

State of Hawaii
Department of Health
Child and Adolescent Mental Health Division

Addendum One

June 3, 2015

To

Request for Proposals

460-15-07

Multisystemic Therapy

May 28, 2015

June 3, 2015

ADDENDUM NO. 1

To

**REQUEST FOR PROPOSALS
Multisystemic Therapy
RFP 460-15-07**

The Department of Health, Child and Adolescent Mental Health Division, is issuing this addendum to RFP 460-15-07, Multisystemic Therapy for the purposes of:

Amending the RFP.

The proposal submittal deadline:

is not amended.

Attached is (are):

Amendments to the RFP.

The RFP Table of Contents and Section 2 Service Specifications are hereby replaced in its entirety with the following revised RFP Table of Contents and Section 2 Service Specifications attached hereto.

If you have any questions, contact:

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Section 2

Service Specifications

Section 2

Service Specifications

2.1 Introduction

The Child & Adolescent Mental Health Division Mission: The mission of Child & Adolescent Mental Health Division (“CAMHD”) is to provide timely and effective mental health prevention, assessment and treatment services to children and youth with emotional and behavioral challenges, and their families.

A. Overview, Purpose or Need

Multisystemic Therapy (“MST”) is a family- and community-based treatment model designed specifically for youth with complex clinical, social, and educational problems. It is an empirically grounded treatment model that has been developed over the past twenty-five (25) years. Please visit www.mstservices.com for more details on MST Services.

MST views individuals as being nestled within a complex network of interconnected systems that encompass the individual, family, and extra familial (peer, school, neighborhood) factors. This “ecology” of interconnected systems is viewed as the MST client. The ultimate goal of MST is to empower families with the skills and resources needed to independently address the difficulties that arise in raising youth, and to empower the adolescent to cope with the family, peer, school, and neighborhood problems.

Over a period of three to five (3-5) months, MST services are provided in the home, school, neighborhood, and community by master’s level professionals with relatively low case loads. A critical aspect of MST is its emphasis on promoting behavior change in the youth’s natural environment. Initial family sessions identify the strengths and weaknesses of the adolescent, the family, and their interactions with extra familial systems (e.g., peers, friends, school, and parental workplace). Identified problems throughout the family are explicitly targeted for change, and the strengths of each system are used to facilitate change.

MST places an extremely strong emphasis on provider and system accountability. The MST therapist, the MST team, and the entire system of care are viewed as responsible for removing barriers to achieving outcomes with every family. It is the responsibility of the MST therapist to engage the family. It is the responsibility of the agency to impart skills so the adolescent and family can sustain progress after treatment ends and achieve the desired

outcomes. It is the responsibility of our system of care to encourage and support these adolescents and families in maintaining their success.

The purpose of this RFP is to provide evidence-based services for a defined group of youth appropriate for referral for MST services. These youth receive the most intensive behavioral health services, and absorb most of the personnel and fiscal resources of the CAMHD. They often have antisocial, aggressive, or delinquent behaviors as their primary presenting issues, and there has been a determination made that these behavioral issues arise more from willful misconduct than from another underlying source of emotional or mental illness. They often have co-occurring alcohol and/or substance abuse diagnoses. There is typically multi-agency involvement with these adolescents, including Department of Human Services (“DHS”) Child Protective Services (“CPS”), Office of Youth Services (“OYS”), and Family Court. Often, youth have used services outside of the home during the preceding year, either a residential treatment facility or a correctional facility.

Services to these youth must be provided in a highly accountable system capable of assuring appropriate access to services, close coordination with all involved stakeholders, effective performance management, and sound fiscal management that will produce positive results.

The CAMHD is requesting proposals from agencies interested in providing MST services in defined communities across the State. Proposals are being accepted from agencies interested in serving single communities or multiple communities. The communities targeted to have an MST team are: Oahu (including Central Oahu, Leeward Oahu, Windward Oahu, and Honolulu), Maui (including Molokai), Kauai, and Hawaii (East and West Hawaii).

This RFP is for the provision of direct MST services only. The CAMHD will support the cost for training and consultation needed by MST teams through a separate contract for MST System Supervision.

B. Planning activities conducted in preparation for this RFP

A RFI was posted on March 23, 2015 for interested parties to provide information and feedback to assist the CAMHD in developing this RFP. Please contact Steven Osa, Program Contract Specialist, CAMHD, at steven.osa@doh.hawaii.gov or 808-733-8386 for more information regarding the RFI.

C. Description of the service goals

Empirical evidence (Source: MST Treatment) strongly supports a social-ecological view of treating antisocial behavior in children and adolescents. The central principle of this view is that behavior is multi-determined through

the reciprocal interplay of the child and his or her social ecology, including the family, peers, school, neighborhood, and other community settings.

The MST approach uses an intensive family- and community-based treatment that addresses the multiple determinants of serious antisocial behavior in juvenile offenders, youth at-risk of out-of-home placement due to behavioral problems, and youth at-risk of school failure because of behavioral problems.

The primary goals of MST are to (a) reduce youth criminal activity, (b) reduce other types of antisocial behavior such as drug abuse, and (c) achieve these outcomes at a cost savings by decreasing rates of incarceration and out-of-home placements. MST aims to achieve these goals through a treatment that addresses risk factors in an individualized, comprehensive, and integrated fashion and that empowers families to enhance protective factors.

For more information on MST Services, please visit www.mstservices.com.

MST has demonstrated:

- Reduced long-term rates of criminal offending in serious juvenile offenders (Source: MST Program Design),
- Reduced rates of out-of-home placements for serious juvenile offenders,
- Improved family functioning,
- Decreased mental health problems for serious juvenile offenders,
- Favorable outcomes at cost savings in comparison with usual mental health and juvenile justice services.

The CAMHD requests the awarded Provider(s) of MST services to assist the State in achieving these outcomes.

Additionally, the awarded Provider(s) will be responsible for:

- Ensuring that youth with multi-agency involvement (e.g., DHS, OYS, Family Court, Alcohol and Drug Abuse Division (“ADAD”), Developmental Disabilities Division (“DDD”)) receive integrated service delivery.
- Ensuring that services for youth who are involved with multiple agencies and have complex mental health issues produce measurable results and are cost efficient.

D. Description of the target population to be served

Eligibility Criteria

MST targets youth with serious behavioral problems, including co-occurring substance abusers and serious juvenile offenders, between the ages of twelve (12) and eighteen (18). To ensure the effective use of MST treatment for youth with a variety of complex problems, and produce results in a cost-effective manner, the following referral criteria must be met.

