

State of Hawaii
Department of Health
Adult Mental Health Division

Request for Proposals

RFP No. HTH 420-6-08 Homeless Outreach - Statewide

Date Issued
November 16, 2007

Date Due
January 4, 2008

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

November 16, 2008

REQUEST FOR PROPOSALS

HOMELESS OUTREACH (STATEWIDE) RFP No. HTH 420-6-08

The Department of Health, Adult Mental Health Division (“DIVISION”), is requesting proposals from qualified applicants to provide homeless outreach services. The contract term will be from April 1, 2008 through March 31, 2009. Multiple contracts will be awarded under this request for proposals.

Proposals shall be mailed, and postmarked by the United State Postal Service on or before January 4, 2008, and received no later than 10 days from the submittal deadline. Hand delivered proposals shall be received no later than 4:00 p.m., Hawaii Standard Time (HST), on January 4, 2008, at the drop-off sites designated on the Proposal Mail-in and Delivery Information Sheet. Proposals postmarked or hand delivered after the submittal deadline shall be considered late and rejected. There are no exceptions to this requirement.

The DIVISION will conduct a videoconference orientation on November 27, 2007. The time and place for the RFP orientation session is stated in Section 1 Administrative Overview of the RFP. All prospective applicants are encouraged to attend the orientation.

The deadline for submission of written questions is 4:00 p.m., HST, on January 4, 2008. All written questions will receive a written response from the State on or about December 20, 2007.

Inquiries regarding this RFP should be directed to the RFP contact person, Ms. Betty Uyema at 1250 Punchbowl Street, Room 256, Honolulu, Hawaii 96813, telephone: (808) 586-4689, fax: (808) 586-4745, email: byuyema@amhd.health.state.hi.us.

PROPOSAL MAIL-IN AND DELIVERY INFORMATION SHEET

**NUMBER OF COPIES TO BE SUBMITTED:
THE 3 COPIES MUST INCLUDE ONE (1) SIGNED ORIGINAL AND ONE (1) SINGLE
SIDED, UNBOUND COPY.**

**ALL MAIL-INS MUST BE POSTMARKED BY UNITED STATES POSTAL SERVICE
(USPS) NO LATER THAN
January 4, 2008
and received by the state purchasing agency no later than 10 days from the submittal
deadline.**

All Mail-ins

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

RFP Contact Person

Betty Uyema
For further info. or inquiries

Phone: 586-4689
Fax: 586-4745

ALL HAND DELIVERIES SHALL BE ACCEPTED AT THE FOLLOWING SITE UNTIL
4:00 P.M., Hawaii Standard Time (HST) January 4, 2008.

Drop-off Site

Oahu:

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

BE ADVISED: All mail-ins postmarked by USPS after **January 4, 2008** and not received within 10 days will be rejected.

Hand deliveries will **not** be accepted after **4:00 p.m., HST, January 4, 2008**

Deliveries by private mail services such as FEDEX shall be considered hand deliveries and will not be accepted if received after **4:00 p.m., HST, January 4, 2008.**

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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 RFP's, state purchasing agencies may add additional information as applicable. It is the responsibility of the applicant to understand the requirements of *each* RFP.

I. Procurement Timetable

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

Activity	Scheduled Date
Public notice announcing RFP	11/16/07
Distribution of RFP	11/16/07
RFP orientation session	11/27/07
Closing date for submission of written questions for written responses	12/6/07
State purchasing agency's response to applicants' written questions	12/20/07
Discussions with applicant prior to proposal submittal deadline (optional)	n/a
Proposal submittal deadline	1/4/08
Discussions with applicant after proposal submittal deadline (optional)	n/a
Final revised proposals (optional)	n/a
Proposal evaluation period	1/14/08 – 1/25/08
Provider selection	1/25/08
Notice of statement of findings and decision	2/1/08
Contract start date	4/1/08

II. Website Reference

The State Procurement Office (SPO) website is www.spo.hawaii.gov

	For	Click
1	Procurement of Health and Human Services	“Health and Human Services, Chapter 103F, HRS...”
2	RFP website	“Health and Human Services, Ch. 103F...” and “RFPs”
3	Hawaii Administrative Rules (HAR) for Procurement of Health and Human Services	“Statutes and Rules” and “Procurement of Health and Human Services”
4	Forms	“Health and Human Services, Ch. 103F...” and “For Private Providers” and “Forms”
5	Cost Principles	“Health and Human Services, Ch. 103F...” and “For Private Providers” and “Cost Principles”
6	Standard Contract -General Conditions	“Health and Human Services, Ch. 103F...” “For Private Providers” and “Contract Template – General Conditions”
7	Protest Forms/Procedures	“Health and Human Services, Ch. 103F...” and “For Private Providers” and “Protests”

Non-SPO websites

(Please note: website addresses may change from time to time. If a link is not active, try the State of Hawaii website at www.hawaii.gov)

	For	Go to
8	Tax Clearance Forms (Department of Taxation Website)	http://www.hawaii.gov/tax/ click “Forms”
9	Wages and Labor Law Compliance, Section 103-055, HRS, (Hawaii State Legislature website)	http://www.capitol.hawaii.gov/ , click “Bill Status and Documents” and “Browse the HRS Sections.”
10	Department of Commerce and Consumer Affairs, Business Registration	http://www.hawaii.gov/dcca click “Business Registration”
11	Campaign Spending Commission	http://www.hawaii.gov/campaign

III. Authority

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

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

IV. RFP Organization

This RFP is organized into five sections:

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

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

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

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

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

V. Contracting Office

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

Adult Mental Health Division
Department of Health
1250 Punchbowl Street, Room 256
Honolulu, Hawaii 96813
Phone: (808) 586-4689 Fax: (808) 586-4745

VI. Orientation

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

Date: November 27, 2007 **Time:** 9:00 a.m. 10:30 a.m.
Location: **Oahu: Keoni Ana Bldg. 1177 Alakea St. Honolulu**
Hawaii: Hilo State Office Bldg. 75 Aupuni St. Basement
Kauai: Lihue Stat Office Bldg. 3060 Eiwa St.
Maui: Maui Dist. Health Office, 210 Imikala St., Ste. 204, Wailuku

Applicants are encouraged to submit written questions prior to the orientation. Impromptu questions will be permitted at the orientation and spontaneous answers provided at the state purchasing agency's discretion. However, answers provided

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

VII. Submission of Questions

Applicants may submit questions to the RFP Contact Person identified in Section 2 of this RFP. All written questions will receive a written response from the state purchasing agency.

Deadline for submission of written questions:

Date: December 6, 2007 **Time:** 4:00 P.M. HST

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

Date: December 20, 2007

VIII. Submission of Proposals

A. Forms/Formats - Forms, with the exception of program specific requirements, may be found on the State Procurement Office website (See page 1-2, Websites Referred to in this RFP. Refer to the Proposal Application Checklist for the location of program specific forms.

1. **Proposal Application Identification (Form SPO-H-200)** - Provides identification of the proposal.
2. **Proposal Application Checklist** – Provides applicants with information on where to obtain the required forms; information on program specific requirements; which forms are required and the order in which all components should be assembled and submitted to the state purchasing agency.
3. **Table of Contents** - A sample table of contents for proposals is located in Section 5, Attachments. This is a sample and meant as a guide. The table of contents may vary depending on the RFP.
4. **Proposal Application (Form SPO-H-200A)** - Applicant shall submit comprehensive narratives that addresses all of the issues contained in the Proposal Application Instructions, including a cost proposal/budget if required. (Refer to Section 3 of this RFP.)
5. **Tax Clearance** – A certified copy of a current valid tax clearance certificate issued by the State of Hawaii, Department of Taxation (DOTAX) and the Internal Revenue Service (IRS) will be required

either at the time of proposal submittal or upon notice of award at the discretion of the purchasing agency.

Refer to Section 4, subparagraph III.A.1, Administrative Requirements, and the Proposal Application Checklist (located in Section 5) to determine whether the tax clearance is required at time of proposal submittal for this RFP. Tax clearance application may be obtained from the Department of Taxation website. (See paragraph II, Website Reference.)

- B. Program Specific Requirements** - Additional program specific requirements are included in Sections 2 and/or 3, Service Specifications and the Proposal Application Instructions, as applicable. If Federal and/or State certifications are required, they are listed on the Proposal Application Checklist located in Section 5.
- C. Multiple or Alternate Proposals** - Multiple or alternate proposals shall not be accepted unless specifically provided for in Section 2 of this RFP. In the event alternate proposals are not accepted and an applicant submits alternate proposals, but clearly indicates a primary proposal, it shall be considered for award as though it were the only proposal submitted by the applicant.
- D. Wages and Labor Law Compliance** - Before a provider enters into a service contract in excess of \$25,000, the provider shall certify that it complies with section 103-55, HRS, Wages, hours, and working conditions of employees of contractors performing services. Section 103-55, HRS may be obtained from the Hawaii State Legislature website. (See paragraph II, Website Reference.)
- E. Compliance with all Applicable State Business and Employment Laws.** All providers shall comply with all laws governing entities doing business in the State. 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 be register 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. (See paragraph II, Website Reference.)
- F. Campaign Contributions by State and County Contractors** – Contractors are hereby notified of the applicability of Section 11-205.5, HRS, which states that campaign contributions are prohibited from specified State or county government contractors during the term of the contract if the contractors are paid with funds appropriated by a legislative

body. For more information, Act 203/2005 FAQs are available at the Campaign Spending Commission webpage. (See paragraph II, Website Reference.)

- 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 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 Deliver Information Sheet. 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. Proposals shall be rejected when:

- postmarked after the designated date; or
- postmarked by the designated date but not received within 10 days from the submittal deadline; or
- 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.

IX. Discussions with Applicants

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

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

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

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

X. Opening of Proposals

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

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

XI. Additional Materials and Documentation

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

The 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.

XII. RFP Amendments

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

XIII. 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 best and final offer/proposal. *The applicant shall submit **only** the section(s) of the proposal that are amended, along with the Proposal Application Identification*

Form (SPO-H-200). After final revised proposals are received, final evaluations will be conducted for an award.

XIV. Cancellation of Request for Proposal

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

XV. Costs for Proposal Preparation

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

XVI. Provider Participation in Planning

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

XVII. Rejection of Proposals

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

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

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

- (1) Rejection for failure to cooperate or deal in good faith. (Section 3-141-201, HAR)
- (2) Rejection for inadequate accounting system. (Section 3-141-202, HAR)

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

XVIII. Notice of Award

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

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

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

Upon receipt and acceptance of the winning proposal, the DIVISION shall initiate the contracting process. The applicant who has been awarded a contract shall be notified in writing that the DIVISION intends to contract with the applicant. This letter shall serve as notification that the applicant should begin to develop its programs, materials, policies and procedures for the contract. The DIVISION will not reimburse applicants for costs incurred related to services not delivered.

