Security Administration, the CENTERS, community designated case manager, the consumers, and a bank for establishing an efficient and flexible financial system in order to implement this money management service.

The representative payee program shall be committed to:

1. Providing services consistent with the Comprehensive, Continuous, Integrated System of Care ("CCISC") model (see Attachment D), with particular attention to principles 3 and 4;
2. Treating consumers with dignity and respect;
3. Empowering consumers to achieve maximum autonomy and self-reliance;
4. Ensuring services for all consumers for the duration of their need; and
5. Acknowledging the right of consumers to make choices and be included in decision making.

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

Adults, 18 years and older, with severe and persistent mental illness, who meet the DIVISION's eligibility criteria and for individuals without access to Social Security benefits.

**E. Geographic coverage of service**

Statewide.

Providers may apply for one (1) or more islands or by county of any island. The provider shall demonstrate the ability to successfully provide the required services in the service area for which they are applying. Providers shall also specify the number of consumers they intent to serve per county.

**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. (N/A)
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 representative payee 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 the DIVISION Crisis Line 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 TWO MILLION AND NO/100 DOLLARS (\$2,000,000.00) 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 claims-made basis and not less than TWO MILLION AND NO/100 DOLLARS (\$2,000,000.00) in the aggregate annually.

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 2.4, 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)

1. The provider shall have a policy that emphasizes a welcoming, empathetic and integrated approach to working with individuals with co-occurring substance and mental illness.
2. Provide money management services that shall include, but are not limited to, the payment of rent, utilities, transportation, food, and clothing for each consumer; assistance with budgeting skills; and providing money on a daily or weekly basis for each consumer's personal use.
3. Develop an initial budget with each consumer upon starting the representative payee program. This shall establish a guide which will allow consumers to practice good money management skills. Budgets shall be re-visited and adjusted each time there is a change in each consumer's financial situation (i.e. rent increase/decrease, etc.).
4. Assist consumers with education on financial issues and practices, allowing them ultimately to resume control of their financial lives and providing them with financial independence. This may include the

provision of opportunities to help the consumer use the payee-ship to develop new skills through both learning opportunities and contingency management arrangements within the payee-ship structure. The provider shall be required to use the standardized Representative Payee (“RP”) Managing Your Money Worksheet, rev. 8/09 and RP Monthly Budget Sheet Form, rev. 8/09, provided in Section 5, Attachments E and F. The usage of forms is dependent upon each consumer’s individualized need.

5. The provider shall identify a representative payee designee to participate in clinical meetings, actively working with each consumer and their case manager, by first determining each consumer’s current needs for day-to-day living and use his or her payments to meet those needs, then forging a plan for stepwise disbursement of discretionary money with graduations toward financial autonomy.
6. Maintain appropriate human and technological resources to manage the accounting responsibilities inherent in managing representative payee ship including, but not limited to:
  - a. Centralized records, with computer software capabilities.
  - b. Professional fiscal staffing who are adequately trained and supervised.
  - c. Accounting procedures to assure that the consumers’ funds are managed appropriately by having adequate documentation of disbursement of funds, including receipts for each consumer.
7. Negotiate with financial institutions to provide checking accounts with no or minimal service charges, if needed.
8. Determine each consumer’s current needs for day-to-day living and use his or her payments to meet those needs. Providers shall use the standardized RP Weekly Expenses Worksheet, rev. 8/09, provided in Section 5, Attachment G.
9. Save any money left after meeting each consumer’s current needs in an interest bearing account or U.S. savings bond. Assist consumers with setting goals to help them strive to save money towards achieving these goals. Providers shall use the standardized RP Individual Savings Goal Worksheet, rev. 8/09, provided in Section 5, Attachment H.
10. Report any changes or events that could affect each consumer’s eligibility for benefits or payment amount such as a change in the amount of a pension or wage change. Providers shall be required to use the standardized RP Change in Event Form for Demographics, rev. 08/12 and

RP Change in Event Form for Finances, rev. 08/12, provided in Section 5, Attachment I. The usage of forms is dependent upon each consumer's individualized need.

11. Provide benefit information to pertinent DIVISION Providers, social service agencies, and medical facilities that serve each consumer.
12. Notify the United States Social Security Administration and the DIVISION of any changes or circumstances that would affect your performance as a representative payee or your decision to continue to serve as representative payee.
13. Complete written reports accounting for the use of funds as outlined by the United States Social Security Administration Representative Payee Report.
14. Return any payments to the United States Social Security Administration for which the consumer is not entitled.
15. Develop and implement a procedure that will allow for the timely disbursement of funds for expenses that each consumer's treatment team has determined to be urgent.
16. Conduct routine consumer satisfaction surveys on the representative payee program and making ongoing program modifications. The provider shall be required to use the standardized RP Consumer Satisfaction Survey Form, rev. 8/09, provided in Section 5, Attachment J.
17. Services shall be authorized by the DIVISION's utilization management process prior to the initiation of services and prior to the expiration of the authorization for continued stay requests.
18. Provide services in a manner consistent with the Comprehensive, Continuous, Integrated System of Care ("CCISC") model, with particular attention to principles 3 and 4.
19. When practicable, the provider shall have an office in the community served with established office hours and is accessible to consumers. The provider shall identify "open" office hours, so that consumers are able to talk with the provider, without an appointment, to discuss emergent issues that may arise. The office setting shall be conducive to meetings with case managers and consumers to discuss representative payee goals and objectives. If it is not practicable to have an office, the provider shall have the capability to use a site that is accessible to consumers.
20. The provider shall have a posted telephone number for consumers to call, should an emergency arise and they are unable to reach their designated

representative payee worker. This telephone number shall be answered by an authorized individual of the provider, during regular work hours, Monday through Friday.