Inclusionary Criteria

- Youth who are recommended for a community-based, family focused program, as an alternative to out-of-home placement due to delinquent or anti-social behavior, **OR**
- Youth who are in an out-of-home placement due to delinquent or anti-social behavior and are recommended for accelerated return to the community, **AND**
- Youth's out-of-home placement is primarily related to issues regarding willful misconduct on the part of the youth. Diagnoses frequently include, but do not exclude, Primary Axis I Diagnoses such as Conduct Disorder, Substance Abuse or a dual diagnosis. Generally, youth do not have a thought disorder or other severe mental illness.
- School truancy or school failure associated with behavioral problems.
- Physical aggression in the home or community, or at school.
- Verbal aggression or verbal threats of harm to others in the context of problems listed above.
- Substance abuse in the context of problems listed above.
- **Youth younger than twelve (12) or youth older than eighteen (18).** There must be agreement between a Provider agency offering MST services and the CAMHD before MST services can be provided to child younger than twelve (12) or youth older than eighteen (18).

Exclusionary Criteria (unless there is an agreement as specified above)

- Youth living independently, or youth for whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends, and other potential surrogate caregivers.

- Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior.
- Juvenile sex offenders where the sex offense occurs in the absence of any other delinquent or antisocial behavior.
- Youth with moderate to severe difficulties with Social Communication, Social Interaction, and Repetitive Behaviors
- Youth with active thought disorder or severe mental illness.
- Youth with moderate to severe Intellectual Disabilities.
- Youth with mental disorders due to a general medical condition.
- Youth with relatively mild behavioral problems that can be effectively and safely treated at a less restrictive level of care.

E. Numbers of Youth to be served and team size

MST historically has been underutilized in Hawaii, with MST therapists typically carrying low caseloads. This is problematic both because of inflated expense to the state and because MST therapists will learn and perform best when they have sufficient opportunities to implement MST interventions across multiple cases. The CAMHD would like the Provider for each contract to “right-size” staffing, based on demand for services and the constraints of the MST model. It is optimal for staff to have flexible geographical boundaries for serving families so that caseloads and team size can be kept within the acceptable range for MST (4-6 cases per therapist, 2-4 therapists per team). Coverage for Molokai historically has been challenging, and it is important to have the therapist living on the island with supervision and vacation coverage provided by the Maui team. Travel expenses for reasonable in-person supervision can be budgeted. The provider shall utilize technology in lieu of travel to the degree that it is clinically appropriate and adherent to the MST model determined in collaboration between the Provider, CAMHD, and MST Group.

During the sixth month period from March to August 2014 the following usage of MST was reported:

Region	Youth Discharged	RFP Contract Area
Central Oahu	7	35
Honolulu	13	
Windward Oahu	5	
Leeward Oahu	10	
Hilo/East Hawaii	12	22
Kona/West Hawaii	10	
Kauai	4	4
Maui/Molokai)	20	20
Total	81	81

These data suggest that about six (6) therapists (on two (2) teams) are needed to serve Oahu, four (4) therapists to serve Maui County, with one (1) therapist located on Molokai, five (5) therapists (on two (2) teams) for Hawaii Island, and 2 therapists (two), the minimum for a team, to serve Kauai. Applicants should use these estimates as a guideline and discuss rationales for deviating from these recommendations in their proposals. Considerations of coverage and obstacles related to travel time may need to be addressed. Within the model-prescribed team size, adjustments in the number of therapists in each area may be made during the contract period -based on utilization data - through discussions between the Provider, the MST System Supervisor and the CAMHD Utilization Management Committee.

F. Geographic coverage of service

The CAMHD seeks a single agency or multiple agencies to manage the MST services within or *in the vicinity of* the following communities:

Hawaii County: 1 contract to provide MST via 2 MST teams

- East Hawaii (inclusive of Ka'u and Pahala)
- West Hawaii (inclusive of North Kohala district and Honoka'a school complex)

Maui County: 1 contract to provide MST via 1 or 2 teams

- Island-wide (exclusive of Hana and Lanai, and inclusive of Molokai Island)

City and County of Honolulu: 1 contract to provide MST via 2 teams serving CAMHD Family Guidance Centers island-wide

- Central Oahu

- Honolulu
- Leeward Oahu
- Windward Oahu

Kauai County: 1 contract to provide MST via 1 team

- Island-wide

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

Funding for services being solicited through this RFP will be a portion of the CAMHD general funds service allocation. Funding for this service is subject to appropriation, budget execution policies, and availability of funding. Federal funds may be used, if available.

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. Cost Principles Compliance

The Provider will comply with the Chapter 103F, HRS Cost Principles for Purchases of Health and Human Services identified in SPOH-201 (Effective 10-1-98), which can be found on the SPO website.

2. Other Applicable Requirements

The Provider shall complete, sign and submit to the State purchasing agency a certification regarding the following (See Section 5, Attachment E):

- Certification Regarding Drug-Free Workplace Requirements;
- Certification Regarding Debarment, Suspension Ineligibility and Voluntary Exclusion;
- Certification Regarding Lobbying;
- Certification Regarding Program Fraud Civil Remedies Act; and

- Certification Regarding Environmental Tobacco Smoke.

The Provider shall comply with all applicable federal, state, and county laws; ordinances, codes, rules, and regulations; and policies and procedures of the CAMHD, as the same may be amended from time to time, that in any way affect the Provider's performance.

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

After-the-fact secondary purchases will not be allowed.

Planned secondary purchases

None.

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

Allowed Unallowed

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

Single Multiple Single & Multiple

Criteria for multiple awards:
Multiple awards, one (1) for each geographic area.

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

Single term (two (2) years or less) Multi-term (more than two (2) years)

Contract terms:

Initial term of contract: 10/01/2015-6/30/16

Length of each extension: Twelve (12) months

Number of possible extensions: Five (5)

Maximum length of contract: Six (6) years

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

Conditions for extension: The contract may be extended annually for additional terms (not to exceed a total of six (6) years) provided that the contract price shall remain the same or is adjusted (increased or decreased) based on a negotiated price mutually agreed upon, subject to the availability of funding. Contract renewals will be based on contracted agency's annual performance review, projections of service needs based on utilization review,

and on CAMHD's determination of need for specific and/or all program components for contract renewal. The contract extension must be in writing.