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

The DIVISION reserves the right to review any subcontractor or provider contracts or agreements prior to the notification of award of the contract.

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

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

XIX. Protests

Any applicant may file a protest against the awarding of the contract. The Notice of Protest form, SPO-H-801, is available on the SPO website. (See paragraph II, Website Reference.) 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.

Head of State Purchasing Agency	Procurement Officer
Name: Chiyome L. Fukino, 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

XX. Availability of Funds

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

XXI. Monitoring and Evaluation

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

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

- (1) Performance/Outcome Measures
- (2) Output Measures
- (3) Quality of Care/Quality of Services
- (4) Financial Management
- (5) Administrative Requirements

XXII. General and Special Conditions of Contract

The general conditions that will be imposed contractually are on the SPO website. (See paragraph II, Website Reference). Special conditions may also be imposed contractually by the state purchasing agency, as deemed necessary. Terms of the special conditions may include, but not limited to, the requirements as outlined in Section 5, Attachment C.

A. Termination of the Contract

1. This contract may terminate or may be terminated by the DIVISION for any or all of the following reasons:
 - a. For any default by the applicant
 - b. For necessity or convenience
 - c. In the event of the insolvency of or declaration of bankruptcy by the applicant
 - d. In the event sufficient appropriated; otherwise unobligated funds no longer exist for the payment of the DIVISION obligations hereunder.

2. Procedure for Termination

The applicant shall:

- a. Stop work under the contract on the date and to the extent specified in the notice of termination.
- b. Notify the consumers of the termination of the contract and arrange for the orderly transition to the new provider.
- c. Place no further orders or subcontracts for materials, services, or facilities, except as may be necessary for completion of the work under the portion of the contract that is not terminated.
- d. Terminate all orders and subcontracts to the extent that they relate to the performance of work terminated by the notice of termination.
- d. Assign to the DIVISION in the matter and to the extent directed by the DIVISION Chief of the right, title, and interest of the applicant under the orders or subcontracts so terminated, in which case the DIVISION shall have the right, in its discretion, to settle or pay any or all claims arising out of the termination of such orders and subcontracts.
- e. With the approval of the DIVISION Chief, settle all outstanding liabilities and all claims arising out or such termination of orders or subcontracts, the cost of which

would be reimbursable in whole or in part, in accordance with the provisions of the contract.

- f. Complete the performance of such part of the work as shall not have been terminated by the notice of the termination.
- g. Take such action as may be necessary, or as the DIVISION Chief may direct, for the protection and preservation of any and all property or information related to the contract which is in the possession of the applicant and in which the DIVISION has or may acquire an interest.
- h. Within ten (10) working days from the effective date of the termination, deliver to the DIVISION copies of all current data files, program documentation, and other documentation and procedures used in the performance of the contract at no cost to DIVISION. The applicant agrees that the DIVISION or its agent shall have a non-exclusive, royalty-free right to the use of such documentation.

3. Termination Claims

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

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

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

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

B. Extension of Contract

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

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

C. Dispute Resolution

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

XXIII. Cost Principles

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

The DIVISION may also be required to make small or major unanticipated modifications to individual contracts. Reasons for such modifications may

include, but are not limited to recommendations made by the DIVISION's technical assistance consultant, national trends, and needs of the Hawaii State Department of Health.

Section 2

Service Specifications

I. Introduction

A. Overview, purpose or need

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

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

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

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

B. Planning activities conducted in preparation for this RFP

The DIVISION published a Request for Information on April 9, 2007 seeking the public's input on the availability of potential service providers, staffing capabilities for services, and culturally specific service capabilities.

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

C. Description of the goals of the service

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

Hawai'i's adult mental health service delivery system is based on the concept of recovery, that consumers can lead fulfilling lives even in the presence of a severe and persistent mental illness. Services are focused on

the need of the individual, not only on symptom relief and stabilization, but on consumer empowerment and the skills needed to lead satisfying, hopeful and contributing lives.

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

The goals of the services described in this RFP include, but are not limited to, reduction of hospitalization, increase of independent functioning, and decrease of contact with the criminal justice system through the effective outreach to and engagement of consumers who are homeless or at risk for homelessness. These goals are met through the achievement of outcome measures which affect the consumer, and of performance indicators which are benchmarks for programs.

D. Description of the target population to be served

Adults with severe and persistent mental illness who meet DIVISION eligibility criteria and are homeless or at risk for homelessness.

E. Geographic coverage of service

Statewide.

Organizations may apply for one (1) or more islands or for specific geographical areas of any island. The applicant shall demonstrate the capacity to provide the required services in the service area for which it is applying. A separate proposal is required to be submitted for each island or geographical area.

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

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

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

2. Disallow all or part of the cost.
3. Restrict, suspend or terminate the contract.

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

Competition is encouraged among as many applicants as possible.

II. General Requirements

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

1. The DIVISION will require accreditation by the Commission on Accreditation of Rehabilitation Facilities (“CARF”), Joint Commission on Accreditation of Healthcare Organizations (“JCAHO”), International Center for Clubhouse Development (“ICCD”), Council on Accreditation (“COA”), or by another DIVISION approved certification/licensing process. Applicants that are currently accredited are required to maintain accreditation. Applicants who are not accredited are required to achieve accreditation within one (1) year from the date of contract award.
2. Applicants shall have an administrative structure in place capable of supporting the activities required by the RFP. Specifically, there shall be clinical, financial, accounting and management information systems, and an organizational structure to support the activities of the applicant.
3. The applicant shall have a written plan for disaster preparedness.
4. The applicant shall cooperate with the DIVISION in approved research, training, and service projects provided that such projects do not substantially interfere with the applicant’s service requirements as outlined in this RFP.
5. The applicant shall comply with all specified, applicable existing policies, procedures, directives, and provider manual of the DIVISION and, any applicable policies, procedures, directives, and provider manual developed in the future.
6. Whenever requested, the applicant shall submit a copy of its operating policies and procedures to the DIVISION. The copy

shall be provided at the applicant's expense with revisions and updates as appropriate.

7. The applicant shall assign staff to attend provider meetings as scheduled by the DIVISION.
8. The applicant shall notify and obtain the approval of the DIVISION prior to the presentation of any report or statistical or analytical material based on information obtained through this agreement. Formal presentation shall include, but not be limited to papers, articles, professional publications, and presentations. The applicant shall not advertise, distribute, or provide to any consumer, any material relating to the contract that has not been approved by the DIVISION. The applicant shall not change the material without the consent of the DIVISION. All consumer satisfaction surveys and methodology must be reviewed and approved by the DIVISION prior to implementation.
9. Consumer Management Requirements:
 - a. Incorporate "best practices/evidence-based practices" in any consumer service.

"Best practices/evidence-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. Applicants will be required to incorporate these into their service delivery and cooperate with educational and monitoring activities.
 - b. Document evidence of consumer input into all aspects of recovery planning inclusive of service related decisions.
 - c. Consumers shall be served in the "least restrictive" environment as determined by the consumer's level of care assessment, as established in section 334-104, Hawaii Revised Statutes and in any appropriate federal guidelines.

- d. Consumers shall be made aware of and have access to community resources appropriate to their level of care and treatment needs.
- e. Consumers shall receive services in a manner compatible with their cultural health beliefs, practices and preferred language.
- f. In accordance with Chapter 11-175, Hawaii Administrative Rules, and any appropriate federal guidelines, the applicant shall respect and uphold consumer rights. The applicant shall recognize the rights of authority of the consumer in the delivery of services, in deciding on appropriate treatment and services and in providing input into the decisions of all aspects of service. The rights of the consumer are listed in Section 5, Attachment D.
- g. The applicant shall have a mechanism for receiving, documenting and responding to consumer grievances, including an appeals process. The mechanism must be consistent with the DIVISION's Policies and Procedures on Consumer Grievances and Consumer Appeals which are found in Section 5, Attachment E.
- h. The applicant shall provide the DIVISION's Quality Management program, a written record of sentinel events, incidents, grievances, and appeals and efforts to address the situation and improve services on-site.
- i. The applicant shall comply with any applicable Federal and State laws such as title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 C.F.R. part 80, the Age Discrimination Act 1975 as implemented by regulations at 45 C.F.R. part 91, the Rehabilitation Act of 1973, and titles II and III of the Americans with Disabilities Act.
- j. The applicant shall describe how they protect confidential information. The applicant shall not use or disclose patient health information ("PHI") in any manner that is not in full compliance with Health Insurance Portability and Accountability Act of 1996 ("HIPAA") regulations or with the laws of the State of Hawaii. The applicant shall maintain safeguards, as necessary, to ensure that PHI is not used or disclosed except as provided by the Agreement or by law. The applicant shall not use or further disclose PHI

for any purpose other than the specific purposes stated in DIVISION contracts or as provided by law and shall immediately report to DIVISION any use or disclosure of PHI that is not provided by contract or by law.

- k. The applicant shall maintain confidential records on each consumer pursuant to section 334-5, Hawaii Revised Statutes, 42 U.S.C. sections 290dd-3 and 290ee.3 and the implementing federal regulations, 42 C.F.R. Part 2, if applicable, and any other applicable confidentiality statute or rule. Such records shall be made available to the DIVISION upon request.
- l. Written consumer consent shall be obtained for individuals and services funded by the DIVISION including:
 - 1) Consent for evaluation and treatment;
 - 2) Consent to release information by DIVISION funded service providers as needed for continuity of care, including after care services; and
 - 3) Other consent documents as needed.

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

- 10. If a subcontractor is used, the applicant shall ensure the DIVISION that they, as the applicant have the ultimate responsibility that subcontractor(s) will provide behavioral health services that meet the criteria of this RFP. Subcontractors must be responsive and responsible to meet the expectations of the applicant and the DIVISION.
- 11. Financial Requirements
 - a. The State may require providers to submit an audit as necessary. If the applicant expends \$500,000 or more in a year of federal funds from any source, it shall have a single audit conducted for that year in accordance with the Single Audit Act and Amendments of 1999, Public Law 104-156.

- b. The applicant shall comply with the COST PRINCIPLES developed for Chapter 103F, HRS and set forth in the document SOP-H-201. This form (SPO-H-201) is available on the SPO website (see Section 1, paragraph II, 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.
- d. Notification of Changes in Consumer Status.

As part of education conducted by the DIVISION, consumers shall be notified that they are to provide the applicant, 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 should complete the DIVISION UM Admission/Discharge/Update form and send it to 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 applicant shall also explain the information and the procedures to be followed by the consumers during the orientation process.

