

September 6, 2016
ADDENUM NO. 2
Developmental Disabilities Division
Crisis Services
RFP Number HTH 501-17-03

The Health Department, Developmental Disabilities Division, is issuing this addendum to RFP Number HTH 501-17-03, Crisis Services for the purposes of:

- Amending the RFP.
- Responding to questions that were asked during the orientation meeting of August 26, 2016 and written questions that were received prior to the August 31st 2 pm deadline.
- Final Revised Proposals

The proposal submittal deadline:

- is amended to <new date>.
- is not amended.
- for Final Revised Proposals is <date>.

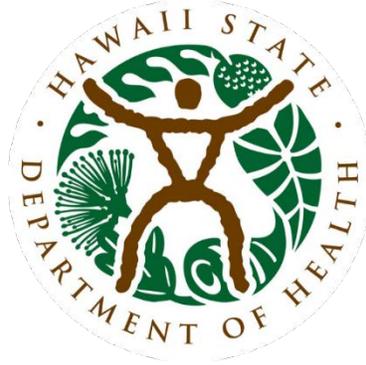
Attached is:

- Amendment to the RFP.
- Answers to questions received prior to the August 31st 2 pm deadline.
- Details of the request for final revised proposals.

If you have any questions, contact:

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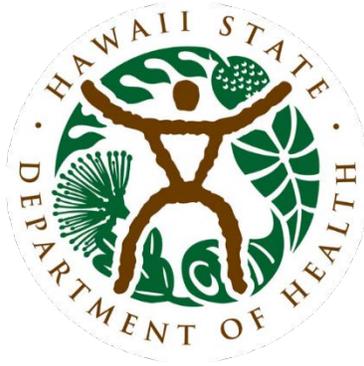
Department of Health
Developmental Disabilities Division
Crisis Services RFP Number 501-17-03

AMENDMENT TO THE RFP

Correction:

Page 2-27, Section 2.5, last sentence reads "Refer to Section 2.9 for more information."

Page 2-27, Section 2.5, last sentence should read: "Refer to page 2-9 for more information."



Department of Health
Developmental Disabilities Division
Crisis Services RFP Number 501-17-03

QUESTIONS & ANSWERS

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Orientation meeting questions and answers - Friday, August 26, 2016

- Q1.** Asking for clarification on contract start date. Will service be going live as of December 28th or does the contract begin and then the services will begin at a later date after a certain period of time?
- A.** In order for there to be a continuity of crisis services for the state, we want the services to go live on December 28th as we have already extended the current contract as long as we can.
- Q2.** We were wondering about the RBT requirements since many of our current employees only have a high school diploma since that is the current requirement. Would the RBT credential suffice for the bachelor's requirement?
- A.** The registered behavior technician (RBT) stands independent of the requirements within the RFP. The RBT credential would not replace the requirement for a bachelor's degree. You may build that development plan for direct support staff to become RBTs into your proposal and cost model.
- Q3.** It says that the licensed supervisor needs to be on staff Monday through Friday at least 8hrs/day. Is there any flexibility with that because sometimes depending on the participants there a supervisor may need to be there during the weekends, also there are some requirements as it relates to OHCA and DD as well for meetings and things for those licensed supervisors, so if they attend the meeting and also do 8 hours per day, we are running into overtime every time. So is there any flexibility with that?
- A.** The intent is for the licensed supervisor to be on the premises on average 40 hours per week. We acknowledge that there may be meetings that require the supervisor to be away from the premises and during those times, the 24/7 availability by phone must be activated. The applicant should include in the proposal the process that will monitor the supervisor's on-premises time and the amount of time spent away from the setting for meetings that cannot be scheduled on-site.
- Q4.** In terms of you guys increasing the education requirements, sometimes participants stay longer then they should because of placement.
- A.** We see this as a short term stabilization service versus a long term placement. We are working to ensure our system supports this. We would welcome in your proposal, ways to address those issues. Funding sources might change if there are longer term service needs beyond the crisis stabilization.
- Q5.** So we have done this service for many years, we have in the past billed waiver for the bed rate and that has never been sufficient for us to sustain the home and now with the increased requirements now that we have to hire more expensive people and the have a licensed staff onsite 40 hours/wk. That will increase our cost. We mostly bill waiver but it is not enough so we also bill CNS. Will this contract allow for the same type of billing?
- A.** We are doing a rate study that will take into account staffing requirements and patterns. In your proposal you can propose based on your actual costs that exceed reimbursement after the waiver is billed. For waiver participants served, the waiver must be billed first.