21. The provider shall have the ability to process and distribute payments within a twenty-four (24) hour period for emergency purposes.
22. If there should be an occasion, when a designated payment/check was not processed by the provider as requested, the provider shall send a written communication to the recipient of the check/funds, informing them of the delay, how it was not caused by the consumer, and the steps the provider shall take to prevent a similar situation from re-occurring in the future. Copies of the letter shall be provided to the consumer and the case manager.
23. Services shall be provided for up to 900 consumers, statewide, by the following projected geographic areas: 20 consumers on the island of Kauai; up to 200 consumers on the island of Hawaii; 75 consumers on the island of Maui; and 605 consumers on the island of Oahu.
24. Providers may not submit authorizations for duplicate services.

**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.

- a. Staff providing representative payee services shall, at a minimum, have a high school diploma with one and one-half (1½) years of experience working in the human services field and one and one-half (1½) years of bookkeeping or accounting experience. However, additional education and experience are preferred.
- b. The provider shall ensure that staff receives supervision appropriate to their level of experience working with individuals with mental illness. Supervision shall be provided by a Mental Health Professional and by appropriately experienced bookkeeping/accounting staff and should target both clinical awareness and growth as well as review of accounting and bookkeeping practices.

- c. The provider shall ensure and document that its personnel receive appropriate education and training in techniques and modalities relevant to their service activity for the treatment and rehabilitation of individuals with mental illness, following the organization's policy and procedures.
- d. The provider shall provide continued education and training for representative payee staff at least semi-annually to maintain and upgrade their skills. The content of the education and training shall be based on a strategic training plan to upgrade the educational and professional qualifications of its staff and shall be developed in conjunction with the DIVISION.
- e. 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.
- f. Attend DIVISION provider meetings as scheduled by the DIVISION.
- g. 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.
- h. 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.

The achievement of the goals identified through this service will be determined through the achievement of the following:

- a. Outcome measures which affect the consumer.
  - 1) Transition status out of program: 3% of consumers successfully transition off representative payee services per year because they are skilled to manage finances of their own.

- 2) Transition status within program: 2% of consumers have successfully increased independence within the representative payee program per year to manage some of their finances on their own (i.e. consumer able to pay phone bill on their own).
  - 3) Social support: evidence of active collaboration with the consumers and case manager is provided to 50% of consumers being served.
  - 4) Education: evidence of education to consumers on financial issues and practices, including opportunities to help the consumer use the payeeship to develop new skills through learning opportunities and contingency management arrangements with the payeeship structure, is provided to 50% of consumers being served.
- b. Performance indicators which are benchmarks for the program.
- 1) Increased coordination: Participation in treatment planning by the representative payee provider with other community providers including, but not limited to, community-based case management providers and CENTERS are done for at least 50% of the consumers being served.
  - 2) Reduction of barriers: staff education is provided to other DIVISION-funded programs to improve collaboration and promote interaction with the representative payee at a minimum of four (4) times a year.

## 5. **Experience**

The organization providing these services shall need to demonstrate the expertise and experience in representative payee 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.

**2.5 COMPENSATION AND METHOD OF PAYMENT**

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

Fixed rate. Representative Payee services shall be based on a structure based on a fixed unit of service rate in which the purchasing agency pays the provider based on the number of units of service delivered. The provider 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.).

**B. Units of service and unit rate:**

<u>Billing Code</u>	<u>Services</u>	<u>Rates</u>
H0046	Representative Payee Services	\$2.65 per day, per consumers without access to Social Security benefits.