It is expected that not all consumers will remember to or be able to provide information on changes to their status. Therefore, it is important for the applicant 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 applicant shall notify each case manager and the DIVISION of changes in consumer status by calling or faxing the information to the DIVISION, UM unit within five (5) calendar days of discovery.

e. Changes in Consumer Status include:

- 1) Death of the consumer
- 2) Change in address, including homelessness
- 3) Change in name
- 4) Change in phone number
- 5) Institutionalization (imprisonment or long term care)
- 6) Short term inpatient psychiatric treatment
- 7) Third Party Liability (“TPL”) coverage, especially employer-sponsored, Medicare or Medicaid

f. Disenrollment from DIVISION

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

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

ninety (90) days either crediting the DIVISION or providing payment to the applicant upon the receipt of a claim.

The Applicant shall:

- 1) Provide a list of service expenses, in the format requested by the DIVISION, for recovery purposes.
- 2) Recover service expenses incurred by consumers from all other TPL resources.
- 3) Inform the DIVISION of TPL information uncovered during the course of normal business operations.
- 4) The applicant shall describe all eligible sources of revenue from third parties and plans to pursue additional sources of revenues.

h. Fraud and Abuse/Neglect

Through its compliance program, the applicant shall identify employees, subcontractors or providers who may be committing fraud and/or abuse. The applicant activities may include, but are not limited to, monitoring the billings of its employees, subcontractors or providers to ensure consumers receive services for which the applicant and the State are billed; monitoring the time cards of employees that provide services to consumers under cost payment arrangements; investigating all reports of suspected fraud and over-billings (upcoding, unbundling, billing for services furnished by others, billing for services not performed, and other over-billing practices), reviewing for over-or under-utilization, verifying with consumers the delivery of services and claims, and reviewing and trending consumer complaints regarding employees, subcontractors and providers.

The applicant shall promptly report in writing to the DIVISION instances in which suspected fraud has occurred within thirty (30) days of discovery. The applicant shall provide any evidence it has on the billing practices (unusual billing patterns, services not rendered as billed and same services billed differently and/or separately). If the billing has not been done appropriately and the applicant does not believe the inappropriate billing meets

the definition of fraud (i.e., no intention to defraud), the applicant shall notify the DIVISION in writing of its findings, adjustments made to billings, and education and training provided to prevent future occurrences.

Any suspected case of physical, emotional or financial abuse or neglect of a consumer who is a dependent adult must be reported by the applicant to Adult Protective Services, or of a child to Child Protective Services, and 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 applicant agrees to provide access to all requested medical records/documents. It is the responsibility of the applicant to ensure that its subcontractors and providers also provide DIVISION and its agents, and in the case of MRO services, the CMS, the OIG, the MQD and their agents, access to requested medical records/documents. Reimbursements for services deemed not medically necessary or not following billing guidelines by the DIVISION or its agent shall be denied. Reimbursements received by applicants for consumers with third party coverage (including consumers with Medicaid and/or Medicare) will be considered full payment (see Section 2.II.11.g.). Any DIVISION overpayments for services shall be recouped by the DIVISION from the applicant.

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

- j. Medicaid

The MQD under the Department of Human Services (“DHS”) administers medical assistance to qualified, indigent, uninsured and underinsured. Aged, blind, and disabled recipients receive medical, dental, and behavioral health services under Medicaid Fee-for-Service from contracted providers. A large group of Medicaid eligible recipients receive medical and behavioral health services from contracted Medicaid Managed Care Health Plans under the QUEST and QUEST-Net programs. A small population of Medicaid Fee-for-Service, QUEST, and

QUEST-Net recipients are enrolled in a behavioral health carve-out program for severely mentally ill adults. This behavioral health carve-out program is contracted by MQD. Some of the services provided to the individuals in the carve-out program are similar or identical to services provided by the DIVISION and consumers enrolled in this program shall receive services through them except for those services not included as a benefit of that program. Section 2.II.A.11.m. describes the MRO and how applicants providing certain services will participate.

- k. The applicant shall submit claims electronically in the HIPAA compliant 837 format unless a waiver permitting use of the CMS 1500 is granted from the DIVISION's Fiscal Unit. Claims shall be submitted for payment within sixty (60) days of the provision of services. Any invoices or requests for payment received after the sixty (60) days will be paid upon availability of funds. Claims for dates of service over one (1) year prior to submission of the original claim shall be denied for untimeliness. (N/A)
- l. If the applicant is required to provide encounter data, the HIPAA compliant 837 format shall be utilized to submit that data electronically. (N/A)
- m. The applicant shall make an application for certification by the DIVISION, as a provider under the MRO within one (1) month of contract award 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. (N/A)
 - 1) MRO services are:
 - a) Assertive Community Treatment (“ACT”);
 - b) Intensive Case Management (“ICM”);
 - c) Psychosocial Rehabilitation Services (“PSR”);
 - d) Intensive Outpatient Hospital Services (“Partial Hospitalization”);

- e) Therapeutic Living Supports Provided in a Mental Health and/or Substance Abuse Residential Setting (non-IMD) (Specialized Residential Services);
 - f) Licensed Crisis Residential Services (“LCRS”);
 - g) Crisis Mobile Outreach (“CMO”);
 - h) Crisis Support Management (“CSM”);
 - i) Respite Beds; and
 - j) Interim Housing;
- 2) The DIVISION shall be responsible for:
- a) Certification of Adult MRO applicants and providers;
 - b) Utilization Management;
 - c) Receipt and adjudication of claims;
 - d) Development and maintenance of a provider manual;
 - e) Monitoring appropriateness and quality of services and claims;
 - f) Paying providers for services; and
 - g) Returning federal share that is disallowed.
- 3) The DHS shall:
- a) Set rates;
 - b) Pay federal match to the DIVISION; and
 - c) Conduct reviews of claims, encounters and other documentation.

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

12. The applicant shall provide current, valid licenses and certificates, as applicable, in accordance with federal, state and county regulations, and comply with all applicable Hawaii Administrative Rules.
13. Insurance Policies. In addition to the provisions of the General Conditions No. 1.4, the applicant, at its sole cost and expense, shall procure and maintain policies of professional liability insurance and other insurance necessary to insure the applicant 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 this Agreement. Subcontractors and contractors shall also be bound by this requirement and it is the responsibility of the applicant to ensure compliance with this requirement. Policies shall not be less than ONE MILLION AND NO/100 DOLLARS (\$1,000,000.00) per occurrence and not less than THREE MILLION AND NO/100 DOLLARS (\$3,000,000.00) in the aggregate annually. The applicant shall name the State of Hawaii as an additional insured on all such policies, except on professional liability insurance coverage. The applicant shall provide certificates of insurance to the DIVISION for all policies required under this Agreement.

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

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, 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 QUEST funding, if possible.
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.

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:	<u>3</u>
Maximum length of contract:	<u>4 years</u>
The initial period shall commence on the contract start date or Notice to Proceed.	
Conditions for extension: Option for renewal or extension shall be based on the provider's satisfactory performance of the contracted service(s) and availability of funds.	

F. RFP contact person

The individual listed below is the sole point of contact from the date of release of this RFP until the selection of the successful provider or providers. Written questions should be submitted to the RFP contact person and received on or before the day and time specified in Section 1, paragraph I (Procurement Timetable) of this RFP. The contact person is Ms. Betty Uyema. She may be reached at (808) 586-4689, fax (808) 586-4745, or email byuyema@amhd.health.state.hi.us.

III. Scope of Work

A. Service Activities

(Minimum and/or mandatory tasks and responsibilities)

The need for effective outreach is particularly critical for homeless mentally ill adults, who are among the least able to access appropriate agencies because they reject traditional mental health and social services. Outreach is the initial and most critical step to connecting or reconnecting homeless persons with severe mental illness who are not currently engaged in treatment. Unlike facility-based mental health services, most outreach programs for homeless people literally take place in the streets. The case manager or homeless specialist may offer a cup of coffee and listen to a homeless person's concerns as the first step in connecting him or her to needed mental health, physical health, social welfare, and housing services. It is through the use of these "non-traditional" methods of outreach and engagement that trust is established with these consumers to eventually link them with needed services.

Engagement is a crucial process. It is a process to establish a trusting relationship between the homeless specialist and the consumer. Engagement reduces fears and builds trust so that the homeless specialist can conduct an assessment of the consumer's needs. The engagement process is often lengthy. To be successful, outreach efforts must be assertive, tailored to the needs and perception of the individual.

Effectively engaging homeless consumers and initiating outreach efforts is the first step toward receiving more formal mental health services. Once adequate rapport and trust is established between the outreach specialist and the consumer, case management services may commence, as a tradition into the formal system of mental health services. This type of case management is intended to serve during this interim period; the time between the initial outreach and engagement efforts, to the time in which consumers are formally linked with a mental health provider. Interim case management provides a slow progression towards this more formal system of care, and constitutes a gentle transition to another level of service. "Interim" case management is also intended to be of short duration of time, serving merely as a bridge or transition to formal case management services.

The goal of this program is to connect homeless consumers with mental health services and other resources to assist them in moving to transitional or permanent housing. Homeless individuals eligible for this service are defined as, homeless adults who are eighteen (18) years of age and older, with a severe and persistent mental illness and substance abuse problem with no fixed place of residence; and individuals who meet the severe and

persistent mentally ill requirements, who have previously been homeless, who have been in housing for less than twenty-four (24) consecutive months, or who are deemed as being at risk of becoming homeless again.

The applicant shall provide the following Homeless Outreach and Interim Case Management services.

1. Provide assertive outreach and interim case management services for consumers in a setting where these consumers feel secure and comfortable. The settings may include, but are not limited, to homeless shelters, streets, residential units, parks, beaches, or wherever consumers congregate.
2. Provide a homeless specialist who shall work flexible hours to reach and establish contact with consumers.
3. Provide case finding and outreach to consumers for the purpose of linking them to services including, but not limited to, entitlements, food, clothing, other personal necessities, and housing including assistance to apply for Federal, State, City, or County rental subsidies including, but not limited to, the Bridge Subsidy, Shelter Plus Care, Section 8, or Section 811, medical treatment, mental health treatment, dental treatment, substance abuse treatment, job training, and other services as needed.
4. Register eligible consumers with the DIVISION and provide the linkage between the consumer, mental health, and other community services. Upon the consumer's registration with the DIVISION, the homeless specialist shall provide interim case management services for that consumer.
5. Respond to all outreach requests from the DIVISION involving homeless consumers requiring service assistance.
6. Link all consumers who are deemed ready for referral by the homeless specialist to the CENTERS.
7. Provide interim case management, case monitoring, service coordination, collateral contacts, and advocacy on behalf of the consumer through face-to-face or telephone contacts for consumers registered with the applicant.
8. Collaborate with the DIVISION to identify and obtain community resources for the consumer including, but not

limited to, community beds and supporting the development of a comprehensive homeless mental health system of care. On a quarterly basis, the homeless specialist shall meet with Community Based Case Management (CBCM) programs, including case managers, to maximize the effective delivery of outreach and interim case management services to consumers. The homeless specialist shall also collaborate with other programs that provide services to homeless, severe and persistently mentally ill consumers.