- Q6.** If we bill waiver first but it doesn't quite cover it, could we bill the contract as well?
- A.** You can propose that.
- Q7.** In terms of how the funding as far as how the crisis funding would work, on the procurement website it listed a maximum annual amount of \$600,000.00 and then as we read through the RFP it appeared that that would be for state funded cost reimbursement and beyond that the selected vendor would be responsible to Medicaid waiver billing like on a fee for service type basis. Is that an accurate understanding of the RFP and the procurement?
- A.** Yes. See pages 2-8 to 2-10 of the Crisis Services RFP, Compensation and Method of Payment is through waiver claims and cost reimbursement.
- Q8.** So that would mean there would be the availability of \$600,000.00 in the state funding, but that's on a cost reimbursement basis and everything else would be on a waiver fee for service arrangement?
- A.** Correct.
- Q9.** Regardless of the demand in the program the limit on state funding for this would be \$600,000.00 per year depending on availability and then anything beyond that would be billed as a Medicaid waiver service?
- A.** Correct. Basically you bill the waiver for services delivered to waiver participants but there may be costs in addition to waiver-reimbursable services that programs are incurring because we need these services. For example, in the waiver you can't bill for the hotline services unless there is a mobile deployment and we realized that. We see the hotline as being an intervention and it cost money to do that intervention, so this is an example where we would see paying state money so that programs receive funding to provide this important intervention.
- Q10.** In the RFP on page 2-27, section 2.5, the last sentence says "Refer to section 2.9 for more information." Where is 2.9?
- A.** There is a typo in the last paragraph of page 2.27 of the Crisis Services RFP. It is supposed to read "Refer to page 2-9 for more information."
- Q11.** Is there any provision to allow for the use of the state funding for an administrative charge if an agency has a typical administrative overhead charge? Is that permissible under that reimbursement structure?
- A.** Administrative costs will be reflected in the waiver rates but if there are administrative costs that would be outside of the rate, you can propose that in your budget.
- Q12.** I thought the rate is that's assumed in the waiver reimbursement, is that a standard admin allocation percentage wise?
- A.** Waiver rates contain variable administrative costs depending on the service.

Written questions and answers

Questions 13-16 relate to the following excerpt:

Under Section 2 of the RFP, Service Specifications, Item 2.5, COMPENSATION AND METHOD OF PAYMENT, page 2-27 states: *“Compensation and method of payment shall be on a Cost Reimbursement basis through electronic Medicaid claims submissions or paper state-fund invoices. Payment shall be made monthly upon submission of the claim or invoice, depending on the fund source for the services delivered. Refer to [Section 2.9 is a typographical error] page 2-9 for more information”.*

The RFP Table of Contents does not list a Section 2.9 but indicates the requirement of applicants to complete a budget work sheet, Attachment F. Form SPO-H-205 Instructions & SPO-H-205B Budget Worksheet. Additionally, Section 2.3.13, Compensation and Method of Payment, page 2-8, Item a. Waiver Claim, indicates that the Provider shall have the capacity to submit Medicaid claims for waiver emergency services based on rates for emergency services and that claims shall be submitted for Medicaid I/DD waiver participants in the crisis program. Item b. Cost Reimbursement, in the same section indicates that the Provider shall also submit monthly invoices for cost reimbursement.