2.4 Scope of Work

The Scope of Work encompasses the following tasks and responsibilities:

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

1. MST Training and Consultation

All contract agency MST therapists, counselors, and MST supervisors will be required to attend scheduled MST training(s) in Hawaii as appropriate.

MST 5-day Orientation Training is currently available via any licensed MST training provider (www.mstservices.com). If/when available via the Hawaii MST System Supervisor, there will be no cost to providers for training attendance. The cost of providing this training (other than travel expenses) is being covered by CAMHD and is not to be included in the proposal budget. Training will include both pre-service and ongoing in-service training and consultation.

Training and consultation, for clinical staff, as part of the MST model's Continuous Quality Improvement design, is provided in three ways: 1) An initial Five-Day Orientation Training; 2) one and one-half day booster trainings shall occur on a quarterly basis; 3) treatment teams and their supervisors shall receive weekly telephone consultation from the System Supervisor, which follows weekly in-person clinical supervision.

a) Five Day Orientation Training

All staff who will engage in treatment and/or clinical supervision of MST cases must attend MST 5-day Orientation training. Agencies are expected to minimize staff turnover and cover contractual obligations until staff can be trained. Training will be provided in-state at no cost (other than inter-island travel expenses) at least annually, or when there is a sufficient cohort of staff statewide requiring training, as determined by the System Supervisor (MST Expert). New staff may work no more than 60 days prior to participating in an Orientation Training. If no Hawaii-based training is available within 60 days, new MST staff may access training via any open-enrollment 5-day training listed on <http://mstservices.com/training/5-day-orientation>. Out of state trainings can be accessed at the agency's expense.

The objectives of the Orientation Training are:

- (1) To familiarize participants with the scope, correlates, and causes of the serious behavior problems addressed with MST family preservation;
- (2) To describe the theoretical and empirical underpinnings of MST family preservation;
- (3) To describe the family, peer, school, and individual intervention strategies used in MST;
- (4) To train participants to conceptualize cases and interventions in terms of the principles of MST; and
- (5) To provide participants with practice in delivering Multisystemic Interventions.

The multi-faceted approach to training includes didactic and experiential components. The participants are required to practice the MST approach through critical analysis, problem solving exercises and role play. It is expected that participants will have read pre-assigned sections of the MST treatment manual prior to the initial intensive training.

- b) **Quarterly On-Site Booster Training**
The Quarterly On-Site Booster Training are designed to provide training in special topics related to the target populations/problems being treated by the MST Therapists/Counselors, and to address issues that may arise for individuals and agencies using the approach (e.g., ensuring treatment integrity, individual and agency accountability for outcome, inter-agency collaboration, etc.). The Booster Training is also designed to allow for discussion of particularly difficult cases. Booster training occurs at or near the program site and is provided by the CAMHD-Contracted MST System Supervisor at no cost to the agency
- c) **Weekly Telephone Consultation** (approximately 45 per year, given holiday and training allowances for the System Supervisor).
Weekly telephone consultation is provided through one-hour conference calls in which the MST team and supervisor consult with the MST System Supervisor regarding case conceptualization, goals, intervention strategies, and progress of each case, according to the MST model and the Child and Adolescent Mental Health Performance Standards (CAMHPS or Orange Book). The weekly consultation is designed to assist the team and supervisor in clearly

articulating treatment priorities, identifying obstacles to success, and developing strategies aimed at successfully navigating those obstacles. In addition to this weekly consultation, it is expected that the Provider will provide onsite supervision by staff that have obtained an advanced degree in a clinical discipline (i.e., psychology, counseling, social work, psychiatry) and have had additional clinical experience with family-based services prior to receiving MST training.

2. MST Program

MST is provided by a team. Teams consist of a supervisor working with a two to four (2-4) MST therapists. Each supervisor may work with one to two (1-2) teams. Each MST therapist serves 4 to 6 youth (4-6) at any given point in time for approximately 3 to 5 (3-5) months.

Services must be provided in accordance with the MST principles, manuals, program standards, and training protocols. Provider must enter into a Licensee Agreement for Provider Organizations with MST Group to provide MST treatment. The specific credentials of the staff or mental health professional, the requirements of the service, the documentation requirements, and the service procurement guidelines are all clearly specified in this RFP.

Individuals and/or Providers with demonstrated successful experience with MST are preferred.

3. MST Referral Process

The MST services sought in this RFP require referrals from a Family Guidance Center (“FGC”) Care Coordinator or other CAMHD designee. Confirmation of the request for services will be completed by the FGC Care Coordinator or other CAMHD designee using a team-based decision model, and guided by protocols developed from generally accepted utilization management guidelines. In order for the CAMHD to develop a cost effective and accountable system, it is required that this referral protocol be followed.

MST Service Team Referral Process will be implemented as follows:

- a) Based upon the target population as defined in this RFP, the FGC Care Coordinator or designee determines and documents the referral to the MST Service Team utilizing the MST referral form and including required attachments. The Provider agrees to accept all referrals that meet the eligibility criteria for the target

population (within the service team capacity at that time).

- b) All youth and families who enter the MST program shall be asked to sign an agreement or contract affirming their willingness to participate in the program and comply with all MST program requirements.
- c) The Provider is required to work with families who are reluctant to participate and who may be uncooperative. Should a family refuse MST services, after agreed upon attempts to engage, the MST Service Team notifies the referring FGC Care Coordinator, in writing, within forty-eight (48) hours of the last attempt to engage the family. This notification shall describe all attempts to engage the family.
- d) Referrals may be made to begin MST thirty (30) days prior to a planned discharge from another program. In this case, MST services will focus on planning for the youth's transition to their home community.

4. MST Program Standards

The MST program must be provided in accordance with the following standards and as described in the CAMHPS, unless given written exception by the CAMHD Medical/Clinical Director.