9. Applicants are encouraged to propose and describe an innovative “mainstreaming” program approach that offers consumers employment and/or training opportunities, i.e. clubhouse, transitional employment positions, full and part time employment, or other types of job training within the organization.
10. Incorporate recovery as a personal process of empowerment in overcoming the negative impact of a psychiatric disability and substance abuse disorder, and instilling hope and maximum independence despite continued presence of illness.
11. Have a policy that emphasizes a welcoming, emphatic and integrated approach to working with individuals with co-occurring substance and mental illness.

B. Management Requirements

(Minimum and/or mandatory requirements)

1. Personnel

- a. The organization shall have a consistently applied, documented method for measuring staff competencies which include, but are not limited to the following:
 - 1) Staff proficiency in treating individuals with a co-occurring substance use disorder using a DIVISION tool or a tool approved by the DIVISION (usually applies to programs providing treatment).
 - 2) Staff competency in providing warm, emphatic approaches in dealing with consumers.

- 3) Staff competencies related to the requirements of the job and the needs of the persons served.
- b. The applicant shall submit position descriptions as a part of their responses to the RFP for direct care and supervisory staff responsible for the delivery of services as indicated in Section 3.III.A. Position descriptions shall include the minimum qualifications, including experience for staff assigned to the service.
 - c. 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.
 - d. The homeless outreach specialist shall have a high school diploma with three (3) years experience in the human services field.
 - e. Supervision of the homeless outreach specialist shall be performed monthly by a staff meeting the minimum qualifications of a Mental Health Professional. Please refer to the Attachment F for a description of these minimum qualifications.
 - f. The applicant shall ensure and document that all staff receive appropriate and regular clinical and administrative supervision at least once a month. Clinical supervision may utilize a combination of the following methods:
 - 1) Individual side-by-side sessions,
 - 2) Participation with staff in organizational staff meetings and regularly scheduled recovery planning meetings, or
 - 3) Regular meetings with individual staff to review their work with consumers and assess clinical performance.
 - g. The applicant shall ensure and document that its personnel receive appropriate education and training in techniques and modalities relevant to their service activity for the

treatment and rehabilitation of individuals with mental illness, following the organization's policy and procedures.

- h. The applicant shall provide continued education and training to homeless outreach specialists at least 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 outreach and interim case management staff, and shall be developed in conjunction with the DIVISION.
- i. At least one (1) training session each contract period shall address the areas of substance abuse and dual diagnosis.
- j. The applicant shall ensure that all of its personnel attend trainings sponsored or required by the DIVISION, as appropriate to the service(s) they are providing. Training shall include compliance with DIVISION requirements for fraud and abuse prevention.

2. Administrative

- a. Services shall be authorized by the DIVISION's utilization management process, by prior authorization or registration, and 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 program 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 applicant shall accept all referrals deemed appropriate by the DIVISION's utilization management process. If the applicant is unable to meet the needs of the referral, the applicant shall work conjointly to find an alternate approach that will adequately meet the needs of the referred case.
- c. Each consumer's entire treatment team shares responsibility for coordination and continuity of the consumer's care, regardless of the service, setting or provider. However, the case manager shall be responsible for coordinating the development of and monitoring the implementation of the Individual Recovery Plan ("IRP")

and shall act as the communications liaison between team members and service providers with respect to the IRP.

- d. All consumers shall be registered for services and have a record open within the DIVISION'S information system. When requested by the DIVISION, the applicant shall obtain and provide the information necessary to register, open and monitor services received. Applicants shall also report all required information when cases are closed or consumers transferred to another level of care within one (1) working day of such action. All recipients shall be registered with the DIVISION and authorized for services as appropriate.
- e. The applicant shall cooperate with the coordination and the transition of services for newly enrolled consumers with the consumer's current DIVISION provider, Medicaid fee-for-service provider, Community Care Services ("CCS"), and/or a QUEST health plan, since many of the eligible consumers already have an established behavioral health care provider.

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

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

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

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

3. Quality assurance and evaluation specifications

- a. The purpose of quality management is to monitor, evaluate, and improve the results of the applicant's services in an ongoing manner. Quality care includes, but is not limited to:
- 1) Provision of services in a timely manner with reasonable waiting times;
 - 2) Provision of services in a manner which is sensitive to the cultural differences of consumers;
 - 3) Provision of services in a manner which is accessible for consumers;
 - 4) Opportunities for consumers to participate in decisions regarding their care;
 - 5) 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) Improved clinical outcomes and enhanced quality of life;
 - 10) Consumer satisfaction;
 - 11) User friendly grievance procedures which resolve issues in a timely manner; and
 - 12) Upholds consumer rights.
- b. The applicant's quality management program shall include, at a minimum, the content indicated in Section 3, I.I.C.
- c. The applicant shall participate in the DIVISION's continuing quality management program and activities as directed by the DIVISION. The applicant shall ensure that

a staff member be available to participate in system-wide quality management meetings as scheduled by the DIVISION.

d. The Quality Management reporting requirements provide:

- 1) Information on the activities and actions of the applicant's Quality Management and related programs; and
- 2) Performance measures.

The objectives of the performance measures are:

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

e. Required Quality Management Activities Reports

The applicant shall provide the following reports and information:

- 1) Annual consumer satisfaction survey report;
- 2) Written notification of any Quality Management Program (if written Program required) modifications;
- 3) Senior personnel changes, 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 applicant, employees, subcontractors or providers as soon as possible, but no later than five (5) working days after the applicant is made aware of the event;

- 7) Notice to Utilization Management of consumer admission and discharge from services or change in level of care in writing within one (1) working day of such action;
- 8) Written notification of suspected fraud within thirty (30) calendar days of discovery, and of consumer abuse and neglect immediately upon discovery; 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 applicant shall be required to meet ongoing informational needs of the DIVISION over the course of the contract period through the production of informational responses in both paper and computer format. The specific content of these requests cannot be readily specified in advance as the DIVISION is required to provide a variety of ad hoc reports to funding sources including the legislature and other branches of State government, as well as to national tracking and research groups, the Federal government, advocacy organizations, accreditation bodies, professional groups, stakeholder groups, and others. Regular requests for information to the applicant shall occur in the following areas, including consumer demographics, consumer needs, clinical and service information including encounter data, staffing and capacity patterns, risk management areas, consumer outcomes, regulatory compliance, organizational processes, resource utilization, and billing and insurance areas. The DIVISION will work with the applicant over the contract period to streamline requests for information when those requests are regular and ongoing.

5. Experience

Staff shall meet the minimum qualifications as prescribed in this RFP.

6. Coordination of services

Refer to Scope of Work, Service Activities in Section 2, III.A.

7. Reporting requirements for program and fiscal data

- a. Reports shall be submitted in the format and by the due dates prescribed by the DIVISION.
- b. The required content and format of all reports shall be subject to ongoing review and modification by the DIVISION as needed.
- c. At the discretion of the DIVISION, providers may be required to submit reports in an approved electronic format, replacing some written reports.

8. **Contract Compliance**

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

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

1) **Timeliness of Data Submitted**

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

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

2) **Accuracy and Completeness**

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

9. Pricing structure or pricing methodology to be used

Cost Reimbursement

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

10. Units of service and unit rate

Not applicable

11. Method of compensation and payment

Providers shall be compensated for homeless outreach and interim case management services on a cost reimbursement basis.

IV. Facilities

Not applicable.

Section 3

Proposal Application Instructions

Section 3

Proposal Application Instructions

General instructions for completing applications:

- *Proposal Applications shall be submitted to the state purchasing agency using the prescribed format outlined in this section.*
- *The numerical outline for the application, the titles/subtitles, and the applicant organization and RFP identification information on the top right hand corner of each page should be retained. The instructions for each section however may be omitted.*
- *Page numbering of the Proposal Application should be consecutive, beginning with page one and continuing through for each section. See sample table of contents in Section 5.*
- *Proposals may be submitted in a three ring binder (Optional).*
- *Tabbing of sections (Recommended).*
- *Applicants must also include a Table of Contents with the Proposal Application. A sample format is reflected in Section 5, Attachment B of this RFP.*
- *A written response is required for **each** item unless indicated otherwise. Failure to answer any of the items will impact upon an applicant's score.*
- *Applicants are **strongly** encouraged to review evaluation criteria in Section 4, Proposal Evaluation when completing the proposal.*
- *This form (SPO-H-200A) is available on the SPO website (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.*

The Proposal Application comprises the following sections:

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

I. Program Overview

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

II. Experience and Capability

A. Necessary Skills

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

B. Experience

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

C. Quality Assurance and Evaluation

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

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

1. A written Quality Management Program description and outlined structure which includes the Quality Committee reporting structure, including Governing Board Involvement, voting composition, and a written process for goal and priority setting following standardized methodology and data collection, which is updated and signed annually.
2. The Quality Management Program must address consumer complaints, grievances, appeals, sentinel events and consumer satisfaction.
3. The Quality Management Program must have a system or policy that outlines how items are collected, tracked, reviewed 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 shall be available to represent utilization and quality management issues at meetings scheduled by the DIVISION.
9. Provision of a utilization management system, including but not limited to the following: a) system and method of reviewing utilization; b) method of tracking authorization approvals; c) method of reviewing invoices against authorizations; d) consumer appeals process; e) annual evaluation of the applicant's utilization management plan; and, g) identification of the person in the organization who is primarily responsible for the implementation of the utilization management plan.
10. A policy and procedure for consumer complaints, grievances and appeals which includes documentation of actions taken, and demonstration of system improvement.
11. Assurance that the applicant has established and will maintain and regularly update the following QM policies and procedures:
 - a. Consumer complaints, grievances and appeals
 - b. Consumer Safety
 - c. Consumer Satisfaction
 - d. Disaster preparedness
 - e. Emergency Evacuation
 - f. Evidence Based Practice Guidelines
 - g. LOCUS/Level of Care Placement
 - h. Compliance