- Q13.** Should agencies responding to this RFP develop an annual budget for all services/costs required to operate the statewide IDD crisis program with the expectation that: (1) IDD waiver participants receiving services would be billed to Medicaid for reimbursement; and that (2) the remaining total monthly budgeted costs, minus the monthly Medicaid billing amounts, would be reimbursed by the State? For example, a crisis system with dedicated professional staff 24/7 availability, 24/7 access to out of home services and call center services will require the Provider to spend for these fixed costs regardless of level of Medicaid waiver member participation in the program—would these costs be reimbursable up to the contract award budget level?
- A.** The Applicant may include in its proposal the fixed costs that are projected to exceed Medicaid waiver reimbursement.
- Q14.** Per the prior question, does the RFP intend that the total approved, contracted annual budget to operate the crisis program would be reimbursable to the Provider in a combination of Medicaid and State funding?
- A.** Yes
- Q15.** What are the specific Medicaid code(s) and corresponding reimbursement rates for waiver emergency services that the Provider will be required to bill under the state wide IDD crisis program?
- A.** Currently, the codes and rates are unchanged from the 2011 Rate Sheet. Crisis Mobile Outreach would bill under T2034 with modifier 52, rate is \$79.20 per hour. Out-of-Home Stabilization would bill under T2034 without modifier, rate is \$504.80 per day. Rates and/or procedure codes and modifiers are subject to change after the rate study is completed and a waiver amendment is approved by the Centers for Medicare and Medicaid Services (CMS). Providers would be notified in writing in advance of any changes to rates and/or procedure codes and modifiers.

- Q16.** Under Section B, Other Current Expenses, Contractual Services – Administrative, of the SPO-H-205B Budget Worksheet, is it allowable to budget a percentage of administrative overhead based on the total annual operating budget for the crisis program (e.g. 15% administrative overhead)? If so, is the Provider allowed to bill these total budgeted administrative costs (based on a percentage of actual costs billed for reimbursement) without being subject to audit such that this reimbursement could serve as an operating reserve or profit?
- A.** Waiver rates include a reasonable allowance for administrative overhead. Providers invoice for services rendered as authorized and are subject to audit. For non-waiver participants, the proposal may reflect actual administrative costs incurred for providing the service.
- Q17.** Is utilization data available to indicate the annual number of individuals anticipated to utilize crisis and related emergency type services under the proposed IDD statewide crisis program?
- A.** No, these data are not tracked.
- Q18.** If out-of-home crisis related services are provided in a four-person community group home setting, what are the anticipated licensure requirements for such a residential setting under Medicaid and the Department of Health, Developmental Disabilities Division?
- A.** Please refer to page 2-27 of the RFP. Out-of-Home Stabilization (OHS) must be licensed by the Hawaii State Department of Health, Office of Health Care Assurance as a Special Treatment Facility. State regulations used for licensing will determine the number of beds and other facility requirements.
- Q19.** Does the anticipated contract start date of December 28, 2016, mean that the selected Provider must have all services in effect and is ready to deliver state-wide crisis services as of that date? Or, is the expectation that the Provider will have services available and in operation within a set time frame from the contract start date? If so, are expenses incurred after the contract award date as the Provider is preparing to start services (i.e. personnel hired and being trained, training costs, per diem and lodging required to implement the crisis program, office costs, etc.) reimbursable?
- A.** Yes, the provider must be able to deliver all services requested in the RFP as of December 28, 2016. Applicants may propose those up-front costs.
- Q20.** The Hawaii State Procurement Office website lists the RFP above, as well as an additional RFP titled No. HTH-501-17-02, "Crisis Services Statewide for Developmental Disabilities Division DDD", with a due date of 08/29/16. In reviewing this RFP document, it appears to be the same or identical to RFP No. HTH-501-17-03, and both RFP's have the same projected contract start date of 12/28/16. Question: Are these RFPs for the same service or do they represent two different solicitations?
- A.** They are for the same service. The previous procurement was canceled.
- Q21.** On the Procurement Office website, Both RFP No. HTH-501-17-02 and RFP No. HTH-501-17-03 show "Approximate funding for year: \$600,000". Question: Does this mean that the maximum annual State funding for the statewide DDD crisis services contract would be limited to \$600,000 and that all other funding available to the selected provider would be from Medicaid waiver reimbursement and third party insurance coverage?
- A.** Yes.