- a) Shall serve a minimum of twelve (12) families each year for each full-time therapist;
- b) Shall maintain a supervisor to direct service staff ratio of one (1) full-time clinical supervisor to not more than two (2) MST teams, where each team consists of two to four (2-4) full-time therapists. The supervisor and MST staff will adhere to the MST treatment model;
- c) Shall assign a caseload of four to six (4-6) families to each MST therapist. Approximately sixty (60) hours of direct contact with each family over an average of four (4) months shall be provided. The final two to three (2-3) weeks may involve less intensive contact to monitor the maintenance of therapeutic gains;
- d) Shall have MST therapists available to the client/family twenty-four (24) hours per day, seven (7) days a week. Each MST therapist shall be available to the clients specifically assigned to them. A rotating on-call schedule should be used for the

therapist's vacation and personal time off;

- e) Shall schedule regular weekly team supervision involving all MST staff, including the MST supervisor, for the purpose of reviewing individual case progress, and consulting on caseworker/client management plans, action steps and activities needed on MST cases. Emphasis shall be on the MST clinical supervision of all active cases and on developing outcome-focused weekly plans to achieve client/family goals; and
- f) Shall consult at a minimum of once monthly with the assigned FGC Care Coordinator for the purpose of case reviews, program compliance, training and other issues.

5. MST Service Standards

The Provider shall provide services in accordance with the following standards:

- a) MST therapists must attempt face-to-face contact with each family within twenty-four (24) hours (immediately if an emergency) of approved referral to MST. If unable to make face-to-face contact within seventy-two (72) hours, the referring FGC Care Coordinator shall be notified immediately.
- b) Provide comprehensive individualized and family-centered MST treatment to each family. The treatment process shall begin with goal setting that addresses the changes that the family would like to see over the treatment period (approximately four (4) months). This process shall focus on specific areas of action to be addressed on a daily or weekly basis. Any barriers to treatment success shall be addressed as soon as they are identified.
- c) Collaborate with the family in developing an enduring social support network in the natural environment.
- d) The MST therapist must provide a range of goal-directed services to each client/family which may include, but shall not be limited to:
 - (1) Improving parenting practices;
 - (2) Increasing family affection;
 - (3) Decreasing association with deviant peers;

- (4) Increasing association with pro-social peers;
- (5) Improving school/vocational performance;
- (6) Engaging youth/family in positive recreational activities;
- (7) Improving family/community relations;
- (8) Empowering family to solve future difficulties;
- (9) Teaching appropriate parenting skills, such as: alternatives to corporal punishment, appropriate supervision of children, age appropriate expectations, choices and consequences, display of greater parent/child affection and trust.
- (10) Family and marital interventions consistent with MST principles;
- (11) Individual interventions for parents and youth consistent with MST principles;
- (12) Aiding the family in meeting concrete needs such as housing, medical care and legal assistance and assisting in making available follow-up support resources as needed;
- (13) Teaching the family organizational skills needed to provide a positive environment (example, teaching budgeting skills, etc.);
- (14) Referring and linking the family with follow-up services when necessary to ensure continued success meeting the family's MST treatment goals;
- (15) Transporting youth/family when necessary and facilitating family plans to access transportation themselves on an ongoing basis;
- (16) Providing service in the client's home, or, at the client's request, a location mutually agreed upon by the therapist and client;
- (17) MST therapists provide service to the youth/family for an average of four (4) months. If needed, a family responding positively to treatment, may receive services for a longer duration for more difficult problems, if approved in writing

by the MST System Supervisor in consultation with the
CAMHD Medical/Clinical Director; and

(18) Termination of services or requesting extended services.

6. Treatment Plan Development

The Provider shall require MST therapists to write a treatment plan for each family. Treatment plans shall be developed in accordance with the following:

- a) Identify the multiple determinants of anti-social behavior for each case.
- b) Identify and document the strengths and needs of the adolescent, family, and the extra-familial systems (peers, school, neighborhood, etc.).
- c) Identify and document problems throughout the family and extra-familial systems (peers, school, neighborhood, etc.) that explicitly need to be targeted for change, in collaboration with the family.
- d) Incorporate the desired outcomes of the key participants and/or stakeholders involved in the family's treatment (e.g. parents, probation, social services, school personnel, etc.).
- e) MST supervisor shall review and approve all treatment plans prior to sending to the FGC Care Coordinator.
- f) Treatment plans shall be sent to the FGC Care Coordinator within five (5) days from the time of the therapist's first meeting with the family. The plan will identify family/client strengths, help the client/family define specific goals, provide instruction in ways to prevent the recurrence of delinquent behavior and other family conflict, and set up resources and skills to maintain ongoing progress. Updates to treatment plans should be submitted to the FGC Care Coordinator as applicable.
- g) The MST therapist shall submit brief monthly reports to that FGC Care Coordinator summarizing activity with each case, using the most current version of the CAMHD Monthly Treatment Progress Summary ("MTPS") Form. Additional material may be attached to the standard CAMHD form if desired.

- h) Providers should provide data required by MST services. These data will be reviewed with the CAMHD during Monthly Network meetings.

7. Termination of a case

Upon termination of a case, the Provider shall submit a written final progress report to the referring FGC Care Coordinator and shall provide the following:

- a) Written notice to the referring FGC Care Coordinator thirty (30) days prior to closing, indicating intent to close. Exceptions to this time frame can be made with the approval of the MST System Supervisor.
- b) A written termination report, using the required format, shall be submitted to the referring FGC Care Coordinator no later than seven (7) days after the case closure. The client's family may be invited to attend the staffing discussion. The termination report shall be approved, in writing, by the MST supervisor, prior to submission to the referring FGC Care Coordinator.
- c) A termination interview with the family to summarize the progress made during treatment, review options for maintaining progress, and assess the family's satisfaction with the MST services that were provided. The referring FGC Care Coordinator shall be invited to the termination interview.

If during a treatment a determination is made by the MST client's treatment team that out of home placement is a more appropriate service, and/or the CAMHD Care Coordinator (CC) is seeking such placement, MST services will be terminated. The MST therapist should attempt to arrange a final meeting with the family to review treatment progress, the family's safety/crisis plan, and reasons for termination. The MST therapist may assist the family in establishing stability while awaiting placement and work with the family and CC to ensure a smooth transition to placement, however such a transition should be relatively brief. The CC will arrange for interim services for the family, if any are needed, prior to the client's placement. Any exceptions to this process require the approval of the MST System Supervisor.

8. Collaboration and Integration of Services

The Provider must agree to collaborate with families, schools, other state agencies, judiciary, and other mental health providers in the provision of integrated services to all CAMHD served youth. The Applicant shall

submit documentation showing evidence of collaborative relationships with families, Community Children’s Councils (“CCC”), schools, provider agencies, and other community organizations in the geographic area involved.

The Applicant shall address measures to be taken to integrate services with schools, agencies, and other CAMHD contracted Providers.