- i. Consumer Rights and Orientation
 - j. Confidentiality/HIPAA
 - k. Treatment Records
 - l. Individualized Service Plans
 - m. Transition of consumers to other programs
 - n. Treatment Team
 - o. Use of Restraints
 - p. Restricting Consumer Rights
 - q. Credentialing Staff
12. A training plan and staff handbook/personnel manual for staff that is responsible for delivery of services. Training shall include but not be limited to: Substance Abuse, Forensics, Sentinel Events, Risk Management, Compliance, HIPAA Compliance, Consumer Rights, Treatment Planning, and Access and Treatment for Non-English Speaking Consumers.
 13. A consumer handbook/brochure(s) that outline services available to the consumer, hours of operations, contact information (phone numbers, and instructions on emergency services), is written at a 6th grade reading level, provides an overview and the applicant's approach to care, and clearly outlines any major program rules that could lead to discharge from services offered by the organization.
 14. A description of the steps that the applicant will take to comply with all of the DIVISION'S reporting requirements as specified in Section 2. III. B. 2., 4., and 7. The applicant shall also indicate how it will use the information in the report to improve its services.
 15. Where there is an intention to subcontract, the applicant must demonstrate that services provided by the subcontractor are consistent with all applicable requirements specified in Section 2 including, but not limited to, compliance with reporting requirements. The applicant must describe the monitoring 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 Individual Service Plan developed by the DIVISION designated case manager and consumer.
 - d. Consumer involvement in service planning.
 - e. Statement that the applicant will participate in the use of outcome instruments at the discretion of the DIVISION.
 - f. Identification of fiscal and program contact person.
17. For services described in this RFP, a statement that the applicant shall participate with the DIVISION'S quality and utilization management process including, but not limited to, case reviews, specific data gathering and reporting, peer review, concurrent review, site visitation, special studies, monitoring, credentialing, and training.

D. Coordination of Services

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

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

1. A history of the applicant's cooperative efforts with other providers of mental health services.
2. Memorandum of agreements with other agencies (if required in the RFP).
3. Applicant's current efforts to coordinate with the DIVISION, CENTERS, HOSPITAL, and other POS providers, and where there is no current coordination, the applicant's plans to do so.

E. Facilities

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

F. Management Information System (“MIS”) Requirements

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

1. A statement about whether the applicant is a covered entity as defined by HIPAA. A statement that the applicant will comply with all HIPAA privacy, security and transactional code set requirements.
2. An explanation of how the applicant currently manages information in order to submit required information and data in the format prescribed by the DIVISION. Required data elements captured in the provider system and reported to the DIVISION may include, but are not limited to: consumer’s last name, first name, middle name, any aliases, social security number, DIVISION-generated unique ID number, DIVISION-generated authorization number(s), Medicaid ID number, Medicare ID number, other third party insurer numbers, address, telephone number, admission date, discharge date, service data using DIVISION approved procedure codes, date of birth, and gender, primary language spoken.
3. The DIVISION may add data reporting requirements or specify required formats for downloading data or submitting claims in the future. Applicants are encouraged to describe their flexibility in meeting changing data requirements.
4. For any Fixed Unit of Service Rate contracts, a statement that the applicant shall submit claims electronically in the 837 format. (N/A)
5. Where infrastructure is lacking to meet MIS requirement, applicants shall propose solutions and include the proportion of cost related to this contract in their response to the RFP.

III. Project Organization and Staffing**A. Staffing****1. Proposed Staffing**

The applicant shall describe the proposed staffing pattern, client/staff ratio and proposed caseload capacity appropriate for the viability of the services. The applicant shall give the number and title of the positions needed to provide the specific service activities. Positions descriptions shall also be submitted. (Refer to the personnel requirements in the Service Specifications, as applicable.)

2. Staff Qualifications

The applicant shall describe in this section of its proposal how it will ensure its compliance with the personnel requirements which include, but are not limited to, licensure, educational degrees, and experience for staff assigned to the program. (Refer to the qualifications in the Service Specifications, as applicable.)

B. Project Organization

1. Supervision and Training

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

2. Organization Chart

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

IV. Service Delivery

A. Scope of Work

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

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

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

requirements in Section 2, III.B.1. Services proposed to be subcontracted out must be included in this description.

2. A clear description of the target population to be served.
3. 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.
4. A description of the methods the applicant will use to determine when treatment goals are accomplished and when to terminate services
5. A description of the accessibility of services for the target population, and a description of impediments to services and efforts to overcome barriers.
6. 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.
7. An indication of the "best practices/evidence-based practices" the applicant incorporates and a citation of the literature to support its "best practices/evidence-based practices". A description of the system it uses to implement and maintain its "best practice/evidence-based practices" program integrity.
8. A statement to assure that the applicant shall conform to the DIVISION's standardized assessment package.
9. Where applicable, demonstration that the applicant is capable of providing twenty-four (24) hour coverage for services.
10. For services with twenty-four (24) hour, seven (7) days a week coverage, description of how the applicant's on-call system works, i.e., methodology relative to applicant's answering service. Specifically describe how consumers access applicant's service and staff availability.
11. Where the service is housing, residential or day treatment / intensive outpatient hospital service, a weekly schedule that can be individualized to consumers and consistent with the requirements of the scope of services described in Section 2.III.A.
12. A description by the applicant of the involvement of the consumer in the decisions regarding the services the consumer receives.
13. A statement by the applicant that it is ready, able, and willing to provide services throughout the time of the contract period.

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

A. General Requirements

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

B. Administrative Requirements

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

V. Financial

A. Pricing Structure

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

The DIVISION is permitting the use of a cost reimbursement pricing structure for the RFP. The cost reimbursement pricing structure reflects a purchase arrangement in which the State pays the contractor for budgeted costs that are actually incurred in delivering the services specified in the contract, up to a stated maximum obligation. All budget forms, instructions and samples are located on the SPO Website (see Section 1, paragraph II, Website Reference). The following budget forms shall be submitted with the Proposal Application:

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

The DIVISION is permitting the use of a cost reimbursement pricing structure for the RFP. The cost reimbursement pricing structure reflects a purchase arrangement in which the State pays the contractor for budgeted costs that are actually incurred in delivering the services specified in the contract, up to a stated maximum obligation. All budget forms, instructions and samples are located on the SPO Website (see Section 1, paragraph II, Website Reference). The following budget forms shall be submitted with the Proposal Application:

B. Other Financial Related Materials

1. Accounting System

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

- a. The applicant shall submit a cost allocation plan showing how costs are allocated across different funding sources.
- b. Also, the applicant shall submit a copy of its most recent audited or compiled financial statements.

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

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

VI. Other

A. Litigation

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

Section 4

Proposal Evaluation

Section 4 Proposal Evaluation

I. Introduction

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

II. Evaluation Process

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

The evaluation will be conducted in three phases as follows:

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

Evaluation Categories and Thresholds

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

III. Evaluation Criteria

A. Phase 1 - Evaluation of Proposal Requirements

1. Administrative Requirements

2. Proposal Application Requirements

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

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

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

1. Experience and Capability Total 20 Points

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

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

a. Necessary Skills (5 points)

- 1) Demonstrated skills, abilities, and knowledge relating to the delivery of the proposed services.
- 2) Demonstrate the ability to respond to consumer complaints, appeals and grievances including those brought to the attention of the DIVISION.

b. Experience (2 points)

Possesses the skills, abilities, knowledge of, and experience relating to the delivery of the proposed services including,

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

c. Quality Assurance and Evaluation (6 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.II.C.12.

d. Coordination of Services (2 points)

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

e. Facilities (0 points)

Adequacy of facilities relative to the proposed services. – Not applicable.

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

- 1) Demonstrate that their management information system (MIS) shall include, but not be limited to, the following:
- 2) Relative to HIPAA requirements:
 - a) The applicant states whether they are a covered entity.

- b) The applicant states they will comply with all HIPAA privacy, security, and transactional code set requirements. (No points if statement is absent or applicant cannot comply.)
- 3) Relative to current MIS:
- a) Applicant is able to collect all required information.
 - b) Applicant currently able to collect some required information with a plan to upgrade the MIS to collect all information by the time the contract begins.
 - c) If applicant is not currently able to collect all required information and unable to do so in the future or no description of implementation plan to collect information, no points shall be applied to applicants that provide this response.
- 4) Relative to the applicant's infrastructure:
- a) A clear statement that their MIS system is fully functional.
 - b) Inclusion of an implementation plan to create a fully functional MIS system by initiation of a contract.
- 5) In regards to flexibility, a statement that describes flexibility in adding data elements or reporting requirements is addressed in their information system.
- 6) Relative to claims:
- a) The applicant is currently able to produce either paper or electronic 837 file. (N/A)
 - b) The applicant will be able to produce an electronic 837 file by the time that a contract is initiated. (N/A)

- c) The applicant is unable to produce an 837 now or in the future. (No points to a provider who will not be able to produce a compliant claim). (N/A)

2. *Project Organization and Staffing* *Total 15 Points*

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

a. *Staffing* *(10 points)*

- 1) Proposed Staffing: That the proposed staffing pattern, client/staff ratio, coverage, and proposed caseload capacity is reasonable to insure viability of the services and complies with applicable DIVISION requirements.
- 2) Staff Qualifications: Minimum qualifications (including experience) for staff assigned to the program, comply with applicable DIVISION requirements. Position descriptions for homeless outreach and interim case management staff are submitted.

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

- 1) Supervision and Training: Demonstrated ability to supervise, train and provide administrative direction to staff relative to the delivery of the proposed services, comply with applicable DIVISION requirements.
- 2) Organization charts: Approach and rationale for the structure, functions, and staffing of the proposed organization for the overall service activity and tasks. 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, accreditation of the service(s) the applicant is applying for if it is an creditable service.

3. *Service Delivery* *Total 55 Points*

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

Evaluation criteria will include the following:

- a. A detailed description of the service that the applicant is proposing to provide including. **(38 Points)**
 - 1) Number of consumers to be served, location, and a reasonable estimate of the number of units of service it will provide.
 - 2) Hours of operation.
 - 3) The services provided and the qualifications of staff providing the services.
 - 4) The services provided to the consumers who may have a co-occurring substance abuse disorder.
 - 5) How the team will operate on a daily basis, including the team meeting, assignment of tasks and the services to be delivered during the day and evening hours.
 - 6) The on-call system including how consumers access this service and staff availability to respond.
 - 7) How the program will provide adequate coverage utilizing qualified personnel when a team position is vacant.
- b. A detailed description of how a consumer is served from point of entry to discharge, aftercare and follow up which includes how the program determines when treatment goals are accomplished and when to move consumers throughout the various services in the program. **(10 Points)**
- c. The description of the services shows how the program incorporates "best practices/evidence-based practices", has literature to support this, and has a system for implementing and maintaining best practice program integrity. **(1 Point)**

- d. The description by the applicant demonstrates consumer involvement in decisions regarding the services the consumer receives. **(2 Points)**
- e. A statement by the applicant that they are ready, able and willing to provide services throughout the time of the contract period. **(2 Points)**
- f. A statement by the applicant that has read the RFP and will comply with DIVISION requirements. **(2 Points)**

4. Financial Total 10 Points

- a. Pricing structure based on cost reimbursement for Personnel costs are reasonable and comparable to positions in the community.
 - 1) Non-personnel costs are reasonable and adequately justified.
 - 2) The budget supports the scope of service and requirements of the RFP.
 - 3) A cost allocation plan clearly describes the allocation of funds across different funding sources.
 - 4) The submission of a copy of the most recent audit report or compiled financial statement.
 - 5) Adequacy of accounting system.
 - 6) An indication of the third party reimbursements the applicant is eligible to receive and of the plans the applicant has made or is making to obtain as many third party reimbursements as possible without collecting payment from more than one payer.
- b. Pricing structure based on fixed unit of service rate (N/A)
 - 1) Applicants proposal budget is reasonable, given program resources and operational capacity.