- Q22.** Right now we have multiple Crisis shelter employees who's highest level of education is a High school diploma. If we are awarded the contract would we be able to "grandfather" those employees over to the new contract? These people already have the necessary experience with the DD population and know how the shelter operates so I believe it would make sense to keep them on.
- A.** Crisis Services Staff must meet all requirements in the Crisis Services RFP specified in General Standards' Qualifications on page 2-14 and Management Requirements for Personnel on page 2-24.
- Q23.** Would the RBT certification be an acceptable substitute for the new bachelor's degree education requirement for direct care staff?
- A.** Please see answer to Q2.
- Q24.** Currently we provide these services and aware that the waiver daily bed rate of \$504.80 is not sufficient to sustain this home. Will allow providers the DDD to bill waiver for the bed rate and additional expenses not covered by the \$504.80 be allowed to be billed to the contract?
- A.** Please see answer to Q13.
- Q25.** Currently, the General Standards state, "A supervisor shall be on the premises at a minimum of eight hours per day (Monday - Friday).
- a)** Will there be any flexibility with the hours, as there may be clinical reasons a supervisor may need to work on the weekends. Additionally, OHCA and DDD have requirements for supervisors to attend off site meetings?
- A.** Please see answer to Q3.
- b)** Regarding the statement "on the premises", is this requirement specifically related to OHS site?
- A.** Yes.
- Q26.** For clarification, a Supervisor must have 3 years experience working with people in crisis and/or people with DD w/acute behaviors AND one of the following credentials: LCSW, LMHC, LMFT, Psy-D, RN?
- A.** Yes, according to page 2-14 of the Crisis Services RFP, 2nd paragraph under "General Standards," item 1 "Qualifications."
- Q27.** Are we able to use the supervisor in dual roles? i.e. RN with proper credentials to be the OHS supervisor also provide RN services (medication administration, etc. while on site?)
- A.** Yes.