9. Statement(s) of Intent

The Applicant shall submit a statement of intent to participate in training, consultation and peer supervision with the MST System Supervisor.

The Applicant shall submit a statement of agreement to deliver MST services in accordance with the CAMHD and the MST principles, standards, and protocols as outlined in this RFP and the CAMHPS.

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

1. Personnel

Provider may choose to hire direct employees, establish a network of subcontracted professional providers, or use a combination of both. If the Provider utilizes a network of independent providers, each subcontracted practitioner must be credentialed, as per the CAMHD Credentialing policies and the CAMHPS.

Provider must agree to assume all responsibility for quality of work provided by employees and subcontracted providers.

All subcontracts require CAMHD prior written approval and must include an agreement to comply with all aspects of this RFP including licensing and credentialing requirements. Upon request, the Provider must provide CAMHD with a copy of each subcontract including applicable licenses and credentials.

The Provider is required to provide all necessary administrative and managerial infrastructures to support the provision of services, in accordance with the requirements outlined in this RFP and the CAMHPS.

The Provider is required to provide all necessary clinical expertise to support the provision of services in accordance with the requirements outlined in this RFP and CAMHPS.

The Provider must maintain a confidential personnel file for each employee. The personnel file must contain documents, including, but not limited to, State and Federal Department of Labor required

employment documents, Hawaii Administrative Rule requirements, and any other requirements outlined by CAMHD.

The Applicant is required to submit with the proposal, and maintain throughout the contract period, policy and procedures that include competency and privileging requirements. The policy must also clearly identify scope over all subcontractors of the contracting agency.

MST *supervisors* must meet the requirements for a Qualified Mental Health Professional specified in the CAMHPS as well as the CAMHD credentialing requirements based upon National Commission for Quality Assurance (NCQA) standards.

MST therapists must meet the requirements for a Mental Health Professional or Paraprofessional as specified in the CAMHD credentialing requirements and the CAMHPS – with the exception that paraprofessionals must have a minimum of five (5) years of appropriate supervised experience.

All MST therapists/counselors shall be assigned to the MST program on a full-time basis. Licensed Social Workers, Marriage and Family Therapists (“MFT”), or Advanced Practice Registered Nurses (“APRN”) are preferred.

Applicant must describe how it will implement measures to ensure that all employees are oriented to the CAMHPS and the Hawaii Child and Adolescent Service System Program (CASSP) Principles (included in the CAMHPS document) . The CAMHPS is available on the following website,
<http://health.hawaii.gov/camhd/>.

Applicant must ensure that it will adhere to all applicable state laws regarding the obtaining and release of client information.

Provider shall be required to fully participate in CAMHD’s performance monitoring activities. The Provider shall describe how they will internally assure the quality of services they deliver at all programmatic levels through in-house quality assurance activities.

In the proposal, the Provider must detail how the quality of all services and employees will be assessed, analyzed, and how corrective actions will be implemented.

The Provider must detail how it will ensure that its personnel adhere to all applicable state laws regarding the obtaining and release of client information and confidentiality.

2. Administrative

All Applicants shall identify the policies and procedures to maintain personnel/provider files of training, supervision, credentialing, and ongoing monitoring all mental health professional/staff performance.

Applicants must identify how they would provide the necessary infrastructure to support the provision of services in compliance with the standards as specified herein.

Provider must maintain supporting documentation for credentialing in separate files on Provider's premises. Provider must make this information available to the CAMHD as requested.

Provider must maintain a written policy and procedure that will identify the Provider's process for primary source verification of all clinical personnel.

Provider must maintain a process for ensuring that credentialed staff have the basic skills and expertise necessary to engage in specific clinical practice assigned.

Provider must maintain a client record for each case accepted. This record shall include, but is not limited to, the following:

- a) Client referral sheet.
- b) Date of initial request for service.
- c) Results of the strength and needs assessment.
- d) Treatment plan.
- e) Weekly MST Progress Summaries.
- f) Goal attainment summary.
- g) Family's response.
- h) Ongoing progress reports, at least monthly, detailing:
 - (1) Specific interventions used and outcomes;
 - (2) Notation of every contact (MST treatment logs) to include date, time and duration of contact;

- (3) Placement status determination, including date;
- (4) Termination Summary; and
- (5) Any other pertinent material deemed necessary or as specified by the most current CAMHPS.

The Provider shall collect maintain and report to the CAMHD, on a quarterly basis, information documenting progress towards achieving the outcome objectives cited in this RFP.

The Provider shall allow the CAMHD representatives or any authorized representatives full access to all case files and administrative records for the purpose of program evaluation and/or contract monitoring.

To ensure consistent administration of the Treatment Adherence Measures (TAM-R), the MST Institute will collect these data on each case. Providers will be responsible for the purchase of this service through arrangements with MST Institute. The average cost is \$100 per client treatment episode, which includes all of the “trials” it takes to reach the family to get a completed TAM-R. The cost for TAM-R collection should therefore be included in the proposed budget and should be based on expected utilization.

The Provider is required to develop and implement agency specific policies and procedures addressing the following areas. These policies and procedures must be reviewed and updated at least every two (2) years. The following agency policies must be submitted with the proposal:

Credentialing The Provider must submit with the proposal and maintain throughout the contract period, a credentialing policy for ensuring that all employees are appropriately credentialed and qualified to provide services. The Provider must maintain a centralized file of supporting documentation for credentialing in separate files on Provider’s premises. The policy and procedure must identify the Provider’s process for primary source verification of all clinical personnel and/or subcontracted Providers. The policy and procedure must describe the process for ensuring that credentialed staff has the skills and expertise necessary to engage in the specific clinical practice assigned.

Cultural Competency The Provider must submit with the proposal and maintain throughout the contract period, a cultural competency policy to ensure that all employees are trained and supervised in providing services in a culturally appropriate manner. This policy should include requirements for cultural assessment and cultural considerations in the treatment planning process.

Workforce Development The Provider must submit with the proposal and maintain throughout the contract period, a workforce development policy that identifies how staff are recruited, oriented, trained, supervised and provided ongoing learning opportunities. The policy must identify agency strategies to retain personnel that meet performance expectations. The policy must include quality assurance tracking to monitor whether each employee is receiving the applicable number of required training and supervision hours. The policy must state the agency's commitment to meet all mandatory training requirements established in this RFP and the CAMHPS.