- 2) A cost allocation plan clearly describing the allocation of funds across different funding sources.
- 3) The submission of a copy of the most recent audit report or compiled financial statement.
- 4) Adequacy of accounting system.
- 5) An indication of the third party reimbursements the applicant is eligible to receive and of the plans the applicant has made or is making to obtain as many third party reimbursements as possible without collecting payment from more than one (1) payer.

c. Eligible Sources of revenue

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

C. Phase 3 - Recommendation for Award

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

Section 5

Attachments

- A. Proposal Application Checklist
- B. Sample Table of Contents
- C. Draft of Special Conditions
- D. Consumer Rights
- E. Division P&P Regarding Consumer Grievances
Division P&P Regarding Consumer Appeals
- F. QMHP and Supervision

Attachment A

Competitive POS Application Checklist

Proposal Application Checklist

Applicant: _____

RFP No.: HTH 420-6-08

The applicant's proposal must contain the following components in the order shown below. This checklist must be signed, dated and returned to the purchasing agency as part of the Proposal Application. SPOH forms are on the SPO website. See Section 1, paragraph II Website References.*

Item	Reference in RFP	Format/Instructions Provided	Required by Purchasing Agency	Completed by Applicant
General:				
Proposal Application Identification Form (SPO-H-200)	Section 1, RFP	SPO Website*	X	
Proposal Application Checklist	Section 1, RFP	Attachment A	X	
Table of Contents	Section 5, RFP	Section 5, RFP	X	
Proposal Application (SPO-H-200A)	Section 3, RFP	SPO Website*	X	
Tax Clearance Certificate (Form A-6)	Section 1, RFP	Dept. of Taxation Website (Link on SPO website)*		
Cost Proposal (Budget)				
SPO-H-205	Section 3, RFP	SPO Website*	X	
SPO-H-205A	Section 3, RFP	SPO Website* Special Instructions are in Section 5	X	
SPO-H-205B	Section 3, RFP,	SPO Website* Special Instructions are in Section 5		
SPO-H-206A	Section 3, RFP	SPO Website*	X	
SPO-H-206B	Section 3, RFP	SPO Website*	X	
SPO-H-206C	Section 3, RFP	SPO Website*	X	
SPO-H-206D	Section 3, RFP	SPO Website*	X	
SPO-H-206E	Section 3, RFP	SPO Website*	X	
SPO-H-206F	Section 3, RFP	SPO Website*	X	
SPO-H-206G	Section 3, RFP	SPO Website*		
SPO-H-206H	Section 3, RFP	SPO Website*	X	
SPO-H-206I	Section 3, RFP	SPO Website*	X	
SPO-H-206J	Section 3, RFP	SPO Website*	X	
Certifications:				
<i>Federal Certifications</i>		Section 5, RFP		
Debarment & Suspension		Section 5, RFP	X	
Drug Free Workplace		Section 5, RFP	X	
Lobbying		Section 5, RFP	X	
Program Fraud Civil Remedies Act		Section 5, RFP	X	
Environmental Tobacco Smoke		Section 5, RFP	X	
Program Specific Requirements:				

Authorized Signature

Date

Attachment B

Sample Table of Contents for the POS Proposal Application

Proposal Application Table of Contents

I.	Program Overview.....	1
II.	Experience and Capability	1
	A. Necessary Skills	2
	B. Experience.....	4
	C. Quality Assurance and Evaluation.....	5
	D. Coordination of Services.....	6
	E. Facilities.....	6
III.	Project Organization and Staffing	7
	A. Staffing.....	7
	1. Proposed Staffing.....	7
	2. Staff Qualifications	9
	B. Project Organization	10
	1. Supervision and Training.....	10
	2. Organization Chart (Program & Organization-wide) (See Attachments for Organization Charts)	
IV.	Service Delivery.....	12
V.	Financial.....	20
	See Attachments for Cost Proposal	
VI.	Litigation.....	20
VII.	Attachments	
	A. Cost Proposal	
	SPO-H-205 Proposal Budget	
	SPO-H-206A Budget Justification - Personnel: Salaries & Wages	
	SPO-H-206B Budget Justification - Personnel: Payroll Taxes and Assessments, and Fringe Benefits	
	SPO-H-206C Budget Justification - Travel: Interisland	
	SPO-H-206E Budget Justification - Contractual Services – Administrative	
	B. Other Financial Related Materials	
	Financial Audit for fiscal year ended June 30, 1996	
	C. Organization Chart	
	Program	
	Organization-wide	
	D. Performance and Output Measurement Tables	
	Table A	
	Table B	
	Table C	
	E. Program Specific Requirement	

Attachment C

Draft Special Conditions

SPECIAL CONDITIONS

1. Campaign Contributions by State and County Contractors. The Contractors are hereby notified of the applicability of Section 11-205,5, HRS, which states that campaign contributions are prohibited from specified State or county government contractors during the term of the contract if the contractors are paid with funds appropriated by a legislative body.
2. Option to Extend Agreement. Unless terminated, this Agreement may be extended by the STATE for specified periods of time not to exceed three (3) years or for not more than three (3) additional twelve (12) month periods, without resolicitation, upon mutual agreement and the execution of a supplemental agreement. This Agreement may be extended provided that the Agreement price shall remain the same or is adjusted per the Agreement Price Adjustment provision stated herein. The STATE may terminate the extended agreement at any time in accordance with General Conditions no. 4.
3. Agreement Price Adjustment. The Agreement price may be adjusted prior to the beginning of each extension period and shall be subject to the availability of state funds.
4. Audit Requirement. The PROVIDER shall conduct a financial and compliance audit in accordance with the guidelines identified in Exhibit _____ attached hereto and made a part hereof. Failure to comply with the provisions of this paragraph may result in the withholding of payments to the PROVIDER.
5. The PROVIDER shall have bylaws or policies that describe the manner in which business is conducted and policies that relate to nepotism and management of potential conflicts of interest.

Attachment D

Consumer Rights

ADULT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL

AMHD Administration

SUBJECT: Consumer Rights

REFERENCE:

Number: 60.909

Effective Date: 10/29/04

History: New

Page: 1 of 7

APPROVED:

Title: Chief, AMHD

PURPOSE

To ensure that specified rights of each consumer are protected.

POLICY

- A. Each provider shall have a statement designed to protect consumer's rights. The statement shall be:
 - 1. Consistent with Federal and State laws and regulations; and
 - 2. Posted in strategic and conspicuous areas to maximize consumer, family and staff awareness.

- B. Each consumer shall have a consumer rights statement that complies with AMHD consumer rights requirements. The statement shall be:
 - 1. Signed and dated by the consumer prior to treatment; and
 - 2. Maintained in the treatment records of consumers.

PROCEDURE

- A. The statement given to consumers must include at the minimum the following language:
 - 1. You have rights no matter what your situation is. Adult Mental Health Division (AMHD) and all its providers will uphold these rights. You have these rights regardless of your:

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- Age
 - Race
 - Sex
 - Religion
 - Culture
 - Amount of education
 - Lifestyle
 - Sexual orientation
 - National origin
 - Ability to communicate
 - Language spoken
 - Source of payment for services
 - Physical or mental disability
2. You have the right to be treated with respect and dignity, and to have your right to privacy respected.
 3. You have the right to know about the AMHD and the services available to you. You have the right to know who will provide the services you use, their training, and experience.
 4. You have the right to know as much information about your treatment and service choices as you need so you can give an informed consent or refuse treatment. This information must be told to you in a way you can understand. Except in cases of emergency services, this information shall include a description of the treatment, medical risks involved, any alternate course of treatment or no treatment and the risks involved in each.

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5. You have a right to information about your medications; up to and including your right not to take them, what they are, how to take them, and known side effects.
6. You have a right to be informed of continuing care following discharge from the hospital or outpatient services.
7. You have a right to look at and get an explanation of any bills for non-covered services, regardless of who pays.
8. You have a right to receive emergency services when you, as a prudent layperson, acting reasonably, would believe that an emergency medical condition existed. Payment for emergency services will not be denied in cases when you go for emergency services.
9. You have a right to receive emergency services when traveling outside the State of Hawaii when something unusual prevents you from getting care from an AMHD provider.
10. You have a right to usually have the same provider when you get services.
11. You have a right to an honest discussion with your providers of the options for your treatment, regardless of cost and benefit coverage.
12. You have a right to be advised if a provider wants to include you in experimental care or treatment. You have the right to refuse to be included in such research projects.
13. You have a right to complete an advance directive, living will, psychiatric advance directive, medical durable powers of attorney or other directive to your providers.
14. You have a right to have any person who has legal responsibility make decisions for you regarding your mental health care. Any person with legal responsibility to make health care decisions for you will have the same rights as you would.
15. You have the right to know all your rights and responsibilities.
16. You have the right to get help from AMHD in understanding your services.
17. You are free to use your rights. Your services will not be changed and you will not be treated differently if you use your rights.

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18. You have the right to receive information and services in a timely way.
19. You have the right to be a part of all choices about your treatment. You have the right to have a copy of your written Individual Service Plan.
20. You have the right to disagree with your treatment or to ask for changes in your Individual Service Plan.
21. You have the right to ask for a different provider or case manager. If you want a different provider or case manager, we will work with you to find another one in the AMHD network. There is no guarantee that you will be provided a new case manager right away, however.
22. You have the right to refuse treatment or medication, or both, to the extent allowed by the law. You are responsible for your actions if you refuse treatment or if you do not follow your providers' advice.
23. You have the right to receive services that are responsive to your racial and ethnic culture including language, histories, traditions, beliefs, and values.
24. You have the right to an interpreter, if needed, to help you speak to AMHD or your providers. You have the right to have an interpreter in the room when your provider sees you.
25. You have the right to ask us to send you mail and call you at the address or telephone number of your choice, in order to protect your privacy. If we cannot honor your request, we will let you know why.
26. You have a right to a second opinion when deciding on treatment.
27. You have the right to expect that your information will be kept private according to the Privacy law.
28. You have the right to complain about your services and to expect that no one will try to get back at you. If you complain, your services will not stop unless you want them to.