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

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

# **Section 3**

# **Proposal Application Instructions**

## Section 3

# Proposal Application Instructions

### General instructions for completing applications:

- *Proposal Applications shall be submitted to the state purchasing agency using the prescribed format outlined in this section. The proposal shall be organized and presented in the sections and subsections designated in the RFP and with prescribed content for each section.*
- *The numerical outline for the application, the titles/subtitles, applicant organization and RFP identification information on the top right hand corner of each page should be retained. The instructions for each section however may be omitted.*
- *Page numbering of the Proposal Application should be consecutive, beginning with page one (1) and continuing through for each section. See sample of table of contents in Section 5.*
- *Proposals are Required to be submitted in a three ring binder.*
- *Tabbing of sections is Required. Each tab should be placed on a separate sheet of paper and shall not be counted as a page. Please remember to identify the tab, i.e., Attachment A, Budget Sheets.*
- *Proposals that are required to be bound, need to be bound on the left side of the page. If the required proposal application is not bound, and pages happen to be missing, the RFP Review Committee will not responsible for the missing pages. Please remember that the use of rubber band(s) does not constitute binding.*
- *Proposals should be **single-spaced, portrait view, with 1” margins on all sides, utilizing a 12 point font size.** The RFP Review Committee will not be responsible if sections of information are missed or cannot be read, due to the use of a smaller font size.*
- *Applicants must also include a Table of Contents with the Proposal Application. A sample format is reflected in Section 5, Attachment B of this RFP.*
- *A written response is required for **each** item unless indicated otherwise. Failure to answer any of the items will impact upon an applicant's score.*
- *Each section shall be scored in its entirety. Information submitted in another section, shall not be considered. For example, in the Project Organization and Staffing section, if the organizational chart is in an attachment, the specific attachment is **required to be identified** in the narrative section.*
- *Other supporting documents may be submitted in an appendix, including visual aids to further explain specific points in the proposal; if used, the information is required to be referenced in the appropriate section.*
- *The Proposal Application shall not exceed 50 pages of main text, not including appendices, attachments, identification form (and/or title page), required forms, and table of contents. Appendices, attachments, identification form (and/or title page), required forms, and table of contents shall not exceed 150 pages. Document pages in excess of the stated page limitation shall not be considered (i.e., page 51, 52, ... and 151, 152, ...).*
- *The applicant's single audit report, financial audit, or compiled financial statements are not included in the above page limitations.*
- *The applicant's training plan and staff handbook/personnel manual for staff that are responsible for the delivery of services are not included in the above page limitations.*

- *This form (SPO-H-200A) is available on the SPO website (see Section 1, paragraph II, Website Reference). However, the form will not include items specific to each RFP. If using the website form, the applicant must include all items listed in this section.*
- *One (1) signed, original (bound) and four (4) copies (three bound, one unbound) of each proposal are required.*
- *Applicants are **strongly** encouraged to review evaluation criteria in Section 4, Proposal Evaluation when completing the proposal.*

**The Proposal Application comprises the following sections:**

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

### **3.1 Program Overview**

Applicant shall give a brief overview to orient evaluators as to the program/services being offered. No points are assigned to the Program Overview.

### **3.2 Experience and Capability**

Ensure that each section is answered completely and thoroughly. Each section shall be scored individually and separately from another section. Applicants are responsible to place the appropriate information in each section to be scored.

#### **A. Necessary Skills**

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

1. Demonstrated skills, abilities, and knowledge relating to the delivery of the proposed services.
2. Demonstrated the ability to respond to consumer complaints, appeals and grievances including those brought to the attention of the DIVISION.
3. Thoroughly describes the agency's vision, mission and goals showing

commitment to serving and supporting adults with severe and persistent mental illness in a manner consistent with DIVISION core values and guiding principles.

## **B. Experience**

The applicant shall provide a description of projects/contracts pertinent to the proposed services.

1. Possess the skills, abilities, knowledge of, and experience relating to the delivery of the proposed services including, but not limited to, previous and current contract performance with the DIVISION and other agencies.
2. The applicant shall provide a description of projects/contracts, including references, pertinent to the proposed services within the most recent five (5) years. The applicant shall include points of contact, addresses, e-mail addresses, and phone numbers. The DEPARTMENT reserves the right to contact references to verify experience. References shall not include employees of the DIVISION.
  - a. Detailed list of experience as an agency providing representative payee related services.
  - b. Detailed list of experience as an agency providing services to adults with severe and persistent mental illness.
  - c. If an applicant has prior experience providing representative payee related services for the DIVISION, describe in detail any problems, concerns or difficulties encountered by the agency or by the DIVISION, which was brought to the agency's attention, and how it was resolved.
  - d. List of contracts with the Department of Health.
  - e. List of other current or prior contracts with the public sector in providing services in general for adults with severe and persistent mental illness. Discuss any problems or difficulties encountered in current or prior contracts. Applicant shall provide a point of contact and telephone number for each contract listed. The DEPARTMENT reserves the right to contact any of the listed points of contact to inquire about the applicant's past service performance and personnel.
  - f. Success applicant has had in recruiting and retaining quality staff.

**C. Quality Assurance and Evaluation**

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

The applicant shall sufficiently describe its quality improvement program which shall be evaluated on the following:

1. Provision of a utilization management system.
2. Provision of a quality management program.
3. A policy and procedure for consumer complaints, grievances and appeals, documentation of actions taken, and demonstration of system improvement.

The agencies quality assurance shall include, but not be limited to, the following elements, and the information shall be submitted in the appropriate three sections listed above.