Coordination of Care The Provider must submit with the proposal and maintain throughout the contract period, a policy and procedure to ensure the coordination of services with other involved agencies or partners including other involved CAMHD Provider agencies, schools, child welfare agencies, juvenile justice personnel and agencies, MedQUEST healthplans, primary care physicians, Medicaid, community service Providers and organizations, and primary care Providers.

Fraud & Abuse Prevention The Provider must submit with the proposal and maintain throughout the contract period, a policy and procedure to ensure that claims are properly supported through appropriate documentation prior to submission to CAMHD. The Provider must be aware that CAMHD will employ a protocol for the identification of potential fraud or abuse in claims' submission through the conduct of periodic reviews of clinician billing practices. This will be accomplished through building thresholds into the electronic billing system that will reject questionable claims, as well as through reviews of quarterly reports that identify outliers to other established thresholds. The Provider will be expected to cooperate fully in the analysis of such reports and to take appropriate action based upon the outcome. The Provider and any all direct care subcontractors are required to make all requested documentation available upon request by the CAMHD or its authorized agents, including but not limited to the MedQUEST Division ("MQD") of the Department of Human Services ("DHS") or their authorized agents.

Seclusion & Restraint The Provider must submit with the proposal and maintain throughout the contract period, a policy and procedure regarding the use of seclusion and restraint. This policy must be in accordance with the CAMHD's Seclusion and Restraint Policy and Procedure (See Section 5, Attachment F)

Incidents & Sentinel Events The Provider must submit with the proposal and maintain throughout the contract period, a policy and procedure to ensure the timely reporting of incidents and sentinel events occurring within the program. This policy must be in accordance with the CAMHD Sentinel Event Policy & Procedure (See Section 5, Attachment G).

Client Rights and Grievances Process Provider must have policy and procedures explaining Consumer Rights and the agency’s Grievance management process.

3. MST Group Licensure

All programs must be licensed by MST Services prior to program startup. The bidder must state agreement to this requirement in the proposal, but holding a license at the time of proposal submission is not required. A letter of support for this proposal is recommended from MST Services, 710 Johnnie Dodds Blvd., Suite 200, Mt. Pleasant, SC 29464; (843) 856-8226. Administratively, the relationship is structured as a license agreement for MST between the Medical University of South Carolina (MUSC) and the bidder organization. MST Services is the MUSC-affiliated organization that grants these license agreements and provides the sole program development and training services in MST throughout the United States and internationally.

To insure qualification for licensure, the bidder must meet the following program requirements:

	MST Program Requirement	Evidence Required for Proposal
1	MST Therapists are full-time employees assigned solely to the MST program.	Statement in proposal indicating that all MST therapists will be full-time employees of the bidder, and that the therapists will be assigned solely to MST.
2	MST Therapists do not have <u>any</u> non-MST program responsibilities in the agency, do not carry <u>any</u> additional non-MST cases, and do not have other part-time jobs outside of the agency.	Statement in proposal indicating agreement to this requirement.
3	MST staff are allowed to work a flexible schedule as needed to meet the needs of the families they are serving.	Statement in proposal indicating agreement to this requirement.
4	MST staff are allowed to use their personal vehicles to transport clients.	Agency policy regarding client transport in personal vehicles.
5	MST staff have use of either cellular phones or pagers so that clients can contact them quickly and conveniently.	Statement in proposal indicating agreement to this requirement.
6	MST Therapists operate in teams of no fewer than 2 and no more than 4 therapists (plus the Clinical Supervisor) and use a home-based model of service delivery.	Statement in proposal indicating agreement to this requirement.
7	MST Clinical Supervisor is assigned to the MST program a minimum of 50% time per MST Team.	Statement in proposal indicating agreement to this requirement.
8	MST Clinical Supervisor conducts weekly team clinical supervision, facilitates the weekly MST telephone consultation and is available for individual clinical supervision for crisis cases.	Statement in proposal indicating agreement to this requirement.
9	MST caseloads do not exceed 6 families per therapist and the normal range is 4 to 6 families per therapist.	Statement in proposal indicating agreement to this requirement.

10	Overall average duration of treatment is 3 to 5 months.	Statement in proposal indicating agreement to this requirement.
11	Each MST Therapist tracks progress and outcomes on each case by completing MST case paperwork and participating in team clinical supervision and MST consultation weekly.	Statement in proposal indicating agreement to this requirement.
12	The MST program has a 24 hour/day, 7-day/week on-call system to provide coverage when MST Therapists are on vacation or taking personal time. This system is staffed by members of the MST team.	Copy of proposed on-call system.
13	With the buy-in of other organizations and agencies, MST is able to “take the lead” for clinical decision-making on each case. Stakeholders in the overall MST program have responsibility for initiating these collaborative relationships with other organizations and agencies while MST staff sustain them through ongoing, case-specific collaboration.	Statement in proposal indicating community stakeholder agreement to this requirement.
14	The MST program excludes youth living independently, youth referred primarily for psychiatric service needs (i.e., suicidal ideation and behavior, actively homicidal, actively psychotic), youth referred primarily for sex offenses (in the absence of other antisocial/delinquent behaviors) and youth with pervasive developmental delays.	Statement in proposal indicating agreement to this requirement.
15	Referrals to non-MST compatible programs (e.g., any form of mandated group treatment, day treatment programs, etc.) are not made while youth are in MST, especially on a “standard” or routine basis.	Statement in proposal indicating agreement to this requirement.
16	MST program discharge criteria are outcome-based rather than duration-focused.	Statement in proposal indicating agreement to this requirement.
17	Referrals for additional services after clients are discharged from the MST program are carefully planned and limited to those that can accomplish specific, well-defined goals. The assumption is that most MST cases should need minimal “formal” after-care services.	Statement in proposal indicating agreement to this requirement.
18	All MST staff, who have been working for more than 2 months, participate in a 5-day orientation training.	Statement in proposal indicating agreement to this requirement.
19	MST Therapists are Masters-prepared (clinical-degreed) professionals.	Job description for MST therapist.

	MST Recommended Program Practices	Evidence Required for Proposal
20	MST Clinical Supervisors are, at minimum, highly skilled Masters-prepared clinicians with training in behavioral and cognitive behavioral therapies and pragmatic family therapies (i.e., Structural Family Therapy and Strategic Family Therapy).	Job description for MST Supervisor.
21	MST Clinical Supervisors have both clinical authority and administrative authority over the MST Therapists they supervise.	Organizational chart indicating line of authority for MST and position of program within bidder’s organization.
22	A “Goals and Guidelines” document is in place. If multiple referral or funding sources exist, separate “Goals and Guidelines” documents are recommended for each.	Statement in proposal indicating agreement to this requirement.