RFP 501-17-02 orientation meeting questions and answers

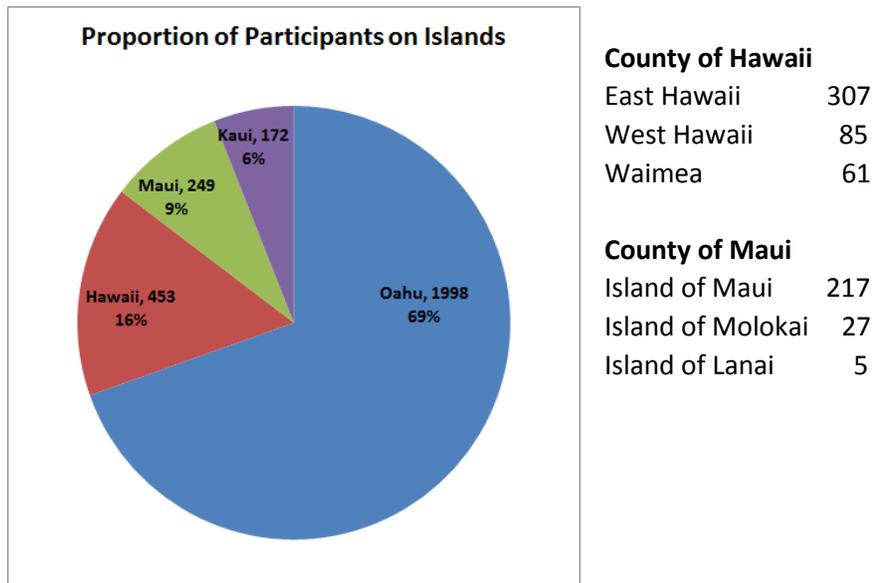
- Q28.** Previously, hotline calls that were stabilized over the phone could not be billed, has this changed? May we now bill for these calls?
- A.** You may propose to bill for Crisis Telephone Hotline (CTH) calls since the staff has to provide that service and we see answering the call as a service as described in the RFP. With the service requirements, and often depending on what that intervention is, you could sometimes prevent having to dispatch mobile crisis outreach staff.
- Q29.** As a follow up to the previous question, is there a reimbursement methodology, or can we propose one for actual proactive outreach with the call center? Using previous claims data or other information we're often able to identify folks who may be at risk of escalating so we'll often do proactive outreach to help maintain that placement through the telephonic outreach.
- A.** It would appropriate to propose that.
- Q30.** What happens, because we currently have a contract that expires December 28th, if for some reason, something happens with the timeline and the new contract is not awarded by December 28th? Have you exhausted your options to extend?
- A.** There is no extension option beyond December 28, 2016.
- Q31.** Are you guys asking for a specific amount of beds (for the crisis shelter)?
- A.** The limits of the license (for the crisis shelter) would primarily dictate that. We did not specify in the RFP, but we would like to see this in the proposals.
- Q32.** This (Crisis Services RFP) is just a piece of the previous contract, are you planning on having more RFP's on services that the previous contract had for training & consultation (T&C), and children TLP?
- A.** Not at this time. The children's TLP is not a part of this crisis services RFP.
- Q33.** There was mention of the urgency for Dec. 28, is there a specific reason for that?
- A.** Yes, our current crisis services contract will end on December 28, 2016, so we need to contract to ensure continuity of care.
- Q34.** This service is this aimed at only adults or children and adults?
- A.** It is aimed for children and adults for Crisis Telephone Hotline and Crisis Mobile Outreach, but not the crisis shelter (also referred to as out-of-home stabilization) which is only for adults.
- Q35.** Regarding family therapy or all the small components, is it going to be separate through Medicaid waiver or all inclusive?
- A.** It will be inclusive under the emergency waiver rate.

- Q36.** Is it up to a certain time period after discharge (from the crisis shelter) or is it going to be ongoing?
- A.** Post discharge, DDD may authorize Training and Consultation to support the fading of crisis support. This will be individualized based on the needs of each participant. For non-Waiver participants, the proposal can address this phase of service and associated costs.
- Q37.** Regarding the credentials for the direct care staff, is everybody at a bachelor's level?
- A.** Yes. Our goal is to make shelter very short term and our approach is that qualified staff can best support this model.
- Q38.** There is no page limit?
- A.** We did not specify a page limit.
- Q39.** I did see you guys are going to take into account outer islands and rural areas where it does take longer to go on crisis visits.
- A.** Yes and that is addressed in the RFP.
- Q40.** Is there a different rate so to speak, say if it is farther out and you do have to go further or is it just...?
- A.** Currently the waiver does not have different rates. The DDD is conducting a rate study and based on influencing cost factors, we may have differential rates.
- Q41.** Now there is a neighbor island rate that is attached to training consultation and emergency outreach, is that something that is going to continue or that something that was taken out of the new waiver?
- A.** New rates will be determined through the rate study process, and will be implemented through a waiver amendment.
- Q42.** Because I live on the Big Island and I know how difficult it is to access services, would it count against the proposal if adding staffing in rural areas to provide some of the services?
- A.** We would like respondents to propose solutions to meet challenges in providing services in rural areas.
- Q43.** You touched on rural nature of some of the neighbor isles, can we propose partnering with providers if we provide necessary training to serve the mobile outreach?
- A.** That would probably be considered a subcontract and is allowed in the RFP.

RFP 501-17-02 written questions and answers

Q44. According to information shared at the informational session on August 4, the Crisis program is expected to serve approximately 3,000 people. Can you provide a geographic distribution of where people who will be served live across the islands? This will help in making informed decisions for staffing and travel requirements.