1. A written Quality Management Program description and outlined structure which includes the Quality Committee reporting structure, including governing board involvement, voting composition, and a written process for goal and priority setting following standardized methodology and data collection, which is updated and signed annually.
2. The Quality Management Program shall address consumer complaints, grievances, appeals, sentinel events and consumer satisfaction.
3. The Quality Management Program shall have a system or policy that outlines how items are collected, tracked, reviewed, and analyzed and reported to the DIVISION as appropriate.
4. The Quality Management Program Work Plan is established annually and selects goals and activities that are based on the annual program evaluation and are relevant to the DIVISION consumer and problem area under review, with designated timelines for the project and indicates department/persons responsible for carrying out the project(s) on the Work Plan.
5. Provision for the periodic measurement, reporting, and analysis of well-defined output, outcome measures and performance indicators of the delivery system, and an indication of how the applicant will use the results of these measurements for improvement of its delivery system.
6. A process of regular and systematic treatment record review, using established review criteria. A report summarizing findings is required.

Additionally, the applicant shall develop a written plan of corrective action as indicated.

7. Provision of satisfaction surveys of consumers.
8. Assurance that a staff member be available to represent utilization and quality management issues at meetings scheduled by the DIVISION.
9. Provision of a utilization management system including, but not limited to the following: a) system and method of reviewing utilization; b) method of tracking authorization approvals; c) method of reviewing invoices against authorizations; d) consumer appeals process; e) annual evaluation of the applicant's utilization management plan; g) an internal Utilization Plan; and h) identification of the person in the organization who is primarily responsible for the implementation of the utilization management plan.
10. A policy and procedure for consumer complaints, grievances and appeals which includes documentation of actions taken, and demonstration of system improvement.
11. Assurance that the applicant has established and will maintain and regularly update the following Quality Management policies and procedures:
  - a. Consumer complaints, grievances and appeals;
  - b. Consumer safety;
  - c. Consumer satisfaction;
  - d. Disaster preparedness;
  - e. Emergency evacuation;
  - f. Evidence-Based practice guidelines;
  - g. LOCUS/Level of care placement;
  - h. Compliance;
  - i. Consumer rights and orientation;
  - j. Confidentiality/HIPAA;
  - k. Treatment records;

- l. Individualized service plans;
  - m. Transition of consumers to other programs;
  - n. Treatment team;
  - o. Use of restraints;
  - p. Restricting consumer rights; and
  - q. Credentialing staff.
12. A training plan and staff handbook/personnel manual for staff that are responsible for delivery of services. Training shall include, but not be limited to: Substance Abuse, Forensics, Sentinel Events, Risk Management, Compliance, HIPAA Compliance, Consumer Rights, Treatment Planning, Housing Quality Standards, Health and Safety, and Access and Treatment for Non-English Speaking Consumers.
  13. A consumer handbook/brochure(s) that outline services available to the consumer, hours of operations, contact information (phone numbers, and instructions on emergency services), is written at a sixth (6<sup>th</sup>) grade reading level, provides an overview and the applicant's approach to care, and clearly outlines any major program rules that could lead to discharge from services offered by the organization.
  14. A description of the steps that the applicant will take to comply with all of the DIVISION'S reporting requirements as specified in Section 2.4B. 2, 4, and 7. The applicant shall also indicate how it will use the information in the report to improve its services.
  15. Where there is an intention to subcontract, the applicant shall demonstrate that services provided by the subcontractor are consistent with all applicable requirements specified in Section 2 including, but not limited to, compliance with reporting requirements. The applicant shall describe the monitoring it will perform to ensure subcontractors are compliant with the DIVISION requirements.
  16. For applicants whose annual contract or estimated reimbursements will be less than \$100,000.00 or whose staff number five (5) or less, a modified Quality Management and Utilization Management Plan are acceptable with prior approval from the DIVISION. A modified quality and utilization management system shall include the following:
    - a. A method for tracking authorizations.

- b. A method for assuring that consumers are informed of their rights, including the right to file a complaint, grievance, or appeal a service delivery decision.
  - c. A method of documenting goals and service activity as they relate to the MRP developed by the DIVISION designated case manager and consumer.
  - d. Consumer involvement in service planning.
  - e. Statement that the applicant will participate in the use of outcome instruments at the discretion of the DIVISION.
  - f. Identification of a fiscal and program contact person.
17. For services described in this RFP, a statement that the applicant shall participate with the DIVISION'S quality and utilization management process including, but not limited to, case reviews, specific data gathering and reporting, peer review, concurrent review, site visitation, special studies, monitoring, credentialing, and training.

**D. Coordination of Services**

The applicant shall demonstrate the capability to coordinate services with other agencies and resources in the community. Demonstration or plan of the applicant's coordination efforts shall include, but not be limited to, the following:

- 1. A history of the applicant's cooperative efforts with other providers of mental health and primary health care services.
- 2. Memorandum of agreements with other agencies.
- 3. Applicant's current efforts to coordinate with the DIVISION, CENTERS, HOSPITAL, and other providers, and where there is no current coordination, the applicant's plans to do so.

**E. Facilities**

The applicant shall provide a description of its facilities and demonstrate its adequacy in relation to the proposed services. If facilities are not presently available, describe plans to secure facilities. Also describe how the facilities meet ADA requirements, as applicable and special equipment that may be required for the services.