23	Funding for MST cases is in the form of case rates or annual program support funding in lieu of billing mechanisms that track contact hours, “productivity”, etc.	No statement required for this proposal. The funding agency has already determined the reimbursement system.
24	The MST program has formal outcome-tracking systems in place.	Statement of what data will be collected, by whom, how often, by what method, how the data will be stored, and how data will be analyzed. (See Program Evaluation Section)
25	Adequate flex funds are allocated per family (recommended \$100/family) to allow therapists to use funds for purposes such as engagement building and one-time help for families with pressing practical needs.	Statement in proposal indicating agreement to this requirement.
26	The MST program uses outcome-focused personnel evaluation methods.	Not required , but if intended, statement in proposal indicating agreement to this requirement.

4. Quality assurance and evaluation specifications

All Providers must participate in at least annually, and possibly more frequently, contract monitoring. This contract monitoring is based on compliance with the standards defined by this request for proposal and compliance with all administrative and fiscal aspects of the contract. The CAMHD Program Monitoring Tool will be used to assess the Provider’s adherence to standards and contractual requirements.

Providers must assure the provision of quality services. Providers must follow the CAMHD Quality Assurance (“QA”) requirements that meet Medicaid requirements. The Provider must create and maintain an internal Quality Assurance Plan (“QAP”) to assure the delivery of quality services and a plan for program assessment and continuous improvement. At a minimum, this plan must address and include:

- a) A description of the organization’s vision, mission, and values, inclusive of:
 - (1) Goals and objectives;
 - (2) Scope of the QAP;
 - (3) Specific activities to be undertaken, including studies;
 - (4) Continuous tracking of issues;
 - (5) Focus on educational and positive behavioral health outcomes;
 - (6) Systematic process of quality assessment and improvement;

- (7) Evaluation of the continuity and effectiveness of the QAP;
 - (8) Resources needed for the activities of the QAP; and
 - (9) A description of how QAP documentation will be maintained and available for inspection and review
- b) A description of how the organizational structure supports and supervises its QAP, and the internal mechanisms involved in quality monitoring process. Description of the roles and responsibilities of organizational staff, youth, families, and direct providers.
 - c) A description of how QA activities findings, conclusions, recommendations, and actions taken shall be documented and reported.
 - d) Demonstration of an active QA committee.
 - e) Description of the utilization review and management programs.
 - f) Description of the following:
 - (1) Plan for ongoing credentialing and re-credentialing compliance;
 - (2) Plan for managing communication of youth's rights and responsibilities;
 - (3) Plan for service accessibility and availability; and
 - (4) Plan for how records will be maintained, including how confidentiality will be ensured in compliance with all relevant state and federal laws and regulations.
 - g) Complete yearly evaluations of workers to assess knowledge of and compliance with MST philosophy and intervention strategies.
 - h) Participate in QA evaluation activities as designated by the CAMHD, including but not limited to service testing methodology. Activities include, but are not limited to, group meetings, site visitations, and peer review of policies and procedures.
 - i) Providers will arrange for the collection of MST TAM-Rs through contracts with the MST Institute (www.mstinstitute.org). These costs will not be covered by the CAMHD directly, but rather

through the proposed budgets. The MST System Supervisor will have access to TAM-R data for all teams.

- j) Provider will be responsible to maintain accurate and current organization, team, and client progress data on the MST Institute Enhanced Website. Access to the Enhanced Website is maintained via contract between the Provider and the MST Institute (www.mstinstitute.org).
- k) Providers are responsible to administer the MST Supervisor and Consultant Adherence Measure. The implementation and scoring of these measures is estimated to take one hour of administrative time per month per MST staff member (a total of five hours per month of administrative time for a team consisting of a supervisor and four therapists).

5. Output and performance/outcome measurements

Providers are required to collect, analyze and report the following information on a quarterly basis. All Providers must submit quarterly reports of quality monitoring including analyses of performance trends through the Provider's quality assurance and improvement processes. Quarterly reports must include data with trend analysis in the quarterly reporting format provided by the CAMHD. Quarterly reports will be focused on a summary of findings and activities over the quarter including analyses of performance trends and patterns, discussion of significant findings, opportunities for improvement, and actions taken to impact performance.

Quality Assurance and Evaluation Reporting Requirements:

- a) All Providers must submit to the CAMHD Performance Management Office ("PMO") a quarterly report forty-five (45) days after the preceding quarter ends.
 - (1) The quarterly report must follow the Quarterly Summary of Quality Assurance Activities format.
 - (2) The following is a list of the reporting areas and the information that should be included in the specific area:
 - (a) Sentinel Events -
 - (i) Analysis of Trends and Patterns
 - (ii) Discussion of Significant Events

- (iii) Opportunities for Improvement Identified
 - (iv) Actions taken to Impact Client Care
 - (b) Clinical Supervision – Individual, Group, and Peer –
 - (i) Analysis of Performance of Supervision Program and Practices
 - (ii) Description of any Barriers to Implementing Supervision
 - (iii) Actions taken to impact effectiveness of supervision
 - (c) Clinical Documentation –
 - (i) Findings of Internal Chart Reviews
 - (ii) Opportunities for Improvement Identified
 - (iii) Actions taken to Impact Quality of Charts and Documentation
 - (d) Facility Conditions (if applicable)
 - (i) Brief analysis of Facility Condition
 - (ii) Opportunities for Improvement Identified
 - (iii) Actions Taken
 - (e) Highlights of other Significant Quality Assurance Findings and Accomplishments
 - (i) Findings
 - (ii) Key Accomplishments
 - (f) Updates on Improvement Plan Activities (if applicable)
- (3) QA Meeting Minutes and Agenda must be submitted with the quarterly report.

- (4) A template for the quarterly report can be electronically provided to the Provider.

6. Experience

Applicants with verifiable expertise and experience will be given preference in the evaluation process.

In order to demonstrate expertise, an agency must provide evidence of training programs, supervisory structure, and other documents showing clinical and/or managerial expertise.