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

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

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

1. An explanation of the:
 - a) Rights and responsibilities of the consumer,
 - b) Grievance and appeal procedures
 - c) Ways in which input is given regarding:
 - the quality of care
 - achievement of outcomes
 - satisfaction of the consumer
2. An explanation of the organization's:
 - a) Services and activities
 - b) Expectations
 - c) Hours of operation

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- d) Access to after-hour services
 - e) Code of ethics
 - f) Confidentiality policy
 - g) Requirements for follow-up for the mandated consumer served, regardless of his or her discharge outcome
3. An explanation of any and all financial obligations, fees, and financial arrangements for services provided by the organization
 4. Familiarization with the premises, including emergency exits and/or shelters, fire suppression equipment, and first aid kits
 5. The program's policies regarding:
 - a) Use of seclusion or restraint
 - b) Smoking
 - c) Illicit or licit drugs brought into the program
 - d) Weapons brought into the program
 6. Identification of the person responsible for case management
 7. A copy of the program rules to the consumer, that identifies the following:
 - a) Any restrictions the program may place on the consumer
 - b) Events, behaviors, or attitudes that may lead to the loss of rights or privileges for the consumer
 - c) Means by which the consumer may regain rights or privileges that have been restricted
 8. Education regarding advance directives, when legally applicable
 9. Identification of the purpose and process of the assessment

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10. A description of how the Individualized Service Plan (ISP) or other plan will be developed and the consumer's participation
11. Information regarding transition criteria and procedures
12. When applicable, an explanation of the organization's services and activities will include:
 - a) Expectations for consistent court appearances
 - b) Identification of therapeutic interventions, including:
 - Sanctions
 - Interventions
 - Incentives
 - Administrative discharge criteria

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

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

Attachment E

**Division P&P Regarding
Consumer Grievances**

**Division P&P Regarding
Consumer Appeals**

ADULT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL

AMHD Administration

SUBJECT: Consumer Grievances

REFERENCE: Consumer Appeals, Consumer Rights,
Recovery Guide

Number: 60.906

Effective Date: 10/26/04

History: New

Page: 1 of 6

APPROVED:

Title: Chief, AMHD

PURPOSE

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

POLICY

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

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

DEFINITIONS

- Action – The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, unreasonable delays in services, or grievances not acted upon within prescribed timeframes.
- Appeal – A request for review of an action made by AMHD, as “action” is defined. Consumer Appeals are discussed in a separate policy and procedure.

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- Consumer – Anyone who is receiving services or potentially could be eligible to receive services.
- Grievance – An expression of dissatisfaction from a consumer or provider, or any authorized representative on behalf of the consumer about any matter other than an action, as “action” is defined.
- Grievance Review – A review process for grievance resolutions. A consumer may request a “grievance review” by AMHD if they do not agree with a provider’s resolution of a grievance.
- Inquiry – A contact from a consumer, or on behalf of the consumer, that questions any aspect of AMHD’s or a provider’s operations, activities, or behavior, or to request change to another provider, and does not express dissatisfaction.

PROCEDURE

1. Inquiry
 - A. Consumers should call their Case Manager for any inquiry or question regarding any aspect of AMHD or a provider’s operations, activities, or behavior, or request to change to another provider.
 - B. If during the contact, the consumer expresses dissatisfaction of any kind, the inquiry becomes an expression of dissatisfaction and becomes a Grievance or Appeal (see Grievance and Appeal process below).
2. Grievance
 - A. Consumers may file a grievance to express any dissatisfaction in regards to the following:
 - AMHD or provider’s operations
 - AMHD or provider’s activities
 - AMHD or provider’s failure to respect the consumer’s rights

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- AMHD or provider's behavior
 - Provider or AMHD employee is rude
 - Provider quality of care
 - AMHD or provider's privacy practices – copies of these grievances are also forwarded to AMHD's Privacy Officer.
- B. A consumer, provider or a consumer's authorized representative, acting on behalf of the consumer, may file a grievance orally or in writing.
- (1) For oral filing of grievance, the consumer may call the Office of Consumer Affairs and a Consumer Specialist will assist the consumer in writing the grievance by completing an AMHD Consumer Grievance Form (see Attachment A), however, any AMHD staff may assist the consumer to complete the Grievance Form. The Consumer will be given an option to receive a copy of the written grievance. The form is forwarded to the individual responsible for tracking grievances within the Office of Consumer Affairs who is defined as the Grievance Coordinator.
 - (2) If a provider or an authorized representative on behalf of the consumer files the grievance orally, the consumer must give their written authorization.
 - (3) The Grievance Coordinator directs the grievance to the appropriate individual within AMHD for investigation and resolution of the grievance. That individual forwards the written results of their investigation and resolution to the Grievance Coordinator for data entry and tracking.
 - (4) All written grievances should be submitted to:

Adult Mental Health Division
Office of Consumer Affairs
Grievance Coordinator
P.O. Box 3378
Honolulu, Hawaii 96801-3378
 - (5) Within five (5) working days of the receipt date, the grievant will be informed by letter that the grievance has been received.

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- (6) Each grievance will be thoroughly investigated by gathering facts from all relevant parties and using the applicable statutory, regulatory, and contractual provisions, as well as AMHD's policies and procedures.
 - (7) AMHD will render a resolution of the grievance within thirty (30) calendar days of the receipt date. If the thirtieth (30th) day falls on a Saturday, Sunday, or State holiday, a resolution will be rendered the next working day. A letter of resolution will be mailed to the grievant and copies are sent to all parties whose interest has been affected by the decision. If the grievant has requested not to be identified, consumer identifying information will be left off other parties' letters.
 - (8) The effective date of the decision will be the date of personal delivery, or if mailed, the postmarked date of the mailing.
- C. The resolution letter includes and describes the following details:
- Nature of the grievance
 - Issues involved
 - Actions AMHD has taken or intends to take
 - Reasons supporting AMHD's decision or action, including references to applicable statutes, rules, and procedures.
 - A statement that AMHD's resolution of the grievance is final, unless the consumer requests an appeal by contacting the Office of Consumer Affairs.
- D. AMHD may grant an extension of the resolution deadline of up to fourteen (14) calendar days if the consumer requests an extension or if additional information is needed. In this case, a letter will be sent to the grievant. The content of the notification will include the following details:
- Nature of the grievance
 - Reason for the extension of the decision and how the extension is in the consumer's interest

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3. Appeals

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

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

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

4. Other Requirements

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

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

- (1) Number of grievances sorted by date, nature of the grievance, county, and provider of services, if applicable;
- (2) Status of Resolution and if resolved, result including feedback, and
- (3) Turn-around times.

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- B. An Aggregate Annual Grievances Report shall be prepared and presented to the Quality Improvement Committee within sixty (60) days of the last quarter of the calendar year. The report shall contain an aggregate data report, analysis by county, and recommendations for improvement of clinical and service areas.
- C. Privacy of the grievance records is maintained at all times, including the transmittal of medical records.
- D. All grievances and related documentation are maintained in a secure, designated area and retained for a period of seven (7) years following the final decision, or closure of grievance.
- E. All grievances that concern provider organization actions and are proven quality of care or non-compliance with AMHD contracts or policies and procedures will be forwarded and collated by AMHD Performance Management and used in certification and contract review activities.

ATTACHMENTS

Consumer Grievance Form

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

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

ADULT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL

AMHD Administration

SUBJECT: Consumer Appeals

REFERENCE:

Plan for Community Mental Health Services IV, B, 1, a, i,
Consumer Grievances, Denial Letter,
Recovery Guide
HRS 91

Number: 60.903

Effective Date: 05/01/03
History: Rev. 10/04, 05/05

Page: 1 of 9

APPROVED:

Title: Chief, AMHD

PURPOSE

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

POLICY

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

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

Medicaid eligible consumers also have the right to request a Fair Hearing for appeals related to Medicaid reimbursable services provided by AMHD. This process does not require a Medicaid eligible consumer to appeal to AMHD first.

DEFINITIONS

- Action – The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, unreasonable delays in services, or appeals not acted upon within prescribed timeframes.
- Appeal – A request for review of an action made by AMHD, as “action” is defined.

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- Consumer – Anyone who is receiving services or potentially could be eligible to receive services.
- Grievance – An expression of dissatisfaction from a consumer or provider, or any authorized representative on behalf of the consumer about any matter other than an action, as “action” is defined.
- Grievance Review - A review process for grievance resolutions. A consumer may request a “grievance review” by AMHD if they do not agree with a provider’s resolution of a grievance.
- Inquiry – A contact from a consumer, or on behalf of the consumer, that questions any aspect of AMHD’s or a provider’s operations, activities, or behavior, or to request change to another provider, and does not express dissatisfaction.
- Medicaid – A federal program administered by the Department of Human Services, Med-QUEST Division which provides medical coverage. Medicaid recipients can receive services from the Fee-for-service program or QUEST managed care health plans.

PROCEDURE

1. Inquiry
 - A. Consumers should call their Case Manager for any inquiry or question regarding any aspect of AMHD or a provider’s operations, activities, or behavior, or request to change to another provider.
 - B. If during the contact, the consumer expresses dissatisfaction of any kind, the Inquiry becomes an expression of dissatisfaction and becomes a Grievance (see Grievance and Appeal process below).
2. Grievance
 - A. Consumers may file a grievance if they express any dissatisfaction in regards to the following:
 - AMHD or provider’s operations
 - AMHD or provider’s activities

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- AMHD or provider failure to respect the consumer's rights
 - AMHD or provider's behavior
 - Provider or AMHD employee is rude
 - Provider quality of care
 - AMHD or provider's privacy practices – copies of these grievances are also forwarded to AMHD's Privacy Officer.
- B. The grievance process is administered by the Office of Consumer Affairs as delineated in the Consumer Grievances Policy and Procedures.
3. Appeals
- A. Consumers may file an appeal for the following actions or decisions made by AMHD:
- Prior authorization for a service is denied or limited
 - The reduction, suspension, or termination of a previously authorized service
 - The denial, in a whole or in part, of payment for a service
 - The denial of eligibility
 - Failure to provide services in a timely manner
 - Unreasonable delays in services, or appeals not acted upon within prescribed timeframes
 - Not satisfied with resolution of grievance
- B. AMHD Utilization Management shall notify consumers about their appeal rights and processes at the time of denial of eligibility or service request. Consumers shall have access to consumer advocacy and AMHD shall assure that any consumer who requests an advocate for this process shall be linked to this assistance.