## **F. Management Information System (MIS) Requirements**

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

1. A statement about whether the applicant is a covered entity as defined by HIPAA. A statement that the applicant will comply with all HIPAA privacy, security and transactional code set requirements. The name, address, and telephone number of the applicant's Privacy Officer and Security Officer.
2. An explanation of how the applicant currently manages information in order to submit required information and data in the format prescribed by the DIVISION. Required data elements captured in the provider system and reported to the DIVISION may include, but are not limited to: consumer's last name, first name, middle name, any aliases, social security number, DIVISION-generated unique ID number; DIVISION-generated authorization number(s), Medicaid Identification Number, Medicare Identification Number, other third party numbers, address, telephone number, admission date, discharge date, service data using DIVISION approved procedure codes, date of birth, gender, and primary language spoken.
3. The DIVISION may add data reporting requirements or specify required formats for downloading data or submitting claims in the future. Applicants are encouraged to describe their flexibility in meeting changing data requirements.

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

## **3.3 Project Organization and Staffing**

Ensure that each section is answered completely and thoroughly. Each section shall be scored individually and separately from another section. Applicants are responsible to place the appropriate information in each section to be scored.

### **A. Staffing**

1. Proposed Staffing

The applicant shall describe and demonstrate that (a) the proposed staffing pattern, consumer/staff ratio, coverage, and proposed caseload capacity are reasonable and appropriate to insure viability of the services and

complies with applicable DIVISION requirements, and (b) that the applicant's assignment of staff would be sufficient to effectively administer, manage, supervise, and provide the required services. The applicant shall give the number and title of the positions needed to provide the specific service activities. Positions descriptions shall also be submitted. (Refer to the personnel requirements in the Service Specifications, as applicable.)

The applicant shall fully explain, justify, and demonstrate any proposed use of a subcontractor to be as effective as in-house staff for the provision of the required services; demonstrate that a proposed subcontractor is fully qualified for the specific work that would be subcontracted, by including a description of the proposed subcontractor's experience, capability, project organization, staffing, and proposed services as set forth for applicants in these RFP's; and explain how it would assure quality and effectiveness of the subcontractor, monitor and evaluate the subcontractor, and assure compliance with all the requirements of the RFP.

The applicant shall fully explain, justify, and demonstrate any proposed use of a volunteer to be as effective as in-house staff for the provision of the required services; demonstrate that proposed volunteers are or would be fully qualified for the specific work assigned, could be relied on, and would be available when and where needed to provide the required services; explain how it would provide sufficient management, supervision, oversight, and evaluation of volunteers, and otherwise assure their work quality and effectiveness; and explain how it will assure that volunteers perform in compliance with the requirements of the RFP.

## 2. Staff Qualifications

The applicant shall describe in this section of its proposal how it will ensure its compliance with the minimum personnel qualifications, which include, but are not limited to, licensure, educational degrees, and experience for staff assigned to the program, and comply with applicable DIVISION requirements. The applicant shall provide the minimum qualifications for staff assigned to the program; include position descriptions; and explain how the minimum qualifications and/or actual qualifications would assure delivery of quality of services. (Refer to the qualifications in the Service Specifications, as applicable.)

## **B. Project Organization**

### 1. Supervision and Training

The applicant shall describe and demonstrate its ability to adequately supervise, train and provide administrative direction to staff relative to the delivery of the proposed services and comply with applicable DIVISION

requirements. The description shall include frequency and method of conducting supervision and documentation of same.

The applicant shall explain how the program organization and assignment of personnel are sufficient for the effective administration, management, supervision, and provision of services under the program to meet the projected caseload. The applicant shall describe the training that would be provided for program staff to strengthen their capability to effectively provide the program services.

## 2. Organization Chart

The applicant shall reflect the position of each staff and line of responsibility/supervision. (Include position title, name and full time equivalency). Both the “Organization-wide” and “Program” organization charts shall be attached to the Proposal Application. The applicant shall describe their approach and rationale for the structure, functions, and staffing of the proposed organization for the overall service activity and tasks. The organization-wide and program-specific organization charts shall accurately reflect the proposed structure.

The applicant shall provide an “Organization-wide” chart that shows the program placement of the required services within the overall agency, and a “Program” organization chart that shows lines of communication between program administration and staff. Written explanations of both charts shall be included as needed for clarification.

The applicant shall demonstrate that the applicant’s proposed organization would be sufficient to effectively administer, manage and provide the required services.

## 3. Evidence of Licensure/Accreditation

Applicable submission of evidence that the applicant is licensed if licensure is required; and for all applicants, current and valid accreditation of the service(s) the applicant is applying for if it is an accreditable service. The applicant shall submit documentation of appropriate licensure and/or accreditation.

### **3.4 Service Delivery**

Ensure that each section is answered completely and thoroughly. Each section shall be scored individually and separately from another section. Applicants are responsible to place the appropriate information in each section to be scored.

**A. Scope of Work**

The applicant shall include a detailed discussion of the applicant's approach to applicable service activities and management requirements from Section 2, Item 2.4 Scope of Work, including (if indicated) a work plan of all service activities and tasks to be completed, related work assignments/responsibilities and timelines/schedules.