In order to demonstrate experience, prior agency performance in providing similar services will be considered in the evaluation process. Applicants are strongly encouraged to identify all previous experience providing the services being proposed and detail the performance of the agency in providing these services, to include contract payer, result of contract monitoring reports, accreditation results, complaints, grievances, and contract outcomes. The documents provided by the Applicant will be used in the evaluation process, with particular attention given to the quality assurance activities implemented based upon feedback or internal findings.

7. Coordination of services

The Applicant shall describe mechanisms to be instituted to ensure that all services provided are coordinated internally within the organization, and externally with the FGC, school(s), any involved Quest or other health plan, other provider agencies, and resources in the community. Specifically, the Applicant shall identify the major groups or agencies that coordination is proposed, and define how this will be accomplished.

The Applicant shall also describe mechanisms for obtaining routine and regular stakeholder input in evaluating performance surrounding this coordination.

8. Reporting requirements for program and fiscal data

The following information must be provided:

- a) Credentialing

Provider will adopt the CAMHD General Standards for credentialing and recredentialing of clinical personnel providing services to eligible youth as detailed in the CAMHPS. This includes the maintenance of written policies and procedures for

credentialing and recredentialing licensed professionals and paraprofessional staff.

The Provider is required to adhere to Medicaid requirements for credentialing and re-credentialing of direct clinical care personnel.

The Provider is required to establish an e-mail address account specifically for its delegated credentialing specialist for direct communication with the CAMHD's Credentialing Specialist.

All direct care personnel including subcontractors must be credentialed prior to providing services to any youth, as defined in the CAMHD Credentialing and Re-credentialing Policies and Procedures (See Section 5, Attachment H).

The Provider is required to electronically submit a regular credentialing status log to the CAMHD Credentialing Specialist in the format as specified by CAMHD's Credentialing Policies and Procedures.

The Provider must submit, in a format and schedule specified by CAMHD, individual staff/subcontractor credentialing files for CAMHD review, detailing the credentialing process and primary source verifications documents for all its direct care employees and subcontractors.

Provider is required to furnish all of the above required credentialing data, reports, and corrective action plans, and any additional reports as requested, in writing, by CAMHD.

b) Training Data

PROVIDER must submit in a format specified by CAMHD, the quarterly Title IV-E Training Activities and Cost Reports (See Section 5, Attachment I) to the CAMHD Fiscal Section, in accordance with CAMHD timelines for submission, and if requested, participate in a CAMHD time study activity. CAMHD will notify PROVIDER of the format and timeline associated with this requirement.

Documentation such as training curricula or detailed content of training provided, sign in sheets with names and positions of staff receiving training, and names of person (s) conducting training and a breakdown of expenses must be available upon request

c) Fiscal Data

Monthly expenditure reports and electronic encounter data (utilization) must be submitted to the CAMHD Fiscal Section in the format specified by the CAMHD (based on the cost reimbursement method of pricing).

Original monthly claims must be submitted within thirty (30) calendar days after the last day of the calendar month. All submissions and corrections must be properly received by the CAMHD ninety (90) days after the last day of the billing month. No claims will be accepted after the ninety (90) day period. Should a provider need to bill beyond the ninety (90) day period, documented contact must be made with the CAMHD Provider Relations before the end of the ninety (90) day period or no appeal will be granted.

Any required corrective action plans and reports on all audit and fiscal monitoring findings must be submitted to the CAMHD Fiscal Section.

All Providers are required to adhere to the CAMHD billing reporting requirements. Provider's submission must comply with the Health Insurance Portability and Accountability Act ("HIPAA") and the CAMHD Policies and Procedures.

Providers are responsible for planning, implementing, and maintaining their own Information System. Providers must also supply the CAMHD with a functional e-mail address that can receive documents as well as notices. The CAMHD will not provide technical support for Provider's Information Systems or e-mail.

Providers are required to have computer hardware that supports Microsoft Windows 7, Microsoft Access 2010, Broadband Internet connection, Internet e-mail, and laser printer.

All Provider reporting data must be submitted in the manner and format specified by the CAMHD.

Prior to issuing payment for services rendered, the CAMHD will verify that the Monthly Treatment and Progress Summary ("MTPS") for required levels of care as defined in the CAMHPS has been submitted. This qualitative review will assist the CAMHD in monitoring service delivery and outcomes.

- (1) The Provider shall submit an annual organization-wide fiscal audit completed by a certified public accountant in accordance with the following standards.

- (a) Generally accepted auditing standards issued by the American Institute of Certified Public Accountants.
 - (b) Government Auditing Standards issued by the Comptroller General of the United States.
 - (c) Office of Management and Budget (“OMB”) Circular A-128 for state and local governmental agencies, if applicable.
 - (d) OMB Circular A-133 for institutions of higher education and other non-profit organizations, if applicable.
 - (e) The audit must be conducted on an annual basis and submitted to the STATE within six (6) months after the close of the organization’s fiscal year.
- (2) Provider will be required to provide cost data to determine specific costs (i.e., treatment, and other expenses that may be required by funding agencies.
 - (3) All Providers are required to be compliant with the CAMHD, State, Federal, Medicaid requirements/rules and regulations for Fraud and Abuse.
- d) Program Data
- (1) The Provider shall, at the completion of the contract period, submit a final written report summarizing contract performance to the CAMHD in a format to be prescribed by the CAMHD.
 - (2) All Providers must submit a quarterly summary of quality assurance findings as identified in the Provider’s QAP.
 - (3) The Provider shall furnish any additional reports or information that the CAMHD may require or request from time to time.

C. Facilities

The Applicant shall provide offices or facilities located in the service area. Facilities shall meet the HIPAA and American Disability Association (“ADA”) requirements, as applicable, and have special equipment that may be required for the services. The physical location of the administrative office and any service offices shall be maximally accessible to clients and families.

2.5 COMPENSATION AND METHOD OF PAYMENT

The method of pricing shall be reimbursement of actual expenditures. The cost reimbursement pricing structure reflects a purchase arrangement in which the State pays the Provider for budgeted costs that are actually incurred in delivering the services specified in the contract, up to a stated maximum obligation. The proposal budget shall be prepared in accordance with Chapter 103F, HRS, Cost Principles. Budget line items are subject to review, approval, and acceptance by the state purchasing agency.

Payments shall be made in monthly installments upon the monthly submission by the Provider of invoices for the services provided. Invoices shall be accompanied by expenditure reports, back up documentation as outlined in the SPO Cost Principles and utilization data for the billing month. Failure to comply with submission of encounter/utilization data will result in payment delays until such data are submitted.