A. The population numbers of participants who receive services from the Developmental Disabilities Division fluctuates, and is currently around 2,880 individuals. The chart below illustrates the geographic location of these individuals and the list to the right of the chart gives a further breakdown of the specific location of participants who reside in the County of Hawaii and the County of Maui.



Q45. What is the approximate breakdown of the number of individuals under 18 and the number 18 or over?

A. As of 8/9/16, Age 18 and younger: **317**; Age 18.01 and older: **2473**

Q46. Is the CMO expected to provide transport to Emergency, Inpatient or OHS facilities or from the facility post-discharge?

A. On rare occasions when the participant cannot be stabilized over the phone, “the CMO is deployed to provide face-to-face on-site response and supports to participants and families experiencing an active crisis...” Please see pages 2-18 to 2-20 regarding CMO in the RFP. The CMO, after assessment, should de-escalate the situation, and if these efforts were not successful, may refer the participant to OHS. If the participant is violent, assaultive and/or are in need of medical care, the CMO makes arrangements for a higher level of care by calling 911 for emergency care. Page 2-19, item (12) states CMO must make “Complete arrangements, including transportation, for more intensive services, such as OHS or hospitalization, in the event the CMO services are not sufficient to stabilize”. Transport post-discharge should be a part of the participant’s discharge plan under OHS pages 2-20 - 2-24 of the RFP.

- Q47.** Are people living in group homes, ICFs or other congregate or facility settings part of the expected Services?
A. Yes, but OHS is for adults only (18 years old or older).
- Q48.** Can individuals/guardians/family members refer to the crisis line?
A. Participants and their families or caretakers may call the crisis telephone hotline.
- Q49.** What is the expectation for training the CTH will provide to parents/families/guardians or existing IDD providers across the islands and what is the funding mechanism for reimbursement for these services? Will they be covered by the waiver?
A. There is no expectation for training outside of what is stated in the RFP.
- Q50.** Is there an expected minimum or maximum budget?
A. DDD's maximum budget for the State portion (cost reimbursement) is \$600,000/year.
- Q51.** Are Shared Savings or Value Based Payments an option?
A. For the initial year of the contract, billing will need to be consistent with current practices. However, alternative payment options may be modified upon agreement by involved parties.
- Q52.** Can we recommend a payment methodology for incoming and outgoing calls from a Triage Center that do not result in a mobile team dispatch?
A. Yes.
- Q53.** What current EMR system are providers using or others in the system using?
A. There are variable systems maintained by each agency.
- Q54.** Is there an expectation they will get on the CTH platform if any?
A. No.
- Q55.** Is there any existing claims, inpatient or other crisis system utilization data we can review, including diagnoses codes?
A. No, this data has not been tracked.
- Q56.** Is there any information or historical call data or data regarding mobile team dispatches available?
A. No, this data has not been tracked.
- Q57.** Is there any information or historical data on the number and frequency of individuals referred in to facilities over the last 12-60 months?
A. No, this data has not been tracked.

Q58. Will there be data sources we can use for claims history?

A. No, this data has not been tracked.

Q59. Are there existing MCOs, Commercial Insurers or other managed care entities we will need to coordinate with?

A. If the participant has medical or psychiatric services, there may be instances that require coordination.

Q60. What is your expectation for OHS facilities? For example the number of beds per facility, number of facilities per island, staffing ratios per facility, or other security and/or facility requirements.

A. The limits of the license (for the crisis shelter) would primarily dictate that. We did not specify. We would like people to propose.

Please refer to page 2-27 of the RFP. OHS must be licensed by the Hawaii State Department of Health, Office of Health Care Assurance. State regulations used for licensing will determine the number of beds and other facility requirements.

Q61. Can we recommend alternatives to secure/OHS facilities for the mobile team to refer individuals?

A. OHS is part of what this RFP is seeking.

Q62. Can you describe the current OHS system? Are these public or private facilities or both?

A. OHS (also known as Crisis Shelter) is currently provided by the crisis services provider who has been contracted by DDD.