A detailed description of the service which the applicant is proposing to provide including:

1. A clear description of the applicant's demonstrated capability of a service delivery system to meet the goals and objectives of the RFP including, but not limited to, appropriateness to consumer populations, communities and regions.
2. A clear description of the services for consumers from point of entry to discharge, including interventions to be utilized. The description must be consistent with the scope of work found in Section 2.4A. and with the personnel requirements in Section 2.4 B.1. The description shall also describe the interventions to be used including behavioral supports. Services proposed to be subcontracted out must be included in this description.
3. A clear description of the target population to be served.
4. A reasonable estimate of the number of consumers it could serve and, where applicable, an indication of its total capacity (e.g. total beds available), and the number of units it will provide.
5. A description of the methods the applicant will use to determine when treatment goals are accomplished and when to terminate services or to transfer the consumer to a lower level of care.
6. A description of the accessibility of services for the target population, and a description of impediments to services and efforts to overcome barriers.
7. The applicant shall provide a thorough description of how they shall not refuse a referral, and that it shall not have an exclusionary policy that is inconsistent with the DIVISION'S guidelines.
8. The applicant shall include a statement acknowledging that that they will not refuse a referral submitted to them by the DIVISION.
9. An indication of the "best practices and/or evidence-based practices" the applicant incorporates and a citation of the literature to support its "best

practices and/or evidence-based practices”. The applicant shall provide a detailed description of the system it uses to implement and maintain its “best practice and/or evidence-based practices” program integrity.

10. A statement to assure that the applicant shall conform to the DIVISION’s standardized assessment package.
11. The applicant shall thoroughly describe the involvement of the consumer in the decisions regarding the services the consumer receives.
12. Where applicable, demonstration that the applicant is capable of providing twenty-four (24) hour coverage for services.
13. For services with twenty-four (24) hour, seven (7) days a week coverage, description of how the applicant’s on-call system works, i.e., methodology relative to applicant’s answering service. Specifically, describe how consumer’s access applicant’s service and staff availability.
14. Where the service is housing, residential, or day treatment/intensive outpatient hospital service, a weekly schedule that can be individualized to consumers and consistent with the renovations if the scope of service
15. The applicant shall describe how it will be ready, able, and willing to provide services throughout the time of the contract period.
16. The applicant shall state that it has read and understands the Request for Proposal and shall describe how it will comply with DIVISION requirements.

**B. General Requirements**

The applicant shall state/describe how it will comply with the general requirements specified in Section 2.3, and document the information in the appropriate section of the RFP.

**C. Administrative Requirements**

The applicant shall describe how it will comply with the administrative requirements specified in Section 2.4 B.2., and document the information in the appropriate section of the RFP.

### **3.5 Financial**

Ensure that each section is answered completely and thoroughly. Each section shall be scored individually and separately from another section. Applicants are responsible to place the appropriate information in each section to be scored.

**A. Pricing Structure**

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

The DIVISION will use a fixed price structure for representative payee services. The applicant is requested to furnish a reasonable estimate of the maximum number of service units it can provide for which there is sufficient operating capacity (adequate, planned and budgeted space, equipment and staff). All budget forms, instructions and samples are located on the SPO Website (see Section 1, paragraph II Websites referred to in this RFP.) The following budget forms shall be submitted with the Proposal Application:

- SPO-H-205 – Budget
- SPO-H-205A – Organization-Wide Budget by Source of Funds (special instructions are located in Section 5)
- SPO-H-206A – Budget Justification – Personnel: Salaries & Wages
- SPO-H-206B – Budget Justification – Personnel: Payroll Taxes, Assessments & Fringe Benefits
- SPO-H-206C – Budget Justification – Travel-Inter-Island
- SPO-H-206E – Budget Justification – Contractual Services – Administrative
- SPO-H-206F – Budget Justification – Contractual Services – Subcontracts
- SPO-H-206H – Budget Justification – Program Activities
- SPO-H-206I – Budget Justification – Equipment Purchases

**B. Other Financial Related Materials**

## 1. Proposal Budget Costs

- a. The applicant shall submit budget sheets that document personnel costs that are reasonable and comparable to other organizations in the community.
- b. The applicant shall submit budget sheets for non-personnel costs and ensure that the costs are reasonable and adequately justified.
- c. The proposal budget shall support the scope of service and requirements of the Request for Proposal.

## 2. Accounting System

In order to determine the adequacy of the applicant's accounting system as described under the administrative rules, the following documents are

requested as part of the Proposal Application (may be attached):

- a. The applicant shall submit a cost allocation plan, clearly providing a fiscally sound explanation of how costs are allocated across different funding sources, not related to the DIVISION. This is one measure that indicates the agency's commitment to serving and supporting adults with severe and persistent mental illness in a manner consistent with DIVISION core values and guiding principles.
- b. The applicant shall submit copies of their single audit report, financial audit, or compiled financial statements for fiscal years ("FY") 2013 and 2014. The FY 2013 and FY 2014 reports or financial statements shall indicate minimal or no material deficiencies and an adequacy of their accounting system.

If an applicant has not had their FY 2014 single audit report, financial audit or compiled financial statement completed, they shall submit a statement indicating when the FY 2014 audit report or FY 2014 compiled financial statement shall be completed, when the applicant shall send a copy of the FY 2014 audit to the DIVISION, and may submit their completed audits or compiled financial statements for FY 2012 and FY 2013.