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- C. Consumers who wish to appeal a decision regarding a Medicaid reimbursable service provided by AMHD and who are Medicaid recipients have the right to ask for a Fair Hearing from the Department of Human Services. These appeals do not have to go through the AMHD appeals process first. Medicaid recipients are directed to contact their Department of Human Services worker for information and assistance.
- D. A consumer, provider or a consumer's authorized representative, acting on behalf of the consumer with the consumer's written consent or if documentation is available to demonstrate the consumer is incapacitated, may file an appeal orally or in writing.
- E. For oral filing of appeal, the consumer (or consumer's representative with the written consent of the consumer or if documentation is available to demonstrate the consumer is incapacitated), may call the Office of Consumer Affairs and must also submit a follow-up written appeal.
- F. The designated case manager, or the designated crisis support manager, may appeal on behalf of the consumer without written consent if documentation is available to demonstrate the consumer is incapacitated. The case manager or crisis support manager shall provide specified clinical information to support the appeal request.
- G. An AMHD Consumer Appeal Form (see Attachment A) may also be completed on behalf of the consumer or consumer's representative. In this case, the completed Consumer Appeal Form will be sent to the consumer or the consumer's authorized representative if a written authorization has been received for review and signature.
- H. The consumer or the consumer's authorized representative must submit the follow-up written appeal or return the signed Consumer Appeal Form to the AMHD Office of Consumer Affairs which is designated as the AMHD Consumer Appeals Coordinator within one (1) week from the receipt date of the oral appeal. If the follow-up written appeal or the signed Consumer Appeal form is not received within the allotted timeframe, a follow-up call will be made to the consumer or the consumer's representative. If the consumer requests an extension for the filing deadline of the written appeal, AMHD will grant another one (1) week to submit the written appeal.
- I. If a written follow-up is not received, the appeal will be closed after thirty (30) calendar days without further action or investigation. The consumer will receive written notification of this.

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

K. All written appeals should be submitted to:

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

4. First Level Appeal

- A. The appeal must be filed within thirty (30) days from the date of the initial action or decision made by AMHD. Exceptions to this deadline may be granted if details regarding extenuating circumstances are provided. At no time will an appeal be considered that is 180 days from the date of the initial action or decision made by AMHD.
- B. Within five (5) working days of receipt of the written appeal, the consumer, provider, or the consumer's authorized representative will be informed by letter that the appeal has been received.
- C. The consumer or authorized representative of the consumer may request to examine the consumer's case file, including medical records and any other documents considered during or before the appeal process by contacting the AMHD Consumer Appeals Coordinator in accordance with federal and state privacy regulations.
- D. All appeals will be thoroughly investigated by gathering facts from all relevant parties and using the applicable statutory, regulatory, and contractual provisions, as well as AMHD's policies and procedures.
- E. For appeals regarding reduction, suspension, or termination of a previously authorized service such care will be continued until resolution of the appeal.
- F. The AMHD Medical Director shall review the denial and shall make a determination (overturning or ratifying the denial). The AMHD Medical Director has the option of obtaining a second physician opinion prior to rendering an appeal decision.

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- G. AMHD will render a resolution of the appeal within thirty (30) calendar days of the receipt date except in the case of an expedited appeal. If the thirtieth (30th) day falls on a Saturday, Sunday, or State holiday, a resolution will be rendered by the next working day. A letter of resolution will be mailed to the provider and copies are sent to all parties whose interest has been affected by the decision. The effective date of the decision will be the date of personal delivery, or if mailed, the postmarked date of the mailing.
- H. The resolution letter includes and describes the following details:
- Nature of the appeal
 - Issues involved
 - Actions AMHD has taken or intends to take
 - Reasons supporting AMHD's decision or action, including references to applicable statutes, rules, and procedures
 - Process for a second level appeal if appeal denied
- I. AMHD may grant an extension of the resolution deadline of up to fourteen (14) calendar days if the consumer requests the extension or if additional information is needed. In this case, a letter will be sent to the consumer. The content of the notification will include the following details:
- Nature of the appeal
 - Reason for the extension of the decision and how the extension is in the best interest of the consumer
5. Expedited Appeals
- A. Any AMHD consumer (or provider acting on behalf of the consumer with the consumer's written authorization) may request an expedited appeal.
- B. An expedited appeal may be authorized if the standard review time frame of AMHD's appeal process may:
- Seriously jeopardize the life or health of the consumer

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- Seriously jeopardize the consumer's ability to access services with limited availability with a resulting loss of function
- C. All expedited appeals will be thoroughly investigated by gathering facts from all relevant parties and using the applicable statutory, regulatory and contractual provisions, as well as AMHD's policies and procedures.
- D. The AMHD Medical Director will review all expedited appeals.
- E. A decision will be rendered within forty-eight (48) working hours of receipt of the request for an expedited appeal.
- F. The decision will be phoned by the AMHD Consumer Appeals Coordinator to the consumer and provider.
- G. The resolution letter includes and describes the following details:
- Nature of the appeal
 - Issues involved
 - Actions AMHD has taken or intends to take
 - Reasons supporting AMHD's decision or action, including references to applicable statutes, rules, and procedures
 - Process for a second level appeal if appeal denied
6. Second Level Appeal
- A. The consumer or appealing party may proceed with a written second level appeal within thirty (30) calendar days from the date of the first level appeal determination letter.
- B. The second level appeal letter along with any additional clinical information shall be sent to the AMHD Chief who shall obtain all relevant documentation from the AMHD UM Coordinator and the AMHD Medical Director. The second level appeal will be thoroughly investigated by gathering facts from all relevant parties and using the applicable statutory, regulatory, and contractual provisions, as well as AMHD's policies and procedures.

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- C. For appeals regarding reduction, suspension, or termination of a previously authorized service such care will be continued until resolution of the appeal by the AMHD Chief.
- D. Expedited appeals which result in an expedited second level appeal shall be reviewed and a decision rendered within forty-eight (48) working hours of receipt of the request for an expedited second level appeal if the request has been designated as such. The decision shall be phoned by the AMHD Consumer Appeals Coordinator to the consumer and provider.
- E. Within five (5) working days of receipt of the written non-expedited second level appeal, the consumer, provider, or the consumer's authorized representative will be informed by letter that the appeal has been received.
- F. AMHD will render a resolution of the appeal for non-expedited appeal within thirty (30) calendar days of the receipt date except in the case of expedited appeal. If the thirtieth (30th) day falls on a Saturday, Sunday, or State holiday, a resolution will be rendered by the next working day. A letter of resolution will be mailed to the consumer and copies are sent to all parties whose interest has been affected by the decision. The effective date of the decision will be the date of personal delivery, or if mailed, the postmarked date of the mailing.
- G. The resolution letter includes and describes the following details:
- Nature of the appeal
 - Issues involved
 - Actions AMHD has taken or intends to take
 - Reasons supporting AMHD's decision or action, including references to applicable statutes, rules, and procedures
 - Statement concerning any other avenues of appeal, if any, available to the appellant.
- H. Consumers or their legal representatives who wish to appeal further must follow the Department of Health administrative appeals process, HR91f, or pursue through the legal system.

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7. Other Requirements

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

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

- (1) Number of appeals sorted by date, nature of the appeal, county level of appeal, and provider of services, if applicable,
 - (2) Number of decisions upheld,
 - (3) Number of decisions overturned, and
 - (4) Turn-around times.
- B. An aggregate Annual Appeals Report shall be prepared and presented to the AMHD Quality Council within sixty (60) days of the last quarter of the calendar year. The report shall contain an aggregate data report, analysis, and recommendations for improvement of clinical and service areas.
 - C. Privacy of the appeal records is maintained at all times, including the transmittal of medical records.
 - D. All appeals and related documentation are maintained in a secure, designated area and retained for a period of seven (7) years following the final decision, or closure of appeal.
 - E. All appeals that concern provider organization actions and are proven quality of care matters or non-compliance with the terms and conditions of AMHD contracts or policies and procedures will be forwarded and collated by AMHD Performance Management and used in certification and contract review activities.

ATTACHMENT

Consumer Appeal Form

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

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

Attachment A

Consumer Appeal Form

Print Name of Consumer:	_____
AMHD ID#:	_____
Mailing Address:	_____
Island:	_____
Phone Number:	_____
Signature of Consumer:	_____ Date Signed: _____
<i>Note to Consumer: By signing this form, you as a consumer are authorizing your provider or any representative (if there's any) to file this appeal on your behalf.</i>	

** Please fill out this section if a provider or a representative is filing the appeal on behalf of the consumer**	
Print Name of Representative:	_____
Relationship to Consumer:	_____
Phone Number:	_____
Mailing Address:	_____
Signature of Representative:	_____ Date Signed: _____

Description of Service: _____

Date(s) of Service: _____

Attachment F

QMHP AND SUPERVISION

Definition and Role of the Qualified Mental Health Professional and Mental Health Professional

Qualified Mental Health Professional (QMHP)

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

The QMHP shall oversee the development of each consumer’s treatment plan to ensure it meets the requirements stated in the Community Plan 2003 and sign each treatment plan.

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

The QMHP shall serve as the L-O-C-U-S (“LOCUS”) expert.

The QMHP shall provide oversight and training.

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

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

Additionally, for Specialized Residential Treatment Programs, the QMHP shall provide day-to-day program planning, implementation, and monitoring.

Mental Health Professional (MHP)

Except for Assertive Community Treatment (“ACT”), the team leader is not required to be a QMHP. Non-QMHP team leaders shall be clinically supervised by a QMHP.

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

- Licensed Social Worker (LSW); or
- Master of Science in Nursing (MSN); or
- APRN in a non-behavioral health field; or
- Master’s degree from accredited school in behavioral health field
 - a) Counseling, or
 - b) Human Development, or
 - c) Marriage, or
 - d) Psychology, or
 - e) Psychosocial Rehabilitation, or
 - f) Criminal Justice.

- Master's degree in health related field with two (2) years experience in behavioral health; or
- Licensed Registered Nurse with two (2) years experience in behavioral health.

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

The MHP may function as the DIVISION Utilization Management Liaison.

Supervision:

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

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

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

The DIVISION funded PROVIDER shall have policies and procedures to select and monitor the MHP team leaders if non-QMHP team leaders are used.

The QMHP and non-QMHP staff does not have to work in the same physical setting but shall have routine meetings as defined in the PROVIDER's policies and procedures.