Q63. Once an individual is referred to and OHS, what is the process to immediately begin working on a plan to transition them back to their least restrictive environment or their home setting?

A. OHS staff should be working with the participant and their circle of supports (including the participants family and case manager) to prepare a "personalized discharge-transition plan."

Q64. If the CTH disagrees with the need to admit an individual to an OHS, what is the process?

A. CTH and CMO must coordinate appropriate services for the participant. See coordination sections on page 2-18 and 2-20 under CTH and CMO respectively.

Q65. Paragraph two of item #3 on page 23 of the RFP states: "OHS services receive referrals from the CMO and will work with the family and care team on gathering information, assessment, treatment, placement, and transition upon discharge. Being time-limited, these services focus on the goal of reintegration of the individual in the community from the moment of admission. These services will also provide support to family members and caregivers along with training and consultation both while the individual is at OHS and will continue to support the participant and the participant's circle of supports in the transition process out of OHS."

QUESTION: *Regarding this section, can you describe who is currently, or will be expected to be responsible for follow-up post-crisis or post-discharge from OHS?*

A. Please see page 2-20 to 2-24 of the RFP. OHS staff is expected to provide a personalized discharge-transition plan for the participant with the participant's circle of supports. The plan is to specify assignments, roles and responsibilities to implement the discharge-transition plan to support the participant so that crisis support will "fade in 90 days." See answer to Q36.

Q66. Also, is there an expectation of follow-up engagement from either the CTH or CMO once an individual has been placed in OHS? Either during the person's OHS stay or afterwards?

A. Yes, to ensure that the participant's needs are met.

Q67. If CTH/CMO believes ongoing follow-up would benefit the individual what is the process/funding for these services?

A. Post discharge, DDD may authorize Training and Consultation to support the fading of crisis support. This will be individualized based on the needs of each participant. For non-Waiver participants, the proposal can address this phase of service and associated costs.

Q68. Is there an expectation for sustained but time limited follow-up with an individual once they have been stabilized or discharged from either a crisis situation or an OHS facility? If so, what is the funding mechanism? If there is not an expectation or a funding mechanism, can we recommend a process and funding?

A. Yes, there are expectations for follow-up with a participant once they are stabilized and discharged for OHS facility. Please look over pages 2-20 to 2-24 on OHS for these expectations. The funding mechanism for post-discharge is Training and Consultation for waiver participants as authorized in the participants Individualized Service Plan. RFP respondents may propose cost and service delivery for non-waiver participants.

Q69. If there is a current Crisis system, how does it integrate/collaborate with current IDD providers as well as the DD Council or the Disability Rights Center?

A. DDD Case Managers provide coordination with other DDD providers. If DD Council or Hawaii Disability Rights Center have involvement with individual participants, this coordination is also done through the DDD Case manager.

Q70. Is the DDD Case Manager a State employee or employed by a private agency or both?

A. The DDD Case Manager is a State employee.

Q71. What is the expectation of CTH coordination with the DDD Case manager during and after a crisis response?

A. See item “f. Coordination” on page 2-18 as well as Page 2-16 to 2-18 on CTH in the Crisis Services RFP.

Q72. PAGE 29 – States when a CMO is not dispatched it is not billable to the waiver. Our organization’s Crisis Call Center is structured to avoid CMO dispatches wherever possible and has proven successful in de-escalation, often without CMO dispatches being necessary.

QUESTION: If we engage in calls with no dispatch, can we recommend a funding system for telephonic-only interventions?

A. You may propose to bill for these calls since the staff has to provide that service. We do see answering the call as a service. With service requirements, and often depending on what that intervention is, you could sometimes prevent having to dispatch somebody. This is very important, and we have built in assessment features so we do see that as being a service.

Q73. Will the division consider proposals exceeding the “Approximate funding per year: \$600,000”?

A. DDD’s maximum budget for the State portion (cost reimbursement) is \$600,000/year.