- c. The applicant has the cash-flow to sustain their entire organization financially for a minimum of three (3) months, throughout the entire contract period, without receiving any payments for this service being procured.
3. The applicant shall describe all eligible sources of revenue from third parties and plans to pursue additional sources of revenue and how the applicant will prevent billing more than one (1) payer and submit overpayments to the DIVISION. The applicant may not bill other payers for services already paid for by the DIVISION or bill the DIVISION for services eligible for payment by another payer.
4. The applicant shall describe its billing/claims process and how it ensures accurate and timely submission of billing/claims based on written documentation which supports the bill/claim, and how it processes adjustments, reconciles payment, and posts payment.

### **3.6 Other**

#### **A. Litigation**

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

# **Section 4**

# **Proposal Evaluation**

# Section 4 Proposal Evaluation

## 4.1 Introduction

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

## 4.2 Evaluation Process

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

The evaluation will be conducted in three phases as follows:

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

### Evaluation Categories and Thresholds

<u>Evaluation Categories</u>	<u>Possible Points</u>
<i>Administrative Requirements</i>	
<i>Proposal Application</i>	
Program Overview	0 points
Experience and Capability	30 points
Project Organization and Staffing	10 points
Service Delivery	40 points
Financial	20 Points
<b>TOTAL POSSIBLE POINTS</b>	<b>100 Points</b>

**4.3 Evaluation Criteria**

**A. Phase 1 - Evaluation of Proposal Requirements**

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

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

Ensure that each section is answered completely and thoroughly. Each section shall be scored individually and separately from another section. Applicants are responsible to place the appropriate information in each section to be scored.

The RFP Review Committee shall use the scale in the table below to rate each section from the RFP from Not Addressed to Excellent. The percentage for the rate level will be multiplied by the maximum number of points for that item. For example, if an item is worth 6 points and the reviewer rated it as Satisfactory response, the score for that item would equal 60% (.06) x 6 = 3.6

<b>0</b>	<b>20%</b> <b>(.20)</b>	<b>40%</b> <b>(.40)</b>	<b>60%</b> <b>(.60)</b>	<b>80%</b> <b>(.80)</b>	<b>100%</b> <b>(1.00)</b>
Not Addressed	Unsatisfactory	Somewhat satisfactory	Satisfactory	Very Satisfactory	Excellent

Rating scale definitions:

Not Addressed: The required information was not present in the Applicant’s proposal.

Unsatisfactory: A major item was not addressed, was addressed incorrectly, or was addressed in the wrong category or section.

Somewhat satisfactory: Applicant appears to have just re-stated the requirements outlined in the RFP. The applicant's submission fails to indicate a clear understanding of the scope of services, lacks original effort in formulating responses; much of the proposal simply repeats back what the RFP stated as requirements; responses indicate a limited understanding of at least some of the scope of services or other requirements of the RFP.

Satisfactory: All major items were addressed. Applicant's submission reflects an understanding of the scope of service and other requirements of the RFP.

Very satisfactory: All items were addressed completely and thoroughly. Proposal includes concise, detailed descriptions of how the provider intends to deliver services. Concepts are stated clearly and evidence of creative or original thinking is present; applicant includes evidence of having researched the services and indicates a solid understanding of the scope of services or other requirements of the RFP.

Excellent: The majority of items were addressed in an exceptionally clear, concise, or original manner; applicant not only indicates a full understanding of the scope of services and other RFP requirements but also the implications of the service for the broader community and the necessity of coordinating services closely with other providers. Applicant's proposal includes value added services or service components which go beyond the minimum requirements outlined in the RFP.

For some sections, which shall be identified, the evaluation criteria to be used shall be on a met, partially met, or unmet criteria.

Met: The applicant meets the requirements of the section (100%)  
 Partially met: The applicant meets only a portion of the requirements of the section (50%)  
 Unmet: The applicant does not address or meet the requirements of the section (0%)

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

**1. Experience and Capability Total 30 Points**

Up to 10 points may be deducted from agencies who in the past demonstrated unsatisfactory performance. Indicators for unsatisfactory performance may include, but are not limited to:

- a. Provider monitoring scores of less than 80% on the overall score.
- b. Provider monitoring scores of less than 80% on the General Review Tool.
- c. Non-Compliance with DIVISION's Quality Management and Business Compliance initiatives.

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

- a. Necessary Skills (5 points)**
  - 1) Demonstrated skills, abilities, and knowledge relating to the delivery of the proposed services.
  - 2) Demonstrated the ability to respond to consumer complaints, appeals and grievances including those brought to the attention of the DIVISION.
  - 3) Thoroughly describes the agency's vision, mission and goals showing commitment to serving and supporting adults with severe and persistent mental illness in a manner consistent with DIVISION core values and guiding principles.
- b. Experience (5 points)**

Possess the skills, abilities, knowledge of, and experience relating to the delivery of the proposed services including, but not limited, to previous and current contract performance with the DIVISION and other agencies.
- c. Quality Assurance and Evaluation (10 points)**

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

  - 1) The applicant has sufficiently described its quality improvement program which shall include the following:
    - a) Provision of a utilization management system.

- b) Provision of a quality management program.
  - c) A policy and procedure for consumer complaints, grievances and appeals, documentation of actions taken, and demonstration of system improvement.
- 2) A training plan and staff handbook/personnel manual for staff that is responsible for the delivery of services. The plan includes the required trainings listed in Section 3.2 C.12.

**d. Coordination of Services (6 points)**

Demonstrated capability to coordinate services with other agencies and resources in the community through written documentation.

**e. Facilities (1 point)**

Adequacy of facilities relative to the proposed services.

**f. Management Information Systems (MIS) (3 points)**

For this section, points shall be assigned on a met, partially met, or unmet criteria.

Met: The applicant meets the requirements of the section (100%)

Partially met: The applicant meets only a portion of the requirements of the section (50%)

Unmet: The applicant does not address or meet the requirements of the section (0)

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

1) Relative to HIPAA requirements:

The applicant states they will comply with all HIPAA privacy, security, and transactional code set requirements.

The applicant lists the names, addresses, and telephone numbers of their Privacy Officer and their



**b. Project Organization (5 points)**

- 1) Supervision and Training: Demonstrated ability to supervise, train and provide administrative direction to staff relative to the delivery of the proposed services and comply with applicable DIVISION requirements.
- 2) Organization charts: Approach and rationale for the structure, functions, and staffing of the proposed organization for the overall service activity and tasks. The organization-wide and program-specific organization charts accurately reflect the proposed structure.
- 3) Applicable submission of evidence that the applicant is licensed if licensure is required; and for all applicants, current and valid accreditation of the service(s) the applicant is applying for if it is an creditable service.

**3. Service Delivery Total 40 Points**

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

Evaluation criteria will include the following:

- a. A detailed description of the service that the applicant is proposing to provide including:
  - 1) Demonstrated capability of service delivery system to meet the goals and objectives of the RFP including, but not limited to, appropriateness to consumer populations, communities and regions. **(10 points)**
  - 2) The applicant shall provide a clear description of the services for consumers from the point of entry to discharge, including interventions or transitions to be utilized. Any services subcontracted out must be included in the description. **(14 points)**

3) A reasonable estimate of the number of consumers it will serve and where applicable the number of units it will provide. **(2 points)**

b. A statement that the applicant shall not refuse a referral and that it shall not have an exclusionary policy that is inconsistent with the DIVISION's guidelines. **(1 point)**

This item shall be evaluated on a met, partially met, or unmet criteria.

Met: The applicant meets the requirements of the section (100%)

Partially met: The applicant meets only a portion of the requirements of the section (50%)

Unmet: The applicant does not address or meet the requirements of the section (0)

c. The program incorporates "best practices/evidence-based practice," has literature to support this, and has a system for implementing and maintaining best practice program integrity. **(2 points)**

d. A description by the applicant of the involvement of the consumer in the decisions regarding the services the consumer receives. **(10 points)**

e. A statement by the applicant that they have read the Request for Proposal, will comply with DIVISION requirements, and are ready, able and willing to provide services throughout the time of the contract period. **(1 Point)**

This item shall be evaluated on a met, partially met, or unmet criteria.

Met: The applicant meets the requirements of the section (100%)

Partially met: The applicant meets only a portion of the requirements of the section (50%)

Unmet: The applicant does not address or meet the requirements of the section (0)

**4. Financial** **Total 20 Points**

Pricing structure based on a fixed unit rate are reasonable and comparable to other organizations in the community.

- a. Personnel costs are reasonable and comparable to similar positions in the community. **(2 points)**
- b. Non-personnel costs are reasonable and adequately justified. **(2 points)**
- c. The budget supports the scope of service and requirements of the RFP. **(4 points)**
- d. A cost allocation plan clearly providing a fiscally sound explanation of how costs are allocated across different funding sources, not related to the DIVISION. This is one measure that indicates the agency's commitment to serving and supporting adults with severe and persistent mental illness in a manner consistent with DIVISION core values and guiding principles. **(5 points)**
- e. The single audit report or financial audit for fiscal years 2013 and 2014 indicates minimal or no material deficiencies and an adequacy of their accounting system. If an Applicant's agency has not had their FY 2014 financial audit completed, they shall submit a statement indicating when their FY 2014 audit shall be completed and when the applicant shall send a copy of the FY 2014 audit to the DIVISION, and may submit their completed audits for FY 2012 and FY 2013. Applicant has the cash-flow to sustain their entire organization for a minimum of three months throughout the entire contract period. **(5 points)**
- f. An indication of the third party reimbursements the applicant is eligible to receive and of the plans the applicant has made or is making to obtain as many third party reimbursements as possible without collecting payment from more than one (1) payer. **(1 point)**
- g. Description of all eligible sources of revenue from third parties and plans to pursue additional sources of revenue. **(1 point)**

**C. Phase 3 - Recommendation for Award**

Each notice of award shall contain a statement of findings and decision for the award or non-award of the contract to each applicant.